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NEWS

‘Reclaiming’ Māori approach to health at heart of midwives’ practice

BY MARY LONGMORE

May 5, 2022

A holistic Māori approach to health including mirimiri (massage), rongoā (traditional healing) and karakia (prayer) is at the heart of a new Hawke’s Bay midwifery practice.

Founded by three Māori midwives — Kiley Clark, Charlene Eparaima and Crissy Coromandel — the practice, Tapuhi Kura, was “reclaiming” such practices, Clark said. “Whether we learnt it from other Māori midwives or whānau, those are practices that we know about and engage in, but that are not in every LMC [lead maternity carer]’s practice here,” she said in a press release.

Hawke’s Bay midwife Kiley Clark

“Our main priority at Tapuhi Kura is caring for our whānau Māori and trying to readjust some of the statistics and inequities that exist,” Clark said. “Rightfully or wrongfully, they are definitely there, and Māori are trying to work in a system that wasn’t designed for us.”

Formerly the Māori midwifery consultant at Hawke’s Bay District Health Board (DHB), Clark said the leadership role helped her to connect and build rapport with other Māori midwives, including Eparaima and Coromandel. That led to Tapuhi Kura, she said.

Unlike the typical mainstream model, their approach was “very collective”, she said. “We have to hui and wānanga together so it works.”

Developing a dedicated community of Māori midwives would help tackle inequalities — and she hoped Tapuhi Kura would encourage others to “step into that space”.

Building relationships with whānau and seeing families created were highlights, Clark said.

Hawke's Bay District Health Board acting director of midwifery Catherine Overfield said it was "admirable" to see such an innovative approach to care.

In a statement to mark International Day of the Midwife on May 5, Overfield said it was a chance to acknowledge and thank the 50 hospital midwives employed by the DHB, and the many self-employed midwives (or lead maternity carers) in the community.

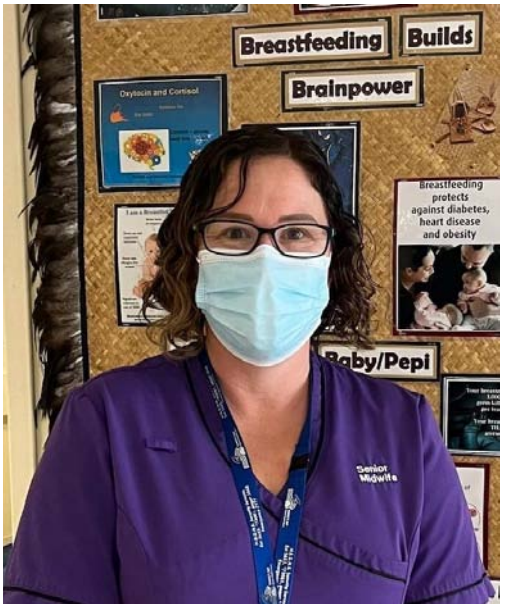
Hawke's Bay midwife Kiley Clark and hapū māmā Olivia Bland

All New Zealand midwives were required to complete a "robust" four-year degree, which set them up to provide care in the community and hospitals. "A midwife's role includes prescribing, ordering and interpreting blood tests and scans, as well as managing any emergencies that might eventuate," Overfield said.

"That first initial two minutes after the birth when people are like – 'holy moly, I did it!' – that's pretty cool."

Hawke's Bay DHB clinical midwifery coordinator Vanessa Bryant said the bonding scheme — which pays up to $3500 per year for midwives who choose to work in hard-to-staff areas such as Hawke's Bay — was a "blessing".

Bryant agreed with Clark that seeing families created was a highlight of midwifery. "That first initial two minutes after the birth when people are like — 'holy moly, I did it!' — that's pretty cool."



Hawke's Bay DHB clinical midwifery coordinator Vanessa Bryant

Of NZNO's 55,561 members, 283 are midwives, according to the latest figures.

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OPINION

‘That’s the scale of the injustice’ – NZNO won’t back down on back pay

BY NZNO CHIEF EXECUTIVE PAUL GOULTER

May 12, 2022

After a “clear and strong” member mandate to turn the district health boards’ pay equity proposal over to the Employment Relations Authority (ERA) to determine backpay, senior nurse rates and how to safely cement pay equity into the system, NZNO chief executive Paul Goulter shares his views.

I had not long been NZNO’s new chief executive, when frustration over the failure to include full backpay, as promised by district health boards (DHBs) in the 2020 collective agreement, boiled over amongst our members.

Paul Goulter

Their proposal fell way short — not only in back pay, but also in ensuring pay equity would be safely enshrined for the profession, and considering senior nurse rates too.

The extent of member upset — robustly expressed on social media as well as through our own delegates — over the backdating was a clear statement that there seemed to be a gap between what was being proposed and what members’ expectations were.

I do understand the sheer scale of what NZNO is claiming needs to be paid to our DHB membership, but that’s the scale of the injustice.

I understand the upset and frustration of our members, — they have been waiting years for this. For the last two multi-employer collective agreements (MECAs) a promise to backpay was part of the settlement. So when they feel that promise hasn't been delivered, such a response is entirely predictable and understandable.

The trick was to find out whether or not we could establish whether those expectations were well-founded legally, which would oblige all parties to ensure the final offer did provide for full backdating — and that was what our legal review confirmed.

Pay rates across all nursing sectors

This is is just the start, as far as I'm concerned. NZNO will be seeking to establish single pay rates for registered nurses, health-care assistants and senior nurses right across the whole system. We're going to go hard to get those rates across all sectors, whether it's iwi/Māori, primary or aged care providers, through pay parity mechanisms.

I do understand the sheer scale of what NZNO is claiming needs to be paid to our DHB membership, but that's the scale of the injustice.

We're going to go hard to get those rates across all sectors, whether it's iwi, primary or aged care providers, through pay parity mechanisms.

There are essentially three issues that need to be resolved and our members have been really clear on these:

- Full backdating to December 31, 2019. Our members clearly feel they are entitled to this and our legal review supports this view. It found that an obligation to back pay had been entered into by the DHBs, and the Equal Pay Act (1972) prevents that from being diminished in any way. This is the biggest issue and we'll be pushing this as hard and urgently as we can. These are long-standing and critical issues and we hope they'll be dealt with as soon as possible.
- Ensuring a mechanism is in place to maintain pay equity into the future.
- The effect of new pay equity rates on senior nurses and their rates. In separate meetings, they're telling us their jobs have been under-valued on the basis of gender and would like further evaluation.

In all these matters, we seem to be at loggerheads with the DHBs, and so members have decided to just hand the whole lot over to the ERA to determine.

Possible outcomes

The Employment Relations Authority (ERA) may push us to enter into mediation or facilitation, where the parties (unions NZNO and the PSA, the Crown, DHBs and Ministry of Health) get around the table again to discuss the issues. We can't predict that but we would enter into that in good faith, as always. We now have a clear mandate from members, we're pretty clear about what needs to happen as an outcome from any mediation or facilitation.

Members stepping up

Overall, we have been very pleased with the high level of member reflection and engagement throughout this process so far and hope to see this continue as we push for pay parity across sectors. We had high numbers participating in the poll over the proposed settlement, and a clear mandate as a result. We have also had high numbers of delegates and members participating in our online meetings, who felt able to be free and frank, quite correctly.

We have also worked really well with our fellow union, the Public Service Association (PSA) throughout this, so that's been really useful also.

Meeting our members online and visiting their regions recently, members made it clear to me that they've been really pleased to see NZNO taking a firm line on this matter.

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OPINION

Changes to how IQNs are registered must balance fairness with safety – Nursing Council

BY NURSING COUNCIL POLICY AND RESEARCH ADVISOR KALPANA JAYANATHA AND PROJECTS LEADER JANE MACGEORGE

May 4, 2022

For some time, the Nursing Council has been considering how to improve the way we assess and register internationally qualified nurses (IQNs), to ensure that our processes are robust and fair.

AdobeStock

In doing this we are conscious of the need to meet several goals. We need to ensure that our processes are fair and not overly burdensome for applicants. We also need to be confident that our processes accurately evaluate the competence of applicants to practise in the Aotearoa New Zealand context. And finally, in keeping with the council's statutory purpose, our

processes must attest to a sufficient standard of practice that will protect the health and safety of the public.

Before we describe our proposals, we would like to first acknowledge and thank you, the nursing professionals, for your continued work during these unprecedented and challenging times, as you provide safe, high-quality care to all of us in Aotearoa New Zealand.

What are we proposing?

We are proposing a move away from an input-based approach (see Table 1 below) to assessment, and towards directly assessing competence to practise. This is also known as an outcomes-based approach and aligns with international trends in nursing regulation. We are also proposing some changes to the English language standard to ensure this is fair, appropriate for nursing, and doesn't raise unnecessary barriers for applicants.

Examples of input-based measures	Examples of outcomes-based measures
• Qualification/nursing degree • Years in practice/post-registration experience	• Test of minimum knowledge required for safe practice • Assessment of baseline skills needed to practise safely

Table 1: Examples of input and output-based measures of competence

Alongside this shift, we want our processes to focus on what it means to practise nursing safely in Aotearoa New Zealand's unique context. This means all nurses, including IQNs, require an understanding of how to apply Te Tiriti o Waitangi to nursing practice, including practising nursing in a way that honours kawa whakaruruhau1. It also means that professional expectations and "how we do things", such as independent and collaborative practice, are understood by IQNs who may be used to working in different contexts.

The detail of what we are proposing, including a technical background document that outlines the rationale for specific proposed changes, can be found on the Nursing Council website (https://www.nursingcouncil.org.nz/NCNZ/publications-section/Consultation/IQN_Consultation_.aspx).

Why? And why now?

We are aware that we are consulting on this issue at a time when the nursing profession and our health system are both under significant stress, with existing pressures being exacerbated by COVID-19.

The changes we are proposing have been considered for a while now. Extensive research, observation of trends in international practice, and evidence about good regulatory practices

have been collated over time and have ultimately come together to form our current proposals. The critical and valued role that IQNs have in our workforce gives this work particular relevance. While we paused this work in recognition of the disrupted nursing environment, we believe it is now important for us to proceed with consultation.

Te Tiriti o Waitangi

In future, we are looking to work with partners as we move toward designing and implementing any changes that come out of this consultation. An example where we already clearly anticipate the need to work in Te Tiriti partnership is in the design of pre- and post-entry education focusing on Te Tiriti o Waitangi, kawa whakaruruhau, cultural safety, and Aotearoa's health system and broader health context (including the ongoing impact of colonisation).

What have we heard so far?

Before opening public consultation on this topic, we have been discussing our proposals with some key organisations and groups. This has helped us gauge initial reaction to our proposals and ensure that those with an especially strong stake in how we assess and register IQNs are not surprised by our ideas. Groups we have had discussions with include IQN associations, competence assessment programme (CAP) providers, major employers of IQNs, professional associations, researchers and educators.

So far, we have heard diverse views about changes to the English language standard, with some expressing concerns about the changes, and others noting that the changes may help to reduce unnecessary barriers for applicants. We have also heard interest in the idea of exploring tests that assess spoken English through computer-based methods.

> **Although this work addresses the position of international nurses as a whole, we are also committed to exploring pathways that may better support transition to registration and working with Pacific communities**

Regarding changes to the education standard, many have welcomed a focus on Te Tiriti o Waitangi and cultural safety prior to entering the register.

We also understand that many have questions about the proposed exam and practical assessment, such as who would design and administer these. At this stage, no decisions have been made about a specific model or approach: this is where we need your feedback and expertise. If these proposals are implemented, we will work alongside sector experts to put robust and appropriate processes in place.

Additionally, we have heard questions about how the proposed changes may impact other processes, such as return to nursing. We are interested in hearing if and how our proposals to improve processes for IQNs may have an effect in other areas.

Finally, we are aware of the specific issues that are faced by some Pacific-educated and registered nurses (RNs) who are in Aotearoa New Zealand, but not working as nurses here. We want to acknowledge the skills and valued cultural expertise these nurses bring to Pacific communities, and to the health and disability workforce as a whole. Although this work addresses the position of international nurses as a whole, we are also committed to exploring pathways that may better support transition to registration and working with Pacific communities and stakeholders on actions in this area.

Please share your thoughts

We want to hear your views and suggestions on what we are proposing. Please visit our website (https://www.nursingcouncil.org.nz/NCNZ/publications-section/Consultation/IQN_Consultation_.aspx) to see our consultation information, including quick-read versions of our proposals and a feedback survey. If you would like to contact us directly for further information and ways to provide commentary, please contact us at info@nursingcouncil.org.nz.

Footnote:

1. Please follow this link, and scroll to the section 'Kawa Whakaruruhau and Cultural Safety' (https://www.nursingcouncil.org.nz/Public/Treaty_of_Waitangi/Te_Tiriti_o_Waitangi_Policy_Statement/NCNZ/About-section/Te_Tiriti_o_Waitangi_Policy_Statement.aspx?hkey=e01b23f4-2e87-43e0-9e89-cb50f7b1929d)

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OPINION

Collapse of negotiations with care workers shows little has changed in how the Government views the work of women

BY KATHERINE RAVENSWOOD

May 18, 2022

Ahead of the 2022 Budget, apprenticeships have been given a $230 million funding boost (https://www.newshub.co.nz/home/politics/2022/05/government-extending-apprenticeship-support-scheme-but-lowering-pay-out.html) while negotiations between care workers and the Government have fallen apart (https://www.stuff.co.nz/national/newsroom-co-nz/300586008/historic-care-workers-pay-equity-deal-under-threat). It's hard not to see this as a gender equity issue.

PHOTO: ADOBE STOCK

Apprenticeships, and the industries they benefit, are held almost exclusively by men, while New Zealand's 65,000 care, support, mental health and addiction workers are predominantly women.

Multiple court cases identified gender discrimination in the way previous governments funded care and support workers.

These court cases led to an historic $2 billion agreement (https://www.stuff.co.nz/taranaki-daily-news/news/91677872/new-era-ushered-in-with-equal-pay-deal-for-care-workers?rm=a) between care workers and the then National-led Government in 2017. But this agreement is set to expire in July and with it, warn advocates, the hard fought gains of care workers across the country.

So, the question has to be asked: do the latest Budget priorities and collapse of negotiations with care workers reflect the fact that five years on from the 2017 agreement, little has changed?

NZNO aged care support workers

An historic settlement

The 2017 Pay Equity Settlement for care and support workers was reached after years of legal action led by aged care worker Kristine Bartlett, other care and support workers and their unions.

The Supreme Court determined that the care workers' low wages and poor work conditions were the result of persistent gender discrimination.

In other words, their pay didn't reflect the skills, experience and knowledge required but instead was based on the fact that most care and support workers were women. In New Zealand, women continue to be paid less than men (https://www.stuff.co.nz/life-style/wellbeing/127126686/from-today-women-are-working-for-free-how-nzs-most-influential-women-are-using-their-out-of-office-to-fight-the-pay-gap).

The government of the day intervened to settle out of court before further legal action could be taken. But negotiations were limited from the outset, with the Government concerned more with curbing costs (https://www.treasury.govt.nz/sites/default/files/2017-11/b17-3704875.pdf) than equal pay.

> **The Government's offer to the unions was about half what the unions had calculated would cover the cost of gender equal pay. The settlement also prevented these same women from taking further action on equal pay until the settlement expired.**

Despite ongoing flaws (https://www.stuff.co.nz/opinion/127849089/pay-equity-settlement-has-not-delivered-all-it-promised) in the settlement, the associated legislation delivered significant pay increases and guaranteed training opportunities (https://workresearch.aut.ac.nz/__data/assets/pdf_file/0004/628681/Pay-Equity-Report-2022.pdf) for the care and support workforce.

Time is running out

After the settlement was reached, the lowest agreed wage rate for care and support workers (https://www.legislation.govt.nz/act/public/2017/0024/28.0/DLM7269176.html) was 121 per cent of the minimum wage; the highest rate came in at 149 per cent of the minimum wage.

Over the past five years, care and support workers' wages have not maintained the same relativity to the minimum wage (https://www.employment.govt.nz/hours-and-wages/pay/minimum-wage/minimum-wage-rates/), let alone gender equal pay.

The current lowest wage rate for care and support workers is $21.84 and the highest is $27.43 per hour. The minimum wage is $21.20. That highest rate offered to care workers is only achieved after several years of training and qualifications as well as experience on the job.

Wages for care and support workers would need to range from at least $25.60 to $31.60 or more to maintain the same relativity to the minimum wage as was seen in 2017.

NZNO delegates in aged care at a Wellington rally last year

Deadline comes as no surprise

That the 2017 Care and Support Workers (Pay Equity) Act expires this year (https://www.stuff.co.nz/opinion/127849089/pay-equity-settlement-has-not-delivered-all-it-promised) is not news for the Government.

Indeed, there have been some discussions on how funding models for this sector should be changed to ensure that the gender equal value of this work is maintained into the future.

However, the Government only recently offered a concrete proposal to care and support workers, despite earlier union calls for agreement and decision ahead of July's deadline.

The offer is a 2.5 per cent to 3 per cent pay increase (https://www.etu.nz/pay-negotiations-for-care-and-support-workers-set-up-to-fail/) on current rates for the next 18 months. This is not even half the inflation rate, amounts to about 70c an hour and does not maintain the wages as gender equal.

> **The offer just does not value care and support work.**

Care and support workers will now have to undergo another equal-pay claim process to reassess wages – despite the earlier court decisions that identified gender discrimination as the cause for low wages within the industry (https://theconversation.com/historic-pay-equity-

settlement-for-nz-care-workers-delivers-mixed-results-114283).

The contrast with 'men's work'

At the same time as care and support workers were struggling to get gender equal pay, the Government made a pre-Budget announcement to invest $230 million (https://www.beehive.govt.nz/release/budget-2022-supports-38000-apprentices-accelerate-recovery) more into apprenticeships in 2023. This follows the $1.6 billion trades and apprenticeships training package (https://www.stuff.co.nz/business/prosper/advice/300165221/apprentices-are-good-for-your-business--heres-five-reasons-why) in the 2020 budget.

There is no doubt that investing in apprenticeships is important for upskilling New Zealanders to meet labour shortages in key industries. But apprenticeships favour male-dominated industries and consequently provide significantly more opportunities for men than women.

At the end of 2020, women still comprised just 12.7 per cent of all apprentices (https://www.tec.govt.nz/assets/Ministerial-papers/B-21-00132-December-2020-Enrolment-Update-Signed-by-Minister_Redacted.pdf), despite the boost to apprenticeships and focus on recruiting female candidates (https://www.stuff.co.nz/life-style/homed/latest/127211965/the-old-ways-are-gone-number-of-women-apprentices-slowly-growing-in-nz).

This figure has remained low despite the gendered impact of the global pandemic – 10,000 of the 11,000 New Zealand workers who lost their jobs (https://thespinoff.co.nz/business/05-08-2020/11000-new-zealanders-have-lost-their-jobs-and-10000-of-them-were-women) during the first year of the COVID-19 crisis were women.

At the same time, care and support workers have operated as essential workers. During the pandemic, care and support workers were on the front line, with many going into people's homes to look after vulnerable patients (https://theconversation.com/low-staff-levels-must-be-part-of-any-reviews-into-the-coronavirus-outbreaks-in-nz-rest-homes-137764).

Despite this role and its risks, care workers struggled to access (https://www.nzdoctor.co.nz/article/urgent-need-ppe-care-and-support-workers) basics such as personal protective equipment (PPE) to protect themselves and the people they support or be recognised for the sacrifices they made in the course of their work.

Time for a long-term solution

The Government has had the power, but not the foresight, to conduct an updated analysis of pay ahead of the expiration of the settlement agreement.

Over the past five years, policy makers could have completed a full equal pay assessment, comparing this job not just to other female-dominated jobs in the public health sector, but to

male-dominated occupations with similar skills, qualifications, risk and experience requirements.

Fully funded gender-equal pay for care and support workers could then have been included in this year's Budget. At the very least, the pay increase on offer could have brought wages to the same level in relation to the minimum wage as in 2017.

It would have been a win for these women, for the people who rely upon their care and support, for our health-care system and our identity as a good country for women in work. Instead, it appears that no matter which government is in power, women are expected to take a back seat to profit, budgets and men.

Katherine Ravenswood, PhD, is an associate professor in employment relations at the Auckland University of Technology.

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DHB nurses opt for Employment Relations Authority ruling over pay equity claim

BY MARY LONGMORE

May 10, 2022

NZNO is "urgently" asking the Employment Relations Authority (ERA) to determine back pay and pay equity rates, after district health board (DHB) members strongly rejected a pay equity settlement proposal.

Nurses on strike in 2021

The results of the poll, which closed at 5pm yesterday, suggest the DHB's proposed settlement

fell far short of nurses' expectations of back pay dating back to December 2019 — a cost the Health Minister Andrew Little has said would be in the "hundreds of millions".

NZNO chief executive Paul Goulter said the results were "strong and clear". NZNO would now engage lawyers to file an application with the ERA to urgently seek determinations on the promised back pay, the new pay equity rates themselves as well as a way to ensure pay equity with male-dominated professions was maintained into the future.

NZNO is urgently seeking three determinations from the ERA.

- Fixing pay equity rates, including addressing senior nurses' concerns about the effects on their comparative salaries.
- Ensuring there is a process to maintain pay equity over time.
- Backdating of the pay equity rates to December 31, 2019, as was formally agreed in the 2020 DHB-NZNO collective agreement.

"We want to move as quickly as possible on this matter and our lawyers have already been instructed to begin the application process to the ERA."

Paul Goulter

Instead of back pay promised in the 2020 multi-employer collective agreement (MECA), in April the DHBs proposed a series of lump sum payments capped at $10,000 per individual "in recognition" of past work.

An NZNO legal review in April found the proposal was contrary to the Equal Pay Act, over the back pay issue.

The ERA's determinations over fixing and maintaining pay equity "may or may not be the same as what has been included in the proposed settlement", Goulter said. Nor did NZNO know how long it would take to make its determination, although urgency would be requested, Goulter said.

The ERA may direct NZNO and DHBs into a mediation or facilitation as its first step, he added.

About 40,000 nursing and health staff covered by the DHB nursing pay equity claim were

invited to participate in the poll, which closed at 5pm Monday May 9. A “significant majority” chose to turn to the ERA rather than proceed with a ratification vote on the offer, Goulter said.

The nursing pay equity claim aims to compare the pay and conditions of the various nursing roles to similar roles in male-dominated professions.

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NEWS

Enrolled nurses' scope of practice to be reviewed this year – Nursing Council

BY MARY LONGMORE

May 18, 2022

NZNO's enrolled nurses (ENs) say they are looking forward to working closely with the Nursing Council to review their scope of practice, after a 2019 survey found ENs preferred not to work "under the direction" of nursing colleagues.

The Nursing Council announced this week plans to fully review the EN scope of practice this year — a year earlier than the previously signalled time-frame of 2023.

This follows two years' of lobbying from the NZNO Enrolled Nurses Section (ENS) over a requirement ENs work "under the direction" of registered nurses (RNs).

ENS chair Robyn Hewlett said the section was looking forward to working collaboratively with the Nursing Council to define a "forward-focused" scope which recognised ENs' distinctive role as one in "partnership" with RNs rather than under their direction.

Robyn Hewlett

The EN role differed from that of an unregulated health worker, she said.

The ENS had originally requested a change in wording of the EN scope, from working "under the direction and delegation of the registered nurse (RN) or nurse practitioner (NP)" to "works in collaboration and partnership" with nursing colleagues.

However, reviewing the entire scope was a good idea, "as we can look at what works well, what is not working well, how can we improve it, so no EN is disadvantaged", Hewlett said.

> **'This new EN scope of practice statement needs to be future-focused for nursing in New Zealand and allow ENs to be able to do more and work collaboratively with the RN or NP rather than under direction and delegation.'**

"We don't want it to be task-orientated. This new EN scope of practice statement needs to be future-focused for nursing in New Zealand and allow ENs to be able to do more and work collaboratively with the RN or NP rather than under direction and delegation."

Nursing Council director of policy, research and performance Nyk Huntington said the review would have two stages. Firstly, it would revisit the current scope statement (https://www.nursingcouncil.org.nz/public/nursing/scopes_of_practice/enrolled_nurse/ncnz/nursing-section/enrolled_nurse.aspx) to ensure it fully represented the current nature and future potential of EN practice. The second stage would look at the competencies underpinning the scope, and the education standards — which set out the council's expectations for EN education.

Nyk Huntington

The review was in the planning stages but was expected to begin within the next few months, Huntington said. Details on how the council would work with the nursing profession on reviewing the scope would be released as it progressed.

Council members decided while setting the strategic plan that revising the EN scope should be a priority, given it was last reviewed 10 years ago and "the council's commitment to enabling high quality EN practice".

Huntington said the council wanted to look at the role of the EN "holistically", rather than just focusing on "the long-standing issue of the 'direction and delegation' terminology".

However, the review did not mean everything would be changed, he said. "We will be asking what currently works well, what doesn't work well, and what is missing."

Huntington hoped the first stage would be completed within six months.

A 2019 NZNO survey found ENs felt the requirement to work "under the direction and delegation" of colleagues such as RNs was too restrictive. The section wanted the wording changed to reflect a more collaborative "partnership" between ENs and their nursing colleagues, Hewlett said at the time.

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NEWS

Frontline health workers 'completely overlooked' in Budget – NZNO

BY MARY LONGMORE

May 20, 2022

NZNO was "profoundly disappointed" with yesterday's Budget, which barely mentioned nurses or their wages and conditions, chief executive Paul Goulter said.

"The health frontline is made up of nurses, health-care assistants and kaimahi hauora across all sectors in crisis, and. . . significant funds were needed in the Budget to address staffing and pay issues," Goulter said.

NZNO had been "very clear" on this, yet the Government seemed "oblivious to the fact that it cannot have a robust and workable health system when there are chronic staffing issues that are worsening every day", Goulter said.

Paul Goulter

Finance Minister Grant Robertson announced on Thursday May 19, $11.1 billion of new funding to run the health system over the next two years, plus $76 million for "workforce development" over the next four years — an amount Goulter described as "loose change".

There was no mention of nursing wages or conditions, or how the Government intended to address the widening pay gap between nurses who work for district health boards (DHBs) and those in other sectors, Goulter said. "That is just going to perpetuate health inequities and staffing problems for non-DHB providers."

“There is an increasing risk of essential health staff leaving New Zealand for overseas.”

NZNO kaiwhakahaere Kerri Nuku said it was “disheartening” with no investment in a “sustained public health response”.

Kerri Nuku

Nuku said funding for workforce development across the Māori health workforce appeared to be “too small to address the wage parity issue” for nurses in Māori health providers.

“‘Māori and iwi health will continue as the poorest cousin in the health system. That’s a tragedy, really.”

Council of Trade Unions (CTU) policy director and economist Craig Renney said the changes in funding for health — especially longer-term funding — were “welcome and necessary” but did not go far enough to boost the health workforce.

“We have concerns that the money. . . will not prove sufficient to properly target need. $76 million of funding will provide part of the solution but not the whole amount,” Renney said in the CTU analysis.

Budget documents (https://budget.govt.nz/budget/pdfs/at-a-glance/b22-at-a-glance.pdf) show a multi-year approach to health system funding “designed to support longer-term planning”.

There were more than 4000 nursing vacancies, difficulties finding enough mental health staff and widening gaps in pay between the public and private health sectors, Renney said. “There is an increasing risk of essential health staff leaving New Zealand for overseas.”

Craig Rennie

Nor was it clear how the money would be provided as the wording allowed for both training and development. “This might mean no new staff at all.”

> **“Māori and iwi health will continue as the poorest cousin in the health system. That’s a tragedy, really.”**

The CTU was also concerned there was no extra funding for the health service reorganisation, due to launch this year, to follow last year’s $486 million. Health reforms were “expensive and time-consuming”, Renney said. “But the lack of even contingency funding being made available for reorganisation means that we have questions about how the costs of service redesign, above the $486 million already provided for, will be managed.”

More ‘secure and sustainable’ funding

Renney said moving from an annual to a two-year funding cycle may help the sector attain a “more secure and sustainable footing” over time, alleviating deficits. “However this will rely on the Government getting the funding right at each stage.”

However, the $168 million provided for the new Māori Health Authority (MHA) over four years appeared “small” in the grand scheme of things, he said.

While it brought the total investment into the MHA to $254 million — or $63.5 million per year, “in the context of a $20 billion+ system, this might appear to be a small amount of funding — around 0.3 per cent of health service purchasing,” Renney said.

Historical under-investment meant that essential hospital and other health infrastructure had not been in place to deal with challenges such as COVID, Renney said.

Breakdown

$11.1 billion over two years for paying off deficits and operating a newly restructured health system, including:

- $1.8 billion annually in 2022/23 for cost pressures including $520 million to clear historical debt.
- $1.3 billion per year for operational support will follow in 2023/24.

Other health spending includes:

- $76 million to grow the health workforce.
- $1.3 billion for health infrastructure such as hospital buildings.

- $202 million for mental health services.
- $191 million for Pharmac over two years.
- $166 million for road ambulances.
- $90 million for air ambulances.
- $168 million for the Māori Health Authority over four years.
- $70 million for Pasifika health over four years.
- $488 million for primary care.
- $1.2 billion for COVID-related public health.

For more details over coming days, see the CTU website. (https://union.org.nz/category/media-releases/)

Kaitiaki
NURSING
NEW ZEALAND

PRACTICE

Introduction to biological medicines

BY HE AKO HIRINGA

May 27, 2022

Biological medicines are being increasingly used to treat a range of conditions in New Zealand. Nurses need to understand what they are, how they are used and possible side effects in the patients they care for.

PHOTO: ADOBE STOCK

Biological medicines are already used in Aotearoa New Zealand and with many more being developed, it's important that health professionals feel comfortable prescribing, dispensing, and supporting patients to use them.

Recent funding changes have allowed the biological

medicine adalimumab to be accessible to more patients who have chronic and disabling inflammatory and immunological conditions. Previously this medicine, available as Humira, was prescribed and introduced to patients in secondary care.

With the recent introduction of a biosimilar version, called Amgevita, this treatment is now likely to be prescribed more in primary care. Practice nurses may be called on to provide patient support with using the injection devices and giving reassurance about the change from one agent to another.

Before learning about any particular biological medicine, it may be useful to work your way through this introduction. We've highlighted five key aspects of biological medicines in an article and a series of short animated videos.

1. Biological medicines and their biosimilars

Small molecule medicines: Most medicines, such as acetylsalicylic acid (aspirin), are small molecule products. This means that they have simple molecular structures with low molecular weight. These small structures are easy to produce or copy. Once a patent expires, other manufacturers can make copies of small molecule medicines by reproducing the exact same active ingredient, which they can then sell as a generic copy.

Biological medicines: By comparison, biological medicines are very large and have complex molecular structures, created by living cells, from specialised ingredients, using an intricate biotechnology process. It is impossible to produce an exact copy of a biological medicine without using the exact same ingredients, the same living cell lines, and identical manufacturing conditions. In fact, it is not even possible to demonstrate that a batch of any biologic is identical to previous batches of the same biologic.

Biosimilars: The first biological medicine of its kind is called the reference or innovator medicine. Once a patent expires for a reference biologic, other manufacturers are able to copy it. However, the innovator company doesn't have to share its patented manufacturing processes (which may include the room temperature, the type of cells that produce the biologic, and the food the cells used to grow it), and since there is always variability in a live biological system, it is impossible to create an identical medicine. But they are able to create a copy that is highly similar, with a different brand name; these are known as biosimilars.

To be approved for use in New Zealand by Medsafe, the manufacturer must demonstrate that their biosimilar has no clinically meaningful differences to the reference medicine in quality, safety and efficacy.

2. Biological medicines and their routes of administration

Reference biologics and their biosimilars are all biological medicines. Biological medicines are the fastest-growing medicine type being developed internationally. Biological medicines that target specific receptors or proteins involved in disease progression in conditions such as rheumatoid arthritis, Crohn's disease, multiple sclerosis and some cancers are already available in New Zealand. Some biosimilars are also funded for use in New Zealand and it is likely that the number of funded biosimilars in New Zealand will increase as the patents on reference medicines expire.

> **Patients receive biological medicines mainly subcutaneously or by intravenous infusion.**

Patients receive biological medicines mainly subcutaneously or by intravenous infusion. Biological medicines cannot be taken orally, since they have limited permeation through the gastrointestinal tract and are rendered ineffective by digestive processes (eg, acidic stomach pH and digestive enzymes). New formulations allowing for buccal, sublingual and nasal administration are starting to come to the market and will continue to be developed.

3. Advantages of biosimilars over the reference biological medicine

Overall, the introduction of biosimilar medicines has the potential to widen patient access to effective biological therapy, to better accommodate restraints within health-care budgets and improve overall patient outcomes.

This is because in most cases, biosimilars are less costly to develop than the reference biological medicine. For the biosimilar to be granted approval in one or more indications, the manufacturer must demonstrate their product is safe, effective, and of comparable clinical quality to the reference biological. However, they do not need to conduct extensive clinical trials, as the innovative manufacturer had to do. Further to this, at the end of a product's patent life, most manufacturers are willing to lower their prices to compete in the biosimilar market.

The availability of biosimilars in New Zealand could potentially:

- improve the cost-effectiveness of biological medicines in various conditions
- improve economic efficiencies by creating a more competitive market with a broader range of cost-effective treatment options
- contribute to ongoing Pharmac sustainability and allow reinvestment in new treatments
- expand access to medicines via broader eligibility criteria or broadening of approved indications
- improve the security of the supply chain, ensuring fewer consumers are affected by medicine shortages.

4. Risks associated with biological medicines

Some health professionals may have concerns about differences in adverse effects and/or allergic reaction profiles between a reference biological medicine and its biosimilar. However, biosimilar medicines are tested and shown to be as safe and effective, and of the same quality as the reference biological medicine.

All biological medicines (both the reference biologic and its biosimilars) have the ability to induce an immune response; this is known as immunogenicity. There are two types of immunogenicity in biological medicines:

- Wanted immunogenicity, as seen in vaccines, where the vaccine stimulates an immune response against the pathogen to create protective antibodies.
- Unwanted immunogenicity, where the body has an immune response to the biologic and neutralises its biological activities or provokes an allergic reaction. These can result in adverse events, which may sometimes be very serious.

The immunogenicity of biological medicines is influenced by numerous factors. These may be related to the medicine used and to the patient's disease and individual characteristics, as well as the dosing schedule and route of administration.

Many studies and systematic reviews examining the safety profiles of biosimilars have been conducted over the last 10 years. These studies have found that the number and type of adverse effects and side effects are the same for biosimilar medicines as for the reference biological medicines.

5. Switching biological medicines

Prescribers may decide with the patient to switch biological medicines to:

- improve treatment efficacy
- improve tolerability
- address issues relating to an administration device
- continue to receive funded treatment
- reduce the cost of treatment due to funding, availability or supply issues.

Interchangeability refers to the possibility of exchanging one medicine for another medicine that is expected to have the same clinical effect. This could mean replacing a reference product with a biosimilar (or vice versa) or replacing one biosimilar with another. Replacement can be done by:

1) Switching, which is when the prescriber decides to exchange one medicine for another medicine with the same therapeutic intent/clinical effect.

2) Substitution (automatic), which is when the pharmacist dispenses one medicine instead of another equivalent and interchangeable medicine at pharmacy level without consulting the prescriber. In New Zealand, biological medicine brands may not be substituted at the pharmacy without the prescriber's agreement.

It is recommended that biological medicines, including biosimilars, should be prescribed by brand name. Brand name prescribing ensures that inadvertent substitution of the biological medicine without the prescriber's knowledge does not occur at dispensing.

It is good practice for both the brand name and the batch number to be recorded at dispensing to allow for tracing, pharmacovigilance and quality assurance processes.

Podcast: Initiating new medicines

There are many points to consider when starting a patient on a new biological medicine. You can learn more about the psychological aspects of starting new medicines in episode one (part 1) of our podcast series *Legendary Conversations*.

* This article is used with permission from the He Ako Hiringa (https://www.akohiringa.co.nz/) website.

Reading the article, watching the videos. completing the quizzes and listening to the podcast can equate to one hour of CPD time.

Nurses can use the Nursing Council's professional development activities template (https://www.nursingcouncil.org.nz/Public/Nursing/Continuing_competence/NCNZ/nursing-section/Continuing_Competence.aspx?hkey=6542ac27-9b56-4e89-b7ae-db445c5cb952) to record professional development completed via Kaitiaki, and they can then have this verified by their employer, manager or nurse educator.

Kaitiaki NURSING NEW ZEALAND

OPINION

Investing in Māori nurses to address health inequities an opportunity for the 2022 Budget

BY NZNO KAIWHAKAHAERE KERRI NUKU AND AUCKLAND UNIVERSITY OF TECHNOLOGY ASSOCIATE PROFESSOR OF PUBLIC HEALTH HEATHER CAME

May 17, 2022

The sudden crisis of COVID-19 has highlighted the deepening inequities in such a dramatic way and laid visible the major challenges within the health sector. On the back of the global pandemic there was always going to be difficult economic and social outcome decisions. With the Budget looming, the political debate about where to invest has already begun.

NZNO kaiwhakahaere Kerri Nuku

Our advice is simple. Invest in Māori public health to keep whānau well. Invest in Māori health providers and Māori nurses and kaimahi to support Māori who need to navigate the health system. Invest in ensuring Māori whānau have the prerequisites of health – food, shelter, peace, education, adequate income and a stable eco-system. This would go some way to addressing the Crown's responsibilities under Te Tiriti o Waitangi and historic under-investment in Māori health.

The Budget must address the long-standing wage disparities for nurses and kaimahi hauora working within Māori and iwi/hapū providers. Māori nurses earn about 25 per cent less than their district health board counterparts. Despite rhetoric, numerous reports and modeling from the Ministry of Health (MOH) they have failed to address this structural discrimination against Māori nurses. Inaction from a government committed to address health inequities on this issue needs to be remedied.

Heather Came

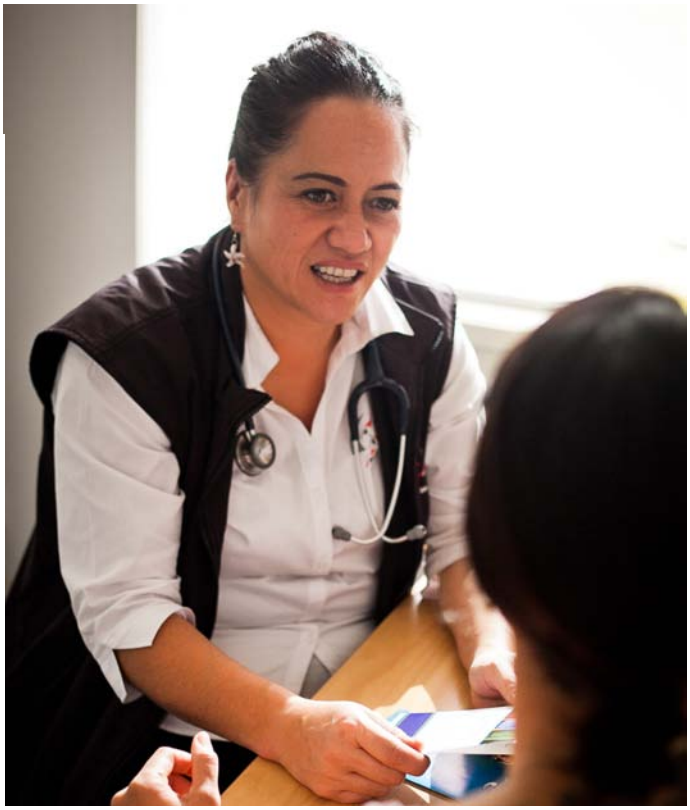
Māori nurses often have multiple competencies being proficient in clinical practice but also possessing cultural expertise, mātauranga Māori and lived experience that allows them to engage effectively with whānau.

The Māori health workforce need to be central to any long-term strategy to improve Māori health and requires dedicated development and resourcing. Māori nurses often have multiple competencies being proficient in clinical practice but also possessing cultural expertise, mātauranga Māori and lived experience that allows them to engage effectively with whānau. This relational approach is critical when working with Māori communities with complex needs and aspirations in a time of economic hardship. There is comfort and ease in engaging with a health practitioner who deeply knows your culture.

Māori health workforce data shows only seven per cent (3510)[1] of practising nurses currently identified as Māori. We need to urgently invest in growing the Māori nursing and unregulated kaimahi workforce and build better Māori health workforce surveillance infrastructure so recruitment and retention can be closely monitored. We need to urgently implement changes to health commissioning practices to eliminate pay inequities. Specifically, the underfunding of Māori health needs to stop and Māori providers need to be funded at a level adequate to cover the expense of kaupapa Māori modes of delivering quality health services.

There is comfort and ease in engaging with a health practitioner who deeply knows your culture.

Māori nurses have been raising this issue for many years but have seen no substantive result. Nurses have met with ministers and associate ministers of health, director-generals and taken this case to the United Nations multiple times. Kotahitanga – a united front – is required by the health sector to finally get this over the line. Māori nurses and kaimahi need economic and employment security now.



Failure to address ethnic pay inequities and also, critically, gender pay inequities will continue to fuel a migration of nurses from Aotearoa as the global shortage of nurses and health-care workers worsens. However, despite the incentives of working overseas, it is clear gender pay gaps and more specifically ethnic pay inequities remain a global issue. Let's sort ethnic and gender pay inequities within the health sector here and watch nurses come back home.

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Kaitiaki
NURSING
NEW ZEALAND

NEWS

Maranga Mai – a call for all NZNO members to rise up

BY MARY LONGMORE

May 10, 2022

NZNO is calling on members to "rise up" and support the launch of its new campaign, Maranga Mai, on International Nurses' Day this Thursday, May 12th.

Chief executive Paul Goulter said NZNO wanted to tackle the nursing shortage crisis "permanently" across every health sector.

NZNO knew nurses, midwives, health-care assistants and kaihahi hauora were all struggling and burning out amid increasing demands in understaffed environments, he said.

"Systemic failure has meant moral injury/distress and burnout across all sectors, not just in the district health boards," Goulter said. "We all know, too, that Māori have relatively poor health outcomes due to systemic racism and failures to honour te Tiriti in health."

	NZNO would be demanding five “fixes”:
1	te Tiriti actualised within and across the health system
2	more nurses across all sectors
3	pay and conditions that meet nurses′ values and expectations
4	more people training to be nurses
5	more Māori and Pasifika nurses

Kaiwhakahaere Kerri Nuku, president Anne Daniels, chief executive Paul Goulter and a range of local and international speakers will be discussing what has led to the current crisis, what members want, how a union can effect change and what members′ aspirations should be across the whole health sector.

Comedian Michele A′Court will host this online event from 11am – 12.30pm this Thursday. Members are invited to register here (https://docs.google.com/forms/d/e/1FAIpQLSc1K0tcRmt1nbFW7W5exHUaEorbK3Npi5xPS_5-mmJkQnL8QQ/viewform). More details and a draft programme are available here (http://www.nzno.org.nz/maranga-mai).

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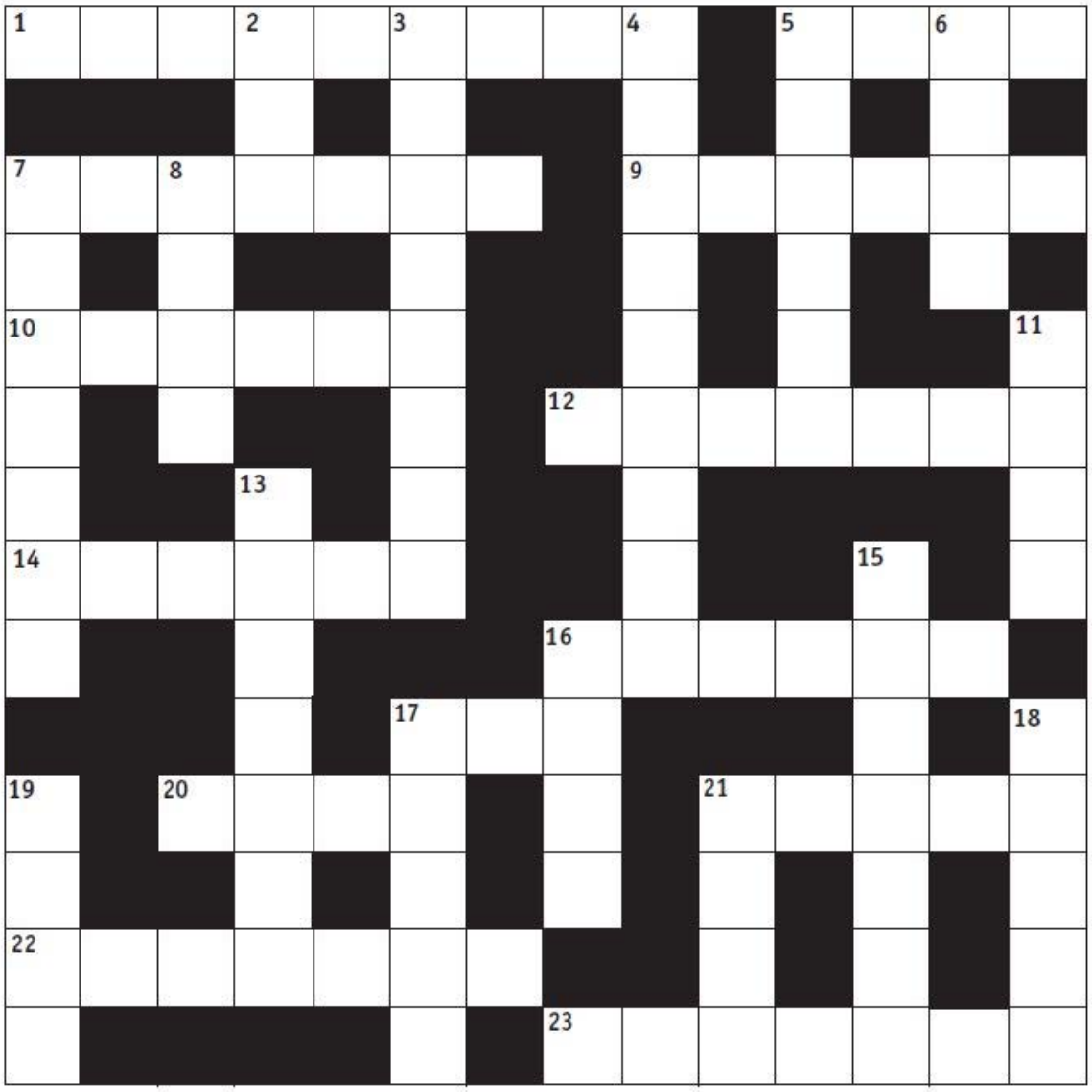
PUZZLES

MAY crossword

BY KATHY STODART

May 9, 2022

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



ACROSS

1) Extremely weary.
5) Deceased.
7) A thousand million.
9) Endure.
10) Sturdy.
12) An official order, eg on need to be vaccinated.
14) Motor.
16) Do again.
17) Compete.
20) One (Māori).
21) Black (Māori).
22) Not a professional.
23) Cleanliness.

DOWN

2) Get sicker.
3) Lack.
4) Process whereby patient leaves hospital.
5) Remove money from public service.
6) End of prayer.
7) Obstacle.
8) Fleshy part of ear.
11) Typed message via phone.
13) One who shifts to a new country.
15) Bloodbath.
16) Lie down.
17) Infectious microbe.
18) Famous fashion magazine.
19) Immerse in water.
21) Rubber stopper in sink.

Kaitiaki NURSING NEW ZEALAND

OPINION

Migrant nurses vital to NZ and need better support, MPs told

BY MONINA HERNANDEZ

May 26, 2022

Migrant nurse leader calls on MPs to better support IQNs, who are vital to the New Zealand health service.

PHOTO: ADOBE STOCK

Migrant nurses need simpler visa requirements, better recognition of their skills and experience, and financial support to settle into New Zealand life and work.

These are the messages I gave in my oral address to the Education and Workforce Select Committee hearing on migrant exploitation in April.

I told MPs on the committee that I spoke to them as a skilled migrant nurse leader advocating for a better life for my fellow skilled migrant nurses.

I explained how important internationally qualified nurses (IQNs) are to New Zealand. They comprise three out of 10, or 31 per cent, of the 62,805 nurses practising in this country, as of March 31, 2021.1 This percentage has been increasing consistently over the years – proof that New Zealand's nursing workforce is dependent on IQNs.

IQNs are important to New Zealand

Even the COVID-19 border closure did not stop IQNs from getting registered as nurses in New Zealand. Around 48 per cent (1850) of New Zealand's new nurses between 2020 and 2021 were trained overseas.1 This is proof once again that migrant nurses helped prop up New Zealand's health-care system when it was bombarded with challenges.

Aotearoa New Zealand does not train and retain enough nurses and so relies heavily on migrant nurses to provide quality care. However, if this country truly embraces diversity, inclusion, and equity, it must improve the way it treats migrant nurses.

Simplified visa category

Graduates of nursing programmes outside New Zealand are required to satisfy several requirements for registration here.2 We strongly appreciate that the Nursing Council has consistently consulted migrant nurses about some of these criteria.

Gaining a nursing qualification in New Zealand takes time, is costly and should be linked closely with immigration.3 Migrant nurses have long been clamouring for a business-as-usual simplified visa category that would allow them to find work immediately after gaining a qualification, instead of being stuck in immigration paperwork.

Is the bar too high?

Once a migrant nurse gains their qualification, another challenge is finding a job and obtaining recognition for their work experience. It is common to hear of migrant nurses who worked in senior nurse or charge nurse manager positions overseas being relegated to lower positions and salary scales here.

Take the case of Nurse S, a charge nurse manager in an endoscopy service in the Middle East with 15 years' experience, who was relegated to a position that is one step higher than a new graduate nurse. Or the case of Nurse M, who was a university lecturer with a master's

degree and published research, who was relegated to the same position as Nurse S.

Monina Hernandez addressed a select committee hearing on migrant exploitation.

Is the bar too high? Are there double standards? Is the health service trying to save money at the expense of vulnerable migrants? If Aotearoa New Zealand truly embraces diversity, inclusion, and equity, then this form of exploitation has to stop.

In my submission, I said migrants should be recognised for the level of skills and work experience they bring in. A national standard recognising the level of skills and work experience of nurses should be drafted and implemented by all health employers.

Aged residential care and migrant nurses

It is common knowledge that the aged-care industry depends on migrant nurses and that there is a nursing shortage in aged care that existed before the pandemic. COVID-19 exacerbated the shortage because of the reduced number of migrant nurses entering the country. The effect of this shortage is an increased risk, not only to residents, but also to staff who are unable to provide quality care due to poor nurse to resident ratios.

Migrant nurses working in aged residential care are vulnerable to exploitation because their visa is tied to a single employer. Some of them may be employed as low-paid caregivers on the promise of support to complete a competence assessment programme (CAP) and then register with the Nursing Council.

> **'Migrant nurses working in aged residential care are vulnerable to exploitation because their visa is tied to a single employer.'**

However, some of them find that they do not have the capability to enrol in CAP because of cost and location. These nurses require a wrap-around settlement package to support them as they to settle in New Zealand.[4] These migrant nurses also need to receive information about the Health and Safety at Work Act 2015 [5] and about their right to join unions.

I asked MPs on the select committee to support migrant nurses by

- Simplifying visa requirements and processing.
- Drafting a national standard that would recognise the skills and work experience of migrant nurses, and having it implemented by all health-care employers.
- Funding a wrap-around settlement package for migrant nurses to ensure their

success in settling into the health system and communities of Aotearoa New Zealand.

Monina Hernandez, RN, MN, CGNC, is a nursing lecturer at Massey University, Albany, and an infection prevention quality and risk manager at Counties Manukau District Health Board. She is a member of the Nursing Council, and a former director on the board of NZNO.

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Kaitiaki
NURSING
NEW ZEALAND

NEWS

Nurses urged to ‘rise up’ at launch of Maranga Mai! campaign on nursing shortage

BY MARY LONGMORE

May 12, 2022

NZNO’s 55,000-plus members were urged to come together and take action over long-standing nursing shortages, at the launch of NZNO’s Maranga Mai! campaign on International Nurses Day.

Nelson members launch Maranga Mai!

“Sitting quietly in the corner and having a whinge about our problems is not going to cut it anymore,” NZNO chief executive Paul Goulter said at Thursday’s launch of Maranga Mai! Members needed to be focused and prepared to act, he said. “The time for talk has passed. This is now a call to action. Maranga Mai! — rise up, rise up as one.”

An estimated 800-plus members attended the event, hosted by comedian Michelle A’Court, many sharing their anger, depair and sadness online over their working conditions.

Goulter said estimated nursing vacancies of 4000 were “not even close” to what what was needed — which was more nurses, caregivers and more Māori and Pasifika health staff. “We need to go further. We need to advocate and find solutions – answers and fixes to the problems that we face.”

The profession had not been listened to by successive governments.. “Just gently asking for them hasn’t worked — it hasn’t worked. We haven’t been listened to. Our needs haven’t been responded to, by governments.. for 30 or 40 years. This crisis has been widely-signalled for a long period and no-one has taken account of what is needed and been accountable for that outcome.”

Paul Goulter

“The time for talk has passed. This is now a call to action.”

There would be rallies, rather than strikes, with nurses “visible” in their communities — involved with local events and elections, Goulter said.

NZNO president Anne Daniels said it was no longer enough to rely on the “fearsome few” to advocate for change. “Every nurse, everywhere, must rise up.”

Nurses needed to know there would be enough nurses to care for patients safely, she said. “The day when we could go home satisfied knowing we had done a good job has long gone. As the most respected health-care professionals in New Zealand, our mana has well and truly been trampled on — there has been no respect for a long time.”

Anne Daniels:

“Our calls to be heard have gone unanswered and now we are breaking, some are broken.”

Repeatedly called upon to fill the shortfall, nurses were “breaking”, Daniels said. “We are a highly skilled workforce who keep trying to meet the ever-increasing demands placed upon us. Our wellbeing absolutely suffers. We suffer from moral injury as we are repeatedly expected choose who gets care and who does not, putting our patients at risk. “Our calls to be heard have gone unanswered and now we are breaking, some are broken.”

But there was hope in collective action – as nurses in Australia [1986 50-day strike] and workers in Kawarau [86-day strike in 1986] had proven, Daniels said.

Goulter announced NZNO’s five fixes:

- Actualising te Tiriti, or “making real” what our aspirations are for Māori and Māori nurses. “Right across the motu, we cannot accept the dreadful outcomes [in] Māori health in this country, and we must give our Māori workforce the right to do what is right to address that.”
- More nurses across the health sector.
- Pay and conditions that meet nurses’ value and expectations.
- More people training to be nurses.
- More Māori and Pasifika nurses.

Political power — making the nursing crisis a major issue for the 2023 General Election — organising widespread action on the ground and maintaining public support were key elements to success, Goulter said. “We have to hit the streets, we have to mobilise and and we have be out there, loud and proud.”

Kaiwhakahaere Kerri Nuku said actualising te Tiriti across the health system was “critical” to

ensure authentic engagement with Māori and "culturally safe practice is carried out for our people", no matter the setting.

Kerri Nuku

Campaigning "is not for the faint-hearted" and required nurses across sectors to work together. "We need to stand side by side as nurses and honour the profession and honour the role we have and the power we can conjure up.. because a force of 55,000 nurses working together is member power to its fullest."

Waiharakeke Biddle

Sharing her personal experiences of inequality, chair of NZNO student body, Te Rūnanga Tauira, Te Waiharakeke Biddle, said there was a lot of inequality between nurses in different areas. This campaign "means equality, it means equity" and hoped it would mean more Māori nurses, which would help whānau.

Nursing leaders from around the world spoke at the launch. Canadian Nurses Association chief executive Tim Guest spoke about the impact of COVID on nurses' mental health, and how nurses could be powerful voice for change if they rose up together. "Please know that you have a partner in Canadian nurses and we are all in this together."

"A force of 55,000 nurses working together is member power to its fullest."

International Council of Nurses chief executive Howard Catton said the ICN supported Maranga Mai! and nurses were at the centre of global health and happiness. "We are the foundation, the bedrock, upon which global health will be built."

The pandemic had taken a "terrible toll" on the global nursing workforce, said Catton, urging nurses to "stay strong, stay united and keep the faith".

Australian Nursing and Midwifery Federation assistant federal secretary Lori-Anne Sharpe said

it had never been more important for nurses to stick together. "We know that we need staff staffing, and appropriate skills mix and we need good working conditions and appropriate remuneration."

Christchurch members 'rise up' at the Maranga Mai! launch

Maranga Mai! project team member Jarrod Bates said more than 420 members registered for the launch but with 10 events around the country, estimated more than double that would have attended.

Sign up here for the campaign: www.maranga-mai.nzno.org.nz (http://maranga-mai.nzno.org.nz/).

Kaitiaki
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NEWS

Purple reigns in Aotearoa for care and support workers

BY MARY LONGMORE

May 23, 2022

Union members turned out around the motu today in support of pay equity for care and support workers in the disability, aged care and mental health and addiction sectors.

Wellington aged care health-care assistant (HCA) and NZNO delegate, Atele Pepa (pictured above, second from left), said she wanted better pay rates locked in, to address a shortage of

workers. “My hope is to attract a lot of younger generation into the workforce, because we’re all getting old. I’m getting old!” Pepa said.

> **“I want to get the message through and I want people to be better off than what they’re getting now. The main goal I have is for people to enjoy the job they do.”**

Many care workers ended up leaving after the 2017 gains, as some facilities cut their hours to accommodate the higher salaries, Pepa said.

In 2017, after nearly two years of legal battles, a historic $2 billion care and support workers pay equity settlement locked in pay increases for workers until July 2022, after finding historic, sex-based discrimination meant they had long been underpaid. It was fronted by Lower Hutt caregiver Kristine Bartlett, and negotiated by NZNO, the PSA and E tū.

Pepa said her Lower Hutt facility was short-staffed “every single day”. Aged care had been going through staffing issues for “years and years” and “they’re not going to fix it unless we push them,” Pepa told *Kaitiaki Nursing New Zealand.*

Wellington rally on Petone foreshore

“I would like to have some decent pay! The cost of living has skyrocketed and a lot of people are finding it hard to make ends meet.”

Pepa said workers needed an increase in line with inflation (6.9 per cent) – to keep up with the cost of living.

Dunedin rally

The work was rewarding but draining, especially without enough staff, she said.

It was “mentally, physically, spiritually and emotionally” demanding work, Pepa said. “I’m one of these people who work six days a week most of the time, and my husband is getting annoyed with it as I don’t have time for my family anymore. We can’t do anything as a family because I’m always tired.”

With a double-income, Pepa's family was able to get by on current pay rates, but single parents and mothers with young children, were "doing it tough" and finding it hard to make ends meet.

"I want to get the message through and I want people to be better off than what they're getting now. The main goal I have is for people to enjoy the job they do."

Kristine Bartlett, who fronted 2017's historic pay equity deal for care and support workers, addresses Wellington's rally.

> **"We can't do anything as a family because I'm always tired."**

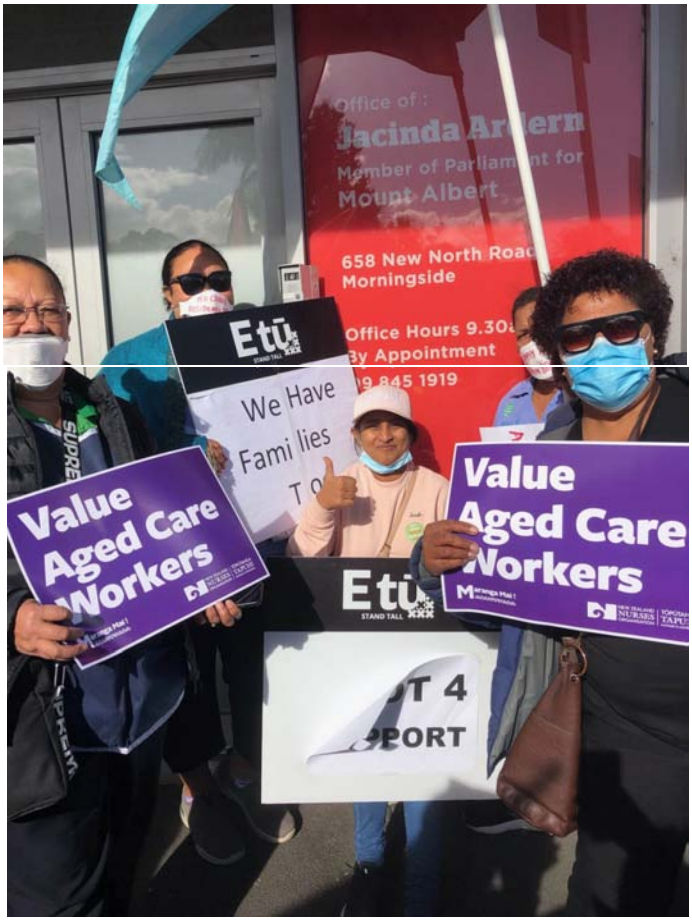
That would benefit communities, as well as workers, she said.

NZNO industrial advisor aged care Lesley Harry said the focus was on renewing the 2017 care and support legislation — which runs out on June 30 — and getting a decent pay increase for members.

NZNO, PSA and E tū represented many of the estimated 65,000 care and support workers in Aotearoa — a large and predominantly female workforce.

Bargaining was continuing this week after the Government's offer of less than three per cent, against a 6.9 per cent inflation rate. Harry said.

Rallies were held in Auckland, Hamilton, Wellington, Christchurch, Dunedin and Invercargill on Monday afternoon. Members are also being encouraged to sign and share a petition in support of care and support workers . (https://maranga-mai.nzno.org.nz/fair_pay_for_care_and_support_workers) Over 10,000 had so far signed the petition, being presented to Parliament tomorrow (Tuesday), Harry said.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Kaitiaki NURSING NEW ZEALAND

NEWS

Rallies planned to support care and support workers

BY MARY LONGMORE

May 18, 2022

Cross-union rallies are being planned around the motu this Monday, May 23, (https://maranga-mai.nzno.org.nz/fair_pay_for_care_and_support_workers) in support of care and support workers across the aged care, disability and mental health and addictions sectors.

NZNO industrial advisor aged care Lesley Harry said the focus was on renewing historic 2017 care and support legislation — which runs out on June 30 — and getting a decent pay increase for members.

Lesley Harry

"The Government's only offered 2.8 per cent as an average, and it's just not enough," Harry told *Kaitiaki Nursing New Zealand,* citing the current inflation rate of 6.9 per cent. "We're calling on all our members to support this campaign, as we will be calling on our care and support members to support other campaigns."

NZNO along with fellow unions, the Public Service Association (PSA) and E tū, had been in negotiations with the Government, but the signals so far were not encouraging, she said.

"The Ministry of Health (MoH) is saying there's just simply no more money. We need that legislation renewed, obviously, to protect our current members, but also in particular for new people being employed," Harry said. "We need to ensure that the value of the settlement is maintained, otherwise, effectively, it falls behind the comparators."

NZNO was treating the issue with urgency and exchanging proposals with the MoH at present, she said. Unions expected a formal offer and "crunch time" over the next week or two — "but in the meantime, we'll campaign hard", Harry said.

> **"The Ministry of Health (MoH) is saying there's just simply no more money. We need that legislation renewed, obviously, to protect our current members, but also in particular for new people being employed."**

"We need members to really convince Government of the need for the envelope to be increased to at least the cost of living at this point in time."

NZNO, PSA and E tū unions together represented many of the estimated 65,000 care and support workers in Aotearoa — a large and predominantly female workforce, Harry said.

In 2017, after nearly two years of legal battles, a historic $2 billion care and support workers pay equity settlement locked in pay increases for workers until July 2022, after finding historic, sex-based discrimination meant they had long been underpaid. It was fronted by Lower Hutt caregiver Kristine Bartlett, and negotiated by NZNO, PSA and E tū.

Kristine Bartlett signs the agreement in 2017 with then-Health Minister Jonathan Coleman.

Employers appeared supportive of the rallies, releasing staff for the day, and other organsations such as Grey Power were also supportive, Harry said.

"It is vital that we have a strong showing at the rallies. Unions have been advocating strongly for increased funding for equity and consistency of pay rates for all our members regardless of where they work," she said. "In a show of solidarity and power let's purple up and Maranga Mai! – rise up – on 23 May at a rally near you."

Rallies (https://maranga-mai.nzno.org.nz/fair_pay_for_care_and_support_workers)are planned for Auckland, Hamilton, Wellington, Christchurch and Dunedin.

MONDAY MAY 23

City	Time	Location

City	Time	Location
Auckland	1:00-2:00pm	Jacinda Ardern's Electorate Office 658 New North Rd, Morningside
Hamilton	12:30-1:30pm	Meet at Grey Street Kitchen, 335 Grey St (12:30pm). Walk to 475 Grey St. Present petition at Jamie Strange's electorate office (1pm).
Wellington	1:30-2:30pm	Heretaunga Boating Club, 138 the Esplanade, Petone
Christchurch	1:30-2:30pm	Bridge of Remembrance
Dunedin	1:00-2:00pm	David Clark's Electorate Office 544 Great King Street North
Invercargill	1:00-2:00pm	Liz Craig's Electorate Office 49 Kelvin Street

Tell us which rally you will attend on May 23 here (https://maranga-mai.nzno.org.nz/will_you_take_action_on_may_23).

Members are being urged to 'purple up' again next Monday in support of care and support workers.

The settlement covered both the NZQA training framework for care and support workers, as well as the salary steps attached to either the framework or years of service, Harry said.

NZNO associate industrial services manager Iain Lees-Galloway meanwhile urged members to sign and share a petition in support of care and support workers (https://maranga-mai.nzno.org.nz/fair_pay_for_care_and_support_workers) started by NZNO / PSA / E tū.

"NZNO has 55,000 members alone. Please sign it then share it through your networks and get

people to take this simple action in support of carers."

The rallies are follow the launch of the Maranga Mai! (https://maranga-mai.nzno.org.nz/) camapign, which is calling for five core fixes across the health system:

- Te Tiriti actualised within and across the health system
- More nurses across the health sector
- Pay and conditions that meet nurses' value and expectations
- More people training to be nurses
- More Māori and Pasifika nurses

Kaitiaki
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OPINION

What does the Budget mean for the health sector in the long term?

BY BRIAN EASTON

May 25, 2022

When the finance minister says the health system is inefficient, what he means is that it is underfunded, says economist and policy analyst Brian Easton.

Brian Easton: '. . . the Budget increased funding to the public health sector; but the increase is not as dramatic as the minister claimed.'

It was surprising that Finance Minister Grant Robertson, in a pre-Budget speech, said that he thought the current health system was "incredibly inefficient".

Of course there are some inefficiencies in health-care delivery, just as there are in private enterprise: mistakes happen, some treatments could have been managed better with hindsight, some are unnecessary (although they are more likely to happen when the patient pays the bill). But to say that health professionals are "incredibly" inefficient is not just rhetoric but insulting to them.

In the next sentence, the minister explains:

> *"Over the past two decades, [district health boards] DHBs have learned to run annual deficit after annual deficit because they know the annual Budget process allows them to do this."*

What he is saying is that the "incredible inefficiency" is not "inefficient" at all (not in the normal meaning of the word anyway), but that the health system is underfunded. It does its best to meet the population's health needs, but that requires it to spend more than the politicians allocate to it. So the DHBs have run deficits. Of course, the Minister of Finance cannot say that because the problem sheets home to politicians. (I know, I know — he is struggling with a myriad of financing demands but it would be better to explain the real problem, than try to shift the blame on to others.)

'The health service does its best to meet the population's health needs, but that requires it to spend more than the politicians allocate to it.' PHOTO: ADOBE STOCK

Uncomfortably, the analysis echoes that of of 30 years ago under the Richardson-Upton redisorganisation* of the health system. (In fairness, Grant Robertson was just 20 then, and such debates probably passed him by. Even so, it reminds us that the political system can be like the Bourbons, who forgot nothing and learned nothing.)

'Meanwhile the professional ethics of health-care workers requires them to respond to need, despite any financial constraints.'

The 1990s upheaval was based on the premise that the public health system was highly ("incredibly"?) inefficient, which could be remedied by imposing over it a new set of managers who might know nothing about health (one confused intensive care units with post-operative care units). It was claimed that their managerial skills – in retrospect they often seemed badly lacking – would reap substantial productivity gains. The often quoted promise was an

improvement of up to 25 per cent, a claim described later by the first Minister of Crown Health Enterprises as a nonsense. Even so, Ruth Richardson, the then Minister of Finance, cut health funding before the redisorganisation started. Consequently, New Zealanders died earlier than was medically necessary.

So it was with apprehension that those with memories approached the health provisions in this Budget. Apparently the Bourbons lived on and the current health system was to be redisorganised to make incredible efficiency gains ("incredible" in the sense of "not credible").

Addressing staff shortages will take time, and patients will suffer as will the stressed staff serving them. PHOTO: ADOBE STOCK

In fact the Budget increased funding to the public health sector; but the increase is not as dramatic as the minister claimed. Excluding COVID-19 funding, the increase for next year (ending June 2023) is 9.0 per cent, a little higher than the increases of the preceding three years of 8.9 per cent, 8.2 per cent and 7.8 per cent. Part of the increases have been about increasing remuneration rates for staff, but the volume of services seems to have increased too. In contrast, under National the increases were largely just keeping up with population pressures and costs. Increases above that are to be welcomed – even 0.1 per cent is an extra $25 million a year (or, as the Government is wont to count, $100 million over four years).

Before discussing where some of this money is to be spent, we need to explore how the redisorganisation fits in, since the secondary care system is where the bulk of the money goes and where the increases are going.

The centralisation of secondary health care (hospitals) has been a trend for the last 80 years since the first Labour government took over responsibility for it in 1938. Health New Zealand (HNZ) is the latest stage. Although we are not exactly sure what that means, it does involve a different funding regime.

In the early 1980s, central government funding of the (then) hospital boards was switched from an ad hoc system based largely on historical patterns to a "population-based" formula. Before then, the system had favoured southern New Zealand and relatively underfunded population-booming Auckland.

The latest version of the formula, which includes factors such as the age distribution and the degree of deprivation as well as population, was introduced in the early 2000s. It was better than what had gone before, but it hasn't worked and the consequential financial discipline has steadily become more easily evaded.

‘. . . one consequence of the new system is that the details are likely to be even more opaque to the public since all the appointments to the system are to be made by the centre.’

Rather than refine the population-based formula, the task of allocating the funds is charged to HNZ who will, no doubt, use a formula but will make ad hoc adjustments for its deficiencies. We can only guess how this will be done, but one consequence of the new system is that the details are likely to be even more opaque to the public since all the appointments to the system are to be made by the centre. I shan’t be surprised if at first the smarter city and district councils, and eventually all of them, set up units to monitor whether their regions are getting a “fair” share of the funding.

I shall be astonished if, overall, Health NZ operates in surplus. A public health system functions by suppressing demand (in a private one the ability to pay does the suppression). Meanwhile the professional ethics of health-care workers requires them to respond to need, despite any financial constraints.

The Budget forecasts have the non-COVID health spend largely stagnating after next year. However there is a provision for additional new operating expenditure across the entire public service ($5 billion next year, rising thereafter); you can be sure that a goodly chunk of it will go into health spending.

The Budget-associated document, *Wellbeing Budget 2022: A Secure Future*, itemises about 40 new health programmes — for new treatment initiatives, new and extended services, for local developments, for ethnic needs and for administration. I focus here on the professional development one.

‘In principle, the Ministry of Business Industry and Employment has responsibility for labour-market development, but the task has been neglected.’

The late George Salmond was concerned about the development of the health labour force even before he became director general of health in the 1980s. It is a bit of a no-brainer really, given the years required to train health professionals and the extent of their migration. In principle, the Ministry of Business Industry and Employment has responsibility for labour-market development, but the task has been neglected. I suspect there is a bit of neoliberalism here – the belief that the market will fix the supply problem by itself.

One hopes that Health NZ, the main employer of our health professionals, will set up its own health labour force unit, but that will take time. In the interim, the 2022 Budget has an initiative to provide funding for health workforce training and development. There are two components:

- $37 million over four years to cover about 1500 more training places for primary care work, including nursing, physiotherapy, pharmacists and optical services and 1000 places over four years for additional workforce (ie about $3900 a place a year);

- $39 million over four years for hauora Māori workforce development, to cover about 1000 workforce training places and 800 workforce places, targeted to increase Māori working in prioritised areas of most need (ie about $5400 a place a year).

To what extent this $76 million addresses the serious staffing shortages can be debated. Until we have workforce development assessment, we shall not know, nor will we really know much about the programmes to address them. Sadly, it is going to take time; patients are going to suffer, as will the stressed staff serving them.

* I avoid the term "reform" because it suggests things will improve. The term "redisorganisation" was proposed by the eminent health economist, Alan Maynard, after quoting Petronius Arbiter, from the novel *Satyricon* (about 60CE): *"I was to learn later in life that we tend to meet any new situation by reorganizing, and what a wonderful method it can be for creating the illusion of progress while actually producing confusion, inefficiency, and demoralization."*

Brian Easton, BSc(Hons), BA, FRSS, CStat, DSc, is an economist, social statistician, policy analyst and historian. He has held a variety of university teaching posts, and is a commentator and well-published author. He was formerly the director of the New Zealand Institute of Economic Research, and was economics columnist at the *The Listener* for 37 years. His most recent book is *Not in Narrow Seas: The Economic History of Aotearoa New Zealand*. More of his writing can be found at his website. (http://www.eastonbh.ac.nz)

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FEATURES

What employment means for people with schizophrenia

BY ALEX PAJEL

May 5, 2022

Health-care professionals need to understand the benefits employment brings to people with schizophrenia.

Employment promotes a positive self-image and self-efficacy.

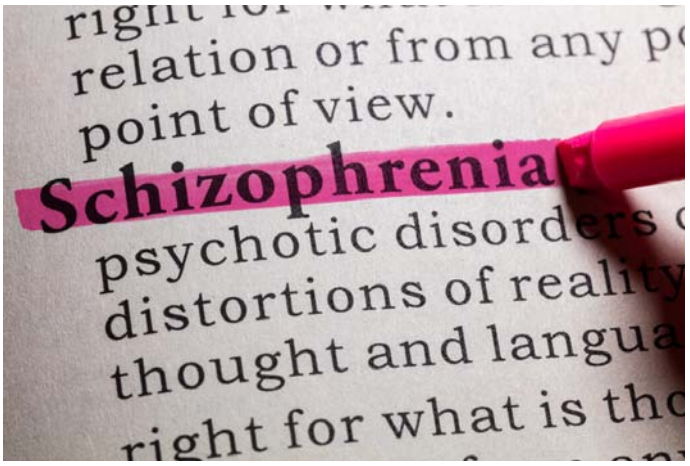
Severe mental illnesses are among the most common causes of disability in the working-age population around the world.1 One of these illnesses is schizophrenia, which affects 20 million people worldwide.2

In New Zealand, a total of 18,096 individuals aged 18 to 64 had a schizophrenia diagnosis recorded on or before December 31, 2015. This is equivalent to a prevalence of 6.7 per 1000 people (0.67 per cent). Prevalence was higher in indigenous Māori (3.36 per cent), compared to non-Māori (2.86 per cent).[3]

The chronic relapsing nature of the illness can be disruptive and may affect the employment of people with schizophrenia.[4] Research has found high unemployment rates among individuals with this disease.[5,6,7,8,9,10]

Chronically unemployed people with schizophrenia are reported to exhibit poor pre-morbid functioning, cognitive dysfunction and increased negative symptoms such as lack of motivation, reduction in spontaneous speech and social withdrawal.[1,8,11,12] Unemployment in people with schizophrenia is also economically costly from a societal point of view.[13]

Despite high unemployment rates among people with schizophrenia, there is evidence that they want to work.[4,5,7,10,14] Employment provides not only the means to independent living and social integration, but also alleviates the impact of symptoms and cultivates a positive self-image, self-esteem and self-efficacy. All of these promote recovery and improve quality of life.[4,10,15]



Unemployment rates are high among people with schizophrenia.

However, various studies have identified barriers to employment for people with schizophrenia. Many of these barriers are similar to those faced by the long-term unemployed.[16] Those with schizophrenia also face the added burden of their illness.[6,7,17,18]

Several studies have proposed solutions to overcome barriers to employment for people with schizophrenia. In addition, a variety of vocational rehabilitation programmes have been developed and implemented over the past few decades in New Zealand and overseas to enhance the vocational capacities of people with schizophrenia.[5]

One such programme, known as Individual Placement and Support (IPS), has been recommended by various studies as a more effective and integrated approach to helping people with severe mental illness to obtain and remain in employment.[12,19,20,21] Although the effectiveness of IPS is well established, implementation of this approach has been challenging and there is still room for

IPS in New Zealand

Across New Zealand, a total of 86 full-time equivalent IPS employment consultants are working with 69 secondary mental health and addiction teams to provide clients with

improvement.[12,21]

Schizophrenia and employment

Schizophrenia is a severe chronic mental illness with most patients experiencing relapses during the course of the illness. It is characterised by distortions in thinking, perception, emotions, language, sense of self and behaviour.

Symptoms of schizophrenia are generally described as positive or negative. Positive symptoms refer to what is abnormally present – that is, delusions and hallucinations. Negative symptoms, on the other hand, refer to what is abnormally lacking or absent in the person with a psychotic disorder. These include lack of motivation, reduction in spontaneous speech and social withdrawal.

There may also be a cognitive dimension to the illness, such as difficulties with memory, attention and executive functioning, and a dimension of affective dysregulation, such as depression and manic symptoms.[2,18,22]

Many studies provide evidence that rates of unemployment are very high among people with schizophrenia.[5,6,7,8,10] A large international study, combining data from 37 countries, found that on average only 19 percent of people diagnosed with schizophrenia were in competitive employment (ie working in the regular labour market), with figures ranging from 16.2 per cent to 22.6 per cent, against an average employment rate in the general population of 75-80 per cent.[23]

Despite high rates of unemployment among people with schizophrenia, there are studies indicating that the majority of them regarded employment as meaningful, and from 55 per cent to 70 per cent were interested in work.[4,5,7,10,14]

Work is considered to have many advantages for people with schizophrenia, not only in terms of employment support.[69]

Although some parts of the country have "excellent" IPS coverage, a significant portion of the country has no service at all. Access to IPS services is described by the Work Counts organisation as "excellent" in Lakes and Nelson-Marlborough District Health Board (DHB) areas, "good" in Taranaki, Northland and Capital & Coast DHBs, "fair" in Auckland and Waikato and "low" in Hutt Valley, Whanganui and Hawke's Bay DHB areas.

There is no IPS service at all in Wairarapa, MidCentral, Bay of Plenty and Tairawhiti DHB areas, nor in any of the South Island DHBs except for Nelson Marlborough, ie Canterbury, South Canterbury, West Coast and Southern. However Work Counts notes that an IPS service is being developed in the Southern DHB region, with talks proceeding between the DHB and the regional Ministry of Social Development (MSD).

IPS services are funded by either MSD, Work and Income or DHBs, and are provided by DHBs, MSD and non-governmental organisations such as Te Mana Oranga, Workwise, Te

financial gain but also in providing a normalising experience, with improved general and mental health and wellbeing, including better cognitive functioning.[9,14,23,24,25,26]

Ara Mahi and Ember.

It has also been found that those in competitive employment were less likely to relapse and more likely to achieve clinical remission, compared to those who were unemployed.[27] One study showed that for people with schizophrenia, employment is correlated with improved social functioning, symptom levels, quality of life and self-esteem.[4,6,10,15]

> **. . . those in competitive employment were less likely to relapse and more likely to achieve clinical remission, compared to those who were unemployed.**

Barriers to employment

People with schizophrenia nevertheless continue to encounter barriers to employment. The barriers are associated with the illness itself, stigma, and discrimination from employers, causing low motivation to work and low self-efficacy. Other barriers include concerns about how working will affect benefits, the low expectations of health professionals, limited access to vocational rehabilitation services, and problems with implementing these services at a national level.[6,7,14,17,28]

Neurocognitive dysfunction is prevalent among people with schizophrenia, which has a strong impact on different areas of functioning, including occupational functioning.[29,30,31] Neurocognitive deficits found in people with schizophrenia include social withdrawal, poor social skills, and poor problem-solving skills, all of which act as barriers to employment.[6,17] The presence of negative symptoms of schizophrenia are seen as a barrier to employment.[4,6,17, 32,33]

There is a body of evidence indicating that people with schizophrenia are affected by stigma and discrimination in multiple areas of their lives, especially in employment.[6,34]

People with schizophrenia commonly report that stigma and discrimination from employers are the biggest barriers to them finding and keeping work. PHOTO: ADOBE STOCK

In a European study, more than 40 per cent of participants with schizophrenia reported moderate or high levels of stigma and almost 70 per cent reported moderate or high discrimination.[35,36]

Discrimination from employers because of the stigma of mental illness was the most commonly cited barrier to getting a job in a study in South London.[6,7,9,18,36] In another study in Australia, it was found that stigma and discrimination affected all aspects of employment, including recruitment, workplace relationships and workplace wellbeing, and significantly affected individuals' ability to obtain and maintain employment.[37]

Stigma may also have a considerable effect on the motivation to work and self-efficacy of people with schizophrenia. As a result of this, people with schizophrenia may not pursue opportunities fundamental to achieving their life goals.[9] Stigma may also cause people with schizophrenia to avoid accessing and using health-care services. An Australian study found low motivation to work and low self-efficacy caused by stigma were barriers to employment among people with schizophrenia.38

A number of studies report the loss, or feared loss, of benefits as a powerful barrier.[36,39,40] A UK study found the social welfare benefit system in that country had a negative impact on people with schizophrenia.[9]

Lastly, health-care professionals and evidence-based rehabilitation services may unintentionally contribute to the barriers people with schizophrenia face in gaining and maintaining employment. There is evidence in the literature that rehabilitation is often not included in the care plans of people with schizophrenia, which reflects the low expectations of health-care professionals.[5] A UK study found that health professionals' low expectations of their patients' capability were evident in low recognition of employment as a desired outcome for people with schizophrenia.[9] People with schizophrenia have also reported a lack of encouragement to work from health-care professionals.[18]

There is evidence in the literature that rehabilitation is often not included in

the care plans of people with schizophrenia, which reflects the low expectations of health-care professionals.

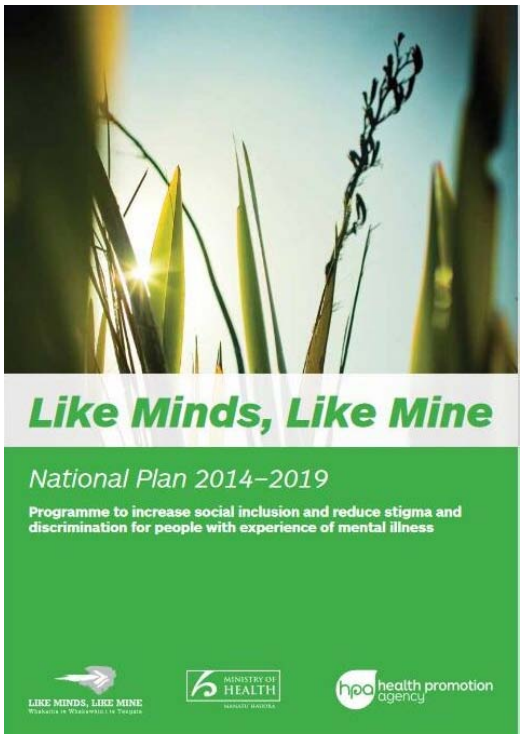
Various studies have shown that there is limited access to evidence-based rehabilitation services and in many countries these services are not implemented nationally.[6]

Overcoming barriers

Various studies have offered methods of overcoming these barriers to employment.[7,19,41,42] Improving medication adherence helps people manage symptoms and prevents relapse, enabling them to function occupationally and socially.[43] Encouraging a change in the culture of workplaces towards social inclusion of people with severe mental illness is an important method of reducing stigma and discrimination.[41]

Research has also found that stigmatising attitudes and behaviours are significantly reduced among people who have engaged in activities involving contact with someone who has experienced severe mental illness.[35,42] Employers who have had interactions with people with severe mental illness are more willing to hire a person with such a diagnosis.[44] Employers' attitudes can also influence whether reasonable job accommodations are made for staff with disabilities.[41]

New Zealand was one of the first countries in the world to set up a national programme to improve the attitudes of employers, health-care professionals and the public to people with mental illness. The anti-stigma programme – which started in 1997 and is underpinned by the social model of disability and the power of contact — is called "Like Minds, Like Mine" (LMLM).[42,44] An evaluation of public attitudes since the programme started found that attitudes towards people with severe mental illness in the target group of 15 to 44 year-olds had improved significantly, especially among Māori, Pacific, Asian and young people.[42,45]



The "Like Minds, Like Mine" programme aimed to tackle stigma around mental illness.

Another study found education of employers and the public was an important way to support people with schizophrenia and to prevent stigma and discrimination in the workplace.[19] It recommended more funding for the development of evidence-based education resources, and that education should start in schools to challenge negative stereotypes.[19,41] Governments should also ensure the social welfare benefit system does not act as a disincentive to finding employment.[9,14]

Another proposed solution is educating all health-care professionals involved in the treatment and management of people with schizophrenia about the relationship between mental health and employment.[9,41] Treatment decisions made by health-care professionals should not negatively affect the work aspirations of people with schizophrenia and should make employment a desired outcome.[18] Health professionals were also essential to strengthening the motivation to work and the self-efficacy of people with schizophrenia, especially when a trusting therapeutic relationship was established, including advice and ongoing support.[6]

Vocational rehabilitation services should be made more accessible and be implemented nationally. A national plan, coordinating interventions across departments and funders, will aid successful implementation.[9,14]

Vocational rehabilitation services

Over the past few decades, a variety of vocational rehabilitation programmes have been developed and implemented in New Zealand and overseas for people with severe mental illness. These include supported employment, eg IPS (Individual Placement and Support); traditional vocational rehabilitation (TVR) programmes such as sheltered employment; psychosocial rehabilitation including prevocational training, and transitional or trial

employment; and volunteer placements.

In sheltered employment, people with severe mental illness work together, usually in a group setting, on factory type work (eg assembling or packaging a product), which involves increased peer support. However, the drawbacks in this kind of employment are the lack of contact with non-mentally ill co-workers and the inability to tailor the job to the individual's interests.[20,28]

Improving medication adherence helps people manage symptoms and prevents relapse, enabling them to function occupationally and socially.

In contrast, psychosocial rehabilitation includes prevocational training, which involves teaching work skills and job search skills; transitional or trial employment is part-time work at less than minimum wage; and volunteer placements see participants paid at a minimum wage.

All of these interventions follow the traditional stepwise "train then place" approach. They adhere to the key principle that a period of preparation is necessary before entering competitive employment.[5,20,37,48,49] Competitive employment is defined as working in the regular labour market and being compensated at, or above, the minimum wage or otherwise prevailing wages for at least one day.[50]

A useful form of rehabilitation that helps people with severe mental illness to obtain competitive employment is supported employment, standardised in the IPS model.[12,14,18,21,46,51] This approach differs from the first two approaches as it is based on the "place then train" philosophy. It incorporates eight key principles that have been well researched with a validated fidelity scale used worldwide for quality improvement purposes.[52]

These principles are:

1. Zero exclusion — every individual who wants to work is eligible for services, regardless of "readiness", work experience, symptoms or any other issue.
2. Focus on competitive jobs in integrated community settings that pay competitive wages.
3. Rapid job search, usually starting within a month of enrolling in the programme.
4. Respect for the individual's job preferences, rather than favouring the judgment of employment specialists and mental health-care providers.
5. Provision of time-unlimited and individualised follow-along support after work is obtained to facilitate maintenance or transition to another job.
6. Integration of mental health and employment services to ensure coordinated delivery

and mutual understanding of the importance of work as a goal.

7. Personalised benefits counselling to inform the individual about the impact of work on any disability benefits they may receive or be eligible for.
8. Systematic job development, maintenance of relationships with various employers and building an employer network.[12,14,21,46,50,53]

Comparing vocational rehabilitation services

Studies have shown that TVR is not effective in helping people with severe mental illnesses find and maintain competitive employment.[48] It is not effective in developing work skills, it promotes dependency and deters clients from finding competitive employment.[20] One study of the vocational activity of 149 clients over 18 months found people with severe mental illness such as schizophrenia enrolled in TVR programmes tended to have higher dropout rates due to the delay between initial training and job placement.[54] Also, the training provided may not correspond to the jobs available to the individuals. Lastly, most TVR programmes are time-limited — services are discontinued after an individual has kept a job for 90 days.[47]

Several randomised controlled trials have demonstrated the effectiveness of IPS over TVR,[55,56,57] and meta-analyses over the years have confirmed this finding. One meta-analysis showed it was superior to TVR in terms of rates of competitive work.[5,20] Another found that IPS participants gained employment faster, maintained employment four times longer during follow-up, earned three times the amount from employment, and were three times as likely to work 20 hours or more per week when compared to TVR.[57]

Longitudinal studies also show that half of all individuals enrolled in IPS become steady workers, maintaining employment for 10 years or longer compared to individuals enrolled in TVR.[28,57]

In New Zealand, case studies at five district health boards (DHBs) with IPS programmes were conducted from 2015 to 2018. These DHBs were Auckland, Counties Manukau, Waikato, Lakes and Taranaki. The case studies showed that 4 per cent of people seen by DHB mental health and addiction services over a three-year period also received IPS, which is higher than for TVR. IPS programme reach in teams with an IPS employment specialist assigned was higher but averaged only 10 percent.[58]

While programme reach within teams with an assigned IPS employment specialist varied slightly across ethnic groups among the five DHBs, it was consistently lower among indigenous Maori, who have a higher estimated population prevalence of schizophrenia.[59]

In New Zealand, IPS has been operating for more than 10 years but coverage across the country is patchy

The effectiveness of IPS for helping people with severe mental illness into employment has been well established since at least the turn of the century. It has expanded across 19 high-income countries outside the United States (US) over the past 20 years, including Australia, Belgium, Canada, China, Czech Republic, Denmark, France, Germany, Iceland, Ireland, Italy, Japan, New Zealand, Netherlands, Norway, Spain, Sweden, Switzerland and the UK.[18,46,55]

However, there are challenges in its implementation. These include inadequate funding and the lack of policy for large-scale implementation.[52] In the US, IPS programmes are funded through a complex blending of state and federal government sources, Medicaid, and vocational rehabilitation payments. Similar problems exist in England where IPS programmes are purchased mainly by regional health and social care commissioning groups and local government. In Australia, there is a single national purchaser of disability employment services but it is only recently that they have officially encouraged the implementation of evidence-based approaches such as IPS for people with severe mental illness.[60]

In New Zealand, IPS has been operating for more than 10 years but coverage across the country is patchy (see panel 'IPS in New Zealand') due to the aforementioned challenges and access is inequitable for Māori. Nevertheless, there is opportunity for change, with a greater focus in government policy on mental health and a plan for cross-government policy to promote service integration.[60,61]

In 2021, the New Zealand government announced a 10-year plan, *Kia Manawanui,* to transform its approach to mental wellbeing, building on the agenda set by *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*.[62] The plan focuses on national actions that government agencies will lead and system changes that the Government can drive.[63]

These include having a coordinated approach to purchasing IPS for people with severe mental illness, establishing technical assistance to support IPS implementation and expanding access to IPS. Improving access to IPS is recommended in a series of reports, most recently the 2018 OECD country report, *Mental Health and Work: New Zealand*, the report of the Welfare Expert Advisory Group and the Ministry of Social Development (MSD) *Working Matters* disability employment action plan. [60,61,64,65,66]

Attention to the needs and aspirations of Māori are needed to address inequities in IPS access.[60,61] Recent Māori wellbeing strategy documents highlight sustainable employment and economic security as key to Māori wellbeing.[66,67,68]

Attention to the needs and aspirations of Māori are needed to address inequities in IPS access. PHOTO: ADOBE STOCK

However, employment and economic security sit alongside a range of culturally-grounded aspirations including cultural identity, participation in te ao Māori, and the health and wellbeing of collectives, including whanau.66,67,68

The importance of collaboration to support employment opportunities for people with mental illness was also emphasised in the Ministry of Health's plan setting out the principles and a framework for meeting mental and social wellbeing needs as New Zealand responds to and recovers from the COVID-19 pandemic.58

Conclusion

The inability to obtain and maintain employment can be psychologically and economically devastating to people with schizophrenia. It also has a negative impact on society as a whole. Rates of competitive employment among people with schizophrenia are low. However, many people with schizophrenia view employment as worthwhile and express a desire to work, due to its many clear benefits.

Nonetheless, people with schizophrenia continue to encounter a multitude of barriers to employment. Proposed solutions to overcome these barriers include education of employers and the public about mental health, education for all health-care professionals involved in treating and managing people with schizophrenia and improving access to evidence-based vocational rehabilitation.

In terms of vocational rehabilitation, the relative effectiveness of IPS over TVR to improve the work outcomes in people with severe mental illnesses has increased over time as the programme has developed and been implemented in New Zealand and overseas.

As the programme improves and expands in New Zealand, attention to and research on

cultural responsiveness, Māori-led approaches and equality of access will be beneficial. Also useful will be research on costs and benefits and the scale of the programme's positive impacts on employment and other outcomes in the New Zealand context.

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This article was reviewed by Anthony O'Brien, RN, BA, MPhil, PhD, associate professor of nursing at Te Huataki Waiora — School of Health, Waikato University.

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Kaitiaki
NURSING
NEW ZEALAND

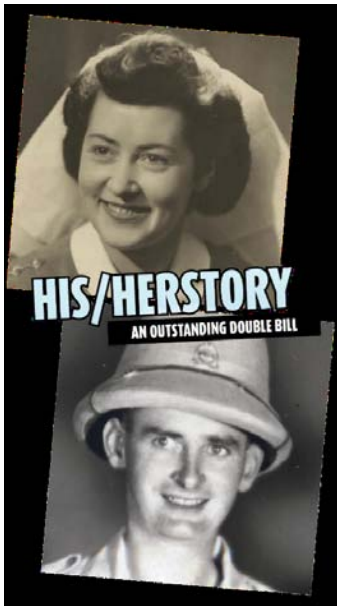
LETTERS

‘Extraordinary story’ of World War II nurse is performed by her daughter

BY COLLEEN MCCOLL

May 4, 2022

HIS/HERSTORY, which is having a season at Circa Theatre in Wellington at the moment (April 22- May 14), is two solo shows — one of which is about a nurse during WWII.



Written and performed by her daughter, Kate JasonSmith, it tells the story of her mother, a nurse, whose hospital followed the war across Europe.

She eventually ended up as part of the liberation of Belsen. It is an extraordinary story.

We would love to bring this to the attention to nurses.

Email your letter to: coeditors@nzno.org.nz.
We reserve the right to edit letters for sense and length. Shorter letters (under 400 words) are preferred. Please include address, nursing qualifications and phone number.

The show is performed as a double bill, alongside a story about a Dunedin butcher who twice escaped his German captors in WWII, and lived in a cave for two years.

Please contact Circa Theatre for more information on 04 801 7992 or book online here (https://www.circa.co.nz/package/his-herstory/?_ga=2.66031918.1250779274.1651620996-1232793004.1651620996).

Ngā mihi
Colleen McColl
Circa Theatre publicist

Kaitiaki NURSING NEW ZEALAND

LETTERS

Researchers seek RNs in aged care

BY RHONA WINNINGTON

May 20, 2022

IT IS now more than six months since the End of Life Choice Act 2019 was implemented in New Zealand, with the latest government statistics indicating that 206 individuals have applied for an assisted death.

Some 66 have had an assisted death, and 10 of these were in the aged residential care sector.

Given the role of registered nurses (RNs) in the aged care sector, and their long-term relationships with residents, they are centrally placed to be the first point of conversation for those considering using the assisted dying legislation. As the Act decrees that no health-care professional can initiate conversations about assisted dying, these requests can be unexpected and, as such, place RNs on the spot to respond.

Email your letter to:
coeditors@nzno.org.nz.
We reserve the right to edit letters for sense and length. Shorter letters (under 400 words) are preferred. Please include address, nursing qualifications and phone number.

A small team of researchers at the Auckland University of Technology (AUT) want to talk to RNs who have responded to assisted dying service requests from aged care residents. We want to find out how you responded, whether the requests were unexpected and what, if anything, can be developed to support you in talking about assisted dying with residents as the service expands.

If you are interested in participating and willing to be interviewed virtually at a time to suit, contact Rhona or Lucy on 027-5147773, or 09-921-9999 x7123 or email ADnursestudy@aut.ac.nz for further information. A koha of a $50 prezzie card will be given after completion of the interview.

Rhona Winnington, RN, PhD,
Auckland

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Te reo Māori support not readily available in past times

BY POLLY GRAINGER

May 18, 2022

I am writing to you about the Kaitiaki news piece "Nursing magazine ditches century-old healthy-food title, finally becomes 'guardian'" by co-editor Joel Maxwell [Feb 25, 2022]

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I am very pleased that the journal has been re-titled to reflect its aims, but I felt that [then *Kaitiaki* co-editor] Joel Maxwell simply demonstrated how our outgoing [acting] chief executive Mairi Lucas was truly disrespectful of our past, and it showed that he agreed with that.

Maxwell reported that NZNO kaiwhakahaere Kerri Nuku identified that *Kaitiaki* founder Hester Maclean was even at that time trying to be inclusive and respectful [to Māori], yet I don't think that Mairi Lucas or Joel Maxwell realise just how fortunate we are these days to be enabled to achieve this respect. We now have dedicated support [for te reo Māori and te ao Māori], people who can ensure we don't make a mistake (if we follow the advice). In Hester Maclean's time, I doubt this was easily available. I believe that Joel Maxwell's article could and should have identified this.

This was a learning opportunity for us to ask for the right advice for our future actions and a

reminder to take more care when using te reo Māori, rather than just spout criticism of our past actions.

Kia pai tō rā: Have a good day,
Nā

Polly Grainger, RN, MN,
Canterbury

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What faith community nurses do

BY DOROTHY FINLAY

May 11, 2022

The NZ Faith Community Nurses Association has been active for over 20 years, but strangely it is not well known in the New Zealand nursing scene.

Based on the community, with clients drawn from an interdenominational background, faith community nursing provides a service in many and varied health-care situations. Let me introduce some of our scopes of practice.

COVID issues, with fears of pain, illness and death, and isolation in the community, open the door for faith community nurses (FCNs) to provide practical help, such as food and home help, and reassurance and hope to encourage the elderly in particular. This reassurance comes in the form of regular phonecalls and prayer support, which provide information and let the client know they are not alone.

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Many who have had surgery delayed need proactive care — such clients need checking on to detect any deterioration of their condition, to lighten the load of overloaded general practitioners.

Valma, a registered nurse with wide experience in public health nursing, has been an active FCN for many years. With expertise in community nursing, as a practice nurse and now a rural-based FCN, Valma has used her teaching skills with nursing students who helped her in clinical situations during the 2021 COVID lockdown. In one case, with district nurses overloaded, she was asked if she would care for a client who required dressings to a discharging cyst on the back; this continued for two months until the patient healed.

With long COVID rearing its head following the pandemic, the FCN has a useful role working

with local medical practitioners to help follow up clients in the community and monitor their progress. There is great scope for FCNs to become the doctor's hands and feet — they are able to provide professional care and liaise with medical and pastoral teams in the community.

In a climate where nursing staff are limited, and with burn-out so common, the FCN can step in and support the needs of many who may be forgotten.

Dorothy Finlay, RN, RM,
NZFCNA Board Member

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LETTERS

What is going on with NZNO?

BY SAM MOJEL

May 11, 2022

I am a long-standing workplace delegate. In spite of this, I am unable to answer my own questions, let alone the questions from NZNO members, about "what is going on with NZNO?"

There seems to be a common thread, whether it is to do with pay equity (PE) or previous MECAs, and that is one of "take this deal now and if you're good little girls and boys Santa will give you more next time, sometime in the future, we don't know when, just be patient". Witness the 2018 and 2021 MECAs.

It is almost unbelievable that we were presented with the PE proposal without payment for hours worked since December 31, 2019.

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We were assured we shouldn't be concerned that the PE process was taking so long as they wanted to get it right and it would be backdated anyway. As a delegate, I repeated this and I am definitely not into apologising for other people's shortcomings, at work or for NZNO! (Most of us didn't actually believe it would be life changing — that's Lotto).

The agreement that approximately 30,000 nurses thought they had — to be paid for "actual hours worked" — has been ignored by the Government.

How can that be possible?

What's up with NZNO that it employs its own lawyers and yet couldn't sew up watertight pay for the "hours worked" deal in 2018 and 2021?

I expect the Government and health bosses to play dirty, but it is almost as if NZNO gets taken by surprise each time it deals with them.

NZNO seems to think it is dealing with employers who are trustworthy and have integrity. This is not the case. That's why we belong to a union! And that's not altogether working out for us right now.

We've been told the PE offer without "pay for hours worked" is illegal.

Is it not standard practice for a lawyer to examine any agreement before it is submitted to us?

The new CEO dealt with the immediate issue himself, and then only because members pointed out that it was totally unacceptable.

It is a bright speck that we have a CEO who took immediate action to get a speedy independent legal review. That was a breath of fresh air and felt quite unlike "normal" NZNO practice. I hope the CEO's ability to act expediently for us will not be fettered.

In future, I think NZNO needs to employ a reputable, top, well-briefed employment lawyer on a retainer at negotiation times, with nurses on the team to observe and consult, to get a result we can trust. I've been having conversations about class action bypassing NZNO, should the Employment Relations Authority not rule favourably for us. The NZNO board of directors risk management committee should consider that.

Sam Mojel, RN,
Auckland