Kaitiaki NURSING NEW ZEALAND

NEWS

Attitudes to vaccination have changed little in 80 years, says former 'fever' nurse

BY UNIVERSITY OF CANTERBURY JOURNALISM STUDENT ANNA SARGENT

July 1, 2022

Former nurse Una O'Neill, of Christchurch, says today's opposition to COVID-19 vaccinations echoes opposition she saw in 1940s England when she nursed in "fever wards" in World War II.

Una O'Neill says her life-long nursing career was "very rewarding".

New Zealand has seen an array of protests over vaccination and vaccine mandates, including a three-week occupation of its parliamentary grounds in February which ended in violent clashes with police.

> **"It's brought it all back to me with the COVID-19 virus."**

O'Neill – who turned 100 last year — says she is amazed that the worth of vaccinations is still doubted.
The "fever wards" she worked on treated people with infectious diseases such as scarlet fever, measles and diphtheria.

Over her long nursing career, the wards slowly closed down as people became vaccinated and the diseases were mostly eradicated, she recalled.

"England had such a lot of isolation hospitals, [but] as far as I know they're few and far between now."

> **"Diphtheria was quite a serious disease, but the people who died were all young – ones who had never been immunised."**

New Zealand, too, had its own infectious disease isolation hospitals (https://wellingtoncityheritage.org.nz/buildings/1-150/9-wellington-hospital-for-infectious-diseases). The country's first vaccination (https://www.health.govt.nz/your-health/conditions-and-treatments/diseases-and-illnesses/diphtheria) was for diphtheria in 1926, which was provided to a few selected schools and orphanages.

By 1941 it was offered routinely to children under seven, and other vaccinations were introduced around this time for tetanus and whooping cough.
O'Neill remembers well the mixed views toward vaccination for diphtheria when she was a fever nurse.

When she asked families if they would have their child vaccinated, many refused — despite the risks the disease posed. Yet, at that time, diphtheria most frequently affected children (https://academic.oup.com/jid/article/181/Supplement_1/S2/840806).

"Diphtheria was quite a serious disease, but the people who died were all young — ones who had never been immunised."

It has been estimated in 1943 alone there were a million cases of diphtheria in Europe, with 50,000 deaths.

O'Neill says it is "very sad" that the merits of vaccination are still being debated now, just as they were back then.

"It's brought it all back to me with the COVID-19 virus."

Creative Commons: Immunisation for diphtheria, whooping cough and tetanus, one of 800 health education posters produced for the Central Council for Health Education (1927-69), Health Education Council (1969-87) and Health Education Authority (1987-2000).

O'Neill outside the Westhulme Fever Hospital in Oldham, England.

O'Neill moved to New Zealand in the 1950s on a nursing contract, and decided to stay here.
She worked in various nursing roles in Canterbury over her life, including as a midwife in Ellesmere.

O'Neill found working as a nurse "very rewarding". She said it was wonderful to see the "laughs and smiles and a good recovery" from a patient who had been very ill when admitted.

This year, O'Neill has had her two COVID-19 vaccinations and booster shot. She says a lifetime of work in the health sector means she knows that vaccinations are keeping people as protected as possible during the COVID pandemic.

At June 20, 95 per cent of the eligible population over-12 had been fully vaccinated for COVID-19, according to Ministry of Health statistics.

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FEATURES

Harris marked a milestone in male nursing

BY WAYNE MCLACHLAN

July 5, 2022

NZ's first male general nurse faced opposition stepping into a female profession.

For his graduation photo, Herbert Harris was made to stand off to the side rather than with the female nurses.

Herbert Harris made history for New Zealand nursing in 1947 by becoming the first man to graduate as a general registered nurse (RN) — enduring some challenges as a result.

Harris, who died at age 94 in 2020, went on to have a long career which spanned both nursing and aviation.

He was born in Dunedin in 1925, to George and Laura Harris, and was the eldest of two children. Harris attended King Edward Technical College and after graduation worked in a variety of occupations including retail and movie theatres.

Herbert Harris

However, these occupations were not satisfying for the intelligent but restless young man. He strived for an outlet for an inquisitive and curious mind. He volunteered for St John Ambulance, which led him to choose a career in nursing.

Although men now account for eight per cent of the nursing workforce, in the 1940s there were none outside psychiatric nursing. At age 18, he applied to train in the registered nurse programme at the Dunedin School of Nursing.

Being the only male in the class, he faced unique and difficult challenges — although he was accepted into the school, there were some staff who were unhappy at his presence. Despite this, he remained focused and graduated in 1947 as the first male general nurse

in New Zealand. In the graduation photograph, he was not included in the main group of female nurses and had to be content at being placed separately to the side.

Worked as theatre nurse

Harris worked as a theatre nurse at Dunedin Hospital, thriving despite the confronting, challenging environment — some staff still found a male nurse unacceptable. On one occasion he sustained a facial laceration from an instrument thrown at him by a surgeon in the theatre. He transferred to Christchurch Hospital, and then to Auckland Hospital, continuing his theatre nursing career.

It was in Auckland that he embarked on a career change, studying law at the University of Auckland. Once qualified, he moved into the aviation industry, working for Pegasus Airlines, which specialised in the transport of thoroughbred racehorses around the world.

On one occasion he sustained a facial laceration from an instrument thrown at him by a surgeon in the theatre.

What followed was a stellar international career in aviation. He worked for Ansett Airlines as manager of corporate services and government relations and later as executive director of the Board of Airline Representatives of New Zealand.

Negotiated airline treaties

He also worked for Qantas Airlines in Australia. In this role, he negotiated bilateral international airline treaties, and airspace management in the Philippines, Iran, and Russia. He enhanced his academic credentials with a Doctorate in Aviation Law from the University of St Petersburg in Russia.

His extensive academic and work resume included many academic and corporate achievements in international aviation organisations he worked for until retirement. A highlight occurred in 1997 when he lead an international team to open new airline routes to Europe across Siberia as an alternative to congested southern routes.

Despite his long aviation career, Harris was very proud of his nursing background and was always interested in contemporary nursing.

The author had the pleasure of meeting Dr Harris in 2003 when he returned to visit his old hospital in Dunedin. He was very interested in how the hospital operated, and seemed very informed about the development of independent nursing roles in the community, especially in stoma therapy. I was impressed with his contemporary knowledge and that he was very much focused on the future.

Wayne McLachlan, RN, BA, *is a duty manager at Dunedin Hospital.*

* The historical information in this article is drawn from personal conversations with Herbert Harris, and with his family after his death.

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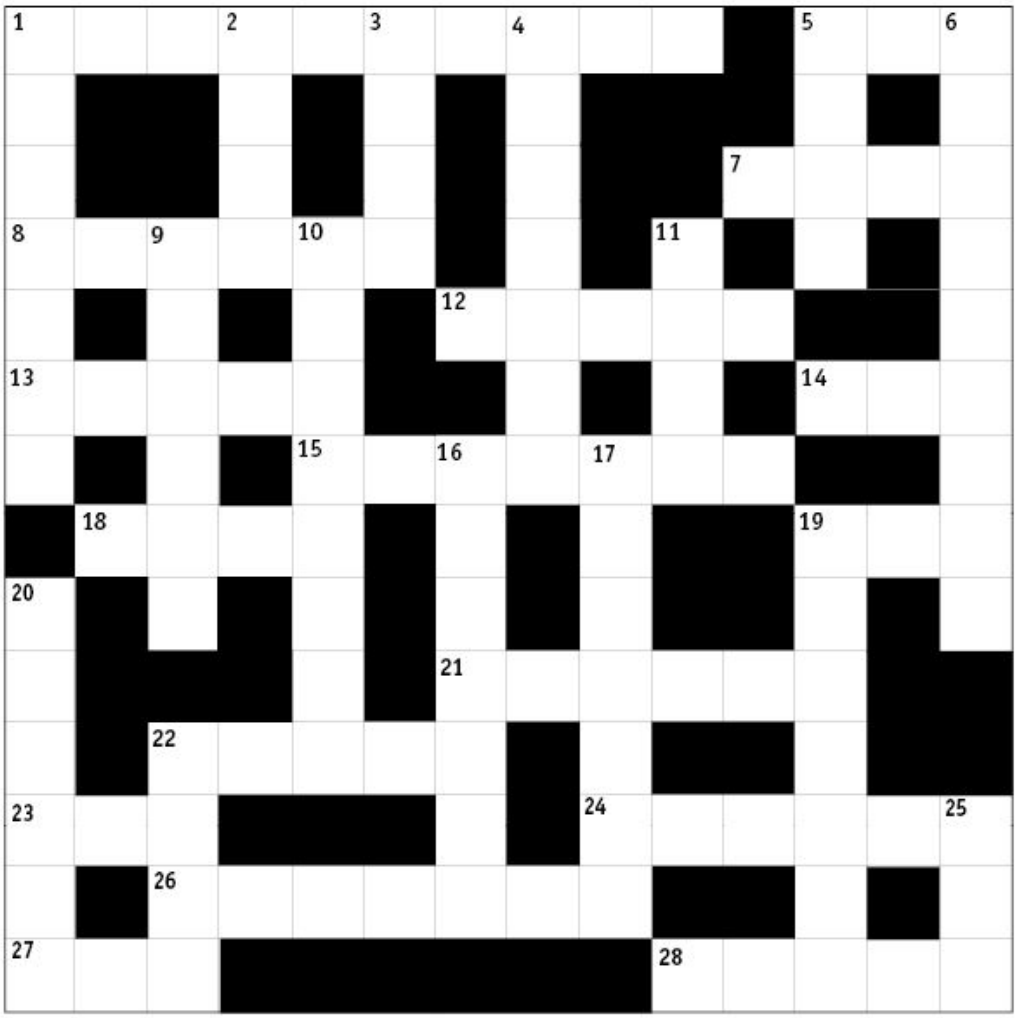
PUZZLES

JULY crossword

BY KATHY STODART

July 26, 2022

Print out this crossword grid (see PRINT tab at bottom right of page), and use the clues below.



ACROSS

1) Brave.
5) A cat's foot.
7) Statistics.
8) Of the mind.
12) What's left in the grate.
13) Human trunk.
14) Short sleep.
15) Re-purpose waste materials.
18) 12 inches.
19) Faucet.
21) These go into the nostrils to supply oxygen.
22) West African nation, capital Brazzaville.
23) Flightless Australian bird.
24) What your inbox is full of.
26) Top-up vaccination.
27) Affirmative reply.
28) Protects clothes while cooking.

DOWN

1) Patterns of weather.
2) Corroded metal.
3) Worth one point in football.
4) Epic journey, first described by Homer.
5) Plead to the Almighty.
6) Genealogy (Māori).
9) Not wide.
10) Procedure to end pregnancy.
11) Bridal headwear.
16) Rotted organic waste.
17) Investigates unusual deaths.
19) More scrumptious.
20) Moves oxygenated blood around body.
22) Baby lions.
25) Male child.

June answers

ACROSS: 1. Emergency. 6. Rima. 8. Tastier. 9. Rural. 11. Eve. 13. Tub. 14. Omits. 16. Vacancy. 17. Itch. 19. Fair. 21. Thaw. 23. Donor. 25. Or. 27. Iti. 28. Diverse. 29. Plagiarism. 30. Ent.
DOWN: 2. Motu. 3. Result. 4. Edits. 5. Caregiver. 7. Irritant. 9. Rejected. 10. Lobby.
12. Holistic. 15. Swastika. 18. Ciao. 20. Urgent. 22. Wring. 24. Nurse. 26. Wins.

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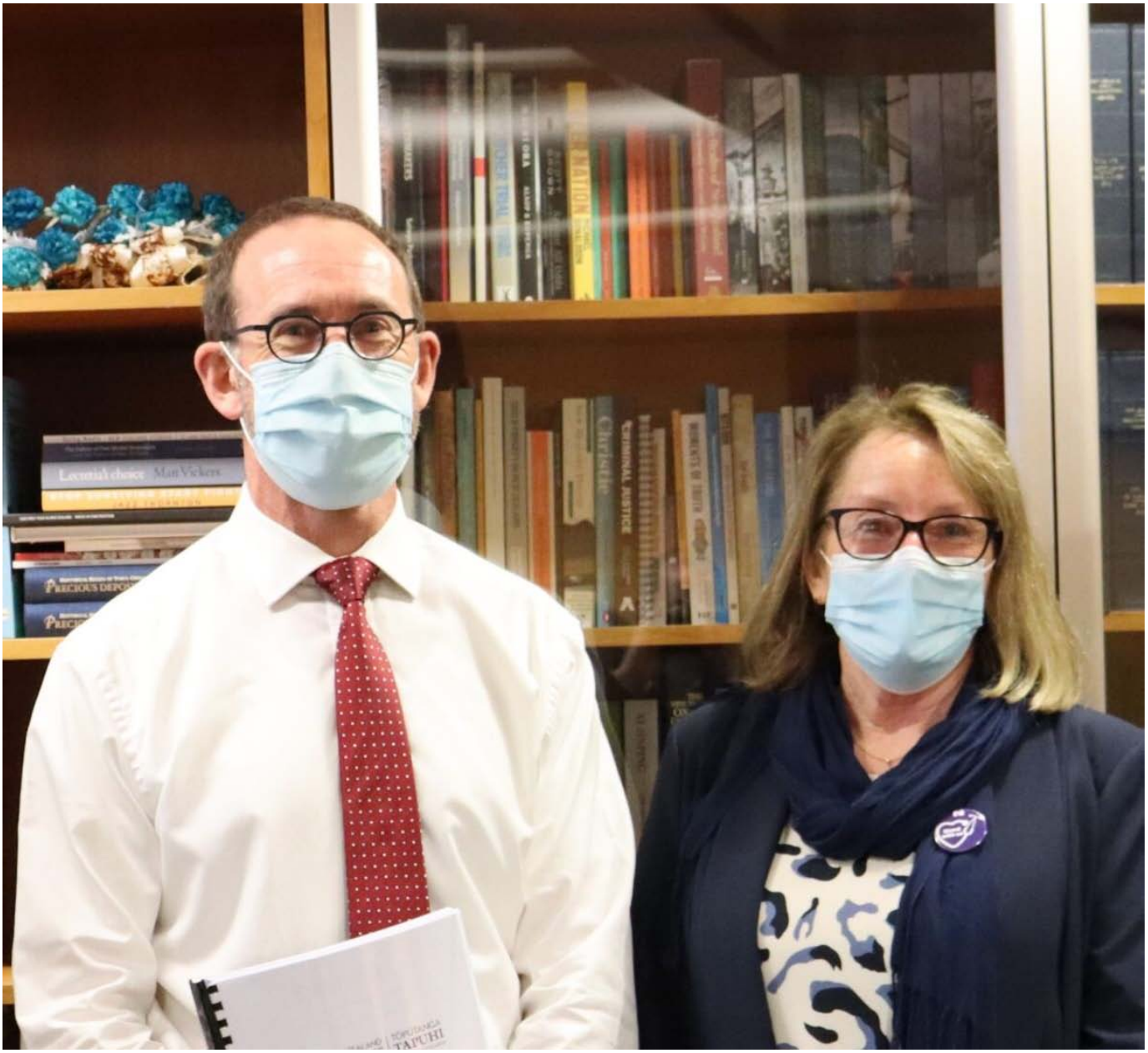
NEWS

Not a crisis minister, really?

BY MARY LONGMORE

July 20, 2022

Thousands of nurses speak out in response to Health Minister Andrew Little's refusal to acknowledge a health system they say is 'in or beyond' crisis.



Wellington nurse Helen Kemp was among the NZNO delegates who met Minister of Health Andrew Little to hand deliver more than 2700 responses from members over current health system and nursing pressures. (Photo: Rob Zorn)

More than 2700 NZNO members in 48 hours have responded to comments from Minister of Health Andrew Little that the health system is coping.

NZNO invited members to respond to Little's assertions (https://www.stuff.co.nz/national/128987661/hospitals-under-pressure-but-health-system-coping-health-minister-andrew-little-says) that while there were "significant pressures" the health system was coping — made a day after a 51-year-old woman had a brain haemorrhage and died (https://www.stuff.co.nz/national/health/300614947/a-woman-left-ed-because-of-long-waits-hours-later-she-had-a-fatal-brain-haemorrhage) last month after leaving Middlemore Hospital's emergency department due to the waiting times.

More than 2700 nurses and other health workers responded in two days to the NZNO survey — 99 per cent of whom said the system was either in or beyond crisis.

"I've always wondered and struggled with the definition of what gaslighting is, you know, but that's it – it's someone saying, 'disbelieve the evidence that's right in front of your face'."

'I have worked over my hours and without meal or coffee breaks for the last 8-10 years with clarity of vision that this has been getting worse every year. This is NOT caused by seasonal flu or COVID. This is caused by systemic underfunding.'

'I didn't enter nursing to do harm and I feel the NZ health system is doing more harm than good at present if you include the patients,the extended whānau of those patients,the staff,the emergency services and community services that support us.'

'Where I work, my colleagues and I are tired, burnt out and people are leaving. The pressure on us in the past two years has been unrelenting, steadily increasing and are being pushed beyond our breaking point. It is not uncommon at the moment to be doing 10-15 plus hours a fortnight over and above our contracted hours. Not just one odd fortnight, REGULARLY.'

'I have worked in the emergency department for the last 26 years. I have watched successive governments underfund and lack any sort of forethought or future planning for our health service.'

'I strongly suggest that the minister does a hands on in one busy hospital so he can see first hand the imploding crisis in health.'

'I can't keep doing this and neither can my colleagues. Morale is at an all time low and has been the reason for our most recent resignations – they aren't leaving for other jobs – they are leaving nursing.'

Wellington cardiology nurse Sarah Ward, one of the NZNO delegates who delivered the messages to Little, said she appreciated the hui. "While crisis is just a word and it's not going to change anything, it [today's meeting] shows the nurses on the frontline that the Minister is actually hearing us and understanding what is going on."

Mental health nurse Trish McNair said she was representing colleagues who were "in distress" — a situation compounded by the dispute over back pay.

Wellington nurse Helen Kemp said it was encouraging the minister had been prepared to listen to the voice of nurses.

'Absolute' crisis decades in the making

NZNO kaiwhakahaere Kerri Nuku said "the Government's insistence that this is just a temporary situation caused by COVID and a cold winter has made nurses feel unheard and completely undervalued".

NZNO president Anne Daniels said decades of poor planning, underfunding and neglect had led to the current "absolute crisis in terms of pay, staffing resources and morale" across the sector.

"This isn't a temporary glitch. Many are seeing it as the end of the road, with 72 per cent of respondents saying they are either seriously thinking of leaving nursing or New Zealand".

Little has also accused the nurses' union of being "unprincipled" over pay equity and back pay negotiations.

'I am a nurse of 50 years and have seen more than my share of 'nursing pressure' but the reality is our current status is much worst in multiple way . . . We have used up our stores and now have been operating on near empty reserves for some time, the end is nigh with no remedy insight. I believe the current health system is a pressure cooker waiting to blow.'

Nearly all — 95 per cent — of respondents said honouring promised back pay to district health board (DHB) nurses and extending DHB pay equity rates to all nurses was one of the most important things Government could do to address the nursing and health crisis.

The NZNO-Government dispute over back pay of up to two years for DHB nurses has been referred to the Employment Relations Authority.

After receiving the 300-page document from nurses, Little told *Kaitiaki* he "appreciated the opportunity to meet frontline nurses representing their colleagues, they left me some material to read and I appreciated the constructive discussion that we had".

'Gaslighting'

Meanwhile, Christchurch GP Dermot Coffey said Little's ongoing denial felt like "gaslighting".

"I've always wondered and struggled with the definition of what gaslighting is, you know, but that's it – it's someone saying, 'disbelieve the evidence that's right in front of your face'," Coffey told *Kaitiaki*. "That's what he's expecting us to do, disbelieve the fact that we're absolutely slammed with work and we can't get people in. We can't offer the care we were offering two years ago and we know that. And that's really distressing."

Dermot Coffey

With waits of more than two weeks to see GPs, it was a "traumatic" time for health workers on the frontline. Coffey said many colleagues were overwhelmed and struggling with burnout. "All he has to say is 'I recognise there is a crisis, we will help you, we will do our best' instead of saying 'there is no crisis, the sector is coping'. It's not."

Former leader of the Association of Salaried Medical Specialists Ian Powell earlier this month described Little's ongoing denial of a crisis in the health system as "incomprehensible (https://www.stuff.co.nz/opinion/129153136/the-return-of-angry-andy-the-health-minister-who-is-denying-the-obvious)".

NZNO has called for an urgent health sector conference to find solutions to the crisis.

'A crisis is working short-staffed day after day, and being unable to provide adequate care to patients due to high workloads. Resulting in an unsafe environment, increased patient vulnerability, and extra stress on staff.'

'Every day on the wards nurses are working extra hours, they have workloads that are unsafe, they miss giving care because they are too busy, the newer nurses feel unsupported. Why can't we say there is a crisis? That is how it feels? It's gaslighting to say that we are not experiencing what we are experiencing.'

'I am tired to the bone . . . after years of fighting for pay equity, decent working conditions,and safe staffing. Post-COVID that laid me up for three weeks and the recovery is long!!! I am seeing colleagues around me falling into depression, despair and leaving the profession or going to Australia. I have been a NZNO delegate for 10 years. The exhaustion is evident.'

'Every single shift 24/7 for most of this year we have had texts asking for nurses to come in to fill gaps in the roster. When you already do 12-hour shifts it doesn't take long before you run out of energy. Nurses get run down & then sick leave is needed so vicious circle there's further holes in the roster.'

Kaitiaki NURSING NEW ZEALAND

OPINION

Nurse leader pleads for funding as staffing shortage forces closure of 900 aged-care beds

BY NZNO COLLEGE OF GERONTOLOGY NURSING CHAIR NATALIE SEYMOUR

July 6, 2022

Nurses in aged care are burning out and breaching their contracts working extended shifts to fill roster gaps, amid increasingly complex need of residents, says an aged care nurse leader.

Those of us working in aged care have become all too familiar with having older people with acute needs admitted urgently in states of heightened anxiety and distress. Often they pass away within a short time.

Natalie Seymour, like many other aged care nurses, is juggling extra shifts with family life. She recently had to pull out of postgraduate studies.

In the facility I manage, over the past month the average stay has been less than three months. This compares to five years ago, when the average stay for residents was 18 months to two years. During 2020, we admitted 168 people and discharged 181 — discharges that were mostly due to residents dying.

By day, I carry out my work as hospital service manager, and then carry on for another eight hours as a clinical nurse on the floor. Recently I worked a 93.5-hour week.

Recently, I had a woman urgently admitted from her home due to carer stress. She required intensive nursing support but passed away just after being admitted, without her family present.

Aged care 'fastest-growing' sector

Aged care is one of our largest and fastest-growing sectors, which provides care to one of our most vulnerable populations, often in Aotearoa's most rural and remote locations.

The voluntary standards (https://tas.health.nz/assets/Health-of-Older-People/ARRC-Agreement-2021-22-effective-1-August-2021-.pdf) (see pp56, 58 and 70-71) for our aged-care facilities state each resident only needs half an hour of nursing care per day — but with residents in recent years coming in older, sicker and in need of more acute care, this is nowhere near enough.

Many have complex needs, requiring a highly skilled nursing workforce to support them to enjoy the best quality of life possible in their remaining time. The clinical nursing teams are at the frontline of providing care and support to these residents, as well as their families/whānau and significant loved ones.

Nursing those approaching the end of their lives also requires particularly caring, compassionate and skilled staff. These nurses must also be able to manage pain and physical symptoms, provide holistic, timely and responsive care, and have teamwork skills — all while preparing the resident and their families/whānau for the approaching end of life.

The level of care provided in many aged residential care (ARC) facilities includes:

- Hospital-level
- Accident Compensation Corporation (ACC) transitional/rehabilitative/serious injury

- End-of-life
- Assisted dying
- Mental health and addiction
- Cognitive impairment requiring a secure environment

We nurses who work in aged care and the community must also support our older people to stay independent as long as possible, whether in their own home or in a care home, for their own wellbeing but also to reduce pressure on hospitals and ARC facilities.

Juggling multiple, acute conditions

In my facility, in an average day, four nurses are expected to manage about 75 residents, many with highly complex issues.

Recently in my facility, two registered and two enrolled nurses across the day were managing three residents with peritoneal dialysis; one receiving hemodialysis; one with a tracheostomy; two with percutaneous endoscopic gastrostomy (PEG) feeds; one with a pleural effusion; four with syringe-drivers; nine who were actively dying and three with drug and alcohol dependency issues. All had complex emotional and psychological needs and physical demands such as being bed or chair-bound, or dysphagia, along with the various social dynamics of their families.

> **Not only did my team get him positively engaged, they provided him with much-needed emotional comfort while also supporting him approach the end of his life.**

The ageing population of Aotearoa New Zealand is rapidly growing. Caring for older people with multiple comorbidities is placing an increasing burden on the health-care system. The complexity and acuity of care needs faced by aged care nurses has increased significantly in recent years.

Short-staffed care homes close off 900 beds

Yet current funded staffing allocations are not always sufficient for the acuity of the resident or what is occurring in the care home at the time. While there have been enough beds to meet demand, there has been a shortfall in the workforce — most significantly in clinical staff, and mostly nurses. This has resulted in nearly 900 aged care beds being closed off nationwide so far this year due to a lack of staff. This has put pressure on communities, families/whānau and other parts of the health-care sector.

One measure of the nursing shortfall is the number of section 31 notices (https://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/information-providers-health-care-services/notifying-incident-under-section-31) filed to HealthCERT — the Ministry of Health's certifier responsible for ensuring hospitals and residential aged and disability care facilities provide safe care, as required by the 2001 Health & Disability Services (Safety) Act.

These notices are based on roster gaps, due to unfilled vacancies or sickness (including COVID-19 which has hit the sector hard), and when acuity of care exceeds available capacity on that shift.

In 2020, there were approximately 200-300 notices submitted to the Ministry of Health (MoH). In 2021, that tripled to 841 and in the first five months of 2022 has already exceeded 800. This highlights a significant and systemic problem with aged-care staffing.

> **The result, for the nursing workforce, is high sick leave, loss of nurses from the profession and a stressful and unpleasant work environment because everyone is exhausted.**

Anecdotally, for us in the sector, we know there have been more complaints to the Health & Disability Commisioner relating to provision of care, sentinel (life-threatening) events and other issues. This rise is likely attributable to staffing problems, although there is no analytical data yet to support that.

Aged care has faced a number of challenges over recent years — and more so since the pandemic began in 2020. Our nurses are working 12 to 16-hour shifts, trying their best to provide care for vulnerable residents. Not only does this often breach their employment contracts, it puts them at risk of burnout.

Our clinical managers and facility managers — myself included — are working extended hours, even sleeping over at times and working

night shifts to provide clinical support and cover while level 4 caregivers (qualified to administer medication) are providing the physical care.

Our nurses are struggling to meet their competency requirements, as stipulated by the Nursing Council, as it is impossible to release them for professional development.

Photo: AdobeStock

Lengthy shifts lead to burnout

I myself am very familiar with this. By day, I carry out my work as hospital service manager, and then carry on for another eight hours as a clinical nurse on the floor. Recently I worked a 93.5-hour week. At the same time, I'm also trying to manage my family life and support my own ageing parents — and somehow trying to find time to care for myself. I recently pulled out of postgraduate nursing studies due to the pressure of work.

The result, for the nursing workforce, is high sick leave, loss of nurses from the profession and a stressful and unpleasant work environment because everyone is exhausted.

Yet aged-care nurses work with high levels of autonomy, amid high expectations from families, while being paid significantly less than their peers in hospitals and district health boards/Health NZ. There can be as much as a $20,000 difference in annual salary.

While the acuity of residents in a care home can be akin to that in an acute medical ward, there is not the same access to medical support — aged-care nurses must make clinical decisions and be fully accountable for them.

> **We hope . . . we can all stand together, instead of in our silos, and recognise we are all burning ourselves out to give quality care for our residents and patients.**

Residents are not just frail and old, they are often significantly unwell and may also be under 65 but with acute health needs.

Some, coming into a care home for the first time, are faced with complex medical treatment and a need to adapt socially, often in a short time before their deaths.

For example, one man under 65 was recently admitted with end-stage lung cancer, no social or family support and a long history of

trauma, mental health issues and a distrust of health professionals. Not only did my team get him positively engaged, they provided him with much-needed emotional comfort while also supporting him as he approached the end of his life.

Facilities charging 'premium' fees

To counter the inadequate government funding, some providers are charging premium room charges which can vary from $10 to $150 per day. With the rising cost of living, many families cannot afford this, yet push themselves into debt, desperate to ensure that their loved one is given safe and high-quality care.

We need our health and political leaders to support our clinical nursing teams to work collaboratively and ensure all New Zealanders have access to high-quality care that meets their particular needs. Ensuring our clinical workforce is adequately prepared and skillful through progressive education and training is important to building a responsive, sustainable workforce which feels recognised and valued.

Natalie Seymour speaking at Parliament's Health Select Committee last month, accompanied by NZNO president Anne Daniels (far left), professional nursing advisor Marg Bigsby (second from left) and kaiwhakahaere Kerri Nuku (right).

We would like to see an acuity tool which determines minimum safe-staffing levels across the sector, with a local, Aotearoa-focused lens, which reflects our diverse communities around the country. We want to see this as soon as possible.

Until then, we call for enough funding to increase our current staffing so that the situation does not get any worse.

The New Zealand Aged Care Association has estimated $94 million is needed to pay ARC nurses (enrolled and registered) on a par with hospital nurses — but this would rise to $166 million after the Health NZ/NZNO pay equity settlement rates are implemented.

The association puts total underfunding of the sector in the range of $400 million.

However, our challenges are wider than pay parity. We hope they will resonate with our nursing colleagues in hospitals and other areas, and we can all stand together, instead of in our silos, and recognise we are all burning ourselves out to give quality care for our residents and patients.

This viewpoint is based on NZNO's submission to Parliament's Health Select Committee last month in support of E tū union's safe

staffing petition (https://www.parliament.nz/en/pb/petitions/document/PET_116136/petition-of-e-t%C5%AB-union-aged-care-safe-staffing-petition) for minimum staffing levels in aged care. Presented by Seymour, the submission was compiled with the help of NZNO professional nursing advisors Marg Bigsby and Michelle McGrath, and industrial advisor aged care Lesley Harry.

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FEATURES

Nurse prescribing – the way of the future

BY KATHY STODART

July 27, 2022

Growing numbers of nurse prescribers are improving access to medicines.

Nurses are trusted by the public and nurse prescribers have shown themselves to be safe prescribers.

Nurse prescribers are having a growing influence in primary care, improving access to medicines where GPs are in short supply.

The number of prescriptions written by nurses in primary care rose nearly 70 per cent to 1.4 million last year, while the number of education programmes for community nurse prescribers approved by the Nursing Council has nearly doubled in the past year.

Ministry of Health prescribing data also shows nurse prescribers in primary care achieving higher rates of prescribing to Māori, high-needs populations and women than GPs.

In light of a worsening shortage of GPs, nurse prescribers are widely regarded as essential for the future health service, improving equity in health care by increasing access to medications, particularly in high-needs and isolated rural areas. (A report from the Royal College of General Practitioners found 50 per cent of GPs planned to retire in the next eight years, on top of an overlying shortage.)

There are three levels of nurse prescribing:

- **Nurse practitioners** (NPs), who can prescribe much as doctors can, and have masters-level education.
- **Nurse prescribers in primary health and specialty teams** who can prescribe for common and long-term conditions, with postgraduate education in prescribing.
- **Community nurse prescribers,** who can prescribe simple medications for straightforward conditions in normally healthy people, and have a work-based training programme combined with online learning.

According to the ministry data, although nurse prescriptions made up only 3 per cent of those issued in primary care last year, the number of nurse prescriptions in this area of care has grown by 68 per cent from around 834,000 in 2019 to approximately 1.4 million in 2021.

However nurses wrote proportionately more prescriptions for Māori, for women and for those in high needs areas than GPs did.

The figures, released by health analytics company Matui, show that in primary care nurse prescribers and general practitioners (GPs) prescribe a similar range of common medicines, and had similar patterns of prescribing across patient age groups.

However nurses wrote proportionately more prescriptions for Māori, for women and for those in high needs areas than GPs did.

In 2021, 21 per cent of nurses' prescriptions in primary care were for Māori, compared to 15 per cent of those written by GPs. Nurses wrote nearly a third of their prescriptions (30 per cent) for people living in areas of high deprivation, compared to less than a quarter of those written by GPs (24 per cent).

Nurses were more likely than GPs to have prescriptions dispensed to women — 61 per cent of nurses' prescriptions going to women compared to 52 per cent of GPs' prescriptions.

Jan Adams is the nursing director of Pinnacle Health, a network of 87 primary practices stretching across the former Tairawhiti, Taranaki, Lakes and Waikato District Health Boards (DHBs), with more than half a million enrolled patients. It provides medical and nursing supervision to the practices, and also some community services itself.

Jan Adams

'Needs to be celebrated'

Adams says the increase in nurse prescribing and who it was reaching "need to be celebrated". The increase showed that more patients were getting quick access to medications, which improved equity, leading to improved health outcomes.

"Nurses are very trusted by the population, and they always establish good relationships with patients. The fact that women are the majority of patients nurse prescribers are seeing — particularly Māori and high needs people — needs to be celebrated."

She believed nurse prescribers were a "very important" part of primary care and would increasingly fill gaps resulting from a shortage of GPs.

Karyn Sangster, formerly deputy chief nurse at Counties Manukau DHB and now a consultant to the Nursing Council, believes nurse prescribing will be a "core component" of nursing in the future and wants to see prescribing incorporated into the bachelor of nursing curriculum.

"This is so nurses, right from graduation, can have access to the medicines list for nurse prescribers, so they can prescribe simple analgesia such as panadol," Sangster said.

"This will save so much time in hospitals, where a nurse could prescribe simple pain relief, rather than having to wait hours for a house surgeon."

Karyn Sangster

She also said the education programmes for community nurse prescribers were "much safer" than standing orders (whereby a doctor or NP can delegate some prescribing to nurses under set circumstances).

The Nursing Council recently increased the number of education programmes for community nurse prescribers from four

Numbers growing

Numbers of all types of nurse prescriber have grown in the past year, with community nurse prescribers growing the most.

Nursing Council data shows that at March 31 this year, there were 199 community nurse prescribers (up 140 per cent from 83 the previous year).

There were 368 nurse prescribers in primary health and specialty teams (up 22 per cent from 301 the previous), and 612 nurse practitioners, up from 533 the previous year.

There were also 53 diabetes nurse

to seven, with programmes now operating in Counties Manukau, Family Planning, the Midlands Collaborative, the former MidCentral and Hawkes Bay DHBs, 2 Districts (covering the former Capital & Coast, Hutt Valley and Wairarapa DHBs), and the South Island Alliance (the five South Island district health boards).

prescribers, but the pathway to this model of prescribing has been closed, and diabetes prescribing is now included in the much broader primary health and specialty teams category.

Pinnacle Health is part of the Midlands Collabarative (comprising five DHBs and eight primary health organisations in the Midlands region of the North Island), and its recently approved annual training programme for community nurse prescribers has 43 nurses enrolled for its August intake.

Adams said: "There is a lot of interest. Community nurse prescribing has grown quickly in a short period in terms of interest and success and will continue to grow."

The course combines online learning with clinical supervision by an authorised prescriber. To be eligible for the course, nurses must have a minimum of three years' clinical experience, including at least one year in the area of practice where they will be prescribing.

Adams says Pinnacle already has 41 community nurse prescribers, though she says there are more than that working in the Midlands region as some are employed by (former) DHBs. Some work as school nurses; others as practice nurses, where for example the nurse could be giving a woman a cervical smear and find she has a urinary tract infection which she can treat on the spot rather than the patient having to come back for an appointment with the GP. Another could be doing an outreach visit to a whānau with a couple of ear infections, which could be treated straight away.

Sangster said community nurse prescribers were also working in sexual health clinics, as public health nurses, and as triage nurses for walk-in patients at primary care clinics, treating those with minor health conditions.

Holistic care and prescriptions

She said nurse prescribers were providing holistic care as well as prescriptions, eg a school nurse could be treating a child with tinea on their feet, and find that their shoes were too small, so refer them to KidsCan for shoes and a raincoat.

Brittany Jenkins

The challenges for nurses becoming community prescribers, Adams said, included getting time to do the course, securing a prescribing supervisor (a GP or NP), and getting enough clinical supervision time with them.

The Nursing Council's director of professional standards, Brittany Jenkins, said the council was also aware of this point. It acknowledged that isolated, remote areas which would benefit from having nurse prescribers had reported finding it difficult to support their development because access to mentorship from a GP or NP might be limited.

Sangster said nurse prescribers had a particularly important role to play in primary care, where the shortage of GPs was restricting access to medication. "But they will always be working in collaboration with the GP, providing care to patients with routine problems, freeing up the doctor's or NP's time to focus on complex patients."

The early development of nurse prescribing in this country, with the advent of NPs and diabetes nurse prescribers, had shown that nurse prescribers were "safe and well-accepted by the public and other health-care professionals. They are cautious and reliable prescribers and are increasing people's access to medicines".

Nurse prescribers in general were gaining more acceptance from medical colleagues, and in fact there were requests from some doctors to increase the types of medicines nurses could prescribe . . .

Sangster said that in a 2013 consultation on nurse prescribing, some medical specialists had worried about antimicrobial stewardship, ie the rise of resistance to antibiotics if nurses were to overprescribe them.

"However they saw that nurses followed the guidelines and were cautious and safe with antibiotics."

Nurse prescribers in general were gaining more acceptance from medical colleagues, and in fact there were requests from some doctors to increase the types of medicines nurses could prescribe, she said.

Jenkins said new government regulations, gazetted on March 23 this year, had expanded the list of medicines available to nurse prescribers. (Community nurse prescribers and diabetes nurse prescribers are authorised to prescribe from their own respective subsets of this list.)

Expansion of this list had the affect of improving access to these medicines, Jenkins said. The list now included all pharmacy-only general sales medications — "so anything a member of the public can purchase, nurses can prescribe".

Nurses could now also prescribe intravenous panadol as well as oral panadol, along with some anti-coagulants, hepatitis C treatments, new diabetes drugs and medical abortion pills.

Jenkins also said a consultation was in progress to consider adding two anti-viral drugs to the nurse prescribing list to help with COVID-19 treatment. She said the Nursing Council also now recognised telehealth consultations as a way nurses could assess patients leading to a possible prescription.

And from June 30 this year, all nurse prescribers were now recertified every three years, instead of annually.

Adams saw a growing role for nurse prescribers as part of multidisciplinary teams, which were becoming increasingly important to provide services to rural communities. These teams, which had access to a GP for advice and support, could include nurses, health improvement practitioners, mental health workers, pharmacists, dietitians and social workers. Such teams worked collaboratively with GP practices, and worked in different ways with patients to improve access and equity.

"For the future, we will see more and more of this kind of collaborative health teams, especially in rural areas."

Sangster said there was a "desperate need" for such health-care teams, including all levels of nurse prescribers, to meet the needs of the rural sector and of Māori and Pacific people.

PRESCRIBING REPORT

Pharmac-sponsored health educators He Ako Hiringa have launched an online prescribing report which shows details of national prescribing practice in New Zealand.

The EPiC Annual Prescribing Report (https://epic.akohiringa.co.nz/), presented as an interactive dashboard, can help all types of nurses focus on key problems of national prescribing practice, such as polypharmacy and underutilisation of medicines in certain populations.

EPiC lead analyst Alesha Smith said the 2022 report showed more key medicines getting to priority groups, and continued reduction in opioid analgesics being prescribed to young people.

It also showed "alarming" levels of polypharmacy in older people, with more than one in 10 people aged over 75 taking 10 or more medications. This data offered aged care nurses the opportunity to assess their patients' risk of polypharmacy harm, she said.

Kaitiaki
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NEW ZEALAND

OPINION

Sitting at the top table – he karanga ki ngā tapuhi Māori

BY PIPI BARTON

July 20, 2022

Māori nurse, lecturer and researcher puts out a call for more Māori nurses to join roopu on growing the Māori nursing workforce.

Pipi Barton

The title of this piece is a reference that perhaps some Māori nurses may be familiar with. I'm not sure of the practices in other iwi around the motu, but where I'm from in Kāwhia it is common practice to have a top table at a hui, or a hākari.
In my iwi, Ngāti Hikairo, it refers to the table where our esteemed visitors may sit, often reserved for the Māori King, King Tūheitia, during our Poukai, but equally reserved for the bride and groom at their wedding or Nan and Koro at their wedding anniversary. This table is usually laden with the best and most delicious kai. At our marae during the Poukai, it is served by our rangatahi in their special aprons.

Equally the top table is referred to when doing iwi and marae business, as the table where the marae trustees or the rūnanga executive sit while residing over hui (meetings). A place where our leaders sit.

I have found myself thrust up to the top table (metaphorically speaking), a place where I don't feel particularly comfortable.

My ruruhi (kuia) once explained to me that you don't just walk in the back door of the marae and expect to go straight to the top table, but rather you start in the kitchen washing the dishes, peeling the kumara and serving manuwhiri. Then, when the time is right, you are expected to move to the front and eventually, one day, may be asked to sit at the top table.

Kerri Nuku

In the Māori world, it is often through the kumara vine that things can happen. Someone tells someone, who then tells someone else and the next thing your aunty is in your ear about a kaupapa that she thinks you should be involved in. This was kind of the situation I found myself in, although it was not my aunties in my ear, but my mentors and peers who suggested it was time I moved to the top table.

I have never been particularly ambitious during my career, just rolling wherever things happened to take me, much preferring to be at the coalface of nursing. With my recent decision (and with lots of encouragement) to begin PhD study, I have found myself thrust up to the top table (metaphorically speaking), a place where I don't feel particularly comfortable.

So here I was, sitting at nursing's equivalent of "the top table", (well one of them), a zoom hui with a variety of nursing leaders from across the country. Now I'm a simple sort of nurse, and tend to use simple words to explain myself, and sometimes I forget and get carried away expressing myself in the Māori way (in case you haven't noticed — it's often through long descriptive narratives), while everyone patiently waits for me to get to my point. So, I have to admit initially I found the environment intimidating, but I am getting used to it now.

Do what you need to do to get you in the right places, and kaua e whakamā, don't be shy. We need you, our future nursing workforce needs you.

The roopu I find myself in is the National Nursing Pipeline Working Group (https://tas.health.nz/employment-and-capability-building/workforce-information-and-projects/the-nursing-pipeline-programme/), a collaboration of nurse leaders from across Aotearoa, looking into how we can increase our nursing workforce in a crucially meaningful way and (hopefully) quickly. I am there representing Whārangi Ruamano (the Māori nurse educators and academics group). For someone who never particularly aspired to leadership in nursing, preferring the flax roots reality, it is a little daunting that I find myself in this situation.

But whether it was my mentors and peers in my ear or my tūpuna on my shoulders, I am where I am supposed to be. You see, my PhD research is about examining the Māori nursing workforce, particularly understanding why the Māori nursing workforce has remained static at 6-7.5 per cent of the registered nursing workforce for 40 years.
I am privileged to sit in this group with many nursing leaders, three of which are Māori – including Kerri Nuku, the kaiwhakahaere of NZNO, and Lorraine Hetaraka, the chief nurse for the Ministry of Health. Both of these Māori nurse leaders are representing all nursing at a national level — a significant achievement when considering our Māori nursing workforce numbers.

Lorraine Hetaraka

Nursing pipeline working group

The priority of the Nursing Pipeline Working Group is to collectively progress improvements to the nursing pipeline in New Zealand and to support the nursing workforce's ability to meet current and future challenges[1]. Through this, a number of key initiatives have been identified:

1. Working with the education providers to identify the reasons why students are not completing their studies, with a special focus on those leaving in both the first and third years of study.
2. Working in partnership with Māori and Pacific nurse leaders and education providers to identify how, as a sector, we can be more responsive to factors affecting the retention of Māori and Pacific nursing students.
3. Looking at options for an enrolled nursing pathway to complete bachelor-level nursing programmes.
4. Looking at options for a pathway to enrolled nursing for those who leave the bachelor of nursing programme.
5. Supporting and assisting the Aged Residential Care Workforce Plan.
6. Strategic review of the NETP/NESP Programme as it transitions to Health NZ.
7. Nursing recruitment campaign.
8. National review of the clinical placement model.

My contribution to the pipeline roopu is prioritising Māori nursing workforce needs. Having undertaken a literature review as part of my PhD study, I have become very familiar with existing research and knowledge. As part of the second initiative – to work in partnership with Māori and Pacific leaders on retaining Māori and Pacific nursing students — a discussion document was provided to the pipeline group[2], outlining the many factors that have contributed to Māori student attrition and ultimately the stagnant state of the Māori nursing workforce. Included in the discussion document were recommendations that could make meaningful differences to the Māori nursing workforce, all of which the pipeline group has endorsed and plans to initiate.

That sense that I have received an 'invitation to a party' but I am convinced there has been a mistake and that the invitation actually wasn't intended for me.

I believe what we have recommended is achievable and am cautiously optimistic that the response will see some serious action to address the inequity in the Māori nursing workforce. But I know I have good reason to be cautious, because for the last 40 years our Māori nurse leaders have consistently spoken out in their desire for change, and it has all seemingly fallen on deaf ears.

So, you can't blame me for having that niggling feeling that perhaps I am being naive. I know many of you will be familiar with that constant sense of marginalisation — it is a hard habit to shake, even when surrounded by those with the best intentions.

More Māori nurses wanted at the table

Recently the National Nursing Pipeline Working Group sent out a letter to Māori nursing roopu seeking more Māori nurses to participate in the various working groups that have been established around each initiative. I encourage Māori nurses to join me and get in involved[3], especially if it's a kaupapa that you are passionate about.

This leads me back to the point of this kōrero — I want to encourage more Māori to consider their career pathways and be ambitious. To you Māori nurses out there, who perhaps like me, have been a little resistant or reluctant to move themselves forward or to take on leadership roles, consider the following fact. When you examine the innovation and leadership in Māori health, you will see Māori nurses have consistently been at the forefront.

> **Now I'm a simple sort of nurse, and tend to use simple words to explain myself, and sometimes I forget and get carried away expressing myself in the Māori way**

When I reflect on the number of incredible Māori nursing students that I have had the pleasure to teach during my time as a nurse lecturer on the bachelor of nursing programme here in Te Taitokerau, and how talented and intelligent and amazing they are, I think about their leadership potential and what incredible nursing leaders they will be.

All I can say is, don't leave it too long (like me), be ambitious, make goals and aspire to be the leaders, because it is you that will make things better. Do what you need to do to get you in the right places, and kaua e whakamā, don't be shy. We need you, our future nursing workforce needs you.

Getting over 'imposter syndrome'

I must admit that my greatest challenge has been getting over the "imposter syndrome" I experience when asked to step up — that sense that I have received an "invitation to a party" but I am convinced there has been a mistake and that the invitation actually wasn't intended for me. When I reflect on my career and experiences, I realise that I have often felt this way, and there is no doubt that this is linked to the racism and bias I have experienced throughout my career. And if I am truly honest with myself, I have allowed it to hold me back, not to put myself out there, allowing it to reinforce the sense of my being an "imposter". My advice to potential Māori nurse leaders who may feel the same way – recognise it, acknowledge it, and push through, haere tonu!

> **But I know I have good reason to be cautious, because for the last 40 years our Māori nurse leaders have consistently spoken out in their desire for change, and it has all seemingly fallen on deaf ears**

We are on the cusp of significant change in the health system, in the nursing workforce and also in nursing education. Nō reira, ko tēnei aku whakaaro, we have entered through the back door, we have dried enough dishes and peeled enough kumara, we have served enough manuwhiri, our kuia nurse leaders have tapped us on the shoulder and whispered in our ear that we need to move up to the front and take our place at the top table. I think it's time to do as we are told.

Heoi anō, ki a tatou nga tapuhi Māori, kia kaha, kia maia, kia manawanui.

Pipi Barton (Ngāti Hikairo ki Kāwhia) RN, MPhil(nursing), *is a nursing lecturer at NorthTec and a PhD student at AUT.*

- See also *Increase nurse workforce now*.

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3. Contact Rebecca Kay at Rebecca.kay@tas.health.nz

Kaitiaki NURSING NEW ZEALAND

OPINION

The struggles facing student nurses in today's world

BY MANU REIRI

July 26, 2022

Resilience is key as inflation heaps pressure on 'beautiful' but stretched nursing students

Class of 2022: National Student Unit with Te Rūnanga Tauira vice-chair Manu Reiri at front (left).

Australian professor of nursing Debra Jackson defines resilience as "*the capacity of individuals to withstand significant change, adversity or risk and is enhanced by protective factors within individuals and environments.*" [1]

We can all agree that significant change has happened in light of the COVID-19 pandemic. Resilient nursing student cohorts have seen, and continue to see, constant adaptation becoming the new normal.

Student and school leaders hui

NZNO's National Student Unit (NSU) committee recently held a hui with the heads of nursing schools nationwide. After research last year[2] suggesting nearly a third of students were dropping out part way through their studies — with even higher rates for Māori (33 per cent) and Pasifika (37 per cent) — one of the questions we challenged the school leaders with was: "What is causing our nursing student colleagues drop out part way through their three-year or 18-month programmes?" We were met with a plethora of rationales, most challenging, some disturbing — however all were realistic about today's financial, social, political and academic climate.

What is unfortunate about this sad fact, is that some of our most beautiful people are putting themselves forward to help treat our country's most vulnerable.

Money pressure

The most common factor for tauira neehi (student nurses) not completing their study was financial stress, ranging from the cost of studying through to the cost of living while studying. The cost of studying is growing ever higher and tauira neehi are taking on bigger student loans which in turn are taking longer to pay off. Many are not entitled to the student allowance and must apply for living costs through their student loan, making their burden of debt even higher. Once they have graduated, this can handicap them and we can see why studying in today's world is becoming less appealing.

Inflation

Let's double down on this with the cost of living while studying. Inflation — as measured by the CPI (consumers' price index; a way of measuring inflation by recording changes in costs of household goods and services) — has almost doubled since this time last year to 7.3 per cent.

Yet through resilience, I persevere. I suppose I'm getting myself ready for when I do graduate and get a pay rise from nothing to next-to-nothing as a new graduate nurse.

One might ponder, as a student nurse, why is the CPI relevant to me? This time two years ago, CPI was just another meaningless acronym you heard people say. Today I feel I have a deeper understanding. As it has for everyone, the higher cost of living has pushed up the cost of my everyday commodities — food, fuel, heating — making it less affordable to live as tauira.

Government funder StudyLink's current model has many barriers to accessing a student allowance. Should you be eligible, it is still debatable whether you would have enough putea (money) to allow you to fully focus on full-time study, without having to pick up work to meet the increased living costs.

Whānau

So far I have painted a picture of the pohara (penniless) tauira — this is the real world for most (myself included.) Yet through resilience, I persevere. I suppose I'm getting myself ready for when I do graduate and get a pay rise from nothing to next-to-nothing as a new graduate nurse.

In reality, nursing, for me, is not about the money. However, in that same reality the money I earn is what sustains me and my whānau. But what does studying look like on the whānau front? Another top reason we are seeing tauira neehi drop out is commitments to the whānau — providing for and spending time with tamariki (children).

Bullying

Sadly, racism, discrimination and bullying rear their ugly faces in tauira circles. What is unfortunate about this sad fact, is that some of our most beautiful people are putting themselves forward to help treat our country's most vulnerable. But because of experiences within their learning environments, they themselves become vulnerable and discouraged. This is not acceptable in any space, placement or workplace.

Manu Reiri

We in the NSU have spoken at length about breaking the barriers to being a student nurse. Lowering the financial burden would be a great start — how that looks exactly is mahi we plan to continue. I am hopeful that with your support, we will rise together — Maranga Mai!

I hope that, with our efforts, future tauira find the struggle less, allowing them to focus on becoming Aotearoa's next top model. . . I mean nurse.

I leave you with the NSU whakatauki: *He tapuhi. He tīpuna. He atua.* Nurses are likened to their tīpuna and atua; their work is divine.

***Manu Reira, (Ngati Kahungunu ki te Wairoa)**, is Te Rūnanga Tauira vice-chair (acting) and representative at the Southern Institute of Technology*.

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FEATURES

Transforming the system to enable good lives for disabled people

BY SUSAN SHAW AND SUSAN SHERRARD

July 1, 2022

Under the health reforms, disabled people get their own ministry and more control over their lives and the support they receive.

Uncoupling disability services from the Ministry of Health avoids conflating disability with illness. PHOTO: ADOBE STOCK.

Major changes in services for disabled New Zealanders have been signalled with the establishment today of Whaikaha, Ministry of Disabled People under the health reforms.

These changes include the philosophical and structural decoupling of disability support from health-care funding and systems. The approach known as Enabling Good Lives (EGL) underpins these changes — it emphasises disabled people being enabled to set goals, plan their lives and access appropriate and individualised resourcing to support them.

The EGL approach has evolved across Aotearoa New Zealand in recent years through leadership and practice initiatives. Those who have experienced the approach will be familiar with it, but as the national roll-out begins (with the new ministry established on July 1), it is timely to explain the context and core concepts to a wider audience.

Introduction

A raft of structural change is underway across the health sector. This includes the disestablishment of district health boards, the emergence of Health New Zealand and the Māori Health Authority and a change in vision and function for the Ministry of Health (MoH).

The reforms were designed in response to the recommendations of the Health and Disability System Review.[1]

Living with a disability does not mean a person is unwell...

The enduring inequitable health outcomes experienced by Māori, Pacific people and disabled communities,[2,3] despite years of reform,[4] support the need for radical change across the health and disability system.

The Future of Health – Te Anamata o Te Oranga website (https://www.futureofhealth.govt.nz/) details the reforms, with explanations of the intention to have a "more equitable, accessible, cohesive and people-centred system that will improve the health and wellbeing of all New Zealanders".

Health and disability

Structures and systems convey meaning, and locating disability sector resources and leadership within MoH has been seen by some as conflating disability with illness, and particularly medicine.[5]

Living with a disability does not mean a person is unwell and this sense that resources and support are linked to diagnosis and treatment extends to messages of needing or seeking cures. For this reason, the decoupling of disability support and resources from health is positive.

The minister responsible for disability issues was moved inside Cabinet following the 2017 election. This signalled the Government's intention to hear and respond to the disabled community. Subsequently, an Office for Disability Issues was established within the Ministry for Social Development (MSD).

This aligned well with the philosophy that underpinned the establishment of the Whānau Ora approach more than a decade ago, led by Dame Tariana Turia while she was a government minister. The Whānau Ora approach places a high value on finding ways to link up services and focusing on the needs of those being served.

One of the most memorable images used to describe it was in terms of reducing the number of cars from different support agencies that could be parked in the driveway of any one household at a time,[6] so there was only one car (and driver) with passengers from other relevant agencies. The cross-agency approach enabled support to be co-ordinated across the traditional boundaries of government departments and service providers.

The Enabling Good Lives (EGL) approach

The Whānau Ora approach enabled whānau to drive their own agenda,[7,8] focusing resources on goals and agreed need, with culturally-centred and individualised support. While holding ministerial roles, Dame Tariana also announced a "new model for supporting disabled people"[9] which made a number of references to "good lives". Cabinet papers outlining the establishment of the Ministry of Disabled People and implementation of the Enabling Good Lives (EGL) approach[10] referred to the links between EGL and Whānau Ora in terms of philosophy and also the value of co-design. The EGL approach has been piloted in three demonstration sites around the country over a number of years.

The concepts which underpin the EGL approach are outlined in five key characteristics, five elements for system change and eight principles. These are summarised in table 1 below.

TABLE 1. CONCEPTS UNDERPINNING THE EGL APPROACH

Five characteristics
1. Self-directed planning and facilitation 2. Cross-government individualised and portable funding 3. Considering the person in their wider context, not in the context of 'funded support services' 4. Strengthening families or whānau 5. Community building to develop natural supports.
Five elements for system change
1. Building knowledge and skills of disabled people 2. Investment in families 3. Changes in communities 4. Changes to service provision 5. Changes to government systems and processes

Five characteristics
Eight EGL principles
1. Self-determination 2. Beginning early 3. Person-centred 4. Ordinary life outcomes 5. Mainstream first 6. Mana enhancing 7. Easy to use 8. Relationship building

Enacting the EGL approach

The recognition of disabled people at a national and governmental level is in part informed by the international context. The New Zealand Government ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)[11] in 2008, the year it came into force. The definition of disability in the convention refers to "long-term physical, mental, intellectual or sensory impairments".

The inequity that disabled people experience was particularly obvious during the COVID-19 pandemic, as they struggled to access care and support.

The group that the EGL approach will initially apply to, as it is rolled out across Aotearoa New Zealand, are those who have previously had access to the Disability Support Services (DSS) provided by the Ministry of Health, specifically those who have physical, sensory, or intellectual disability and are under the age of 65.

This means there are groups of people who meet the definition of disability under the UN convention, such as those living with mental health issues and wellbeing or addiction issues, those who have any impairment and are over the age of 65, and those supported by ACC are not currently included within the roll-out of the EGL approach.

The inequity that disabled people experience was particularly obvious during the COVID-19 pandemic, as they struggled to access care and support. The experience and impact of this during the Omicron outbreak, compiled in a Human Rights Commission report[12] and summarised in Table 2 below, provide insight into the issues.

TABLE 2: EXAMPLE OF CHALLENGES FACED BY DISABLED PEOPLE DURING THE COVID-19 OMICRON OUTBREAK

Issue	Finding or example[12]
Access to testing and vaccines	"...three of the main tools used during Omicron – vaccination, RATs and masks – have often been inaccessible to disabled people and their whānau. (p.23)
Access to care and support	"When carers were away, for example, due to having tested positive for the virus, not all disabled people and their whānau were able to find people to cover their usual carer, or they were not able to find carers with suitable expertise, for example, where replacement carers were not able to communicate with Deaf people using basic NZSL" (p. 32).
Access to PPE	"Access to personal protective equipment (PPE) for support workers and carers was raised as an issue by numerous submissions. A number reported that some disabled people and their whānau were unable to access PPE for support workers until they or their support worker tested positive for COVID-19. Even after testing positive, there appeared to be no guarantee that PPE would be supplied to ensure disability supports could continue safely for disabled people" (p. 32)

The decentralisation of disability support funding and increasing flexibility in access to services is occurring around the world. In Australia, individualised funding across the sector has been rolling out since 2013.[13] This is in line with international trends to focus on the individual.[14] The New Zealand Government's 2022 Budget[15] specifically referred to these initiatives, as outlined in Table 3 below.

The commentary acknowledged that:

> *"Disabled people currently face significant barriers to experiencing positive wellbeing, including disproportionate representation in poverty statistics and experiences of inaccessibility and discrimination. While work to reform the disability support system has been underway for more than a decade, substantial investment is required to meaningfully support people with disabilities" (p. 23)*

TABLE 3: NEW ZEALAND GOVERNMENT 2022 BUDGET DETAILS SUPPORTING EGL15 (P.22-23)

Funding	Detail
$735 million	to address volume and price pressures facing disability support services, to meet additional demand and ensure sustainability of providers
$100 million	to support a regional-based rollout of the Enabling Good Lives approach, providing disabled people and their families and whānau with greater choice and control over their lives and supports,
$108 million	to establish a new Ministry for Disabled People and support its ongoing operations.

Working with the EGL approach

Moving to a new structure and model for managing resources presents new opportunities and also a number of challenges. For disabled people and their whānau, the primary focus will be on their aspirations and goals and identifying the best available resources to support them. They will need to become familiar with the approach and navigate their way through it, with support if they choose.

For service providers, there are likely to be significant changes, particularly as long-standing needs assessment-based approaches are no longer emphasised. Moving the focus to individualised, aspirational goal setting and planning reduces the requirement for practitioners or agencies to assess specific entitlements.

People working within the system are likely to notice disabled people utilising a broader range of support and resources. The philosophical basis and principles of the EGL approach will need to be understood and implemented across the system. This will require updating position descriptions, education and training programmes, and practice expectations.

Across the health and disability sector internationally, there is increasing recognition of lived experience. Its importance is being recognised in the design, delivery and evaluation of education programmes,16 for roles in the sector, and also through the awarding of academic credit.17,18 The EGL approach is committed to genuine engagement with disabled people, including providing them with opportunities to have the expertise which arises from lived experience recognised, both in academia and in the workforce.

Conclusion

Transformational change, required to address inequities, is underway across the health and disability system. This includes radical structural and philosophical changes that will enable disabled people and their whānau to set goals and access resources focused on them. This EGL approach has similarities with the Whānau Ora approach as it reaches across agencies and activities.

The EGL approach represents change for all of those involved in the disability sector and it is essential that practitioners have an appreciation of the key concepts that underpin it, and its wider context.

Susan Shaw, BN, MEd Admin, EdD, Dip Tchg, PFHEA, *has a background in education, health and disability. She works at AUT and is the principal investigator on a project re-envisaging the education of health professionals. Her commitment to navigating boundaries between professions, systems and the communities they serve is grounded in her personal and professional lived experience.*

Susan Sherrard, BN, MA(Hons), PGDip Psych, MNZM, *identifies as a disabled woman and has been active in the disability community for 30 years. She has worked in nursing, psychotherapy, education, advisory and leadership roles within the disability community and in service provision and workforce development. She is a member of a project team engaged with the EGL approach.*

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Kaitiaki NURSING NEW ZEALAND

OPINION

Vigilance needed over New Zealand's hard-won abortion rights

BY EMMA MACFARLANE

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New Zealand's gains in abortion rights could 'easily' be lost as in the United States, warns a senior women's health nurse.

Emma Macfarlane

On March 23, 2020, Aotearoa New Zealand introduced the Abortion Legislation Act,[1] and in doing so decriminalised one of the most common gynaecological procedures anyone will have in the course of their life. An estimated one in four pregnancies result in abortion globally.[2]

Statistics in Aotearoa show that in 2020 there was a slight increase in abortions compared to 2019. However, in general there is a continuing trend towards a decline in the number of abortions.[3] Abortion will always be necessary — no method of contraception is 100 per cent effective and there are always reasons why people will choose to have abortions.

In Aotearoa, people who choose to end their pregnancies up to 20 weeks' gestation can do so without providing a reason and they cannot legally be declined.[1] It is their choice, and their reason is their business. The legislation also allows abortion to be provided in multiple settings (including via telemedicine) and by a range of health practitioners (including nurses, nurse practitioners and midwives).[1]

We have also recently seen the introduction of The Contraception, Sterilisation and Abortion (Safe Areas) Amendment Act 2022,[4] whereby abortion providers can apply to the Ministry of Health to enact a safe zone around their service to protect people accessing and providing abortions.

If, as anti-choice campaigners believe, safe abortion is murder, then so is banning access to safe legal abortion. The difference in these views is only in who dies.

From a pro-choice perspective, these developments demonstrate a positive change in advancing access to safe, legal abortion in Aotearoa. However we must not be complacent. This advance in sexual and reproductive health and rights was won by a democratic process and could just as easily be lost in the same fashion.

Roe v. Wade

In June we saw the American Supreme Court overturn Roe v. Wade. This was a 1973 Supreme Court ruling which ensured legal access to abortion in the first trimester as a constitutional right, across all states. For pro-choice advocates, its loss is seen as a major step backwards in human rights. Anti-choice (otherwise known as "pro-life") campaigners are celebrating this as a win.

Photo: Stuff Ltd. Protestors in Wellington earlier this month marched over the United States' Supreme Court decision to overturn Roe v. Wade.

There is no doubt that anti-choice activists are as earnest in their beliefs regarding the wrongfulness of abortion, as pro-choice activists are in their belief in the right of the individual women/pregnant person to decide. However, if the overturn of Roe v. Wade was truly about the preservation of life, why would the same country tolerate such relaxed firearm controls?

If this was really about the sanctity of life, why does the United States of America (USA) not have universal access to funded health care? And why would the same country still have states that impose the death penalty?

> **This advance in sexual and reproductive health and rights was won by a democratic process and could just as easily be lost in the same fashion.**

When abortion is illegal or highly restricted, people still have abortions but they are more likely to die from unsafe procedures.[5] Furthermore, it is people who are most disdvantaged in society (ethnic minorities and those with disabilities, complex health needs or living with high deprivation) who experience the most significant morbidity and mortality rates associated with pregnancy, when there is restricted access to safe abortion.

If, as anti-choice campaigners believe, safe abortion is murder, then so is banning access to safe legal abortion. The difference in these views is only in who dies.

No room for complacency in New Zealand

We would be wrong to think that people's right to safe, legal abortion is ensured for the future in Aotearoa. The Abortion Legislation Act 2020 was enacted because people of New Zealand used the democratic process to make it happen. Equally, a democratic process can be used to take it away.

Those of us who believe that abortion is an essential part of sexual and reproductive health and rights need to continue to be vigilant and actively participate in local and national advocacy to support increased access to safe, equitable, accessible abortion care.

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