Report of the Ministerial Taskforce on Nursing

Releasing the potential of nursing
Disclaimer

The opinions expressed in this report are those of the Ministerial Taskforce on Nursing and do not necessarily represent the views of the Minister of Health or the Ministry of Health.
FOREWORD

In February this year I announced the establishment of the Ministerial Taskforce on Nursing to undertake the first major review of nursing in New Zealand for more than 15 years.

I chose to establish the Taskforce in response to calls from nurses and nursing organisations who had been telling me that there were obstacles to the nursing profession realising its full potential with respect to health service delivery. I thought it was important to make sure that the health sector effectively uses what nurses have to offer.

I believe that there can be much smarter utilisation of nursing skills. The nursing profession needs to continue to adapt to meet the challenge of radically changing delivery of health care.

My intention was that the Taskforce would consider a whole cluster of inter-related issues pertaining to health care and nursing. The Taskforce has now completed that exercise and this report documents their findings, recommendations for the Minister of Health, and suggested strategies for change.

The Taskforce has faced a mammoth task and a short timeframe. I am aware of the many hours of work which the Taskforce members have put into meetings, consultation and drafting this report. The completion of this report is no small measure of the dedication shown by those involved.

The process employed by the Taskforce has encouraged dialogue and has brought the issues to the attention of some of the key players. It is my hope that the release of this report will continue to encourage debate and discussion about the role and potential of nursing. I hope that nurses will take the time to read this document and think about the opportunities for them to help paint the picture of a health sector which can deliver quality health services in a more responsive, innovative, effective, accessible and collaborative manner.

I look forward with interest to considering the recommendations and strategies contained in this report.

Hon Bill English
Minister of Health
PREFACE

The Minister of Health has shown international leadership in commissioning a Ministerial Taskforce on Nursing. We were charged with identifying the barriers that prevent nursing from improving the service to its patients and devising strategies to remove those barriers. This has been a unique opportunity to develop a context in which the full potential of nursing can be realised. Further, to ensure that this report represents the opinions of nurses and not just members of the Taskforce, we undertook an extensive consultation process.

The Taskforce members have been greatly assisted by the willingness and enthusiasm which nurses and the wider health and disability sector have demonstrated in the consultation process. We have been impressed by the challenge of most organisations to accept the terms of reference of the Taskforce and to work constructively and in a forward-looking way with colleagues. Compromise, in the name of finding consensus has, with one exception, been a positive and unifying experience.

Unfortunately, in spite of considerable effort and weeks of discussion, we were unable to find consensus with the New Zealand Nurses Organisation (NZNO). The NZNO has been part of the Taskforce for the last five months and hence was privy to all negotiations and documentation from the outset. Many changes were made to drafts of this report to accommodate the concerns of the NZNO. The outstanding issues, as far as we can determine, relate primarily to the status and role of the NZNO rather than to the Taskforce’s terms of reference or to patient outcomes.

The NZNO is the largest nursing organisation in New Zealand. This does not mean that it is the only organisation that can represent nurses. The unwillingness of the NZNO to join consensus in forward-looking recommendations is, in the Taskforce’s view, itself a major barrier to progress for nursing practice in New Zealand.

The Taskforce believes that the opportunity to improve the nursing service to the New Zealand community is through the recommendations in this report. We urge nurses to read the report and to judge it on its own merits. It is with great regret that we must present this report without the support of the NZNO.

This report begins by drawing attention to the breadth and depth of the contribution that nurses make to health services in New Zealand. The quality of nursing care in New Zealand is high and patients frequently acknowledge the commitment, dedication and skill of the nurses who have cared for them.

However, the roles of nurses are changing rapidly with advancements in technology and other developments in methods of health service delivery. The level of need of individuals and communities is also increasing. Our discussion highlights barriers which are preventing the full potential of nursing from being realised, in both the current environment and in the health system of tomorrow.

The focus of the report is on the major barriers and strategies for change that will enable registered nurses to contribute to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders. There are other barriers and strategies which the nursing profession itself needs to address.
The implementation of the recommendations proposed in this report will make the first – but essential – step toward a more effective and innovative nursing workforce. This report lays the foundation for the maintenance and development of a safe and effective nursing workforce into next century. It also builds a clear pathway for those nurses who wish to further their career through advanced and specialist nursing. The Taskforce issues a challenge to nurses to take up the new opportunities that implementation of these recommendations will present.

Hon Dame Ann Hercus  
(Chair 23 February – 30 June 1998)

Toni Ashton  
(Chair 1 July – 21 July 1998)
Dear Minister,

We have much pleasure in presenting to you our report on releasing the potential of nursing. Nurses represent the largest part of the professional health workforce: there are over 40,000 registered nurses in New Zealand, about 29,000 of whom are currently practising. Our consultation process has revealed that there are real barriers to nurses providing an effective and innovative service. While there are barriers to nursing developing to its full potential, there are also many strategies that will address these barriers.

The Taskforce has consulted as widely as possible with both individual nurses and interest groups who have close associations with the nursing workforce. A number of recurring themes emerged during this consultation process. We have categorised these themes under six headings: the scope of nursing practice; access to funding; education; research; management and leadership; and workforce issues. There are in addition a set of issues which relate specifically to Māori nursing but which cut across these six broad categories.

The problems that emerged are complex and interwoven. This means that the strategies we recommend are inter-related (and sometimes interdependent). If the full potential of nursing is to be released, it is imperative that these strategies are implemented in a planned and unified way. The Taskforce respectfully urges you to act upon our recommendations.

Hon Dame Ann Hercus
(Chair 23 February – 30 June 1998)

Toni Ashton
(Chair 1 July – 21 July 1998)
THE TASKFORCE AND ITS TASK

The Ministerial Taskforce on Nursing was established in February 1998 by the Minister of Health, the Hon Bill English, in response to a consensus proposal from nursing leadership and nursing organisations a month earlier. The Minister gave the Taskforce the following terms of reference:

To recommend strategies to remove the barriers which currently prevent registered nurses from contributing to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders.

In addition, the following conditions were placed on the work of the Taskforce:

1. That issues relating specifically to midwifery practice were outside the brief of the Taskforce. This decision was reached in conjunction with the New Zealand College of Midwives.

2. That issues relating specifically to enrolled nurses were outside the brief of the Taskforce. This decision was reached in conjunction with the New Zealand Nurses Organisation (NZNO).

THE TASKFORCE MEMBERSHIP

The Minister appointed nine members to the Taskforce. They are:

The Hon Dame Ann Hercus (chairperson from 23 February to 30 June 1998):

Toni Ashton
Health Economist, University of Auckland (chairperson from 1 July to 21 July 1998)

Dr Jenny Carryer
Lecturer (Nursing), Massey University
Executive Director, College of Nurses Aotearoa (New Zealand)

Beth Cooper-Liversedge
Clinical Director, Nursing & Professional Practice, Good Health Wanganui
Nurse Executives of New Zealand

Frances Hughes
Chief Nursing Advisor, Ministry of Health

Judy Kilpatrick
Head of School, Nursing and Midwifery, Auckland Institute of Technology
Chairperson, Nursing Council of New Zealand

1 Dame Ann retired as chairperson on 30 June because of her departure to Cyprus to take up a United Nations appointment.
The Taskforce has been supported by its secretariat within the Ministry of Health: Sheila Swan and Benedict Hefford.

THE TASKFORCE’S APPROACH

The Taskforce was formally established by the Minister of Health, the Hon Bill English, on 23 February 1998 and was required to report to the Minister with recommendations by 30 June 1998. The reporting date was subsequently extended to 21 July.

It was immediately evident that the Taskforce had a very large task to accomplish within a very short timeframe. Despite these time pressures, the Taskforce decided that extensive consultation needed to be at the heart of its approach – consultation with individual nurses, nursing groups, Māori, health and disability services agencies, Government agencies, providers and others. There were two reasons for this:

✦ to ensure that as many voices as possible had the opportunity to contribute their perspective to the work of the Taskforce, adding considerable value and depth to the knowledge within the Taskforce
✦ to provide an indication of the likely support for the changes that would arise from the Taskforce’s recommendations. If nursing is to move forward to make a fuller contribution to the delivery of health and disability services, there must be support for this throughout the different areas of nursing, within decision-making bodies, and within key stakeholder organisations.

The consultative processes used by the Taskforce in formulating its report meant that it was able to reach beyond the issues of a single occupational group. Instead, it has touched upon every facet of the health and disability services sector because nurses in their daily work are found in every part of the sector.

The range and depth of these consultative processes convinces the Taskforce that its recommendations accurately reflect the current issues within nursing, and reveal the future potential for nursing to contribute ‘to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders’. The Taskforce has subjected its findings to considerable debate and discussion, and believes its final recommendations to the Minister are sound, robust and capable of being actioned without delay.
THE TASKFORCE CONSULTATION PROCESS

To develop a consultative process that was genuinely wide-ranging and soundly based, the Taskforce decided on five separate streams of consultation:

Consultation with individual nurses

The Taskforce decided from the outset that consultation with individual nurses was central to its work. To this end, more than 30,000 one-page questionnaires, with a covering letter explaining the Taskforce’s terms of reference, were mailed out to individual nurses through existing networks. The Taskforce deeply appreciates the help given by the New Zealand Nurses Organisation, the College of Nurses Aotearoa (New Zealand), the Australia and New Zealand College of Mental Health Nurses and the Nurse Executives of New Zealand in distributing the questionnaires.

The Taskforce was pleased by the level of response it received from individual nurses, and by the high level of agreement amongst them. This has greatly assisted the work of the Taskforce, by providing clear themes that have shaped the direction of the report.

The Taskforce wishes to thank the individual nurses who contributed to this process. It was evident that many took a great deal of time and effort – especially those who forwarded detailed submissions.

Consultation with agencies in the health and disability services sector

Over 400 sector agencies were invited to make a submission to the Taskforce. These agencies were sent the same questionnaire that was sent to individual nurses, along with a covering letter outlining the purpose of the Taskforce and its terms of reference.

The range of agencies invited to make submissions was diverse. It included nursing organisations, Government departments, Government agencies, medical organisations, Māori provider groups, Pacific Island provider groups, and a number of other organisations with an interest in the health and disability services sector.

The submissions received from these groups contained much valuable information about the sector as a whole, and about the function of nursing within the sector.

Consultation with key stakeholder agencies

The Taskforce recognised that there were a handful of agencies who had key roles within the health and disability services sector and who would have insights that would be particularly relevant to the work of the Taskforce. Representatives of these agencies were invited to attend a Taskforce meeting to discuss key issues. A similar invitation was also extended to a limited number of organisations whose written submissions highlighted areas that the Taskforce wished to discuss in further depth.

The following key stakeholder agencies met with the Taskforce during this process: the Accident Rehabilitation and Compensation Insurance Corporation (ACC), the Health Funding Authority (HFA), the Ministry of Women’s Affairs, the New Zealand Public Service Association, the New Zealand Nurses Organisation, the Health Research Council, Health
Consultation with Māori

At its first meeting, the Taskforce explicitly acknowledged two facts: that both the Ministry of Health and the Taskforce itself endorse the partnership relationship expressed in the Treaty of Waitangi; and that the Taskforce considered itself bound by the Treaty relationship. In support of this, the Taskforce took the following decisions:

- to offer full support to Denise Wilson (Ngāti Tāhinga), and to acknowledge her leadership within the Taskforce on issues for Māori
- to set aside the same budget for Māori hui as for focus groups
- to seek advice on consultation procedures.

The Taskforce wishes to acknowledge and thank Te Puni Kōkiri and Te Runanga o Aotearoa of the New Zealand Nurses Organisation for their valuable help and support in planning and undertaking consultation with Māori. With the assistance of Te Puni Kōkiri the Taskforce undertook a series of six hui with groups of Māori nurses and other interested Māori around New Zealand. The issues raised in the hui are detailed in Chapter 8.

Consultation with focus groups

From the outset, focus groups were planned as an integral part of the Taskforce’s approach: they were to be the means of gaining greater ‘depth’ on specific issues. Once its initial analysis of individual submissions was completed, the Taskforce undertook a series of 10 focus-group meetings throughout New Zealand. The Taskforce did not attempt to invite every nurse leader to focus groups; instead it attempted to cover the spectrum of nursing practice across the country. Nurses were invited to attend focus groups according to their area of expertise.

The Taskforce is extremely grateful to all of those who attended focus groups – especially those who had to travel long distances to do so. We also appreciate the efforts of organisations who made their facilities available for the focus groups.

Further detail about the consultation process can be found in the Appendices.
THE TASKFORCE’S REPORT

These five streams of consultation outlined above were more than the sum of their parts: they were an interweaving of common themes that emerged in many different ways and from many different voices.

The consultative process therefore provided a vast wealth of information and opinion to the Taskforce. In addition, the Taskforce has undertaken a literature review and has drawn upon its own knowledge and experience. These processes have come together to form the analysis and recommendations in this report.

The Taskforce considered all the information that came to its attention and then worked within the terms of reference to produce this report. This report is not a critique of current nursing initiatives and good practice in New Zealand. It is focused on barriers and strategies to advancing nursing practice.

The report of the Taskforce, which follows, begins with recommendations to the Minister. The Taskforce’s analyses of the barriers that prevent nursing from making a greater contribution to health care in New Zealand, and the strategies for change that form the basis for the Taskforce’s recommendations, are contained in the subsequent eight chapters.
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>3</td>
</tr>
<tr>
<td>Preface</td>
<td>5</td>
</tr>
<tr>
<td>Letter of Transmittal</td>
<td>7</td>
</tr>
<tr>
<td>The Taskforce and its Task</td>
<td>8</td>
</tr>
<tr>
<td>The Taskforce Membership</td>
<td>8</td>
</tr>
<tr>
<td>The Taskforce's Approach</td>
<td>9</td>
</tr>
<tr>
<td>The Taskforce's Report</td>
<td>12</td>
</tr>
<tr>
<td>Recommendations</td>
<td>15</td>
</tr>
<tr>
<td>The Ministry of Health (Manatū Hauora)</td>
<td>15</td>
</tr>
<tr>
<td>Health Funding Authority (HFA)</td>
<td>16</td>
</tr>
<tr>
<td>Ministry of Women’s Affairs</td>
<td>17</td>
</tr>
<tr>
<td>Clinical Training Agency (a Division of the HFA)</td>
<td>17</td>
</tr>
<tr>
<td>Accident Rehabilitation and Compensation Insurance Corporation (ACC)</td>
<td>17</td>
</tr>
<tr>
<td>Directors of Area Mental Health Services (DAMHS)</td>
<td>18</td>
</tr>
<tr>
<td>Nursing Council of New Zealand (the Council)</td>
<td>18</td>
</tr>
<tr>
<td>Health Research Council (HRC)</td>
<td>19</td>
</tr>
<tr>
<td>Ministry of Education</td>
<td>19</td>
</tr>
<tr>
<td>New Zealand Insurance Council and the New Zealand Hospitals Association</td>
<td>19</td>
</tr>
<tr>
<td>Nurse Executives of New Zealand and Nurse Educators in the Tertiary Sector</td>
<td>19</td>
</tr>
<tr>
<td>Continuation of the Taskforce</td>
<td>19</td>
</tr>
<tr>
<td>1 Introduction</td>
<td>20</td>
</tr>
<tr>
<td>1.1 Nursing in the Context of Health Care</td>
<td>21</td>
</tr>
<tr>
<td>1.2 Measuring the Difference that Nursing Makes</td>
<td>23</td>
</tr>
<tr>
<td>2 Expanding the Scope of Nursing</td>
<td>26</td>
</tr>
<tr>
<td>2.1 The Development of New Nursing Roles</td>
<td>26</td>
</tr>
<tr>
<td>2.2 Prescribing Rights, Diagnostic and Laboratory Tests, and Specialist Referrals</td>
<td>30</td>
</tr>
<tr>
<td>2.3 Responsible Clinicians</td>
<td>33</td>
</tr>
<tr>
<td>2.4 Nursing Competencies</td>
<td>34</td>
</tr>
<tr>
<td>2.5 Strategies for Change</td>
<td>35</td>
</tr>
<tr>
<td>3 Access to Funding</td>
<td>39</td>
</tr>
<tr>
<td>3.1 Access to HFA Funding</td>
<td>39</td>
</tr>
<tr>
<td>3.2 Access to ACC Funding</td>
<td>41</td>
</tr>
<tr>
<td>3.3 Access to Private Insurers</td>
<td>42</td>
</tr>
<tr>
<td>3.4 Strategies for Change</td>
<td>43</td>
</tr>
<tr>
<td>4 Education</td>
<td>47</td>
</tr>
<tr>
<td>4.1 Undergraduate Education</td>
<td>47</td>
</tr>
<tr>
<td>4.2 The First Year of Clinical Practice</td>
<td>52</td>
</tr>
<tr>
<td>4.3 Postgraduate Education</td>
<td>54</td>
</tr>
<tr>
<td>4.4 Strategies for Change</td>
<td>57</td>
</tr>
</tbody>
</table>
5 Research
5.1 The Extent of Nursing Research 62
5.2 The Use of Nursing Research 63
5.3 Strategies for Change 64

6 Management and Leadership 66
6.1 Nursing Involvement in Policy and Health-Care Strategy 66
6.2 Nursing Leadership 68
6.3 Leadership Development 69
6.4 Strategies for Change 70

7 Workforce Resourcing 73
7.1 Stress Resulting from Working Conditions 74
7.2 Clear Career Pathways 75
7.3 Systems for Costing Nursing Services and Determining Skill Mixes 76
7.4 Information Systems for Future Workforce Needs 77
7.5 Strategies for Change 77

8 Issues for Māori 80
8.1 Representation and Consultation 81
8.2 Education 82
8.3 Research 84
8.4 The Framework within which Health Services are Delivered 85
8.5 Leadership 86
8.6 Strategies for Change 87
8.7 Recommendations from the Hui 87

Appendices
Appendix 1: Individual submissions 90
Appendix 2: Organisations which made written submissions to the Taskforce 93
Appendix 3: Organisations which made oral submissions to the Taskforce 96
Appendix 4: Individuals consulted during the hui held by the Taskforce with the assistance of Te Puni Kōkiri (the Ministry of Māori Affairs) 97
Appendix 5: Individuals consulted during focus groups held by the Taskforce 98
Appendix 6: The Taskforce process 99

References 100
RECOMMENDATIONS

In making its recommendations to the Minister of Health, the Taskforce stresses that the issues raised in this report are multi-dimensional and interwoven. In turn, the strategies require a high degree of collaboration between agencies and professional groups. It is imperative that the strategies are implemented in a cohesive manner. The contribution that nursing can potentially make to a more responsive, innovative, effective, efficient, accessible, and collaborative health-care service for New Zealanders will be less if strategies are chosen and implemented in a fragmented and piecemeal fashion.

THE MINISTRY OF HEALTH (MANATU HAUORA)

The Taskforce recommends that the Minister of Health require the Ministry of Health to:

1. design an overarching framework for occupational regulation, which allows the requirements recommended in the review of the Nurses Act 1977 to occur. We recommend an approach that best achieves the following objectives:
   - speedy implementation
   - consistency across professions
   - flexibility (in allowing new areas of practice to develop)
   - consumer safety
   - accountability (Strategy 6, Chapter 2, section 2.5).

2. take responsibility for initiating the legislative change necessary to ensure that nurses have legal protection similar to that offered to medical practitioners (under the Medical Practitioners Act 1995) when undertaking quality audit procedures (Strategy 3, Chapter 2, section 2.5).

3. urgently address the current limitations of the Nurses Act 1977 which prevent the Nursing Council enforcing competency-based practising certificates and specialist and advanced competencies for practitioners. The Ministry will be required to address this issue in advance of the review proposed above in point one (Strategy 6, Chapter 2, section 2.5).

4. actively encourage and support nursing groups to submit proposals for other scopes of practice to be considered for nurse prescribing; and provide advice on how these can gain approval without each having to be considered separately by Cabinet (Strategy 1, Chapter 2, section 2.5).

5. develop a memorandum of understanding between the Ministry of Health and nursing organisations which emphasises and formalises the contribution nurses can make to policy (Strategy 1, Chapter 6, section 6.4).

6. require the Chief Nursing Advisor and Te Kete Hauora (the Māori health group within the Ministry of Health) to work with the Māori Health Commission, Te Punī Kōkiri and national nursing groups representing Māori nurses to develop a plan and a process for furthering the recommendations contained in Chapter 8.
7. work with the Ministry of Education to review the current arrangements for the purchase of undergraduate clinical training; in particular, investigating the cost implications created by the original unbundling exercise (Strategy 1, Chapter 4, section 4.4)

8. facilitate a process with the Crown Health Association and nursing organisations to discuss issues surrounding clinical career pathways, and an acuity system, for nurses and their impact on clinical practice. This will build on the existing work already achieved by the New Zealand Nurses Organisation and the Nurse Executives of New Zealand (Strategy 2, Chapter 7, section 7.5).

9. work with the Ministry of Education in undertaking a review of the number of polytechnics offering undergraduate nursing programmes, for the purposes of ensuring the provision of education and clinical experience of a high quality which matches the needs of the health and disability services sector (Strategy 1, Chapter 4, section 4.4)

10. undertake policy development work in consultation with the Ministry of Education and the Clinical Training Agency to review the current policy that the Clinical Training Agency be responsible for the funding of post-entry programmes in which 30 percent or more of the total programme is clinical experience (Strategy 4, Chapter 4, section 4.4).

**Health Funding Authority (HFA)**

The Taskforce recommends that the Minister of Health require the HFA to:

1. make policy changes which allow nurses to order laboratory and diagnostic tests, and specialist-referral rights (Strategy 2, Chapter 2, section 2.5)

2. encourage the primary-care organisations with which it contracts to make more effective use of practice nurses, including direct access to nurses by patients and including nurses within management structures (Strategy 3, Chapter 3, section 3.4)

3. make the policy changes necessary to allow practice-nurse services to be purchased directly by the HFA in those situations where the general practice continues to receive the General Medical Services benefit (Strategy 1, Chapter 3, section 3.4)

4. fund and support the development of a project group to develop costing models for nursing services and the contribution that nursing services make to consumer care. The outcome of the project group will be a tool to assist the HFA in costing the services they provide (Strategy 3, Chapter 7, section 7.5)

5. re-prioritise in order to fund and support the development of nurse-led services (Strategy 2, Chapter 3, section 3.4); in particular:
   a) nurse-led integrated services, similar to the nurse-led pilots currently operating in the United Kingdom
   b) innovative services in identified ‘health-gain’ areas
   c) services that assist in developing clinical experience for nurses, for example, community health centres (Strategy 2, Chapter 4, section 4.4).
These nurse-led projects will need financial support similar to that provided to Independent Practitioner Associations during their establishment phase, and developmental support as nurses establish familiarity with the required information systems requirements, contracting and negotiation skills, and evaluation and monitoring skills. The HFA will undertake a project management role in the initial stages of establishment.

6. develop an HFA organisational policy which requires involvement of, and advice from, nurses and nursing organisations on all health and disability policies, funding strategies, standards-development and service specifications

7. re-prioritise in order to fund and support senior clinical nurses to undertake management and leadership education (Strategy 3, Chapter 6, section 6.4; Strategy 5, Chapter 8, section 8.7).

**MINISTRY OF WOMEN’S AFFAIRS**

The Taskforce recommends that work, led by the Ministry of Women’s Affairs, be undertaken on gender barriers and work-measurement systems as they relate to nursing, with particular reference to the future forecasting of the nursing workforce (Strategy 4, Chapter 7, section 7.5). The Ministry of Women’s Affairs will need to work with the proposed Māori issues inter-agency team in addressing issues which impact particularly on Māori (Strategy 4, Chapter 8, section 8.7).

**CLINICAL TRAINING AGENCY (A DIVISION OF THE HFA)**

The Taskforce recommends that the Minister of Health require the Clinical Training Agency, via the Chief Executive Officer of the HFA, to:

1. work with nursing organisations to develop and fund a national framework for the first year of clinical practice (Strategy 2, Chapter 4, section 4.4)

2. undertake policy development work in consultation with the Ministry of Health and the Ministry of Education, to review the current policy that the Clinical Training Agency be responsible for the funding of post-entry programmes in which 30 percent or more of the total programme is clinical experience (Strategy 4, Chapter 4, section 4.4)

3. examine urgently the inadequate funding of postgraduate nursing education, to ensure that any decisions are in line with the broad principles outlined by the Taskforce in this report (Strategy 4, Chapter 4, section 4.4).

**ACCIDENT REHABILITATION AND COMPENSATION INSURANCE CORPORATION (ACC)**

The Taskforce recommends that the Minister of Health encourage ACC to:

1. work with the Nursing Council and nursing organisations to clearly identify the services ACC wishes to purchase from nurses and the competencies required to deliver those services (Strategy 4, Chapter 3, section 3.4)
2. continue the initiative in moving away from fee-per-treatment funding toward funding on a ‘case’ basis (Strategy 5, Chapter 3, section 3.4)

3. continue to improve their focus on purchasing preventive services (Strategy 5, Chapter 3, section 3.4)

4. take responsibility for initiating legislative change to the General Practitioner Cost Regulations (1993), which will allow nurses to claim reimbursement from ACC for injury-related assessment or treatment services in primary care settings (Strategy 4, Chapter 3, section 3.4)

5. take responsibility for initiating legislative change to the Referred Treatment Cost Regulations (1990), which will allow nurses to be identified as preferred providers of ACC services (Strategy 4, Chapter 3, section 3.4).

DIRECTORS OF AREA MENTAL HEALTH SERVICES (DAMHS)

The Taskforce recommends that the Minister of Health, through the Director of Mental Health, direct the DAMHS to develop a clear and transparent process for the appointment of responsible clinicians under the Mental Health (CAT) Act 1992. This process is to reflect the spirit of the Act (Strategy 5, Chapter 2, section 2.5).

NURSING COUNCIL OF NEW ZEALAND (THE COUNCIL)

The Taskforce recommends that the Minister of Health direct the Council to:

1. develop and, immediately following the required legislative change in the Ministry of Health recommendation 4 above, implement competency-based practising certificates for all registered nurses (Strategy 6, Chapter 2, section 2.5)

2. work with nursing organisations, agencies in the health and disability services sector, and postgraduate education providers to develop, recognise and validate specialist competencies, within a larger framework, which are linked to nationally consistent titles (Strategy 6, Chapter 2, section 2.5)

3. work with ACC to clearly identify the services which ACC wishes to purchase from nurses and the competencies required to deliver those services (Strategy 4, Chapter 3, section 3.4)

4. urgently audit schools of nursing on the teaching of competencies for mental-health nursing that were developed in 1997 and incorporated into the undergraduate curriculum; and report on this to the National Mental Health Workforce Co-ordinating Body and the Ministry of Health (Strategy 1, Chapter 4, section 4.4)

5. establish accreditation criteria for community-based clinical settings to allow nurses to more readily specialise in community care (Strategy 2, Chapter 4, section 4.4).
HEALTH RESEARCH COUNCIL (HRC)

The Taskforce recommends that the Minister of Health request the HRC to give priority to establishing, funding and supporting a nursing research centre. Such a centre would require support to eventually become self-funding (Strategy 1, Chapter 5, section 5.3; Strategy 3, Chapter 8, section 8.7).

MINISTRY OF EDUCATION

The Taskforce recommends that the Minister of Health invite the Minister of Education to:

1. co-operate with him in endorsing a joint Ministry of Health and Ministry of Education undertaking to review the number of polytechnics offering undergraduate nursing programmes, for the purposes of ensuring the provision of education and clinical experience of a high quality which matches the needs of the health and disability services sector (Strategy 1, Chapter 4, section 4.4)

2. undertake policy development work in consultation with the Ministry of Health and the Clinical Training Agency, to review the current policy that the Clinical Training Agency be responsible for the funding of post-entry programmes in which 30 percent or more of the total programme is clinical experience (Strategy 4, Chapter 4, section 4.4).

NEW ZEALAND INSURANCE COUNCIL AND THE NEW ZEALAND HOSPITALS ASSOCIATION

The Taskforce recommends that the Minister of Health make this report available to the New Zealand Insurance Council and the New Zealand Hospitals Association (Strategy 6, Chapter 3, section 3.4).

NURSE EXECUTIVES OF NEW ZEALAND AND NURSE EDUCATORS IN THE TERTIARY SECTOR

The Taskforce recommends that the Minister of Health encourage the Nurse Executives of New Zealand and Nurse Educators in the Tertiary Sector to meet and consider the development of joint clinical/educator appointments (Strategy 2, Chapter 5, section 5.3).

CONTINUATION OF THE TASKFORCE

The Taskforce recommends that the Minister of Health support and resource the continuation of the Taskforce, in its current form, until March 1999 with the specific objective of overseeing the implementation of the recommendations and strategies in this report.
1 INTRODUCTION

We start from the central question: what is nursing and what can it become? To do justice to this topic requires an in-depth piece of work well beyond the scope of this Taskforce, and indeed, entire textbooks have been written on this topic. We have outlined important descriptions of nursing for non-nurse readers but have avoided using definitions, as these often become limitations in themselves. Our report will explore the nature of nursing, and will chart a path towards making the best use of this valuable resource.

Nurses\(^2\) are present across the entire spectrum of health-service delivery – and, with over 40,000 registered, they are the largest part of the professional health workforce. The most common image of the nurse is in a hospital ward or general practice, but in reality nurses are found in a much wider range of health and disability services settings.

There is a nurse at work in child-health services, residential-care facilities, mental-health services, community services, marae, independent-nurse clinics, public-health services, occupational health and safety, the defence forces, sexual-health services, ACC case management, prisons, policy development and implementation, health-service management, education and research – as well as in many other settings. In all of these areas, nursing knowledge and skill makes a distinctive contribution to the delivery of health care and client outcomes.

From the outset the Taskforce was charged with the task of identifying the barriers that currently prevent registered nurses from improving the service they deliver to New Zealanders. Underpinning such a request is the assumption that nursing has the ability to make a difference to health outcomes, in both acute and community settings. There is limited New Zealand research to clearly justify this assertion, but international research is available, and has been cited.

There are significant pieces of work which demonstrate areas of unmet health need for individuals, groups and communities in New Zealand.\(^3\) Need is often related to service co-ordination, access, transport (particularly in rural areas), socioeconomic status, and poor matching of service need and service provision. This document begins with the premise that nurses – because of their number, distribution and preparation – are a valuable resource to be built on and developed when meeting the health-care needs of New Zealanders.

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\(^2\) The Taskforce looks only at nursing done by registered nurses (with the exception of Chapter 8, where we briefly discuss enrolled nurses in the context of Māori nursing). So, to make this report less cumbersome to read, we will use the word ‘nurse’ to refer to registered nurses, and ‘nursing’ to refer to nursing done by registered nurses.

\(^3\) Some examples of such documents are: Towards a national child health strategy: a consultation document, Wellington: Ministry of Health; The people of the Midland Health region (Te iwi o te waka hauora ki te pukou te ika) A series of reports on the health status of the people of Midland Region; The report of the involvement-in-change conference, Wairarapa Community Health Council (1997); the series of documents produced by the Public Health Commission, which covered many topics including improving and protecting the public health, alcohol use, cannabis and health, cervical cancer, child abuse, child-hearing loss, and fluoride and oral health. The Taskforce is aware that many other documents also detail the mental and physical health status of New Zealanders.
1.1 **Nursing in the Context of Health Care**

Nursing is a combination of many elements: knowledge, styles and models of care, professional codes, clinical skills and attitude. Central to nursing is the client relationship which emphasises continuity of services and care, and provides monitoring and evaluation of all health-care components for that client. Nurses are a continuing presence across the whole spectrum of a client's care, whereas other more specialist health professionals may deal with only specific aspects of that person's care.

In everyday practice, nurses provide a unique contribution to care outcomes through their presence and thoughtful assessment, planning, implementation and evaluation activities which are focused on the 24 hour experience of patients and their families.\(^4\)

Nurses work in collaboration with medical practitioners and other health professionals as part of health-care teams, and they also offer services and skills that complement these other professionals.

While nursing is most frequently practised as a collaborative activity, it is a separate profession with its own body of knowledge. Furthermore, under the Nurses Act 1977, nurses are fully responsible and accountable for their actions. Despite this, there is a widely held belief that medical practitioners carry medico-legal responsibility not only for themselves but also for the actions of nurses - that in some sense the patient 'belongs' to the medical practitioner throughout all stages of care and treatment.

This sense of 'natural' medical leadership also extends into the broader areas of health promotion and health maintenance, even though these are not a significant aspect of medical education and training. By contrast, nursing education - in both theory and practice - specifically addresses the concept of health. The nursing concept of health includes the impact of culture, gender and socioeconomic status on both people's understanding of good health and their access to it. Key areas of nursing involve working alongside people to teach health and safety practices, and helping others to maximise health in difficult circumstances.

In describing what nurses do, the Taskforce became aware of the gap between what nursing is in its intent and theoretical foundation, and the degree to which that potential is lost because many practice settings are powerfully influenced by medical definitions and outcomes. In general practice, for example, not all nurses are able to contribute as full team members because of a combination of factors, such as their limited access to physical workspace and resources, their position as a 'helper' rather than autonomous professional, and the lack of specialist postgraduate education which would enhance their partnership and practice skills.\(^5\)

Students enter nursing programmes with high expectations of making a useful social contribution and providing a caring service from a basis of scientific knowledge. Graduates expect to provide a professional and holistic service, and to be pro-active about social concerns. Research has demonstrated the process by which some nurse graduates relinquish


their theoretical preparation in order to comply with the dominant ethos of the practice setting. Alternatively, some choose to abandon nursing in favour of other careers.

**The Contribution of Nursing**

A series of examples is the best way to show the distinctive qualities of the contribution of nursing. These illustrations of nursing practice are by no means exhaustive.

- The nurse is the health professional who monitors a blood transfusion, who recognises the signs and symptoms of a potential allergic reaction, and who immediately intervenes to prevent possible loss of life.
- The nurse ensures that someone who has just had a stroke does not now have an impaired gag reflex and can safely be fed, so preventing the aspiration pneumonia that could require intensive care and so add thousands of dollars to the cost of treatment.
- It is the public health nurse working in a school who identifies the withdrawn and malnourished child with poor hearing. The nurse will initiate and co-ordinate appropriate interventions for the child, including support for and liaison with the family or whānau.
- Nurses are the continuous link between the hospital system and the family whose son has just been admitted to the Intensive Care Unit with a life-threatening head injury. During the next few days and nights, they provide interpretation, support and explanation while carrying out the skilled maintenance of human existence in a highly technological environment.
- Nurses and nursing, not medical care, prevent the pressure sores that can cause pain, delay recovery, and cost many thousands of dollars to treat.

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M Miles (1997) Why they leave: a Heideggerian hermeneutic study of the reasons why ten registered nurses left nursing practice to enter the professions of medicine or law. A thesis submitted in partial fulfilment of the requirements for the degree of Master of Health Science, Otago University.


7 Some of these examples are from S Gordon (1997) Life support: three nurses on the front lines. Boston: Little Brown & Co.
The nurse sits with a client who is ‘hearing voices’, and provides consistent guidance and support to stop that client from acting on what the voices say. The nurse is responsible for assessing physical state, mood, and ‘risk’ as part of setting priorities for a client’s management plan; and the nurse co-ordinates care for the client as well as communicating with and supporting the family.

The rural nurse will be called upon to suture the hand of a farm worker who lives and works in an isolated community and is unable to get to a GP.

It is the nurse in a hospital who gives medication, manages pain and side effects of treatment, acts instantly to intervene if there are life-threatening changes in a patient’s condition, and alerts physicians when they are needed. And, with average acuity of in-hospital patients rising, nurses in hospitals are increasingly engaged in skilled monitoring and evaluation of a patient’s condition and comfort.

Furthermore, the nursing model of care is not confined to the ‘hands-on’ practice of nursing. Nurses in advisory and leadership positions work to ensure that the principles of the nursing model of care are carried through into policy, planning, administration, education and management.

1.2 MEASURING THE DIFFERENCE THAT NURSING MAKES

It is not straightforward to measure the total contribution nursing makes to health outcomes because this partly involves measuring skills such as explaining, listening and understanding the needs of clients. Research shows that these types of skills are valued by clients, but they are not readily quantifiable. Notwithstanding these difficulties, it is possible to measure and cost - in a range of practice settings – the contribution nursing makes to the delivery of health and disability services and patient outcomes.

Internationally, there is now a substantial body of research showing that nurse-led health services – both in the community and in acute hospital settings – have positive effects on health-care delivery and on the health outcomes of clients. Nursing can be shown to be more cost-effective than medical services in a number of settings, with no loss of safety and effectiveness.

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A British study has shown that nurses are more likely than doctors to follow protocols, to use a drug formulary, and to have an overall lower pattern of prescribing. They are also more likely to emphasise non-prescription approaches and prevention strategies.\footnote{11} In another British study, nurses trained in ear care and working as part of primary care teams helped to reduce costs, GPs’ work-loads, and the use of antibiotics. Clients also reported improved satisfaction with their care.\footnote{12} Where nurses are case managers there is reduced length of stay for elderly patients.\footnote{13}

Recent nurse-led pilots in primary health care in England have provided a way forward for nurses to manage, lead and contract medical practitioners in for services. These pilots have heralded a different approach to primary and some secondary care services.

Such projects could spell the end to the traditional GP role... In the future GPs will specialise in certain conditions and refer patients to other nurses. Indeed, nurses are often better at routine management of chronic conditions such as asthma and diabetes.\footnote{14}

Acute services in hospitals also benefit from the extensive use of nurses – that is, patients cared for by nurses recover faster from surgery, spend less time in hospital and are less likely to be readmitted.\footnote{15} Five major studies by medical and nursing researchers found positive links between the numbers of nurses involved in care, their educational qualifications, and lower mortality rates and decreased lengths of hospital stays for patients.\footnote{16}

\begin{itemize}
\item \footnote{12} Fall et al. (1997) An evaluation of a nurse-led ear care service in primary care: benefits and costs. British Journal of General Practice 47, pp 699-703.
\item \footnote{14} W Moore (1998) Family doctors: a quiet revolution is taking place in primary health care, with nurses increasingly doing work that was once the exclusive province of GPs. The Guardian. 1 July, pp 4-5.
\item \footnote{16} Cited in S Gordon (1997) op. cit.
\end{itemize}
There is now a large body of international evidence on the cost-effectiveness of the nursing model and its approach to health services. These range over neonatal care, first visits to a practitioner and visits for continuous care.\(^{17}\) Nurses in advanced practice can (and do) substitute for doctors in the United States, providing a variety of primary-care services.\(^{18}\) One American economist has estimated that the cost to the United States of not using advanced-practice nurses to their fullest potential is US$6–9 billion a year.\(^{19}\) This is only a small proportion of total United States spending on health services, but it is nevertheless a worthwhile saving that can be redirected into other health priorities.

Future developments in health care could make the role of the nurse even more central to health and disability services delivery:

Researchers at the University of York in England have arrived at the startling conclusion that anywhere from 30% to 70% of the tasks currently performed by doctors could safely be passed on to nurses with existing technology.\(^{20}\)

The primary- and secondary-health-care services of various countries are organised in different ways and, therefore, service and cost-effectiveness measures are not strictly comparable from one country to another. The international research, however, clearly makes a case for the role and scope of nursing in New Zealand to be expanded. The Taskforce believes that the benefits from expanding the role and scope of nursing will result in better health outcomes for consumers and in more effective health-care services.

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\(^{17}\) For neonatal care, see R L Bissinger et al. (1997) \textit{A cost effectiveness analysis of neonatal nurse practitioners. Nursing Economics March–April 1997, 15 (2), pp 92–9.} The data on visits is from \textit{Nursing Data Bank – nursing costs of care. Nursing Economics November–December 1993, 1 (6), p 349.}

\(^{18}\) Some of the contributions nurses are making to health care in the United States with innovative community practices can be found in M P Donahue (1996) \textit{Nursing: the finest art} (2nd ed) St Louis USA: Mosby.

\(^{19}\) Attributed to Len Nichols in \textit{Nursing Data Bank. Nursing Economics November–December 1993, 1 (6), p 349.}

2 EXPANDING THE SCOPE OF NURSING

The demand for intelligent nursing care today and in the future could not be greater. The old certainties and safety structures of the welfare state are breaking down as advancement in technology and also changes in service delivery occurs. Complex combinations of services – state, voluntary, social, health, educational and environmental – are often struggling to articulate with each other. More than managerial magic will be needed to turn the rhetoric into partnership. Above all it will need intelligent, imaginative nurses capable of navigating and delivering complex courses of care. To do this will take tremendous practical, political, organisational and technical abilities – skills of the highest order.21

To release the potential locked up in the nursing workforce, far-reaching changes are needed in the organisation of health-care delivery. Tinkering at the margins will not be enough. Nursing needs to be central to all future developments in health care in order to support improved service integration and better health-care planning. In addition, nursing may offer increased access for groups with poor uptake of services.

This chapter looks at nursing in terms of making a fuller contribution to health care. The mechanisms for increasing the contribution include the development of new nursing roles alongside specific structural, procedural and legislative changes. The chapter focuses on:

- the development of new nursing roles that are not confined along the traditional community/hospital boundaries (section 2.1)
- prescribing, ordering diagnostic and laboratory tests, and referring clients to specialists (section 2.2)
- the appointment of nurses as ‘responsible clinicians’ under the Mental Health (CAT) Act 1992 (section 2.3)
- the need for measures of competency (section 2.4).

Strategies to overcome these barriers are discussed in the final section (2.5).

2.1 THE DEVELOPMENT OF NEW NURSING ROLES

The ability of nursing to contribute to a more responsive, innovative, effective, efficient, accessible and collaborative health-care service is hampered as requirements for advanced and specialist nursing have either not been developed or, where they have, no formal process exists to link these with the Nursing Council of New Zealand. The Nursing Council has responsibility to ensure the ongoing competency of nurses’ practice, they also approve nursing programmes. If groups continue to develop competencies without such a link, the Taskforce feels that there is a risk of fragmentation and rigidity through too many different specialities or advanced roles developing.

In health jurisdictions overseas, roles such as nurse practitioners and clinical nurse specialists are well established – and their development has helped improve delivery of health services. In the United States, in particular:

... there are over 23,000 nurse practitioners and some 50,000 clinical nurse specialists. Nurse practitioners are recognised in all US states and have legislated authority to prescribe in up to 47 of them. US nurse practitioners have separate malpractice insurance, are recognised as independent providers by many insurance funds, and, in 1997, have been granted independent primary-care funding rights by Medicare. A 1986 report by the US Federal Office of Technology Assessment estimated that 60%-80% of primary-care services could be performed by nurse practitioners with similar results and at a lower cost.

In New Zealand, the title ‘nurse practitioners’ or ‘independent nurse practitioners’ has been used primarily by a group of nurses who offer nursing services directly to the public. The Taskforce believes that these nurses have been extremely courageous in their efforts to improve client services and enhance patient care – but the role played by this group is not to be confused with the concept of an ‘advanced nurse practitioner’. Groups such as neonatal nurse practitioners are more clearly prepared for (and already in effect contribute to) an advanced nurse practitioner role. The key difference lies in the educational preparation for the role.

The use of the title ‘nurse practitioner’ in New Zealand needs to be clarified, particularly in relation to advanced and specialist practice roles. The Taskforce supports the work in progress by the Nurse Executives of New Zealand, and encourages the inclusion of other nursing stakeholders.

The role of nurses prepared at an advanced level requires a set of core expectations, but these are expressed a little differently in the range of possible practice contexts. These nurses offer direct access to clients seeking health care. They undertake assessments, diagnose, and initiate treatments which fall within the range of knowledge and skill appropriate to the role. They undertake care planning, care delivery, care co-ordination, and the monitoring of patient or client progress. In addition, they will work with client or patient groups across the hospital/community interface and will support individuals and families in achieving better health (especially in community settings).

The Royal College of Nursing describes a ‘nurse practitioner’ as a nurse who has completed a specific course of study and:

- makes professionally autonomous decisions
- receives patients/clients with undifferentiated and undiagnosed problems
- screens patients/clients for disease risk factors and early signs of illness

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22 Nurse practitioners are nurses prepared at an advanced educational level beyond a first degree.
23 Bissinger et al. (1997) op. cit. The data on visits is from Nursing Data Bank – nursing costs of care, op. cit., and Donahue (1996) op. cit.
• develops a care plan with an emphasis on preventative measures
• provides counselling and health education
• has autonomy to admit or discharge patients/clients
• has authority to refer to health providers.

In summary, the advanced nursing role offers a means of providing highly skilled care, co-ordination of particular patient groups across the hospital/community interface, and a high level of family health-care service.

There is also a need to further develop and support the clinical-nurse-specialist role. This role is undertaken by a nurse who has both substantial experience in a particular clinical specialty and advanced learning in that area of specialist care. The clinical nurse specialist is a crucial member of a health-care team. There are good, but few, examples of this role in New Zealand – for example, the diabetes nurse specialists, respiratory nurse specialists, and pain nurse specialists. These now need to be recognised and endorsed by the Nursing Council.

The Taskforce believes that the role of advanced and clinical specialist nurses is central to improved patient services in the context of future changes to health and illness service delivery. Nurses will make a significant and valuable contribution to patient experience and patient outcomes when they use their co-ordination, leadership, and nursing skills and knowledge across the hospital/community interface. There are already New Zealand examples of clinical specialist nurses co-ordinating and providing care. Initial study shows that these nurses are effective in preventing admission, facilitating early discharge and improving patient quality of life.

The potential for nursing to make a difference to health care will require a process of transition. The Taskforce wishes to emphasise the importance of working in collaboration with medicine in developing advanced roles for nurses. The two professions will need to engage in careful communication which focuses on patients’ best interests. In a New York study of 34 managed-care organisations, 44 percent listed nurse practitioners as primary care providers. When this information went public, the medical society initiated a campaign to undermine public confidence in nurse practitioners and to push for legislation that would limit nurses’ independence.

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EXISTING STRUCTURAL BARRIERS

The current mechanisms for health purchasing constitute one of the barriers that prevent more nurses from working effectively across the hospital/community interface. Where payments to providers are based on treatment volumes, the delivery of health care is shaped by what the provider gets paid for rather than what patients need for improving and maintaining their health. Nurses recognise that increased specificity and explicitness in health purchasing is important. But the current system brings with it a narrow product definition, and this creates barriers to the provision of a comprehensive health service that is focused on patients’ needs.

In addition, there are very few Ministry of Education or Clinical Training Agency-funded educational programmes currently available that prepare nurses for clinical specialist and nurse practitioner roles. Those that do exist are funded via employers or professional organisations and may not be linked to the Nursing Council’s education framework. General and specific changes to educational provision are urgently needed; this is discussed in detail in Chapter 4.

Policies and practices that specify which particular health professional is permitted to admit, refer, approve sick leave and discharge patients also prevent nurses from taking a more active role in the co-ordination and provision of comprehensive health services across the hospital/community interface – as do lack of prescribing authority and lack of access to laboratory and diagnostic tests (this is discussed in more detail in section 2.2).

EXISTING ATTITUDINAL BARRIERS

An overwhelming number of submissions to the Taskforce raised concerns about the perception that other health professionals hold about the skills, education and expertise of nurses.

Nurses in secondary-care settings are not always considered to be contributing significantly to the health outcomes of patients; instead they are viewed as the providers of the necessary hotel, hygiene and basic-care requirements of patients. And in community settings there has been no substantial development of nursing services despite the transfer of considerable patient/client need previously met in acute care or institutional facilities. This emphasises the need for the development of more defined career pathways which encompass the autonomous and specialist nature of nurses’ work.
2.2 **Prescribing Rights, Diagnostic and Laboratory Tests, and Specialist Referrals**

2.2.1 **Prescribing Rights**

International studies suggest that the advantages of nurse prescribing are:

- improved patient care through better delivery of services and improved patient education
- a more comprehensive service, since nurses are viewed by consumers as more approachable than other health professionals
- better collaborative teamwork with other health professionals, and increased opportunities for autonomous practice by nurses
- reduced health-care costs through improved health education and promotion, better compliance with treatment, more efficient delivery of services, and an overall reduction in the use of drugs as a first line of treatment.\(^\text{29}\)

When the Taskforce began its work, the matter of prescribing rights for nurses in New Zealand was unresolved (although it had been under investigation for a number of years) and a considerable number of submissions raised it as an issue. Since then, however, the Minister of Health has indicated support for extending prescribing rights to nurses (and other health professionals) under certain conditions. The Minister has also asked the Ministry of Health to begin work on the introduction of limited prescribing rights to nurses working in two particular ‘scopes of practice’: child/family health and aged care.

The Taskforce strongly supports this first step towards prescribing rights for nurses. We also recognise that such rights have to be phased in, so that appropriate educational and competency mechanisms can be established. Certainly, prescribing rights for the two initial scopes of practice should be developed and implemented. But this should not be at the expense of work being done on prescribing rights in other scopes of practice. Sexual health, family planning and diabetes management, for example, have already been identified as areas where nurse prescribing is worthwhile. The Taskforce does not wish to see any ‘gap’ developing between the introduction of prescribing rights for different scopes of practice and questions why each new scope of practice requires Cabinet approval before it can be considered for prescribing rights. The Taskforce believes the most appropriate body to consider new scopes would be the Nursing Council.

Patient safety is of paramount concern to the nursing profession, and the Taskforce has every reason to believe that the profession is committed to working collaboratively with medical providers and other health professionals in developing safe mechanisms for nurse prescribing.

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2.2.2 **DIAGNOSTIC AND LABORATORY TESTS, AND REFERRALS TO SPECIALISTS**

The advantages of granting nurses access to diagnostic/laboratory testing and specialist referrals are similar to those of granting prescribing rights.

**EXISTING STRUCTURAL BARRIERS**

Nurses have difficulty accessing diagnostic and laboratory tests\(^30\) because the laboratories and imaging/radiography services carrying out the tests are unable to claim reimbursement when a test is ordered by a nurse. In most circumstances, reimbursement is provided by Health Benefits Limited (HBL) in accordance with its contract with the HFA. The HFA also has a contract with laboratories for services with a list of authorised orderers.

To complete a consultation that requires diagnostic or laboratory testing, nurses working in the community, and in general practice, often have to get a doctor to sign forms, or they have to arrange a separate appointment with the doctor to get the tests done. In hospital, a nurse will have to ring the house surgeon or registrar and request that they come to the ward to sign the form and possibly see the patient.

This can result in conditions that are either diagnosed late or not diagnosed at all. It can also lead to client over-servicing, increased cost to the client if they have to visit their general practitioner, delayed or impeded access to treatment, and untreated or poorly treated health problems when clients do not follow the advice to visit a GP to get tests done.

The Taskforce is aware that nurses working in some community settings are able to apply to the HFA for a deed authorising them to order a range of laboratory tests.\(^31\) This gives them an order number, which allows the laboratory to invoice the HFA for services. The Taskforce welcomes this initiative. (The arrangement in some other settings, where the doctor may have pre-signed forms and has agreed that the nurse can order tests, is not satisfactory.)

Not being able to order diagnostic or laboratory tests is another barrier to nurses working as independent providers, particularly in the area of chronic disease management where nurses are key providers of health services. The Working Group on Limited Prescribing Rights for Nurses regarded nurses’ access to diagnostic and laboratory tests as a logical extension of prescribing rights:

> It would be helpful to nurse prescribers to have access to laboratory testing. For example, diabetes nurse specialists who might be able to prescribe should be able to order tests such as HbA1C, fructosamine, renal and liver functions and lipid profiles. Without access to these tests nurses will be unable to undertake diagnoses and the necessary follow-up treatments for their patients.\(^32\)

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\(^{30}\) Diagnostic and laboratory tests include laboratory tests, radiological tests (such as x-rays) and ultrasonography.

\(^{31}\) Currently the Taskforce understands this is only available in the northern region.

Removing the structural barriers to nurses ordering diagnostic/laboratory tests will assist intervention strategies, the management of chronic conditions, and the development of cost-effective and integrated services. For example, nurses would be able to initiate treatment immediately for fractures by ordering x-rays as soon as a patient presents with a suspected injury; specialist continence nurses would be able to order ultrasound tests to monitor the bladder function of a person with continence problem; and nurses working with children would be able to ascertain more quickly whether a sore throat in an at-risk child is the beginning of rheumatic fever that requires immediate intervention.

If nurses can order diagnostic and laboratory tests, then it follows that they should also have access to specialist services. Currently, only a few nurses are able to refer their client directly to a specialist: most referrals have to go through a GP or a hospital doctor. This is in spite of the fact that the nurse often has much more specific information about the client’s condition than the referring doctor does, and has the overall knowledge and experience needed to make the referral. In such cases, the current process involves unnecessary double-handling and delays. It also hinders the timeliness of a client’s treatment.

The nursing profession has an absolute responsibility to initiate the teaching of clinical-assessment skills for diagnostic and laboratory testing, and to make this training mandatory for all nurses who want the right to order such testing (see Chapter 4, Strategy 3). It should also be noted that education and training programmes in this area, and all related competencies, need to be under the jurisdiction of the Nursing Council, as the body able to endorse accountability mechanisms.

A further barrier to the full utilisation of nursing is present in the expectation that certificates of absence from work, or other commitments, will always be signed by a medical practitioner. This limits client access and may impact on full client choice. It is particularly inappropriate when absence is due to illness such as the common cold or influenza, or the care of a sick child.

The barrier arises from employer expectation that medical practitioners will sign certificates, and a failure to nominate nurses and medical practitioners in employment contracts.

**Existing attitudinal barriers**

It is possible that there will be opposition from some medical practitioners to a further expansion of the scope of nursing practice. Such opposition may be presented as concern for patient safety, or that nurses are to become cheap ‘replacement doctors’. The Taskforce is absolutely convinced that no nurse wishes to support unsafe practices. Equally, we are not aware of any nurse in New Zealand who wants to become a ‘replacement doctor’; this would devalue the distinctive esteem in which nursing is held by nurses.

There is also some resistance within nursing to expanding the scope of nursing practice – from nurses who see it as a ‘medicalisation’ of nursing. This perception is unfortunate, because it assumes that any procedure done traditionally by doctors is ‘medical’ and that taking on such procedures will diminish the value of nursing. This is not necessarily the case. The taking of cervical smears – a procedure that used to be done exclusively by doctors – is now done regularly by nurses and has become a feature of well-women care provided by nurses. It has not led to nursing becoming more medicalised.
Another possible concern is that overall health-care costs will rise if nurses expand their role. There is no reason to believe this will happen. A 1993 analysis of research studies on primary care found that nurse practitioners ordered more, but cheaper, laboratory tests and had the same prescribing rate as doctors.  

EXISTING LEGISLATIVE BARRIERS

There are no legislative barriers to nurses ordering laboratory and diagnostic tests, or to referring clients to specialists.

However, the extension of prescribing, diagnostic and laboratory testing, approval of sick leave, and specialist-referral rights to nurses brings into focus the issue of quality audit, which is constrained by a legislative barrier.

As the role of nursing expands, quality audits will become increasingly necessary. Currently, it is difficult for nurses themselves to undertake quality audits of nursing services, as they have no legal protection against claims that a quality action was not undertaken in good faith. Medical practitioners who undertake quality audits have this protection under the Medical Practitioners Act 1995, and nurses must be given the same protection. If nurses are not given this protection, it is likely that quality audits of nursing services would be done by doctors. This is inappropriate.

2.3 RESPONSIBLE CLINICIANS

All mental health nurses actively manage their clients' care. And many are 'duly authorised officers' (DAOs), who are responsible for emergency treatment of clients under the Mental Health (CAT) Act 1992. But very few nurses become a 'responsible clinician' – the health professional who is in charge of a client's care under the Mental Health (CAT) Act 1992. Most responsible clinicians are psychiatrists, or psychiatric registrars (who are in training).

Submissions to the Taskforce pointed out that having nurses as responsible clinicians would provide clients with better-quality care and a wider access to services. Having nurses working as responsible clinicians would lead to a more efficient use of staff resources, and would open the way for greater teamwork and collaboration in mental health services.

EXISTING STRUCTURAL BARRIERS

Evidence received by the Taskforce during its consultation process suggested that mental health nurses generally do not know how to apply or be considered for responsible-clinician positions.

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This is compounded by the inability of the Nursing Council to endorse the specialist competencies developed by the Australian and New Zealand College of Mental Health Nurses. The lack of an enforceable ‘measure of competency’ creates difficulties for both nurses who may want to apply for a responsible-clinician position, and for the Directors of Area Mental Health Services (DAMHS) in considering nurses’ applications.

EXISTING ATTITUDINAL BARRIERS

Responsible clinicians are appointed by the DAMHS, under the Mental Health (CAT) Act 1992. The Act specifies that psychiatrists or other registered health professionals can be appointed as a responsible clinician in charge of a patient’s treatment. There may be a reluctance on the part of the DAMHS to consider non-psychiatric health professionals as responsible clinicians.

2.4 NURSING COMPETENCIES

‘Competencies’ or ‘measures of competency’ are descriptions of the skills and knowledge required to perform a given task effectively and to work safely in a particular area of practice.

Currently, a requirement for ongoing competency does not exist as a statutory requirement. There are competencies for registration, which set the skill standards required for registration as a nurse, but there is no continuing re-evaluation of these competencies throughout a nurse’s career. The New Zealand Nurses Organisation has developed some ‘specialist’ competencies – for example, for coronary care, flight nursing and specialist diabetes nursing, and the Australia and New Zealand College of Mental Health Nurses has developed mental health nursing competencies, but, at present, these all lack a link to the Nursing Council.

The lack of national enforceable specialist competencies is a particular barrier to nurses receiving funding for services – especially funding from ACC and private insurers. Without a recognised system of specialist competencies, funders have no mechanism for defining the nursing services – and outcomes – that they may wish to purchase directly from nursing services. (This is discussed more fully in Chapter 3.)

Furthermore, the lack of a process for re-evaluating competencies throughout a nurse’s career limits the profession’s ability to demonstrate that all working nurses are proficient in general nursing practice or in specialist areas. Skills and knowledge can atrophy, or can fail to keep up with developments, whenever any practitioner spends a lengthy period away from a particular area of practice. And where there is no process in place to demonstrate practitioner proficiency, then client safety is at risk.

The Royal College of Nurses, in a discussion paper on nurse practitioners, recommends that there be a provision for recording recognised qualifications on a national register.34 The Taskforce supports this and believes the Nursing Council should hold any national register.

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34 Royal College of Nurses (1997) op. cit.
EXISTING LEGISLATIVE BARRIERS

The Nursing Council is well on the way towards a process for monitoring competency through a system of personal portfolio preparation. It has also indicated that it is willing and ready to work on validating and recognising specialist competencies developed by the New Zealand Nurses Organisation and the Australia and New Zealand College of Mental Health Nurses. However, the Nursing Council (which is a statutory body whose powers are granted to it by legislation) does not have the authority to enforce specialist competencies. Nor does it have the authority to require continuing competency or the registration of specialist qualifications. The Nurses Act 1977 does not allow for this.

2.5 STRATEGIES FOR CHANGE

STRATEGY 1: THE DEVELOPMENT OF ADVANCED NURSING ROLES

Supporting strategies that will be absolutely essential in developing advanced nursing roles in New Zealand have been outlined elsewhere in this report. They include: addressing requirements for pre-entry clinical experience, the first year of practice, and postgraduate education (Chapter 4, Strategies for Change 1, 2 and 3); setting up the mechanisms to support nurse prescribing, referrals, approval of sick leave and ordering of tests (Strategy 2 in this chapter); and a framework for endorsing specialist competencies (Strategy 6 in this chapter).

STRATEGY 2: EXTENSION OF PRESCRIBING, DIAGNOSTIC AND LABORATORY TESTING, AND SPECIALIST-REFERRAL RIGHT

The Taskforce endorses the Minister of Health’s announcement of his support for the extension of prescribing rights to nurses. However, we wish to add three particular comments which are important in terms of a strategy for change.

First, we support models of nurse prescribing that offer flexibility. Such flexibility would include a range of mechanisms from collaboration to full independence; and we note that the word ‘collaboration’ does not mean ‘under supervision’.

Second, we support the consideration of further scopes of prescribing practice by the Ministry of Health, but request that the Minister of Health brief Cabinet on the unnecessary need for Cabinet to approve each scope of prescribing practice as it is considered.

Third, we see the right to order tests and to refer clients to specialists as natural developments of the extension of prescribing rights. All three are firmly within our terms of reference.

Reimbursement technicalities must no longer exclude nurses as a group from ordering laboratory and other diagnostic tests.
The Taskforce believes that the HFA policy which allows nurses to order a set range of laboratory tests should be extended throughout the country. In the northern region the range of tests was determined by the medical director of primary care, the nursing manager, and the manager of laboratory services, in consultation with nurses. The Taskforce wishes to emphasise that this has not resulted in over-ordering of tests by nurses; nor has it created financial risk for the HFA.

A similar approach needs to be taken throughout the country to the ordering of diagnostic (radiological and ultrasonography) tests; that is, the HFA needs to change its policies, to allow nurses as a group access to reimbursement provisions for diagnostic-test ordering.

The Taskforce also suggests that the Employers Association needs to alert employers of the need to accept certificates for absence from work from a clinician who is appropriate to the reason for absence. This may be a nurse, midwife, doctor, or other health professional.

In our proposals, we place a great deal of weight on the ability of nurses to contribute to a more team-oriented and collaborative health service. We firmly believe that measures such as these will lead to more integrative and cost-effective services, rather than a further fragmentation of services.

### Strategy 3: Clarification of accountabilities

Clarity in accountability and clarity in the processes for ensuring accountability are an integral part of expanding the scope of nursing.

Nurses have legal autonomy for the care and intervention decisions they make within their defined scope of practice. That is, other health professionals are not responsible for the care and intervention decisions made by nurses within their area of professional competence. Nurses are fully responsible for their own actions and are legally accountable on that basis. Nurses will therefore be fully accountable for their responsibilities in prescribing, diagnostic and laboratory testing, and specialist-referral - just as they are now for their current responsibilities. This must be made clear, not only to nurses but to all who work in health and disability services.

Because nurses are legally accountable within their own areas of professional competence, professional indemnity insurance is essential. All nurses should have such insurance. The Taskforce is concerned that a number of nurses are practising without indemnity cover, even though the professional nursing organisations already offer indemnity cover to their members. We strongly believe that all nurses must practise with professional indemnity insurance.

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35 At present the Taskforce is aware that this policy is widespread only in the northern region of New Zealand.

36 Information provided to the Taskforce on request, by HFA North Office (June 1998).
Nursing services also need to have a system of quality audits. This is necessary for maintaining public confidence in the ability of nurses to take on these new responsibilities. Quality audits would ensure that nurses are following any protocols for their use of prescriptions and ordering of tests, are operating within their area of defined competence, are keeping adequate patient records, and are carrying out any other requirements related to their practice. Furthermore, nurses must be able to carry out these quality audits themselves: to enable them to do so, they must have the same legal protection as medical practitioners do when they carry out a quality audit.

**Strategy 4: An emphasis on collaboration**

The Taskforce stresses the need for a strong environment of teamwork and collaboration between health professionals. As a matter of course, nurses will consult with other health professionals who are involved in the treatment of the same client. The interests of the client must always remain paramount, whatever the degree of autonomy a health professional may have.

**Strategy 5: Responsible clinicians**

The Taskforce firmly believes that mental health nurses should be able to be appointed as responsible clinicians if they can demonstrate professional competency. For this to happen it will be necessary for the Nursing Council to endorse the competency standards already developed (after ensuring these recognise the competencies necessary to be ‘in charge’ of a patient’s treatment). The Taskforce then wishes to see a process for applying to be a responsible clinician developed. To this end, the Director of Mental Health should direct the DAMHS (Directors of Area Mental Health Services) to develop clear and unambiguous processes for the appointment of responsible clinicians. These processes must follow the spirit of the Mental Health (CAT) Act 1992, and be made known to health professionals working in mental health services.

**Strategy 6: Nursing competencies**

Appropriate nursing competencies will need to be developed, validated and formally recognised for both on-going competency and specialist and advanced nursing. So that these competencies can be enforced, the Nurses Act 1977 must be amended to give enforcement powers to the Nursing Council.

The Taskforce notes that the Ministry of Health is developing a consultation document on competency assurance of health professionals. Given the likely changes to occupational regulation, the establishment of a competency-assurance regime will be of considerable importance to nursing in the longer term. The Taskforce understands that the Ministry is looking at a range of options, but we do not know the detail of the options, or which option will be preferred. However, we believe that any competency regime must provide a mechanism that ensures the ongoing competence of all practitioners, allows them to work together in the same environment to achieve the same objectives, and is flexible enough to develop competencies for new or emergent fields of practice. Furthermore, the underlying objective of the regime must be to support the provision of safe and cost-effective services to clients.
We firmly believe, nevertheless, that the lack of enforceable nursing competencies is an immediate barrier to nursing's ability to make a fuller contribution to health care, and that work in this area urgently needs to proceed.

The task of developing, recognising, and validating nursing competencies belongs with the Nursing Council. The nursing organisations, particularly the New Zealand Nurses Organisation, who have done substantial work in this area, need to work closely with the Nursing Council. Other organisations with an interest in the development of competencies such as ACC and the Ministry of Health also should work with the Nursing Council in this.

As part of the process of recognising competencies for New Zealand nursing practice, the Nursing Council needs to establish a framework for specialisation. The categories for competency must be broad: if they are not, there is a risk of having a proliferation of detailed sub-specialties which will limit the flexibility of nursing practice. The International Council of Nurses has developed characteristics and criteria for recognising specialties in nursing and the Taskforce recommends these to the Nursing Council as a tool for defining competency boundaries in New Zealand.

The competencies that are developed for New Zealand nursing also need to be linked to nationally consistent nursing titles, so that all nurses using a particular title can be recognised as having particular competencies.

This chapter has looked at some of the barriers to expanding the scope of nursing practice, and has noted how the currently limited role of nursing results in decreased access for many clients. We have identified new roles that nursing could develop - such as advanced nurse practitioners and responsible clinicians - and also ‘new’ procedures that many nurses could undertake to the benefit of their patients or clients. We have also indicated that these expansions must be underpinned by processes which assure New Zealanders that the nurses who undertake these procedures and roles are competent to do so.

Expanding the scope of nursing, however, will depend to a considerable extent on access to funding - especially in terms of community-based services. We look at aspects of this in the next chapter.

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3 ACCESS TO FUNDING

A number of legal impediments restrict nurses’ access to funding for services delivered in the community. As well, structural and attitudinal barriers related to funding are likely to continue to limit nurses’ potential involvement in community-based health care, even after many of the legal barriers are removed. The issues surrounding particular sources of funding differ in their scope and effects, and so each will be dealt with separately.

This chapter looks at barriers that affect nurses’ access to funding for community-based services, in terms of:

- the Health Funding Authority (HFA) (section 3.1)
- ACC (section 3.2)
- private medical insurers (section 3.3).

Strategies to overcome these barriers are discussed in the final section (3.4).

3.1 ACCESS TO HFA FUNDING

EXISTING STRUCTURAL BARRIERS

Nurses provide much of the care to patients in the general-practice setting, and the Taskforce is aware that many nurses are providing innovative and valuable services to clients, both independently and in full collaboration with general practitioners. We are also aware, however, that the potential of nurses in primary care is not being fully realised.  

HFA funding for all general-practice services has traditionally been paid to general practitioners, who in turn employ practice nurses. This means that, although general practice is said to involve a team concept, it is difficult to develop a team culture where the contribution of nurses is equally valued as part of the practice. The payment of the general medical services (GMS) benefit on a fee-for-service basis also creates a barrier to the direct access to nurses by patients, even though this may often lead to more appropriate and more efficient service provision.

The HFA’s recently released vision for the next five years in general practice proposes a population-based funding system for treatment and disease prevention. Under these proposals, the current fee-for-service GMS and practice nurse subsidy will be replaced by a block budget paid to primary-health-care organisations; this budget will be based on the number of patients enrolled.

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38 J Michel (1997) op. cit.
39 Health Funding Authority (May 1998) The next five years in general practice. Auckland: Health Funding Authority.
The Taskforce supports the general shift towards the population-based funding of primary care. This funding mechanism embodies incentives to use the most cost-effective provider, and therefore offers scope for considerable improvement in the efficiency and diversity of service provision. However, the extent to which this potential is realised will depend crucially on the vision and sound judgement of the service that receives the funding, and on the willingness of GPs to work in partnership with practice nurses. In the absence of full participation by nurses at the management level, attitudinal and professional barriers to more effective nursing practice are likely to remain. Although there are now a few cases where nurses are part of the management group of an independent practitioner association (IPA), this is not usually in a senior capacity – nor as a shareholder.

A population-based system of funding also potentially removes the need for patients to see a GP before funding can be accessed, and so allows greater flexibility in the use of the primary-care team. Nevertheless, it cannot be assumed that this barrier will be removed automatically by the proposed new funding arrangements. Patients will still be required to pay the user charge for general-practice services on a fee-for-service basis. Moreover, population-based funding to primary-care organisations may not necessarily translate into population-based funding to individual practices. The HFA has stated that it wishes to fund primary-care organisations – such as IPAs – which have a minimum enrolled client group of 30,000 people. Each primary-care organisation can then redistribute funds to its members as it chooses. Some IPAs have stated a philosophical commitment to fee-for-service practice. Thus, even though funding to these IPAs will be on a population basis, individual members of the IPA may still be paid on a fee-for-service basis. Some GPs may also continue to be paid the GMS benefit under section 51 of the Health and Disability Services Act 1993, at least in the short term.

While nursing-led practices are feasible under the HFA proposals, their development is likely to be constrained by a number of factors. To receive funding, nurses will have to provide evidence of an enrolled client group. But the traditional system of payment to GPs means that New Zealanders are not accustomed to regarding nurses as a key provider of (or fund-holder for) primary health care. Information system requirements for maintaining age/sex registers, for the protection of client privacy, and for the exchange of client information will also be a significant cost barrier to a fledgling new practice.

**EXISTING ATTITUDINAL BARRIERS**

These structural barriers also flow into attitudinal barriers. The work of nurses is not given the same professional weight as that of GPs in many practice settings, and the nurse is seen as a helper rather than an autonomous professional. It is almost impossible to achieve more equal recognition when the GP owns the business and is also the nurse’s employer – particularly when the nurse may be only a part-time employee.

This undervaluing (and consequent under-utilisation) of the professional expertise of nursing was a recurring theme in the Taskforce’s consultation with focus groups, and also in many of the submissions that we received.

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40 J Michel (1997) op. cit.
3.2 ACCESS TO ACC FUNDING

ACC payments for the assessment and treatment of injury-related accidents are made to specific service providers. Traditionally, nurses have not been one of these providers, even though they carry out much of the work on a provider’s behalf. This continues to be the case, despite some recent developments by ACC, and it is a barrier to the development of effective nursing services.

It has also led to a more expensive cost structure for ACC, which the Corporation acknowledged in its submission to us:

In historically recognising only medical practitioners as the providers of primary care services, the corporation has not only eliminated a source of competition but also paid a cost in sustaining prices that are higher than a treatment warrants.41

CONTINUING BARRIERS TO RECEIVING ACC FUNDING

There are some encouraging developments in ACC funding. Since 1996 ACC has been able to fund providers directly, rather than through the RHAs/ HFA. One result of this has been that a number of rural nurses around the country (in areas without a GP) have direct contracts with ACC – although these are for providing specific procedures, rather than overall treatment.

Overall, however, a number of structural and legislative barriers still hamper the ability of nursing to contribute fully to accident treatment.

EXISTING STRUCTURAL BARRIERS

There is a gap between ACC’s requirements of its providers and nursing’s ability to demonstrate that nurses can meet these requirements. ACC requires clear definitions of, and reliable measures of outcomes for, the procedures and interventions that it purchases. This in turn requires measures of competency for the providers involved. But, as discussed earlier in Chapter 2 (section 2.4), nursing has not yet developed such measures.

ACC is unwilling to fund professionals who cannot demonstrate a standard set of competencies in the services it wishes to purchase. Without a standard set of competencies, and without a definition of outcomes, the corporation has no way of knowing whether a claimant is better or worse off after treatment from an alternative provider.

Clear differentiation between nursing services and other providers’ services is needed if nurses are to provide contestable injury-treatment services to ACC.

The current system of paying ACC fees on a per-treatment basis is also a barrier to a wider use of nursing services in ACC treatments, in that it can discourage GPs from referring their patients to district or community nurses, who are paid by ACC through its bulk-funding agreements with hospitals and their related health services. This can result in inconvenience for the patient, inappropriate care, and over-servicing (see the case study below).

Case study: a district nurse’s experience

‘I received a referral requesting daily visits to a lady to dress a leg ulcer. My assessment revealed that this lady had been visiting her GP’s surgery daily for the previous two weeks for dressings to a traumatic wound. The lady is suffering from chronic obstructive airways disorder, and found it extremely difficult to make this journey every day. She advised me that the wound was being treated through ACC and she had not been informed that the District Nursing Service was an option. The referral from the GP was for the holiday period with an intention that the GP would continue with the care afterwards. I gave the lady options and she chose to continue with district-nurse visits . . . On assessment of the wound, daily dressing changes were not indicated and by using appropriate products I have reduced the dressing changes to 3 x weekly and the wound is healing. I do not consider that the GP had this patient’s best interests in mind, rather that the ACC payments were the influencing factor in his decision-making. I could give several further examples in support of my argument.’ (Extract from a submission to the Taskforce.)

EXISTING LEGISLATIVE BARRIERS

Under the General Practitioner Cost Regulations (1993), only a GP can claim reimbursement from ACC for injury-related assessment or treatment services in a primary-care setting. Nurses cannot claim, even though they often carry out many of the treatments for accident victims. In addition, nurses are not specified as preferred providers under the Referred Treatment Cost Regulations (1990).

These current arrangements in ACC funding mean that – even if the scope of nursing is expanded (as discussed in Chapter 2) and nurses are able to prescribe, order diagnostic and laboratory tests, and refer accident patients to specialist providers – nurses will still be unable to directly claim reimbursement from ACC. They can have their work rubber-stamped by another health professional, as happens now. But this will usually mean inconvenience for the patient, and delay in their treatment.

In ACC’s view, ‘the doctor in this situation does not add value to the treatment and may well incur an additional unnecessary cost. The corporation is able to audit the services and outcomes of a nurse provider as easily as it is able to audit the services provided by the GP’.42

3.3 ACCESS TO PRIVATE INSURERS

Access to funding from private insurers has the potential to expand opportunities for nursing and to improve patient care – particularly in the areas of post-operative care and rehabilitation, wound and acute-pain management, and palliative care.

Currently, however, private insurers do not recognise that nurses can provide such services directly to patients. Part of the barrier here appears to be attitudinal: a failure to see nurses as

42 Ibid., pp 2-3.
autonomous practitioners. This situation is exacerbated by the fact that most health-service providers and nursing agencies – who could advise insurers on such technicalities – have limited access to senior nursing advice. But there is also a very real structural barrier. Private insurers, like ACC, are unwilling to include nurses amongst their approved providers unless nursing services are defined and the competencies needed for those services specified.

3.4 Strategies for Change

Strategy 1: HFA Funding of Primary Health Care

The Taskforce welcomes the move by the HFA towards population-based funding for primary health-care services. However, in order to overcome some of the outstanding attitudinal and professional barriers to effective and efficient nursing practice, we recommend that the HFA encourage the primary-care organisations with which it contracts, to implement mechanisms which encourage the more effective use of practice nurses, including direct access to practice nurses by patients, and the involvement of nurses in the governance and management of primary-care organisations (see Strategy 3).

The Taskforce considers that, in cases where GPs continue to receive the GMS benefit as a fee-for-service payment, practice-nurse services should be purchased by the HFA directly. It would also be preferable for these funds to be managed by nurses where possible. The HFA may wish to link the practice-nurse payment to some minimum set of competencies in order to ensure quality of service.

Strategy 2: The Encouragement of a Wider Range of Provider Organisations through HFA Funding

As we have noted earlier, new nursing-led practices may be possible under the population-based funding formula. But their development is most unlikely, given the proposed HFA funding requirements; that is, requirements for a minimum enrolled population of 30,000, for funding being based on historical use of the GMS, and for detailed information systems and technology.

A more positive approach may be for the HFA to begin developing and supporting the widest possible range of provider structures. These must be broader than the traditional range of models, and should include collaborative team approaches where nursing services are nursing-led. Such nursing services could include:

- small groups of nurses working together in specific geographic locations
- nursing services specialising in areas such as wound care, immunisation, adolescent health, palliative care, and sexual health
- services that sub-contract to other organisations or contract directly to the HFA

42 In Britain, 10 nurse-led pilots were established in April 1998 to deliver services to a wide range of groups, for example, services to homeless or at-risk children and families, adult protection, community safety, and wound and ulcer management. See UK Department of Health (1997) The new national health service white paper. London: UK Government.
lead primary-care providers who also broker a range of services for their clients

sole nurse practitioners.

It will also be necessary for the HFA to ‘underwrite’ the development of new provider structures like these. The precedent for this has been set with the underwriting of IPAs in the past. At the very least, if the HFA were to apply its general funding requirements to these new structures, a staged transition process would be essential: the requirements are too stringent for newly developing structures. Again, there is a precedent for this in the IPAs’ development.

The Taskforce is aware of the HFA’s strong interest in “services that meet the greatest needs and have the highest potential for health benefit”.

We also note that there are a number of benefits from encouraging a wider range of provider organisations. These are:

- the encouragement of the concept of teamwork and collaboration: the creation of a partnership of various health professionals, each making their contribution within an integrated approach
- the promotion of a multi-disciplinary approach to health care, where the responsibility for services does not necessarily remain with the GP
- the involvement of nurses (the largest part of the health workforce) in planning, decision-making and service development at provider level
- an improvement in access to health care as nurses begin to provide more services – particularly as independent practitioners
- an increasing focus on health and wellness rather than on disease and illness.

**Strategy 3: More innovative management structures**

The Taskforce believes that all governance and management structures in health-care organisations should reflect the skills of their workforces and should support teamwork and collaboration.

The intention here is to make sure that nurses are involved in the governance and management of the organisation in which they work. Also, more efficient use of the nursing workforce is likely if decisions about the employment of nurses is made by nurses themselves. So the management structures of organisations should include nurses at all decision-making levels (this point is developed further in Chapter 6, section 6.1).

Possible models could be found in the structures of integrated-care organisations (ICOs). Some of these are administered by a management committee or community board, with the day-to-day running of the service being the responsibility of a clinic manager. The health

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44 Health Funding Authority (1998) op. cit., p 3.

45 The benefits of improved health care from collaborative health-care teams can be found in S Campbell, The role of nursing in primary health care in J Salvage & S Heijnen (1997) Nursing in Europe: a resource for better health. Copenhagen: WHO Regional Office for Europe. Campbell also cites a number of studies showing the cost effectiveness of nursing services when compared with GPs, often with as good if not better patient outcomes.
professionals – practice nurses, GPs and midwives – are usually all employed on salary, and they work as part of a multi-disciplinary team that places all on an equal basis and supports true collaborative teamwork. The Taskforce is aware of models of this type in New Zealand – for example, that employed by Health Care Aotearoa.

**Strategy 4: A greater range of ACC service providers**

A number of ACC initiatives could give nurses a wider role as service providers to the corporation. The Taskforce broadly supports the work ACC is doing on:

- developing a policy for the purchase of injury-treatment services from rural nurses
- defining the products it wishes to buy from service providers and measuring the treatment outcomes that result from using different types of providers
- establishing the competencies it requires from service providers for specific health outcomes; however, as noted in Chapter 2, the Taskforce firmly believes that ACC must work with the Nursing Council in developing specific competencies for nursing services.

The Taskforce notes that, before ACC can expand its range of service providers, the ‘restriction’ clauses in the General Practitioner Cost Regulations (1993) and the Referred Treatment Cost Regulations (1990) need to be removed or significantly amended.

Nursing can assist ACC by working with it in developing services that are efficient, effective and lead to better outcomes. Some examples of this are:

- ensuring that the senior structure of ACC includes nursing advisors
- educating their case managers about nursing practice
- developing ACC nurse-led services involving the management of chronic pain, head injuries, stress, and post-trauma rehabilitation (this will add to the work currently being done by ACC in rural and trauma services)
- developing services which include nurses acting as brokers, helping ACC clients to access a range of treatment and rehabilitation services
- developing and funding pilots which lead to sustainable models of new nursing services
- providing ‘seeding’ money for the setting up of autonomous nursing services.

ACC’s submission to the Taskforce clearly stated the type of support it needs from nursing:

> If ACC is to achieve its aim of purchasing the most effective healthcare at the most efficient price then the corporation will require support from the nursing profession. This support is needed to clearly identify the products it purchases and the competencies required to deliver those products while achieving superior outcomes. Further, there needs to be support for the training of providers whose competencies match those

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46 A few useful examples of ICO structures can be found in J Ovretveit (1998) Integrated care: models and issues, Health Care Review Online. However, not all of the models cited in this study have potential for increased nurse involvement in management.
required to complete the task. Finally the corporation needs the support of the nursing profession to ensure the public are confident that the nursing providers are capable of delivering a service which is on a par or better than that provided at present.47

The Taskforce believes that nursing is up to ACC’s challenge, and many of its strategies and recommendations are designed to provide the environment and infrastructure to make this possible.

**STRATEGY 5: A ‘case’-based approach to ACC funding**

ACC’s current initiatives in funding on a ‘case’ basis rather than through fee-per-treatment are a positive move, and the Taskforce believes that ACC should continue in this direction. Payment on a ‘case’ basis gives ACC an incentive to use the most cost-effective provider. This could well be a primary-care practice with a strong nursing component or a solely nursing team practice. Another possibility is for ACC to make payments to team practices for specified injury-treatment services. This could work in a similar way to the population-based funding proposals of the HFA.

Payment on a ‘case’ basis also encourages an emphasis on accident or re-injury prevention – and nurses are well placed to contribute to this because of their focus on health promotion and protection.

**STRATEGY 6: Access to private-insurer funding**

Private insurers must be informed of the specific services that nursing is capable of delivering to their clients. A process for doing this should be developed and carried out by nurses’ professional organisations. As well, the specific services that nurses can provide will need to be linked with the specialist competencies that are being developed for nursing (as outlined in Chapter 2, section 2.4).
4 EDUCATION

A remarkable achievement by nursing during the last decade has been the creation of a single point of entry into the profession. Students can gain a bachelor of nursing degree – which leads to registration – from any of 15 polytechnics throughout New Zealand.

The organisation and resourcing of nursing education, however, is of increasing concern to the profession. It was a consistent theme at the Taskforce’s focus groups, and in submissions from nurses and sector agencies. There is considerable doubt whether current arrangements are adequately serving the needs of nursing today, let alone its future requirements. The health sector is changing rapidly, and the education of nurses is struggling to keep up:

Changes which affect nursing practice and nursing education are occurring almost every day... The challenge facing nurse educators in the turmoil of today is to find ways to work with nurses in practice to implement strategies which ensure each new teaching/learning programme takes into account the different expectations of the state, the learner, the profession, the consumer of nursing, and the employer. This is not an easy task, and it has never been more difficult.48

Nurses must feel confident that the education and training they have received fully support their professional needs – both initially and throughout their careers. The current structure and status of nursing education makes this unlikely.

The focus of this chapter is on the barriers that affect:

- undergraduate education (section 4.1)
- the first year of clinical practice (section 4.2)
- postgraduate education (section 4.3).

The final section (4.4) looks at strategies to overcome these barriers.

4.1 UNDERGRADUATE EDUCATION

The initial education programme for nurses has undergone significant change in the last 30 years. It has gone from a specialised course taught entirely in hospitals (with some hospitals offering a structured full-year orientation programme for new graduates), to a general degree taught in polytechnics.

Undergraduate education of registered nurses

Undergraduate students of nursing currently undertake a three-year bachelor’s degree programme in one of 15 polytechnic schools of nursing throughout New Zealand. Programmes differ in their organisational structure but all adhere to the standards set by the Nursing Council of New Zealand and to the requirements of the New Zealand Qualifications Authority for degrees. Every programme must provide 1500 hours of clinical experience in a variety of settings – including mental health, acute hospital services, residential care, general practice, and community services.

Nursing knowledge as taught in the undergraduate programme combines a comprehensive understanding of health, illness, human growth and development, and biological and environmental determinants of health. Bioscience, pharmacology, introductory psychology and sociology are taught – in particular as they relate to either the maintenance of health or the experience of illness. The promotion of mental health, recognition of mental illness, and interpersonal and communication skills are all key components of the programme. Nursing students learn the principles for prevention of cross infection, the safe administration of therapeutic agents, and the diverse skills for caring for people who are ill or injured and who require complex technological interventions or control of symptoms and maintenance of comfort and dignity during the dying process. Nursing knowledge also includes the in-depth analysis of health and health-seeking behaviour, and students learn how to promote good health at both an individual and a community level. This list is by no means exhaustive, but the essential point is that nursing education produces multi-skilled beginning practitioners who with appropriate transition-to-work processes are poised to become a vital component of health-care delivery.

Existing structural barriers

When the nursing programme was first taught in polytechnics in the mid 1970s, it was a three-year diploma in nursing that led to registration as a nurse.

From 1990, polytechnics have been able to offer their own degree programmes. Some institutions wished to offer a four-year undergraduate degree, but the Ministry of Education would only fully fund a three-year base degree. Fourth-year funding was restricted to honours students or diploma graduates undertaking a conversion degree from single registration (for example, in psychopaedic nursing) to comprehensive registration.

There were considerable gains from the implementation of the new degree structure. Greater emphasis, for instance, was placed on the use of health research in the development of evidence-based practice. This resulted in a clearer linking of nursing theory to practice, and aided the development of critical and reflective thinking in nursing graduates.
The Taskforce recognises that there are some problems with undergraduate education of nurses. The Nurse Executives of New Zealand (NENZ) submission to us provided evidence that there are variations in the standards of clinical competence shown by new graduates. This issue needs to be addressed. The Taskforce is not recommending a full-scale review of nursing undergraduate programmes, but it wishes to indicate some areas of concern in programme content, the nursing education environment, and the provision of clinical training.

**Programme content**

Specialty training became less central to polytechnic undergraduate nursing diplomas after these incorporated into one programme the previous hospital-based specific programmes in general and obstetric, psychiatric, and psychopaedic nursing. This change in emphasis has meant that the needs of defined specialty areas such as mental health have become difficult to meet in every polytechnic nursing programme. The Nursing Council has recently consulted with the mental-health sector to develop clear guidelines for teaching mental health within undergraduate nursing courses. Careful monitoring is now required to assess the adequacy of all programmes, in order to produce nursing graduates who are ready to take up positions in mental health – and also postgraduate education in mental health if they so choose.

The recent separation of nursing and midwifery degrees means that there is the potential for confusion about what constitutes the appropriate content of either programme in the area of women's health. The Taskforce’s view is that nursing programmes must clearly prepare nurses who are skilled in the full range of women's health concerns, with the sole exception of the management of birth, which is properly the province of midwifery.

A number of submissions reviewed by the Taskforce identified the need to improve the skills of nurse graduates in the assessment of physical and mental health. Improvements must be made here as a firm foundation for the proposed development of advanced practice roles and the addition of diagnostic testing and prescribing skills.

Māori have also reported concern about the preparation of nurses to work with Māori, in particular the inclusion of kaupapa Māori in undergraduate nursing education. This issue is discussed fully in Chapter 8.

**Nursing education environment**

During the 1990s polytechnics have been subjected to a funding squeeze. In many instances, these funding pressures resulted in a downsizing of the lecturing staff while student numbers continued to increase. As well, the shortened academic year\(^49\) has meant there is less time in which to deliver the required content.

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\(^{49}\) When undergraduate education first transferred to polytechnics, the academic year was 40 weeks long. Since then it has gradually shortened, and is now between 30 and 32 weeks; over three years this amounts to a total loss of approximately 30 weeks.
Nursing lecturers have made an enormous effort to increase their own academic qualifications while maintaining high course work-loads. This has been an important factor in maintaining the quality of nursing degrees. Inevitably, however, there are still relatively limited numbers of nursing lecturers with a completed master’s degree; yet this is a basic requirement for teaching in a research-based bachelor’s degree. New Zealand is a small country and the existence of 15 polytechnic schools of nursing means that these human resources are thinly or unevenly spread.

There are further pressures. The nature of polytechnic education is to facilitate student success, with policies and procedures specifically designed to encourage students to make repeated attempts at successfully completing a course. In addition, there is a commercial requirement on polytechnics to fill courses and to keep them full.

For nursing, all this poses particular challenges. The nursing programme places students, and ultimately graduates, in situations where patient safety is of prime importance. There can be a considerable tension for nursing educators in balancing the conflicting needs of the institution and the profession. This tension is one more factor in the quality variations that can be observed between polytechnic nursing programmes.

Clinical training

Two separate but closely related issues powerfully affect the provision of clinical experience for nursing students. These issues are: the current approach to funding clinical training, and the provision of adequate clinical placements in which students can gain a good-quality learning experience.

Following a review in 1992, funding arrangements for clinical training were restructured. Three funding transfers took place in the health and education sectors:

- from Vote: Health to Vote: Education for the purchase of clinical undergraduate education
- from hospitals to the Clinical Training Agency (CTA) for the purchase of post-entry clinical training (this funding was ring-fenced for a year)
- from Vote: Education to Vote: Health for a small amount of funding for in-service education.

These funding shifts resulted in polytechnics purchasing clinical training placements for their students from hospitals and other providers. The Ministry of Education provides funding (in the form of the clinical subsidy) to polytechnics for this purpose. Since the unbundling exercise, there has been increasing pressure on the number of clinical placements available for undergraduate students. This pressure is related to three factors:
the requirement for hospitals to act in a business-like manner (this means that the price charged for clinical training is often greater than the level of subsidy provided by the Ministry of Education, which has been dealt with in three ways: by increasing student fees, by decreasing the duration of clinical placements, and by educational institutions using other funding to subsidise placements.

- a reported lack of clear communication between tertiary education institutions and hospitals.
- a timing difference in the budget cycles of tertiary educational institutions and hospitals (the educational institutions need information on clinical placement costs well in advance of the start of courses, in order to set fees; the hospitals require an indication of firm clinical placement numbers before they can calculate their costs and charge an appropriate fee).

The 'market' environment resulting from the above unbundling process has created problems in paying for clinical training from agencies. Community and voluntary agencies formerly donated their clinical placements; now, understandably, they expect payment. The original funding allocated by the Ministry of Education for the purchase of clinical training was for training provided by hospitals only, not for that supplied by other agencies. The effect has been to reduce the numbers of students that can be placed in clinical training programmes. It has also stimulated discussions in the nursing and education sectors about reducing the number of clinical hours required by undergraduate students. The Taskforce does not support any reduction in the current requirements for clinical placement hours, and there is no evidence to support such a change.

An additional challenge to providing clinical experience for nursing students is the continuing rationalisation of acute secondary services in hospitals. Changes in the configuration of health and disability services mean that some polytechnics no longer have ready access to an appropriate range of services for the placement of students. There is also often a lack of congruence between the differing needs and requirements of education programmes and hospitals. For instance, hospitals cannot always accommodate the student-oriented requirement of polytechnics to place students between the hours of 9 to 5, Monday to Thursday.

Quite clearly, the rational self-interest of polytechnics in offering undergraduate nursing programmes if there is a market for them and the rational self-interest of hospitals and other agencies in charging what the market will bear for clinical experience is not serving the best interests of nursing education in New Zealand.

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50 Based on the results of a survey of negotiations over price and access for clinical training, (1998) Ministry of Education.

51 Ibid.


53 Based on the results of a survey of negotiations over price and access for clinical training, (1998) Ministry of Education.
Many degree programmes are producing graduates with a comprehensive understanding of health, illness, human growth and development, biological science and the environmental influences on health. These nurses have learnt to communicate effectively, to assess and evaluate health needs, and to provide culturally safe care.

These nursing graduates are multi-skilled health professionals ready to build on their knowledge and to gain advanced clinical skills in a chosen practice area. It is in this transition to practice that further barriers to effective nursing education occur. In some cases, the barrier is a mixture of inconsistent preparation in the undergraduate programme and the lack of a properly structured first year of practice. For many other students, the lack of a structured first year of practice is the main barrier to contributing effectively as a nurse.

4.2 The First Year of Clinical Practice

What is known as the first year of practice marks the transition from student to practising nurse. Nursing has no history of formal internship - although in some hospitals the year following hospital-based training acted like an internship. Programmes to support new graduates into their first year of practice - such as formal and informal preceptorship, mentoring and orientation programmes - have varied in quality and length of programme. There have been alarming instances of new graduates being employed on a casual basis as part of an emergency ‘pool’, where they are expected to practise in a range of clinical settings without having gone through an appropriate orientation process.54

Since the loss of the structured fourth year when the nursing programme moved to polytechnics in the 1970s, there has been a growing expectation by employers that nursing graduates will be ‘work-ready’ in any setting. Undergraduate nursing programmes, however, have had a stated aim of preparing multi-skilled beginning practitioners only. These beginning practitioners are then ready for further education and consolidation in chosen practice areas. Communication between employers and educational institutions about these differing aims and expectations has been inadequate. The Taskforce notes that other professions do not expect their graduates to be fully work-ready upon graduation. Many professions, such as teaching and accountancy, make use of a period of provisional registration to signal the fledgling status of novice practitioners.

The Taskforce believes that this transition period is a vital time in the development of a truly professional and effective nurse. It is where new-graduate nurses should be strengthening and consolidating their knowledge and clinical skills, developing skills in decision-making and priority setting, and gaining confidence through the increased application of what has been learnt as an undergraduate.

EXISTING STRUCTURAL BARRIERS

Two major barriers affect the transition of nursing graduates into the workforce:

- there are few established nursing structures for entry into community practice, despite the increasing shift of health-care services towards home and community settings.
- there is an expectation by many employers in acute settings (mainly hospitals) that graduates will immediately take up a high work-load and a high level of responsibility with little structured help or support.

These barriers are discussed below.

Practice in the community

Historically, there has been a belief that all graduate nurses should experience one or two years of practice in an acute setting (that is, a hospital) before working in the community. There is no research evidence to support this belief or the practice it has engendered. As well, it is becoming increasingly difficult to implement.

What should be influencing the new-graduate transition are the changing patterns of care delivery - such as more day surgery, reduced length of stay in hospital, more care in the community, rising average acuity of in-hospital patients, and increased use of technology and new therapeutic approaches. This suggests that nurses should increasingly be able to choose between working in the community or in a hospital, without necessarily having had post-registration clinical experience in both settings.

Submissions to the Taskforce commented on the lack of any clear structures for the transition to nursing in the community. New graduates tend not to be employed in community settings, and this forces them to work in hospitals first (whether they want to or not). There are difficulties with new nursing graduates transferring to community settings in areas where leadership role models are scarce (so that graduates really do form links between theory and practice), and in developing clinical career pathways in the community. Leadership in community nursing is under-developed, and so the sector has been unable to develop any systematic approach to transition to practice. This is one of the causes of the difficulties that new graduates face when they enter community practice directly from their undergraduate programme.
Lack of structured support during the first year of practice

A number of submissions commented on the pressure graduates are under to perform almost immediately in their practice setting. Currently, all polytechnics are required to prepare their graduates to work in the whole range of health and disability services settings – including medical/surgical, mental health, child health, maternal health, aged care, as well as in the community. Students are also required to meet the academic requirements for a degree. Without a properly structured and supported first year of practice, it is little wonder that some graduates feel disillusioned and dissatisfied during this year.  

There are no national formal requirements or frameworks for structuring a nursing graduate’s first year of practice. Consequently, considerable variation exists in what is available. Some services provide formal new-graduate programmes, and these offer an excellent start for those nursing graduates fortunate to secure a place. The most developed programme is probably that funded by the CTA for mental health nursing graduates. This offers both clinical experience and education components during the first year of practice.

4.3 POSTGRADUATE EDUCATION

One of the great paradoxes of Western health care lies in the fact that our industrialised societies have given a large group of women – and some men – responsibility for the care of the sickest of our citizens without simultaneously giving them the education, authority, respect, and resources needed to fulfil this mission. In Canada and the United States, and most other Western nations, nurses are the largest profession in health care, outnumbering doctors almost four to one. Yet for over a century nurses have been struggling to obtain the kind of high-quality education doctors take for granted.

It is apparent that the role of nurses is changing rapidly in Western societies. New Zealand is no exception. Nurses working as part of multi-disciplinary teams in hospitals are more likely to see patients whose conditions are acute. The same patients are also likely to spend less time in hospital because of improvements in surgical and anaesthesia techniques and in the provision of care. Fewer people now need to enter hospitals because of more effective primary-care treatments, and there is a move towards self-care by individuals and their families. Nurses will continue to provide expert care in all these settings – from the increasingly ‘hi-tech’ acute hospital setting to the ever-expanding area of care in the community.

Existing postgraduate education

The main forms of postgraduate nursing education are:

- Masters or graduate diploma programmes, with either a self-chosen area of practice development within a broadly based Master of Nursing programme, or an endorsement in a clinical area. These programmes are undertaken in both universities and polytechnics, and are funded by the Ministry of Education and the student.

• Programmes in mental health nursing. These programmes are undertaken in universities, polytechnics and hospitals. They are funded by the CTA and the Ministry of Education, with the hospital making a contribution in the form of release time for its staff.

• Graduate diploma programmes, which are run at the request of a specific hospital. These are undertaken by polytechnics and hospitals. In the last few years – since hospitals have been run as businesses – there has been a steady reduction in the investment by hospitals in clinical training. Such courses are now almost non-existent.

• A range of clinically based education programmes developed by the clinical sections of the New Zealand Nurses Organisation. Some of these programmes are delivered by polytechnics, and are internationally recognised.

• Short-term clinically based courses run by health-service providers to meet ongoing education needs. These are not nationally recognised or portable.

Currently there are 500 nurses enrolled in master’s degrees and about 20 enrolled at PhD level.

The expanding role of nursing in New Zealand – and in particular the recent announcement of extending prescribing rights to nurses – highlights the immediate need for these types of new roles to be addressed in postgraduate education. The New Zealand nursing workforce is in a transition phase. All newly registered nurses are now graduates of a bachelor programme, and many experienced nurses have completed or are in the process of completing a conversion programme to a degree qualification. There are, however, many other experienced nurses who do not have the bachelor degree. These varying levels of educational attainment amongst nurses pose a challenge to educational organisations in how they design postgraduate programmes and other forms of post-registration education.57

EXISTING STRUCTURAL BARRIERS

The Taskforce knows from the submissions it received that there is enormous frustration expressed by nurses at what they see as a lack of postgraduate education – particularly clinically focused programmes – that is relevant to their needs. In addition there are significant access problems, such as the high cost of postgraduate education and the fact that programmes with clinical components are necessarily available only in one or two centres. These barriers become more marked when, in most cases, there is unlikely to be any increase in earnings from achieving a postgraduate qualification.


57 Descriptions of these programmes can be confusing. The Taskforce has termed all education undertaken after registration as ‘postgraduate’ for simplicity. This includes postgraduate education done in universities, polytechnics and clinical settings. The situation is made even more confusing because some nurses who do not hold a bachelor of nursing degree are advancing to master’s level in some programmes – a trend likely to continue.
Education for nursing at the postgraduate level is ad hoc, inconsistent and largely driven by initiatives from educational institutions, rather than from any analysis of the needs of the health sector. The lack of consistency and coherency between programmes is a significant barrier to creating a more structured programme of postgraduate education that is relevant to the practice of nursing at an advanced/specialist level. This becomes a vitally important issue in the context of expanding the scope of nursing. To develop advanced practice roles, specialist competencies, and prescribing, diagnostic and other skills depends on well-planned and well-resourced postgraduate education programmes – discussed in Chapter 2.

Funding arrangements are the other major barrier that influence the effectiveness of postgraduate education. Funding is currently split between the Ministry of Education and the Clinical Training Agency (CTA). The split means that the CTA funds postgraduate programmes which have over 30 percent clinical content. Submissions to the Taskforce highlighted this split as arbitrary and counter-productive.

The caps on student numbers have been removed from courses funded by the Ministry of Education (apart from very expensive courses such as medicine, dentistry and large-animal science); these programmes are now student-enrolment driven. This is very attractive to education providers as they have the ability to offer more courses if they are able to attract students. This may be an incentive to run unlimited postgraduate programmes in nursing with a low clinical content (that is, less than 30 percent). This is, however, the exact opposite of what is required if postgraduate programmes are to develop in response to the actual needs of nursing.

Particular problems and barriers relate to CTA funding. The CTA was created to purchase post-entry clinical training for the health and disability services sector. The bulk of the CTA’s funding (some 90 percent) is currently invested in medical education. This medical preponderance reflected the original unbundling exercise and the relatively low levels of nursing postgraduate programmes at the time. Despite some attempts in its early years to shift the mix of what it funds, the CTA has been unable to divert significant resources towards postgraduate nursing education. Shifts in the funding mix – while they may benefit the health and disability services sector – are often seen as ‘radical’ if they alter the status quo. Moves to provide more funding for postgraduate nursing programmes are likely to be resisted by the medical profession if they are at the expense of the CTA’s support of medical education.

In addition, CTA contracts are often short term. Education providers are reluctant to commit resources to these short-term contracts, and students have little ability to influence the course content they wish to have provided, except as employees of providers.

**Existing attitudinal barriers**

There is an unfortunate tendency for many nurses themselves to question the value of postgraduate education and to challenge the views and approaches of those nurses who have become highly educated in nursing. Nursing, like medicine, is a practice-based discipline and there can be suspicion of more-educated colleagues whose approaches may seem over-theoretical at first. Nevertheless, despite the barriers, there are groups of nurses pursuing

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advanced education - often at great personal cost as they balance demanding jobs, high workloads, and family responsibilities. These nurses recognise the clear link between continuing education and the quality of the service they provide, the end result of which is providing positive health outcomes for clients.

4.4 Strategies for Change

Education is an exceedingly complex area. In the time available to it, the Taskforce can do no more than put forward strategic directions on a number of issues. The strategies that the Taskforce proposes are frequently interlocked because the barriers that give rise to the strategies are also interlocked. Decisions that are made about the undergraduate degree, the first year of practice, and postgraduate qualifications affect the other links in the chain. Strategies for change cannot be seen in isolation: a strategic direction needs to be set for nursing education and then this direction needs to be progressively implemented. A similar approach has been taken in mental health services, where a strategic direction was established and then a plan to implement that strategy was developed.

The education of nurses is an investment in the health sector, but this investment needs to be managed as efficiently and effectively as possible. It is difficult to see a path forward if there is a continuation of the current arrangements for sharing responsibility between various Crown agencies for the purchase and provision of nursing education. Market mechanisms do not always work efficiently - or as they should in theory - when the total environment is not market-driven.

Answers need to be found to the potentially endless proliferation of nursing courses at both undergraduate and postgraduate level, the impasse over purchasing clinical experience between polytechnics and hospitals, and the postgraduate funding split between the Ministry of Education and the CTA. The Taskforce believes the Government's funding of nursing education needs to be spent effectively, so that it helps develop nurses into the positive force for better health outcomes that international research tells us is possible.

Strategy 1: Undergraduate education

There are significant pressures on the undergraduate nursing degree and more are likely to come. The Taskforce proposes the following courses of action.

- The number of polytechnic nursing programmes need to be reviewed jointly by the Ministry of Health and the Ministry of Education. The Taskforce is concerned that currently programmes are not producing graduates of a consistent standard, that teaching resources are too thinly spread, and that students are not always receiving appropriate clinical placements.

- The Nursing Council audit of programmes must specifically address the teaching of physical and mental-health assessments and the practical application of nurses' learning; in addition, more emphasis should be placed on specialty areas such as mental health.

- A better mechanism for meeting the costs of undergraduate clinical training needs to be developed by the Ministry of Education. A clearer specification of the respective roles and responsibilities of polytechnics and health-service providers for clinical training is
required. This specification would also apply to the clinical component of the first year of practice. The Taskforce notes that the current payment to providers is a subsidy only, which is paid in recognition of provider input. (This payment was part of the original unbundling exercise and should have been cost-neutral for CHES; however, this was not always the case.)

- Urgency needs to be given by the Nursing Council to auditing the competencies for mental-health nursing developed in 1997, and then reporting back on these to the Mental Health Workforce Co-ordinating Body and the Ministry of Health. Without this auditing process, the mental-health sector has no information on whether these competencies are working adequately. Furthermore, mental-health nurses appear to face difficulties in having their issues feed into policy development for nursing education. The Taskforce believes that its proposed memorandum of understanding between the Ministry of Health and professional nursing organisations will assist groups, such as the mental-health nurses, in gaining better access to policy-making.

**Strategy 2: The First Year of Clinical Practice**

There is agreement in the nursing profession that the first year of practice needs to be urgently reviewed. The Taskforce proposes the following courses of action.

- The development of a national framework for what should constitute the first year of practice for new graduates is needed. This would cover the status of graduates; the elements of the workplace orientation programme; the expected outcomes from the year for students and employers; the relationship between education, skill development and employment during the year; and the funding arrangements. A guided transition programme now exists for mental-health nursing and this should be used as a template for nursing as a whole.

The Taskforce believes that the health sector should stop treating first-year nurse graduates as if they are fully experienced professionals. Nursing graduates need to be treated in the same way as other professions treat their graduates – that is, they should work largely under supervision during their first year in the workforce.

- Funding for a more structured first year of practice needs to be fully investigated. Options for this include renegotiating the conditions of employment for graduates during their first year of practice. In effect, graduates would exchange a portion of their income in return for reduced working hours, guaranteed supervision, relevant clinical education, and a planned programme of clinical experience (possibly as a rotation of different types of clinical setting). Other areas for freeing up money could come from the more effective use of CTA money, and the savings to hospitals and other health providers from better-trained and more productive graduates entering the profession after their first year of practice.

- Development work is needed on a system of community-based placements as the first stepping-stone to career pathways in community care. One approach would be to establish accreditation criteria for clinical settings in community-based services. The Nursing Council would set these criteria, which would be based on the nursing resources and standards expected of a service offering clinical placements. This then allows nurses to move into and to specialise in community care without the usual pattern of completing their first few professional years in a hospital-based acute setting.
The Taskforce proposes that community health centres be developed in association with polytechnic and university schools of nursing. Funding for these centres would be shared between the HFA and the schools of nursing. In effect, the centres would be based around nurse-led primary-care teams which also provide ‘contracted’ medical services. Such centres would act as an important community resource, while providing a clinical setting for nursing students where students could work under the guidance of experienced nurse practitioners.

**Strategy 3: Postgraduate Education**

There are a number of significant barriers at postgraduate level that require attention. Postgraduate education is central to nurses expanding their scope of practice and gaining the advanced or specialist skills they will need in the health services of tomorrow. The Taskforce proposes the following courses of action.

- The postgraduate education framework recommended by the Nursing Council needs to be implemented by tertiary education providers. This framework is designed to support the cohesive development of postgraduate education and allow for national consistency.

- There needs to be more involvement by the providers of nursing services in the development of postgraduate nursing education. This should be a true collaboration between educators and service providers. Educators would be responsible for the academic quality of programmes, with direction on appropriate content being provided by nurses in practice. In addition, nurses in practice would be responsible for the development of relevant clinical experience in practice settings. Increasingly, there needs to be shared accountability between health and disability service providers and education providers in the development of postgraduate education for nursing.

- Where the development of specific specialist competencies raises the need for postgraduate education in particular areas, as in the instance of prescribing rights or to facilitate ACC purchasing, this should properly be the domain of the Nursing Council.

- If funding arrangements remain as they are at present (see Strategy 4), the division of funding for postgraduate courses between the CTA and the Ministry of Education needs to be urgently reviewed to allow postgraduate courses with clinical content higher than 30 percent to be funded by the Ministry of Education.

**Strategy 4: Funding of Postgraduate Education**

Devising a strategy for the funding of postgraduate nursing education has posed a considerable challenge to the Taskforce. It is not a simple matter to anticipate the structural changes likely to occur in the near, and not so near, future.

The current situation – which splits funding for postgraduate nursing education between the Ministry of Education and the CTA – is clearly not serving the best interests of nursing education. The Taskforce has a preference for joining the two streams of funding: this would immediately remove the arbitrary split that means postgraduate nursing funding is disjointed. However, the Taskforce judges that this is not a likely scenario, and we are also aware that the current role of the CTA is to be reviewed shortly.
In this unstable environment, the Taskforce sees two possible strategies for meeting the needs of postgraduate nursing education.

The first of these is to direct the CTA to increase its funding of postgraduate nursing education. This increase should occur incrementally over the next five years and be increased to 60 percent of the total CTA budget. This proposal is in line with the original intent of the CTA.

The second strategy is based on the Taskforce’s understanding that the proposed review of the CTA could lead to changes in the organisation of funding for postgraduate nursing education. This may result in funding being ‘mainstreamed’ within the HFA. In this strategy, the Taskforce accepts that the key issue is not so much where the money sits, but rather the use to which it is put.

In any event, the Taskforce is clear that a number of broad principles must be placed around the use of funding for postgraduate education programmes. These principles are:

- that service-provider interests are explicitly acknowledged when decisions to fund programmes are made. This was one of the principles which pre-empted the development of the CTA and one which the Taskforce believes is essential in matching education opportunities with the needs of the health and disability services. The recent removal of caps from almost all courses means that the market will determine the levels of education available. In order to prevent a proliferation of education-driven but clinically inappropriate programmes, the purchaser – whether this is the CTA, the Ministry of Education, or a combination of both – needs professional advice from nursing. The Taskforce proposes that this come from the following key areas:
  - a formal link between the funder of education programmes, nursing organisations and health-service employers
  - existing professional nursing bodies
  - the Chief Nursing Advisor
  - the development of a stronger link between education providers and the Nursing Council.

- that funding decisions are made with a national focus. The Taskforce recognises that local providers will have particular needs, but is concerned that small, locally run programmes be evenly balanced with postgraduate education which meets the need for the continued development of nursing specialties.

- that there is a funding formula similar to that currently used by the CTA. This formula recognises, and allocates funding for, the unique needs of health professionals – in particular, the need for health professionals to be released from work to attend courses, the need to travel to education centres, and the need for educators to retain their clinical competence.

- that a clear accreditation framework is developed for all postgraduate programmes. Currently accreditation of programmes and programme providers is split between the New Zealand Qualifications Authority (NZQA), the Nursing Council, and the Committee on University Academic Programmes (CUAP), depending on whether courses are run by polytechnics or universities. The Taskforce would like to see a more
uniform accreditation process which continues to recognise service providers as key stakeholders.

This chapter has identified that a natural consequence of expanding the range and quality of postgraduate education programmes is that demand will be stimulated for nursing research that is relevant to those programmes. This research in turn will feed back through the education programmes into the practice of nursing.

The following chapter looks at the issues involved in raising the profile of nursing research.
Nursing research is an essential element in improving nursing practice: it provides a sound basis for the approaches and techniques used in nursing. Without research, there is a risk of practices remaining based on unexamined traditions that do not offer patients the best possible outcomes.

Nursing research is generally in-depth and qualitative. Most research studies either explore patients’ experiences (with a view to providing greater understanding of particular states of illness or disability), or they examine nursing practice (in order to understand or critique health-promotion practices). The emphasis on a qualitative approach stems from a particular and strongly argued position: that nursing knowledge is about human experience of health and illness in the context of people’s lives, and that the richness of such experience is only given full expression and meaning in qualitative data collection. Aspects of people’s experiences of health and illness are difficult to quantify, yet they provide important directions for improving health outcomes.

The focus of this chapter is on the barriers that affect:

✦ the extent of nursing research (section 5.1)
✦ the use of research (section 5.2).

The final section (5.3) looks at strategies to overcome these barriers.

5.1 The Extent of Nursing Research

Not enough nursing research is done in New Zealand. This is largely due to the minimal availability and uptake of postgraduate education.

Most of New Zealand’s current nursing research is carried out under the auspices of postgraduate degree programmes. The first New Zealand master’s-degree theses appeared in the late 1970s and the first nursing doctorate in 1988. Each year since then has seen a steady growth in the numbers of nurses engaged in masters or, to a much lesser extent, doctoral theses. There is a second group of nurses who complete research degrees outside the strict confines of nursing: in health-related or health-commentary areas such as sociology or health policy. Overall, however, the numbers of nurses engaged in research are a tiny proportion of the nursing profession.

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60 In recent years there has been an increasing trend – especially internationally – for nurses to undertake quantitative research. Most of this research centres on the efficiency and effectiveness of nursing services.

61 Research carried out by nurses in clinical practice is negligible.
As mentioned above, the majority of nursing research is qualitative. But most major sources of research funding tend to favour studies which use quantitative strategies and which are believed to generate more ‘concrete’ and generalisable findings. The one notable exception is the Health Research Council (HRC), which has made a significant effort to support qualitative research.

Furthermore, research grants more readily go to those with a track record of receiving funding, and it is proving very difficult for nurse researchers to break through this barrier.

5.2 The Use of Nursing Research

The nursing research that is done needs to be more widely used – not only by nurses but also by other health professionals. But there are barriers to this.

Nursing research often remains unpublished, or is published in academic nursing journals which are read by a growing number of nurses but appear unlikely to be read or even known to members of allied disciplines such as medicine.

In North America and Britain there is a growing presence of nursing research which directly examines cost, efficiency and quality outcomes related to nursing inputs into health services. Some of this work has already been noted in Chapter 1. However, there is evidence that some decision-makers in health services tend to read the trade literature and not research literature.\(^\text{62}\) There is therefore no consistent use of this aspect of nursing research, and many decisions continue to be made in the absence of any clear measurement of nursing input.

Where nursing research is published in book form it becomes ‘invisible’ in an ironic mirroring of what happens to nurses themselves when they physically move away from direct bedside care. For example, the Dewey decimal system of classification, which underpins library classification, operates a remarkably limited definition of nursing which has previously been described as ‘defining nursing as the hands-on bedside stuff’.\(^\text{63}\) So ‘serious’ nursing research is hard to classify and, as a result, is hard for other researchers (and policy-makers) to locate.

The Taskforce also notes that many nurses seem to be unaware of the value of nursing research, or are reluctant to acknowledge that ‘academic’ research has a role to play in improving nursing practice. This is likely to change in the future, as more nurses undertake postgraduate education and post-registration education programmes.

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\(^\text{62}\) Shamian & Gerlach (1997) op. cit.

5.3 **Strategies for Change**

**Strategy 1: A Focus for Nursing Research**

The Taskforce believes it is vital that more nurses undertake research. We also believe that research findings – from both nursing research and research done by other disciplines – should be more readily available to all nurses, for use as a basis for nursing practice. The Taskforce sees the establishment of nursing research centres as the best way to achieve this.

There should be at least one nursing research centre, funded through HRC. It must be nurse-led and appropriately staffed. It must also be established with measurable outcomes and a reasonable timeframe in which to become self-funding or primarily self-funding.

The purpose of the nursing research centre would be:

- to co-ordinate the production of New Zealand research which clarifies the relationship between nursing input and health outcomes
- to encourage nurses to increase their research output, and their use of research
- to promote the use of nursing research more widely amongst health professionals
- to give nursing a co-ordinated base from which it can contribute to multi-disciplinary research in health, and also to social research
- to provide a visible site for other disciplines to access both nursing research and nursing researchers.

The centre would establish and support research programmes, develop research networks, and act as a resource for nurses interested in accessing research from other disciplines. It would also promote the incorporation of a nursing perspective in other fields of research: nursing has considerable potential for contributing to ethics research, for example, because of its patient-advocacy point of view. It would both provide funding directly, and facilitate access to other sources of funding.

The centre would also be important in providing a base which develops and supports opportunities for nursing research that is done by Māori for Māori. The need for greater access to research resources by Māori is also discussed in Chapter 8.
Strategy 2: Better Links Between Education and Health Providers

Nursing research can also be strengthened by greater collaboration between clinical practice settings and nursing-education institutions. This can be achieved through joint clinical appointments that span both the practice setting and the educational institution. The trend internationally is for such appointments to be at the level of a clinical ‘chair’ (which requires the holder to have a doctorate and usually some post-doctoral experience). Given the current scarcity of nursing doctorates in New Zealand, however, most of these appointments would initially need to be made at master’s-degree level.

So far the Taskforce has looked at issues related to the scope of nursing practice, funding (of community-based services), education, and research. All these issues featured strongly in submissions to the Taskforce - as did management and leadership, to which we now turn.
6 MANAGEMENT AND LEADERSHIP

New Zealand’s nurses constitute a major industrial grouping in their own right and, with over 40,000 registered, they are by far the largest part of the health-professional workforce. Their influence on the management and direction of health care, however, is in inverse proportion to their numbers.

Submissions to the Taskforce spoke about the near-total exclusion of nurses from managerial decision-making in health care. They also made the point that nursing involvement in decision-making has been progressively whittled away, especially since the replacement of nurses by non-nurse managers in the management structures adopted by hospitals in the last four to five years.

It is part of the Taskforce’s strategic vision that nurses will have a much greater involvement in the decisions that are made about health care, and that their leadership will develop a clearer consensus on key issues within nursing and within the health and disability services sector.

This chapter looks at the main barriers that prevent nurses contributing more fully at a managerial level and through professional leadership. The main focus is on:

+ involvement in policy and health-care strategy (section 6.1)
+ nursing leadership (section 6.2)
+ leadership development (section 6.3).

Strategies to overcome these barriers are discussed in the final section (6.4).

6.1 NURSING INVOLVEMENT IN POLICY AND HEALTH-CARE STRATEGY

EXISTING STRUCTURAL BARRIERS

Nurses are involved at all levels of patient care, and in hospitals they provide 24-hour care. Furthermore, as outlined in Chapter 1, nursing has a client-centred focus which deals with a person in all their life circumstances. As a result, nurses have a unique overview of the needs of clients and communities.

Increasingly, this perspective is being lost in ‘fragmentation’ as service contracts specify particular components of service to be provided. ‘Community’ services are purchased and provided separately from ‘hospital’ services - even though they are provided by the same provider.

The Taskforce believes that the lack of nursing involvement in policy and health-care strategy has exacerbated this fragmentation of servicing. Nurses – with their focus on continuity and

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co-ordination – have an invaluable contribution to make at a senior management level in providing a balanced picture of the continuum of care that leads to positive health outcomes.

Internationally there is evidence that, where nursing has a strong leadership role in the health sector, patient outcomes are improved. The issue here is that if nurses are not involved in the organisation of services and the control of resources within an agency, then they are unlikely to receive the right mix of responsibilities and resources needed to maximise their contribution to health-care services. This point has been made abundantly clear in the Report of the Health and Disability Commissioner into safety standards at Christchurch Hospital (Canterbury Health Limited) during 1994–1996. One of the Commissioner’s major findings was the lack of nursing leadership at the time. Many of the recommendations by the Commissioner relate to the importance of strong, centralised and accountable nursing leadership within a hospital. The Taskforce was told that Christchurch Hospital’s story was not unique.

The current health and disability services sector shows minimal involvement by nurses at the strategic-resource level. The Taskforce wishes to strengthen the input of nursing advice into all levels of policy through the Ministry of Health and other key agencies in the health and disability services sector.

The HFA’s new organisational structure has no senior nursing positions, nor does ACC receive any nursing advice at a senior level. This has to change. Sensible decisions cannot be made about the allocation of scarce resources in health care when there is no senior management input from the largest resource in the health and disability services sector.

At the hospital level, the message the Taskforce received from submissions was that people in senior nursing positions in hospitals feel undervalued and that senior-nurse positions no longer have real involvement in corporate and strategic decision-making. Senior nurses are members of the executive team in two-thirds of New Zealand’s public-sector hospitals, yet there is a sense that some managers do not feel that senior nursing positions add much value in the increasingly business-oriented world of health care. Furthermore, senior nursing positions in hospitals are largely advisory and have little control over nursing resources. Nurses hold the nursing-services budget in only five (out of 21) public-sector hospitals; a greater number have some influence over budget decisions, but this depends on the ‘grace and favour’ of the manager who has formal budget responsibility.

Chapter 3 (section 3.1) has already commented on the fact that very few nurses are represented at the management level of primary-care organisations. As well, submissions to the Taskforce have indicated there are significant gaps in nursing leadership in specific health-care settings – particularly in community-based services and in mental health services.

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65 Shamian & Gerlach (1997) op. cit.

66 Part of an oral presentation by members of the New Zealand Nurses Organisation to the Ministerial Taskforce on Nursing (29 May 1998).

67 Information provided to the Taskforce on request (June 1998).

68 Information provided to the Taskforce on request (June 1998).
EXISTING ATTITUINAL BARRIERS

The key agencies in the health and disability services sector do not fully recognise the contribution a senior nurse can make in areas such as policy development and planning at both a strategic and an operational level. This reflects a seemingly pervasive attitude amongst senior management that nursing has little to offer in terms of strategy or resource management.

Support for nurses in leadership positions has not always been forthcoming from the nursing profession itself. Submissions commented that there were few support systems available for nurse leaders, including leadership development programmes. One submission noted that:

Significant numbers of the nursing workforce only understand and value leadership which focuses on the ‘here and now’ clinical and operational aspects of nursing. They do not understand, value or support strategically focused company level leadership, especially if it is provided in the absence of effective clinical leadership.69

Another submission saw a missed opportunity by nursing during the 1970s and early 1980s to create a more facilitating approach that required less supervision by others:

. . . nurses tended to justify the inclusion of ‘senior’ positions as career development potential rather than as facilitating the work of the individual nurse with patient/clients and families. Thus, the way in which nurses in senior positions could create an environment which enhanced nursing practice, in the interests of all concerned, was not clearly articulated or valued.70

6.2 NURSING LEADERSHIP

EXISTING BARRIERS

The size and diversity of the nursing workforce has meant that its members are represented by more than one professional body. While these various organisations work together on behalf of nursing, there have been times when consensus has not been possible because of differing interests and objectives. There is strength in diversity – but also the risk of fragmentation and lack of unity.

The Taskforce was made aware from both individual and group submissions, and from its focus-group consultations, that nurses see the past lack of unity as a powerful barrier hampering the development of nursing practice. The focus on internal politics has diverted nursing away from the real issues in health. It has also limited the potential effectiveness of nursing leadership in the wider health and disability services sector.

There is, however, no clear mechanism through which consensus can be sought and legitimate disagreements mediated. This is at the heart of the barriers to the development of nursing leadership. There needs to be a mechanism through which the profession as a whole can be consulted, through which it can communicate a unified strategic direction and vision, and through which it can work collaboratively on the developmental strategies that will improve health outcomes for New Zealanders.

**Nursing organisations in New Zealand**

The professional nursing groups in New Zealand are:
- Australia and New Zealand College of Mental Health Nurses
- College of Nurses Aotearoa (New Zealand)
- National Council of Māori Nurses
- New Zealand Nurses Organisation – this is the largest professional nursing group in New Zealand, and it is the only group to include an industrial focus.

As well, there are a number of other organisations that have an advocacy and leadership role within nursing. The most prominent of these are:
- Nurse Educators in the Tertiary Sector (NETS) – a senior nurse educators group whose main interest is nursing education and development
- Nurse Executives of New Zealand (NENZ) – a grouping of senior nurses from major health providers whose main interest is nursing practice and the practice environment
- Nursing Council of New Zealand – a statutory body whose prime responsibility is public safety.

### 6.3 Leadership Development

**Existing barriers**

The series of barriers that have been discussed in 6.1 and 6.2 flow on to the issue of leadership development. It is difficult to develop a sense of nursing leadership in an environment where this is not valued by the sector’s top management or even by the nursing workforce itself. Couple this with the perceived lack of unity among professional organisations, and the result is a near crisis in the development of nursing leadership.

Education for future nursing leadership is essential. In the US, for example, it is considered an integral part of overall nursing education. One submission to the Taskforce expressed this as follows:

> There is a range of skills that nurses, and nurse leaders need to develop to create a responsive workforce . . . nursing cannot wait for these skills to develop within the current structures . . . Instead, retraining and upskilling of nurse leaders should occur in a phased programme over the next two years. This programme should reflect the multi-
disciplinary nature of the nursing environment so should not be exclusively about nursing.\textsuperscript{71}

Some of the suggested skills for this programme included holding contractual responsibilities, strategic development, relationship development within the health and disability services sector, health-policy development and analysis, and professional nursing development within a business model.

### 6.4 Strategies for Change

**Strategy 1: Increasing the involvement of nursing in policy and health care strategy**

The Taskforce's overall strategy is to more fully utilise the skills and competencies of nurses throughout the health and disability services sector. The strategies for access to funding and for expanding the scope of nursing practice will necessarily involve the profession at more strategic levels of health-care policy. How organisations such as the HFA, ACC and other funders obtain nursing expertise at a senior management level is up to them. However, the Taskforce strongly believes that they need to do this.

The role of nursing in achieving better patient outcomes has been firmly established. To make the best use of this, there must be people in senior nursing positions who are involved in leading, supporting and developing nurses and allocating resources in order to achieve the best possible outcomes.

More work needs to be done in preparing nurses to take on top-level management positions. A survey carried out in Denmark, Finland, Iceland, Norway and Sweden identified the management functions that were considered most important for senior nurses to have, if high-quality patient care was to be ensured. These included:

- planning of policy, programmes, resources, and organisational structure
- standards-setting
- information management
- training and development, and personnel administration
- budgeting and accounting
- monitoring and evaluation.\textsuperscript{72}

The Taskforce firmly believes that at all levels nurses should be responsible for the nursing budget within provider organisations – whether these be hospitals, IPAs or some other form of general practice. As part of this, clinical and management practices must ensure that nurses become more fully involved at a management level in provider organisations, and that they are given the skills-development education that allows them to be effective at this level.

\textsuperscript{71} K Wheeler (1998) Submission by Arthur Andersen to the Ministerial Taskforce on Nursing, p 3.

It would be appropriate for the HFA to include, in its contracting requirements, management specifications that enable this to be achieved (as we have already suggested in Strategy 3 of Chapter 3).

The Taskforce also proposes that the Ministry of Health form a memorandum of understanding between themselves and nursing organisations to strengthen the nursing input to policy development.

**Strategy 2: Nursing Leadership**

The drive for improved leadership must come from the profession itself. A unified approach to leadership is a necessary first step for nursing. Once the direction has been established, then the various nursing organisations can begin to develop programmes that will support nurses in leadership positions. More detail on specific measures to develop leadership are contained in the next strategy.

**Strategy 3: Developing Nursing Leadership**

Problems in the sector’s leadership development are not just restricted to nursing. Funding is needed to establish a multi-professional health leadership development programme, which in its first three years should give priority to nursing enrolments.

Funding is also needed for at least the next three years to help nurses develop business leadership skills. This funding should come from the HFA, and also from the Crown Company Monitoring Advisory Unit (which has funded leadership-development projects in the past). Having business leadership skills will enable nurses to compete more effectively in the health marketplace. It will also give nurses the necessary skills to manage budgets and to take a fuller role in strategic decision-making.

A programme funded by the Clinical Training Agency (CTA) is needed to further develop leadership in clinical nursing practice - with a particular focus on the evaluation of health outcomes, supervision and mentoring, innovative and collaborative practice models and workforce development.

These leadership-development programmes need to be supported by research into nursing’s contribution to policy and strategic decision-making, and the relationship of this to health outcomes. The results can then be used to direct future leadership development. The Health Research Council would be responsible for funding this research.

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In this chapter, the Taskforce has proposed that nurses be involved at a management level in all provider organisations and that nursing leadership be supported and more fully developed. The need for strong nursing leadership flows into workforce resourcing issues. It is difficult to maintain the morale of nurses in institutions if leadership is lacking, and declines in nursing morale can have an effect on patient outcomes.

In the next chapter, the Taskforce looks at some important workforce resourcing issues and their relationship to quality of care.
Career structures and professional development are closely linked to job satisfaction, quality of care and risk management. Many submissions from individual nurses to the Taskforce focused on the issue of the professional status of nursing. Submissions reflected nurses’ perceptions that their skills, education and expertise are not respected by other professionals.

Nursing is a profession dominated by women, and as such experiences the inequity in pay and conditions commonly associated with female employment. The difference between the average wage paid to men and that paid to women is commonly referred to as the ‘gender pay gap’. Research shows that New Zealand women earn 19 percent less than men per hour and 26 percent less per week. The gender pay gap is an issue that affects economic efficiency and growth, the incentive to train and work, the ability to support families, the ability to provide for one’s retirement, and equity and participation.

It is also useful to identify the following general trends which influence the pay and conditions of nurses internationally: health-care sector reform, which is explicit about the need to contain rising costs of health-care delivery; funding of the health-care sector, which in New Zealand is mainly public; decentralisation – for example, regional bargaining for nurses’ pay; and patient advocacy, where the issue of patients’ rights is an important factor. These factors have all influenced the working environment of nurses in New Zealand.

The focus of this chapter is on the barriers which affect:

- stress resulting from working conditions (section 7.1)
- clear career pathways (section 7.2)
- systems for costing nursing services and determining skill mixes (section 7.3)
- information systems for future workforce needs (section 7.4).

The final section (7.5) looks at strategies to overcome these factors.

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73 Ministry of Women’s Affairs (June 1997) An economist’s approach to the gender pay gap. A paper prepared for the CTU Summit, Closing the Gap.

74 Ministry of Women’s Affairs (1998) Oral submission to the Ministerial Taskforce on Nursing.

7.1 Stress Resulting from Working Conditions

Existing Structural Barriers

Internationally, the nursing workforce has faced increasing stress and pressure in recent years. This often results in nurses feeling undervalued and dissatisfied. These sentiments were expressed to the Taskforce in submissions received from individual nurses, which also highlighted that when nurses are under stress, and carrying a high work-load, they are unable to deliver the most effective service to consumers. When nursing morale declines, the quality of patient care also declines: this relationship has been clearly established in the Health and Disability Commissioner’s report into Christchurch Hospital.\(^{76}\)

Stress arises from a variety of sources (some of which are discussed in more detail in other sections of this report):

- the lack of formal measurement tools to adequately measure the ‘nursing difference’. This makes it impossible to accurately determine the numbers of nursing staff and the right mix of skills necessary to provide safe and effective care - which means that when nurses have concerns they are unable to quantify them.
- occasional non-replacement-of-nursing-staff policies in hospitals in times of budget pressure.
- an increased use of casual staff. Extensive use of nurses employed on casual contracts negates accepted professional support and safety measures for all nurses and may affect patient care.\(^{77}\) Casual staff may be denied ongoing professional development and may work with limited support in unfamiliar clinical situations. They also require closer supervision, which increases the responsibility of permanent nurses.
- lack of recognition of nursing leadership within organisational management structures.
- nurses’ real income. Since the Employment Contracts Act was implemented for nurses in 1993, the income of many nurses has fallen in real terms. This can be partly linked to the increased casualisation of the nursing workforce.
- increase in the average acuity of patients. People in hospital are more acutely ill than in the past. They require more specialised and technologically advanced care, and more constant monitoring. Those in the community also require more advanced care than in the past.
- funding pressure on private and community health-care providers. There is stiff competition for funding and contracts among private and community providers, with a consequent reduction in job security and pay and conditions for nurses employed by these services.

\(^{76}\) Health and Disability Commissioner (1998) op. cit.

\(^{77}\) The Health and Disability Commissioner’s report into Christchurch Hospital recommended that the ratio of casual staff to permanent staff should be no more than 30 percent per ward shift. Health and Disability Commissioner (1998) op. cit., p 64.
nursing pay scales. The current nursing pay scale provides few rewards for nurses who take on extra responsibility, practice at an advanced level, undertake postgraduate education or research, have a great deal of on-the-job expertise, or are involved in formal or informal teaching of junior staff. The International Council of Nurses describes this as a problem of the pay scales being compressed with little spread between the top and the bottom.\textsuperscript{78}

Working in a poorly managed, stressful environment, has two major impacts.

1. Nurses are unable to undertake tasks which in a ‘crisis’ environment are not regarded as strictly necessary, so activities such as preceptorship, mentoring, protocol development, and reflective practice are neglected. This compromises the overall quality of nursing care.\textsuperscript{79}

2. There are increased difficulties in retaining staff (particularly senior and experienced staff) and in recruiting new nurses to the profession. This is illustrated by the fact that while just over 40,000 nurses are registered, only 29,000 are actively practising as nurses.\textsuperscript{80}

### 7.2 Clear Career Pathways

#### Existing Structural Barriers

Nurses are not recognised for having specialty areas of practice or for practising at an advanced level. Some hospitals have developed clinical career pathways where nurses put together a portfolio which illustrates the level at which they practice, extra responsibilities undertaken and other types of involvement in the sector (for example, conference attendance). Clinical-career-pathway levels, however, are not yet linked to remuneration in all hospitals and health services. Many nurses are still paid based on years of service, not level of expertise or contribution to the organisation.

The lack of consistent national standards to demonstrate nurses’ level of practice and specialty knowledge is a complex issue for employers. Employers cannot be sure of the abilities of a nurse in their employ if there is no transparency around the skills of that person; in turn the employer is reluctant to remunerate nurses for advanced skills. The current ad hoc development of clinical-career pathways will not completely solve this issue as employers will, understandably, develop the programme that suits their individual needs. This process will not necessarily lead to nationally transferable skill levels or titles.

\textsuperscript{78} International Council of Nurses (1997) op. cit., p 76.

\textsuperscript{79} These issues are not just confined to New Zealand. The Canadian Nurses Association (Association des infirmières et infirmiers du Canada) Report on the Canadian Nursing Workforce (May 1998) raised many of the same issues as submissions to the Taskforce. There were concerns by Canadian nurses over client safety, client/ nurse ratios, nursing skill mixes, and the casualisation of the nursing workforce.

\textsuperscript{80} New Zealand Health Information Service (1998) 1997/98 Nursing Workforce Database.
Nurses, through their own initiative and hard work, have developed specialties in areas such as diabetes management, neonatal care, palliative care, intensive care and mental health. Too often, however, specialist nurses are seen by their managers as being interchangeable with other nurses in different areas of practice. Nurses who move into senior positions often lose their ‘nurse’ title and become ‘duty managers’ or other such titles. Anecdotal evidence to Taskforce members suggests that in some cases nurses in management have been actively encouraged to deliberately obscure their nursing identity. This belittles nursing, treating it as if it were a mere launching pad to something more important.

7.3 **SYSTEMS FOR COSTING NURSING SERVICES AND DETERMINING SKILL MIXES**

**EXISTING STRUCTURAL BARRIERS**

Current costing systems in the health and disability services sector – at both hospital level and within the community – cannot accurately cost the nursing component of care. This is an obvious barrier to nurses being able to make a quantifiable and justifiable case for additional staff or extra resources. It also prevents nurses having control over their own service areas because a budget cannot be worked out for these services.

Acuity systems, which measure the need for nursing services in relation to various patient conditions, need to be developed and used more widely in the New Zealand health and disability services sector. Without an adequate acuity system, it is impossible to work out the numbers of nurses and the mix of skills required for different service areas. These systems are an efficient method for calculating nurse staffing numbers based on patient needs rather than patient numbers. Significant cost savings have been identified through the use of these systems in hospitals overseas.

Linked to this is the fact that New Zealand does not have a nationally consistent system to measure and recognise the skill mix of nurses. These systems are not abstractions which have no impact on client care. The Health and Disability Commissioner’s report into Canterbury Health commented that:

> There is evidence to show that staffing numbers, skill mix and patient volumes affected nurses’ ability to meet patient needs. The high utilisation of casual nurses during 1996 compounded skill mix difficulties and the ability to develop the expertise of the casual nurses. Staff did not always have adequate experience to cope with outliers. This situation compromised the quality and safety of patient care . . . The ability to differentiate the skill of the workforce is essential to achieve a satisfactory skill mix, and existing systems did not facilitate this.

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81 Detailed information on acuity systems is contained in Development of a patient dependency/workload measurement system at the Rozelle Hospital (1993) Sydney: Rozelle Hospital.

82 Ibid., p 12.

7.4 INFORMATION SYSTEMS FOR FUTURE WORKFORCE NEEDS

EXISTING STRUCTURAL BARRIERS

New Zealand has no centralised national workforce planning agency in the health and disability services sector – and it is one of the few advanced nations in this situation. Various agencies produce nursing statistics but these are not brought together and analysed. The Taskforce believes that the demand for nursing services is rapidly changing and in both the opening chapter and the chapters on education and scopes of practice we have outlined some of the likely future trends in nursing.

The changing pattern of nursing is a world-wide phenomenon, and nursing shortages are likely to be on a global scale. New Zealand has achieved a single point of entry to the profession and a high level of pre-registration clinical hours compared with other countries, for example, Australia. New Zealand nurses are well regarded internationally and New Zealand needs to be prepared for shortages elsewhere in the world and the effects these will have on this country’s supply of nurses.

Currently, 1000 nurses a year graduate from the polytechnic undergraduate programmes, but whether this is sufficient or insufficient for New Zealand’s needs is unknown. There is a great deal of potential information on this: both the New Zealand Health Information Service and the New Zealand Nurses Organisation hold raw data about nurses and nursing, but no analysis of this data is carried out. Prescriptive quota-based workforce planning is obviously inflexible and unworkable. But without current and accurate information on workforce trends, it will be difficult to match the future (and rapidly changing) demand for nursing services with the supply of nurses.

7.5 STRATEGIES FOR CHANGE

STRATEGY 1: STRESS RESULTING FROM WORKING CONDITIONS

Working conditions that produce stress are an important issue for nurses. When nurses are continually placed into high-stress working environments with little recognition of advanced or specialty practice, remuneration also becomes an issue.

The strategies to address working conditions and the value placed on the contribution of nurses are inter-linked with all of the strategies discussed so far in this report. Improvements in access to postgraduate education, expanding the scope of nursing practice, the development of nursing leadership, support for new graduates in the first year of practice and other initiatives will all improve the working conditions of nurses and raise their professional status and visibility.

The Taskforce believes that the need to improve the visibility and understanding of nurses’ roles is particularly important in relation to employers. A clear information link needs to be established between the employers of nurses and nursing professional organisations so that an ‘education process’ about nursing can take place.
STRATEGY 2: CLINICAL-CAREER PATHWAYS

Clinical-career-pathway initiatives already under way in some hospitals and health services need to be continued, with the overall objective of moving toward national consistency. Typically, pathways will have up to five levels of practice which will then translate into levels of remuneration. This will encourage nurses to advance their skills and will give them a formal process for professional development. In time the levels will also match the development of specialist competencies. The advantages of clinical career pathways are three-fold: they will allow nurses practising at advanced levels to articulate their practice through a formal and recognised mechanism; they will provide a measure of the skill mix of staff, allowing for better matching of staff skill to patient acuity; they will give employers assurance about the competencies of their nursing workforce.

The development of clinical-career pathways requires the co-operation of employers (both hospital and community-based), the Nursing Council, and professional nursing organisations. Employers will have the main responsibility for continuing development of, clinical-career pathways, with the Nursing Council being responsible for providing the link to practising certificates.

STRATEGY 3: SYSTEMS FOR MEASURING AND COSTING NURSING SERVICES AND DETERMINING SKILL MIX

The HFA has agreed to fund a project (involving nursing professional organisations and practising nurses) to create a data set for costing nursing services. Work is already under way on similar projects and these initiatives need to be further resourced and developed. The information from these types of projects will assist the HFA in its pricing and costing work for hospital and health services contracts. A fully developed costing model will mean that the ‘nursing cost’ can be clearly spelled out in contracts. It is part of the Taskforce’s strategy that these nursing budgets should be held and managed by nursing leaders within hospitals and health services.

Nationally consistent systems to measure acuity and recognise the skill mix of nurses need to be developed. The Taskforce proposes that these initiatives be undertaken jointly by the Crown Health Association and nursing organisations, building on work already done in this area by the New Zealand Nurses Organisation and the Nurse Executives of New Zealand.

STRATEGY 4: INFORMATION SYSTEMS FOR FUTURE WORKFORCE NEEDS

An inter-agency project should be established between the Ministry of Health, the Department of Labour, the Ministry of Women’s Affairs and the HFA to investigate workforce issues, analyse existing data and identify gaps where extra data is needed. The project group should work closely with the organisations that currently hold nursing data, and those with a vested interest in the outcome of such work, particularly professional nursing organisations. The group will also need to have a monitoring role to ensure the continuing relevance of nursing workforce forecasting.
Many of the barriers and strategies raised so far in the Taskforce’s report apply to the health and disability services sector generally. But there are a number of issues that are specific to Māori and extend beyond the ambit of the Taskforce’s terms of reference.

These issues are described in greater detail in the final chapter.
What is the greatest treasure in the world?

I could only reply

'Tis people, 'Tis people,

He Tangata He Tangata

The thrust of the consultation process with Māori was undertaken, with the assistance of Te Puni Kōkiri, in a series of six hui held in Dunedin, Palmerston North, Gisborne, Rotorua, Auckland, and Whangarei. The hui were attended by Māori nurses, health providers and organisations, and health workers. There was an opportunity to contribute by completing the questionnaire and by submissions; however, provision was not made on the questionnaire for contributors to identify as Māori. In addition, Te Puni Kōkiri recommended that an advisory group be set up to support the Taskforce’s Māori member in undertaking consultation with Māori.

The consultation process with Māori was not without its difficulties. This was caused by Māori believing that there was no acknowledgement of the partnership of the Treaty of Waitangi in the Taskforce’s terms of reference. Māori also expressed concern at the process used for the selection of the Māori representative on the Taskforce. As well, the National Council of Māori Nurses declined an invitation to participate in the overall consultation process on grounds related to representation and process.

This chapter details the results of the hui. It discusses the main barriers and strategies that arose from the hui. A number of issues raised in the hui related to nursing in general and were not particular to Māori; these issues have not been discussed in detail in this chapter and are covered elsewhere in the report. Instead, this chapter focuses on issues particular to Māori nursing which were raised in the hui.

The following aspects need to be outlined in order to provide context for the discussion that follows:

- A tension exists when attempting to elicit a ‘pan-Māori’ vision, rather than an iwi vision, and therefore the information collected reflects the individual perceptions of Māori nurses and health workers who attended the hui, rather than being representative of Māori in general.
- While the focus of the Taskforce was nursing, it was evident that many of the issues for Māori nurses involved wider Māori realities.
- Māori view health in a particular holistic manner. This involves healing the ‘entire’ as opposed to a ‘part’.
- The strategic directions outlined at the end of the chapter are those received from Māori who attended the hui. Some of these fall outside the terms of reference of the Taskforce. The Taskforce does not consider itself the appropriate body to comment on these. Instead it has opted to recommend that these strategies be further developed by a more appropriate body. Where strategies relate directly to the work of the Taskforce a cross-reference is made to other sections in the report.
8.1 Representation and Consultation

Issues related to representation and consultation were seen as barriers by Māori who attended the hui. As mentioned, such issues were raised at each hui in relation to the Taskforce process, but it was recognised that these problems also reflect issues well beyond the Taskforce itself. The hui commenting that Māori were continually being consulted on issues related to health, leading to ‘consultation fatigue’ - a feeling compounded by the sense that the information shared did not result in change for Māori. The seemingly continual targeting of Māori for consultation is at a cost, as little or no reimbursement is often provided for either absence from work or travel to attend hui. Māori nurses often wished to be involved in consultation processes but due to inadequate funding are often unable to be released from work, or to travel long distances to attend.

The process of selecting representatives to attend hui was problematic. This arose from the lack of a transparent process, the absence of tikanga, and Māori not selecting who Māori want. Concern was also expressed that Māori representatives were often alone, with little recognition of the additional work involved in being a Māori representative. Often kaumātua and kuia are not part of the representation, yet are essential for the support and safety of representatives when walking amongst Māori. The hui felt this was caused by the selection of Māori representatives being undertaken in isolation from existing processes within Māoridom. This is interpreted as a seemingly total neglect of the partnership between non-Māori and Māori as enshrined within Te Tiriti o Waitangi, particularly tino rangatiratanga contained within Article 2. Consultation was seen to be undertaken within a non-Māori framework; this raised concern that, despite the bicultural nature of Te Tiriti o Waitangi, a lack of recognition existed in relation to the differing timelines and processes.

The nurses, and others consulted in the hui, commented that it is inappropriate to neglect the structure of iwi-hapū-whānau and Māori authorities in consultation processes that seek to obtain a unified vision of Māori health. Each iwi knows the health needs, and related needs, of its people. The use of processes that are acceptable and appropriate to Māori for representation and consultation are vital for the achievement of positive health outcomes.

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84 What you do, protocol.
85 Wise, experienced members of the whānau.
86 Older woman or women.
87 Treaty of Waitangi.
88 Sovereignty.
89 Iwi - tribe; hapū - groups of whānau with common ancestral links or sub-tribe; whānau - relationships that have blood links to a common ancestor, or a family.
8.2 Education

Undergraduate education

Māori health is a concern not only to Māori; it is also targeted as a health priority by the Government. One reason for poor Māori health statistics relates to accessibility, affordability, and appropriateness of the health services provided.\(^90\) According to Māori consulted through the hui, there are insufficient numbers of Māori nurses educated to work in the particular area of Māori health and to address the low health status among Māori. Although Māori nursing students constitute over 10 percent of total nursing students (which could be considered a reasonable proportion), this figure is low when compared to Māori health needs. The scarcity of Māori nurses is exacerbated by the increase in Māori health-provider groups (who provide health services particularly for Māori); having more Māori provider groups requires even more Māori nurses skilled in providing health care appropriate to Māori.

The difficulties that exist in recruiting Māori into comprehensive nursing programmes are many and complex. Whānau is of paramount importance for Māori. The geographical location of educational institutions often requires potential nursing students to relocate and isolate themselves from whānau. This is often not a viable option. Having children young, as many Māori women do,\(^91\) means that undertaking a three-year nursing programme is often unrealistic. In addition, many Māori feel that in academic terms they are inadequately prepared for meeting the demands of the degree-level nursing programme. This often deters potential students.

While recruitment is an issue, so is retention. Anecdotal evidence indicates that a significant number of Māori do not complete the nursing programme. Information shared at the hui throws light on the reasons why retention is an issue, and this is discussed below.

A number of Māori nurses at the hui said that Māori undergo a loss of identity upon entering the education system. Whānau support and commitment is considered by many Māori to be imperative, yet geographical distance may preclude this from being available. The needs of the whānau take priority over educational needs, and this may result in students not being able to meet course requirements due to fulfilling whānau obligations.

Māori consulted at the hui reported that the educational environment is a major barrier – even though attempts have been made within some educational institutions to make it more appropriate. The barrier revolves primarily around nursing education being delivered within a Western paradigm that gives little or no recognition to Te Tiriti o Waitangi and therefore lacks relevance for Māori. This is made worse by a failure to recognise the Māori ‘world view’ or philosophy as a valid way of learning and functioning. The combined result is that access to, and structures for, support are inadequate for Māori nursing students.

It is widely acknowledged by educators that Māori learning styles differ from the way in which education is delivered. There appears to be little attempt by education providers to


\(^91\) Health and Disability Analysis Unit (1996) The people of the Midland Health region (Te iwi o te waka hauora ki te pukuo te ika) Vol. 2 Health status; Part II The health status of young people (Te hauora o nga rangatahi) Hamilton: Midland Health.
offer teaching methods which recognise and incorporate different learning styles. Māori expressed concern that Māori nurse educators are few in number and frequently carry high work-loads. In addition, they are providing support and often re-teaching content outside their subjects areas to ensure that Māori progress successfully through the programme. This additional teaching reflects the different learning style of Māori students, and the additional commitment of those Māori educators to support Māori students - with little institutional recognition.

Attitudinal barriers also impact on the retention of Māori students. Despite the release of the cultural safety document in 1996 by the Nursing Council, Māori consulted at the hui felt that little or no improvement in the attitudes of non-Māori nurse educators had occurred. This is evidenced by Māori students being called on to justify the way in which they support one another, or the supports put in place for them in some institutions.

**Case study: attitudinal barriers for Māori students**

Two students worked together for support in their learning, and in their preparation for assessment work. The philosophy of the programme clearly stated that there was a fostering of co-operative learning. Yet when their assignments were marked they were accused by the marker of copying and cheating as some pieces of work were identical. The students wrote their own assignments but shared the literature. The pieces of identical work were unmarked direct quotes - these students, during their first semester on the programme, were still developing their writing skills. (Case cited during the hui.)

The lack of support provided for Māori necessitates their conformity with the dominant paradigm. This in turn raises concern that Māori nursing graduates have a loss of identity, and that the loss of identity impacts on the ability to deliver services to Māori. To be effective in working with Māori, nurses need to have a good grounding in Māori kaupapa. As one kaumātua explained during a hui, it is important to have te reo and tikanga (as well as qualifications) when working with Māori to improve health outcomes. Māori nurses need to be appropriately prepared to work with Māori clients. This means education needs to blend kaupapa Māori with nursing knowledge.

**POSTGRADUATE EDUCATION**

The issues raised in the hui regarding postgraduate education for Māori are similar to those outlined above, and to the issues raised in Chapter 4. In addition, educational institutions were seen to be slow to respond to Māori and their health needs. It was felt that postgraduate education should be responsive to Māori health needs and provide courses which prepare Māori nurses to work in Māori provider groups and independent practice. The provision of appropriate postgraduate education is particularly important for nurses working in remote and rural areas, and, as discussed in Chapter 4, for those contemplating undertaking education to achieve prescribing rights.

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92 Māori culture and values.

93 Māori language.
Access to resources (such as funding and computer facilities) tends to be a barrier to Māori undertaking postgraduate studies, particularly for those undertaking distance learning. This problem is compounded by the fact that many Māori provider groups have limited resources available, resulting in diminished educational opportunities within these settings.

Another barrier for nurses was the New Zealand Qualifications Authority and ACC structures and the transportability of qualifications. Nurses often undertake a variety of courses which are applicable to their daily work and appropriate for working with Māori, yet these qualifications are not recognised by bodies such as ACC; for example, counselling qualifications specific to working with Māori.

**Enrolled nurses**

While enrolled nurses did not form part of the Taskforce’s terms of reference, their role in Māori health care was constantly raised at the hui. Historically, enrolled nurses have been an integral part of the Māori nursing workforce. But there has been a decline in the number of enrolled nurses employed within health-care services, and education for enrolled nurses is no longer available.

While enrolled nurses in some areas have been offered the opportunity and the support needed to complete the comprehensive nursing programme and so become registered nurses, this has not been a realistic option for many. Whānau needs and commitments, the level of academic preparedness, geographical isolation from educational institutions, funding (for those not supported by employing bodies), and the personal desire to become a nurse influence the ability and willingness for many to upgrade their nursing qualification.

The hui delivered the message that enrolled nurses have a valuable contribution to make in the Māori health area. The perception of those consulted at the hui was that the many Māori enrolled nurses bring more than nursing skills to the provision of an accessible and appropriate health-care service which aims to improve the health status of Māori. Qualifications were only one of many attributes required when working with Māori. The hui also noted that in order for health and disability services for Māori to be effective, appropriate providers must be available.

**8.3 Research**

Māori undertake alternative ways of practising which achieve positive health outcomes for Māori, yet these are often not recognised as they are unable to be validated. Māori nursing knowledge developed from a research base is profoundly lacking. This was identified as an important need and a current barrier to improving health outcomes. It was felt that there is a need for education on research methodologies appropriate to Māori and on how to access funding. Many were unaware of the funding available through the Health Research Council targeted specifically for Māori health. The need to encourage, mentor and develop research among Māori nurses is essential in order to reveal the effective ways in which these nurses work with their clients and achieve positive health outcomes.
8.4 THE FRAMEWORK WITHIN WHICH HEALTH SERVICES ARE DELIVERED

Te Tiriti o Waitangi recognises Māori as a Treaty partner and therefore Māori should be able to deliver health services which reflect tikanga and appropriate accountability lines. However, the frameworks imposed by non-Māori act as barriers for Māori nurses and other health providers. These frameworks are often inappropriate to, and incongruent with, the delivery of kaupapa Māori health services.

Incongruent frameworks result directly from attempts to reduce the holistic Māori world view, which does not lend itself to reductionism. Non-Māori frameworks do not encompass the central place of iwi-hapū-whānau. Yet under the provisions of the Treaty of Waitangi and tino rangatiratanga, Māori have the right to frameworks and structures they see as appropriate. The result can be likened to trying to fit a square peg in a round hole – it doesn’t fit.

Inappropriate frameworks make it difficult for some Māori to respond accurately and adequately to non-Māori accountability requirements. When health care is practised in a holistic manner it is difficult to separate aspects that are inextricably intertwined. It was noted on several occasions that the problem of inappropriate frameworks exists within nursing. For example, Māori are currently absent within the structure of the Nursing Council, and there is no deliberate mechanism whereby Māori can ensure representation on the Council, and this poses a problem when disciplining nurses who work within Māori provider units (which function in ways different to those of mainstream services).

Kaupapa Māori services are described in the Mental Health Commission’s Report of key messages to the Mental Health Commission from hui held February–April 1998:

When it comes to our minds and our wairua, it is not appropriate to receive treatment based on just the Mainstream Services model. We have Māori minds and a Māori wairua and therefore need to be treated by Māori under the concept of whakawhanaungatanga. We know that practising this way produces far better results for Māori people with a mental illness.

The absence of an appropriate framework which recognises Māori kaupapa creates conflicts in practice. Māori nurses often have to reconcile the different expectations placed on them by the mainstream services model and Māori clients, and this can result in high levels of staff burn-out.

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94 Spirit, spirituality.
95 Establishing links.
The number of Māori health providers has increased from 30 in 1993 to over 220 in 1998, but there has been no concurrent increase in the numbers of Māori in the health-provider workforce. There are difficulties in attracting experienced nurses to provider groups – in particular, a lack of appropriate preparation for working with Māori clients, inequity and disparity in remuneration and work conditions compared to those working in mainstream services, and a perception that funding allocated by the Government does not get to the stated kaupapa in full. Feedback from the hui indicates that this lack of Māori in the health-provider workforce is a barrier to meeting the health needs of Māori and affects the ability to improve health outcomes for Māori.

Inequity and disparity in remuneration and conditions is a particular problem for nurses working in Māori provider units; this inequity compounds the gender inequity discussed in Chapter 7. The level of remuneration is low compared with that in mainstream services, and this acts as a disincentive for nurses to work with Māori (see following case study). This is compounded by a lack of formal recognition of the additional knowledge and skills Māori nurses bring with them – in particular, those skills that allow nurses to relate to, and meet the needs of, Māori. These attributes are central when working with Māori patients and whānau, but they are difficult to fulfill without some of the nurse’s existing work-load being relieved. Additional expectations and accountabilities are in place for Māori nurses who have responsibilities not only to their employing bodies but also to iwi. In instances where support is provided, this is within a non-Māori framework, ignoring the Māori part of the nurse which requires support and nurturing. Māori nurses experience double inequities: gender and ethnicity.

Case study: inequities in pay

During the hui, numerous examples of inequities were recounted. One example cited a psychiatric nurse who was working within a hospital Māori mental health team and was being paid $10,000 less than a colleague in mainstream mental health who had the same qualifications and levels of experience.

8.5 Leadership

Chapter 6 discusses leadership issues, and some of these issues were also raised in the hui. The health reforms removed nursing structures, and those now in place are seen by many Māori nurses as being unstable. The absence of positive role models does not allow nurses to fully develop and meet the challenges of the current environment, or to develop expanded practice. The lack of recognition of leadership and the inability of Māori nurses to come together and discuss issues contributes to an ineffectual input on health issues, and was seen to have a potential impact on health outcomes.

The removal of nursing leadership positions and nursing structures has had a deleterious effect on nursing as a whole and on Māori nursing as a component. The current ‘management’ environment within health is not attractive to Māori nurses, who feel that they are often undervalued and that movement into leadership positions is not encouraged. The hui also pointed out that the level of remuneration for nurses in leadership positions was insufficient and inequitable when compared to the level of responsibility required. Reference was made to hospitals’ pay structures for nurses: they do not acknowledge additional responsibilities undertaken by those in leadership positions.

8.6 Strategies for Change

It was evident throughout all the hui that Māori nurses and health workers have a commitment to achieving positive health outcomes for Māori. It was also evident that many are frustrated by current restraints and barriers which inhibit both current practice and its future development.

The hui have put forward several recommendations to the Taskforce to address the barriers identified in this chapter – some of which fall outside the terms of reference. The Taskforce considers it vital to put forward all of the recommendations made, but, for two reasons, has only commented on some of them: firstly, the Taskforce membership is a culturally inappropriate mix; secondly, as mentioned, some of the recommendations are outside the Taskforce’s terms of reference.

The Taskforce wishes to emphasise that strategies to address Māori health and nursing issues are vital, and recommends that an inter-agency team be established to consider and advance all of the issues raised in this chapter in an appropriate and meaningful manner. To reduce the risk of fragmentation it is important that this group address those issues raised in this chapter as well as those noted in other parts of the report. This group could consist of representatives from the Te Kete Hauora (the Māori Health Group within the Ministry of Health), the Māori Health Commission, and Ministry of Education, Te Puni Kōkiri, and the National Council of Māori Nurses and Te Rūnanga o Aotearoa of the New Zealand Nurses Organisation.

8.7 Recommendations from the Hui

Strategy 1: Representation and Consultation

The end point of representation and consultation with Māori must be about improving the health status of Māori. This means translating the intricacies of a holistic health paradigm into health and disability services which achieve positive health outcomes. To achieve this, processes for representation and consultation must be transparent, recognise differing timelines and processes, and defer to iwi to utilise the processes already in existence. Funding must also incorporate the need for Māori to be released from work and to travel to attend hui.
Furthermore, in order to achieve appropriate representation and consultation of Māori in the improvement of Māori health in general and Māori nursing in particular, the hui recommend the establishment of a Taskforce on Māori Health, with members chosen by Māori. This Taskforce should take a holistic approach to Māori health and examine all aspects of Māori health-care services and delivery. Its end purpose would be a positive health outcome for Māori.

**Strategy 2: Education**

In order to meet Māori health needs, it is essential that Māori nurses be adequately and appropriately prepared to work within a Māori framework. The Taskforce discusses the content of undergraduate education in Chapter 4, and suggests that the existing undergraduate curriculum be reviewed to ensure kaupapa Māori is incorporated for Māori students and delivered in an appropriate manner.

The hui recommend that support and resources be provided by the Ministry of Education for the establishment of formal links between kaupapa Māori wānanga and nursing programmes, for the express purpose of developing curricula with knowledge appropriate to the nursing of Māori.

The hui recommend that the Ministry of Education's equivalent-full-time-student (EFTS) funding be reviewed to provide additional funding for the support offered to Māori nursing students within educational institutions. This strategy aims to improve the retention rates of Māori in nursing programmes.

The hui recommend that the current and future place of the enrolled nurse be explored by the Nursing Council of New Zealand. It is important that this process focuses primarily on achieving positive health outcomes for Māori.

**Strategy 3: Research**

The hui identified the current paucity of research related to Māori nursing as a problem requiring urgent attention. They recommend that the Health Research Council widely promote the funding and support available for research by Māori nurses. It is also very important that appropriate mentoring and support is provided to those undertaking research. An increased focus on Māori nursing research will develop a body of knowledge for, and about, Māori nurses and record the successful approaches of Māori nurses in practice. Research is discussed in greater depth in Chapter 5, where the Taskforce proposes that a research centre for nursing be established, which would include a focus on research done by Māori.

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*Place of learning.*
Strategy 4: The Framework Within Which Health Services Are Delivered

The hui would like to see programmes aimed at developing the skills necessary for contracting and managing funds available to Māori nurses. Such skills are necessary in the current health environment and are likely to become more important in the future with the continued development of independent providers. Funding for such programmes could be provided via the CTA. (Chapter 6 discusses this issue more fully.)

The achievement of appropriate accountability lines could be achieved by the Ministry of Health exploring the feasibility of creating a parallel Māori Health Funding Authority.

Research that examines the Māori health workforce - where Māori are working, salaries, work-loads, career pathways, education needs, and those entering into nursing - would contribute not only to workforce initiatives, but also to addressing the inequities and disparities which currently exist.

Strategy 5: Leadership

Sound Māori nursing leadership is essential for the development of a workforce that can enter the 21st century and face its challenges. To this end, the strategic directions that have been outlined for leadership (see Chapter 6) apply to Māori. They must, however, be appropriate to a Māori framework and way of functioning.
APPENDIX 1: INDIVIDUAL SUBMISSIONS

The Taskforce received 1137 submissions in response to the mail-out to individual nurses (questionnaire overleaf). In addition, 10 submissions were received after the closing date, and after the Taskforce had discussed the content of individual submissions.

While submissions were targeted at individual nurses, it was evident that some nurses took the opportunity to group together to make a submission. Others elected to send more than one submission. For these reasons it is not possible to determine the total number of nurses represented by submissions.
QUESTIONNAIRE TO NURSES (please use additional sheets if necessary)

Question One:
Please identify one barrier – structural, legislative, attitudinal or intra-professional, which you believe prevents registered nurses from contributing to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders. If you wish to identify more than one, please use a duplicate of this sheet.

Question Two:
In what way (or how) does the above create a barrier to registered nurses contributing to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders?

Question Three:
How would health care delivery be affected by removing the above barrier?

Question Four:
What exact strategies are needed to remove this barrier?

Question Five:
Is there any other comment you would like to make?

Please indicate if you are:

1. A registered nurse
2. An enrolled nurse

Please return this questionnaire to:

Ministerial Taskforce on Nursing Secretariat
Ministry of Health
3. Other (please specify) □ PO Box 5013
                            Wellington
APPENDIX 2: ORGANISATIONS WHICH MADE WRITTEN SUBMISSIONS TO THE TASKFORCE

1. Accident Rehabilitation and Compensation Insurance Corporation, David Rankin: General Manager – Health Providers
2. Arthur Anderson, Kim Wheeler
3. Auckland Adventist Hospital, Terry Gracez and staff nurses
4. Auckland Healthcare Services Ltd, Auckland Diabetes Centre, Community Health Services, Paul Drury; Medical Director
5. Auckland Healthcare Services Ltd, Graeme Edmond; Chief Executive
6. Auckland Healthcare Services Ltd, Mental Health Services, senior nurses
7. Auckland Healthcare Services Ltd, Nursing and Midwifery, Jocelyn Peach; Director Nursing and Midwifery
8. Auckland Institute of Technology, Faculty of Health Studies, School of Nursing and Midwifery, Mary MacManus; Programme Leader
9. Auckland Public Health Nurses Forum
10. Australian and New Zealand College of Anaesthetists, Malcolm Futter; Honorary Secretary
11. Australian and New Zealand College of Mental Health Nurses Inc, New Zealand Branch, Brian Pickering; President
12. Capital Coast Health (CCH), Anita Bamford; Chief Nurse Executive, on behalf of CCH nurses
13. Centre for Rural Health, Jean Ross; Rural Practice Nurse Co-ordinator
14. Christchurch Polytechnic, Faculty of Health and Sciences, School of Nursing, Midwifery and Health Education
15. Clinical Training Agency, Dr Winston McKean; Acting Manager
16. College of Nurses Aotearoa (NZ) Inc, Marion Clarke, Stephen Neville, Candy Cookson-Cox; Board of Directors
17. College of Nurses Aotearoa (NZ) Inc, Canterbury Branch
18. Committee Advising on Professional Education (CAPE)
19. Family Planning Association, Sue Ineson; Executive Director
20. Health and Disability Commissioner, Robyn Stent; Health and Disability Commissioner
21. Health Care Aotearoa Inc, Peter Glensor; National Co-ordinator
22. Health Funding Authority, Central Office, Dr Fran McGrath; Group Manager
23. Health Funding Authority, Northern Office, Māori Health Development Division, Gwen Tepania-Palmer; General Manager
24. Health Funding Authority, Northern Office
25. **Health Funding Authority, Southern Regional Health**, Christine Crane; Contract Operations Manager

26. **Health Waikato Ltd, Waikato Hospital**, Sue King, on behalf of five senior nurse clinicians and educators

27. **Health Waikato Ltd, Waikato Hospital**, Ward 25 nurses

28. **Healthcare Hawkes Bay**, Community Health, Heather Charteris; Diabetes Nurse Specialist Chairperson and Educator

29. **Healthcare Hawkes Bay, Community Health**, Virginia McEwan; Project Leader


31. **Lakeland Health Limited Mental Health Service**, Brian Pickering; Nurse Consultant mental health

32. **Massey University Albany, School of Health Sciences**, Dr Judith Christensen; Associate Professor

33. **Medical Council of New Zealand**, M A H Baird; President

34. **Midcentral Health**, Jane Dransfield; Nursing Consultant

35. **Ministry of Women’s Affairs**, Katherine Baxter; Manager Policy for Chief Executive

36. **National Directors of Mental Health Nursing**

37. **National Health Committee**, Gae Griffiths; Acting Chair

38. **National Mental Health Workforce Development Co-ordinating Committee**, Margot Mains; Chairperson

39. **New Zealand Nurses Organisation**, Brenda Wilson; Chief Executive Officer

40. **New Zealand Nurses Organisation, Canterbury Nurses Forum**, Eileen Brown; Co-chairperson

41. **New Zealand Nurses Organisation, Canterbury Regional Mental Health Section**, Karen Moke; Chair

42. **New Zealand Nurses Organisation, Diabetes Nurse Specialists Section**, Helen Snell; Diabetes Nurse Specialist

43. **Newtown Union Health Service**, nurse practitioners

44. **Nurse Educators in the Tertiary Sector**, Barbara Robertson Green; Co-ordinator

45. **Nurse Executives of New Zealand**, Jocelyn Peach; Secretary

46. **Nursing Council of New Zealand**

47. **Nursing Independent Ltd**, Catherine Cooney; Director

48. **Otago Polytechnic, Nursing and Midwifery Department**, Robin Day; Head of Department

49. **Patients Rights Advocacy**, Anna du Jonge

50. **Takapau Health Centre**, Ingrid Cheer and Helen Carver; Nurse Practitioners

51. **Te Puni Kōkiri, Ministry of Māori Development**, Dr Ngatata Love; Chief Executive

52. **The Christchurch School of Medicine, Department of Public Health and General Practice**, Les Toop; Head of Department
53. The Royal New Zealand College of General Practitioners, Ralph Wiles; Chairperson
54. The University of Auckland, TAD Early Intervention Project, Rose Lightfoot; Project Manager
55. The Waikato Polytechnic, Nursing and Health Studies, Eileen Chambers and Denise Irvine; Principal Lecturers
56. Victoria University of Wellington, Department of Nursing and Midwifery, Joy Bickley; Senior Lecturer
57. Wairarapa Community Health Council, Allen Hair; Chair
58. Wairarapa Health, Masterton Hospital, John Pansters; Nurse Advisor

One organisational submission was received after the Taskforce had discussed organisational submissions.
APPENDIX 3: ORGANISATIONS WHICH MADE ORAL SUBMISSIONS TO THE TASKFORCE

The following organisations made oral submissions to the Taskforce; some of these organisations also made separate written submissions (see Appendix 2). Others provided some written detail when accepting an invitation to meet with the Taskforce, and followed this up in discussion.

Accident Rehabilitation and Compensation Insurance Corporation
Alcohol Advisory Council of New Zealand with the University of Auckland TAD Early Intervention Project
Australian and New Zealand College of Mental Health Nurses
Christchurch School of Medicine
Committee Advising on Professional Education
Health Care Aotearoa Inc
Health Funding Authority
Health Research Council
Ministry of Education
Ministry of Health
Ministry of Women’s Affairs
National Directors of Mental Health Nursing
New Zealand General Practitioners Association
New Zealand Medical Association
New Zealand Nurses Organisation
New Zealand Public Service Association
Nurse Educators in the Tertiary Sector
Paediatric Services Review
The Royal New Zealand College of General Practitioners
University of Otago, Faculty of Medicine
APPENDIX 4: INDIVIDUALS CONSULTED DURING THE HUI HELD BY THE TASKFORCE WITH THE ASSISTANCE OF TE PUNI KOKIRI (THE MINISTRY OF MAORI AFFAIRS)

Anna Ashford
Sam Bishara
Pat Bodger
Candy Cassidy
Sharon Challis
Ngarunoo Cherrington
Mr and Mrs Connelly
Candy Cookson-Cox
Ivy Curtis
Dickie Dewes
Tui Ferris
Trisha Flood
Diane Gisborne
Miriam Going
Dianne Grant
Tere Gravenor
Heather Hallmond
Jo Hape
Ngaire Harris
Orana Harris
Christine Hawea
Sonia Hawea
Marama Henry
Tangiwairua Hieatt
Emily Hohapata
Delwyn Howe
Diane Irwin
Glensy Jenkins
Charlene Kershaw
Jacquie Kidd
Carol Kimberley
Jo Kingi
Tarewa Kingi
Anaru Kira
Mori Kramers
Queenie Mahanga
Martin Mariasouce
June Mariu
Patricia McCarthy
Ngawini McLean
Tia Minnoch

Lin Morrison-Ngatai
Eleanor Murphy
Luana Murray
Evelyn Ngamanu
Robyn Ngarangione
Christine Nicholas
Helen Pahu
Hera Paiea
Merle Patena Ormsby
Bessina Pehi-Rewi
Debbie Poananga
Marion Pohio
Sandy Potaka
Mere Pou
Rerehau Pounsfora
Lou Te Hine Pouri Jurlina
Topsy Ratahi
Yvonne Raureti-Carson
Terahingahinga Reti
Denise Riini
Christine Rimene
Karaka Roberts
Mereana Roberts
Raey Stainton
BJ Taare
Nora Tahapehi
R. K. Tamahana
Mate Tapiata
Ngaati Tawhiao
Marion Terry
Graeme Thompson
Paea Thompson
Jacque Udesike
Rangi Waikari
Hamiora M K Waiti
Wiki Walker
Daphne Wharepapa
Peri Whiu
Rosalie Williams
Terelyn Wirihana
APPENDIX 5: INDIVIDUALS CONSULTED DURING FOCUS GROUPS HELD BY THE TASKFORCE

Jan Adams
Judy Baker
Kevin Baker
Angela Baldwin
Mary Baldwin
Anita Bamford
Shona Blair
Betty Blake
Marian Bland
Sue Boyle
Eileen Brown
Ngairie Buchanan
Margaret Cain
Mary Carney
Mia Carroll
Heather Casey
Helen Casey
Judith Christensen
John Cochrane
Faye Davenport
Jane Dransfield
Mary Fairhall
Colleen Fakalogotea
Ann Foley
Joan Forde
Barbara Fox
Jenny Gamble
Jenny Gordon
Terry Gracez
Waveney Grennell
Lynn Grose
Chiquita Hansen
Alison Harrington
Karen Hawke
Gay Hayes
Chris Hendry
June Henwood
Janet Hewson
Nina Hill

Sue Hina
Chris Hopkins
Cedly Huckle
Margaret Jaimeson
Margaret Jeffer
Denise Jensen
Susette Johns
Raewyn Johnson
Clara Joseph
Teina Kake
Rihi Karena
Nigel Kee
Beth Kelly
Anne Kemp
Gemma Kennedy
Rhondra Khan
Rhonda Knox
Richard Lakeman
Joanne Leamy
Elizabeth Lee
Sherry Lilley
Cheryl MacDonald
Judith MacDonald
Elaine MacFarlane
Annette MacKenzie
Donna Mayes
Helen McKenzie
Bev McKeran
Mary McLean
Shirlee McLean
Roger McLeod
Lynd Messervy
Louise Morrice
Judi Mulholland
Mary Munn
Marnie Neway
Julie Nicholls
Elizabeth Niven

Andrea Nixon
Megan Ogle
Lyn Ohlsen
Jan Paterson
Jillian Pearce
Debbie Penlington
Jenny Phillips
Karen Phillips
Brian Pickering
Helen Pocknall
Suzy Poppe
Kate Prebble
Janine Randle
Liz Reed
Lyndsay Rendall
Rosaleen Robertson
Jean Ross
Louise Rummel
Di Russell
Regneta Russell
Tom Ryan
LeAnne Samuels
Lyn Smith
Helen Snell
Liz Stayart
Maryanne Sweeney
Jenni Tarrant
Susan Taylor
Burt Teekman
Rosemary Thompson
Sue Thompson
Colleen de Vore
Jill Walker
Paul Watson
Cathy Webdale
Pat Webster
Kim Wheeler
Susan Wood
APPENDIX 6: THE TASKFORCE PROCESS

Through the consultation process the Taskforce gathered a substantial quantity of information. Below is a brief description of the process the Taskforce used to analyse this information. Qualitative analysis was used as the type of data collected does not lend itself to reliable quantitative analysis.

INDIVIDUAL SUBMISSIONS

The barriers and strategies identified in individual submissions were coded (using a Microsoft Excel spreadsheet) into descriptive categories. A list of these categories, and their frequency of occurrence, was presented to the Taskforce for discussion. The Taskforce then grouped the most commonly occurring issues together into themes, and these themes became the initial chapter headings in this report. Some comment was received which did not relate to the Taskforce terms of reference: this was read but not necessarily incorporated.

WRITTEN ORGANISATIONAL SUBMISSIONS

Copies of written organisational submissions were given to all Taskforce members to read. These were subsequently discussed at Taskforce meetings.

ORAL ORGANISATIONAL SUBMISSIONS

All Taskforce members were present during the various organisational presentations. The Taskforce took the opportunity to question those who presented, clarifying detail of what had been said. Some presenters also took the opportunity to clarify detail in follow-up letters to the Taskforce.

HUI

Information gathered through the hui was collated and summarised into key theme areas; these themes then became the basis for the section headings in Chapter 8.

FOCUS GROUPS

The barriers and strategies identified during focus groups were brought together and summarised. The summary document was then discussed by the Taskforce.

It must also be acknowledged that information was gathered by individual Taskforce members through informal processes and contacts. This information was brought to Taskforce meetings/teleconferences and discussed. Individual Taskforce members were able to access their own networks of expertise to seek fuller clarification or commentary.
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