Development of the New Zealand Nursing Workforce: Historical Themes and Current Challenges

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Abstract

Development of the New Zealand nursing workforce has been shaped by social, political, scientific and inter-professional forces. The unregulated, independent and often untrained nurses of the early colonial period were succeeded in the early 1900s by registered nurses, with hospital based training, working in a subordinate role to medical practitioners. In the mid/late 1900s, greater specialization within an expanding workforce, restructuring of nursing education, health sector reform, and changing social and political expectations again reshaped nursing practice. Nursing now has areas of increasing autonomy, expanding opportunities for postgraduate education and leadership roles, and a relationship with medicine which is more collaborative than in the past. Three current challenges are identified for nursing in New Zealand’s rapidly evolving health sector; development of a nursing focused knowledge culture, strengthening of research capacity, and dissemination of new nursing knowledge.

Key words: Nursing history, workforce development, New Zealand
Introduction

Workforce development must look both to the past and to the future. This is particularly true for nursing, which, as the largest of the health professions, must address emerging health sector challenges by building on its own rich and complex history. In New Zealand, recent initiatives in workforce development and a changing policy environment present nursing with the opportunity, indeed the necessity, to re-examine professional roles and culture. As in other countries, current nursing practice in New Zealand has been shaped by a variety of social, political, scientific and inter-professional forces and processes over the last century or more. These historical processes will be examined to highlight key themes and challenges in the development of nursing in New Zealand.

Colonization and an emerging health workforce

Until the 1860’s, the small but rapidly growing New Zealand colony had no public health system, only a small number of cottage hospitals in the main centres of settlement and the goldfields of Otago and Westland, and a small and unregulated health workforce. There was no national system for licensing of doctors, nurses, chemists, herbalists and other health workers, who practiced and prescribed separately (Bryder 1991). Nursing as an occupation was not well defined and nursing duties were often intertwined with homemaking and the care of children (Sargison 2001).

With rapid growth of the settler population in the late 1800s, from about 2000 when the Treaty of Waitangi was signed in 1840 to over 500,000 in 1881, relations between health providers were shaped increasingly by issues of professional and political control (New Zealand Department of Health [NZDOH] 1972, 1974; Gauld 2001). Some health workers, including masseurs (later physiotherapists), medical electricians or galvanists (later radiographers), and
nurses became subordinate to medicine. Opticians, chiropractors and osteopaths resisted subordination. Chemists assumed responsibility for pharmaceutical preparation and supply as doctors’ relinquished personal preparation of prescribed medicines (NZDOH 1972, 1974; Bryder 1991). Dentists developed as a separate profession in parallel to medicine. Regulation also made certain health related practices illegal, through the Tohunga Suppression Act (1907) and the Quackery Prevention Act (1908).

**Professionalisation and Control**

Nursing and midwifery changed rapidly between the 1880s and World War I. The educational status and social position of nursing was transformed as hospital trained nurses took over from independent and untrained nurses, this process aided by the 1901 Nurses Registration Act. The number of nurses increased dramatically, census figures recording 259 in 1874 and 2,830 in 1911. New Zealand’s first nurse to be registered was Ellen Dougherty who qualified for the Wellington Hospital Certificate in 1889 (Wilson 2001).

Nursing scholarships for Maori were initiated by James Pope, Inspector of Native Schools for the Department of Education, in 1898 (Wood 1992). The purpose of these scholarships was to train Maori to work with their own people. According to Masters (2001) Mereana Tangata was the first Maori Registered Nurse in New Zealand, receiving her registration in November 1896, ahead of Akenehi Hei in 1908. Maori nurses were able to train for full nursing qualification from 1905 (Wood 1992). Although training in nursing was predominantly for women, Harding (2003) noted that men were also undertaking nursing roles, however the introduction of Nightingale-trained nurses in the late 1870’s more clearly defined nursing as a female profession in New Zealand. It was not until 1939 that the Nurses and Midwives Act (1925) was amended and men were permitted to register as nurses on the Male Nurses Register.
Regulation of nursing brought new standards of training, though nursing and midwifery remained under the direct control of medicine, which became the model of professionalisation for other health occupations, thereby controlling access to scientific knowledge. Sargison (2001) noted that nursing reform was shaped by members of the medical profession who had asserted themselves as social and political leaders. This relationship between medicine and nursing was illustrated by the advice of Christchurch’s esteemed Nurse Maude “To hear a nurse answer ‘Yes, Sir’ is surely more professional than ‘Yes, Dr’…. Whatever a nurse may think, her duty is to obey without expression of opinion as after all the patient is in the doctor’s charge, the nurse being required simply to carry out his instructions faithfully” (Maude 1908, 36). Wilson (1998) described the concept of professional closure, whereby the medical profession promoted exclusionary behaviours to control other health related groups.

French (2001a) outlined more fully the unequal power and knowledge between nursing and medicine utilizing a Foucauldian framework. Historically, knowledge was imparted to nurses from doctors who also exerted control over practice, particularly through their influence on legislation. Tully and Mortlock (2005) discussed the impact of gender differences and the significance of control of access to knowledge, given that nursing was primarily a career for women and medicine a career for men, in an era of more rigid gender roles than characterises today’s health workforce. The medical profession dominated the state nursing examination from its inception in 1901, by writing and marking the examination in the absence of nursing input until 1937 (French 2001a).

**Hospital based training in a public health system**

By the 1930s, the main health professions were clearly defined by specialised education, distinct licensing legislation, and by their relationship with each other. The skills and culture of
nursing were absorbed through live-in apprenticeships in secondary care hospitals with acculturation to their hierarchical structures, dress codes, protocols, and decision making process (French 2001b).

The post-Depression election of a Labour government in 1935, on the promise of a free and comprehensive health system, established a broad framework for the New Zealand health sector, and hence for nursing practice, for the next half century. By 1940 Labour had begun state funding of hospitals, had assumed responsibility for psychiatric hospitals, introduced sickness and invalid benefits, and had also introduced a maternity benefit as a full payment to the doctor. After an impasse with a resistant Medical Association (Wright-St.Clair 2001), agreement was finally reached to retain a fee-for-service system in primary care, but with a government subsidy to reduce the cost to the patient. Thereafter, the work of the hospital based nurse was typically that of rostered, state supported, state controlled employment, under medical oversight in an increasing complex secondary care environment. In primary care, the role of the nurse was to support a fee-for-service general practitioner.

Expansion, specialization and educational change

In the decades following World War II the health sector expanded to become one of the major areas of employment and government expenditure in New Zealand. Increased efficacy and improved efficiency of medical treatments contributed to the creation of new medical disciplines and sub-disciplines, with their own body of knowledge, training and regulatory frameworks. Greater medical specialization and advancing biotechnology also created an increasingly complex scientific, diagnostic, treatment and administrative infrastructure. Inevitably these developments led to greater specialization and the need for advanced expertise among the growing and increasingly diverse nursing workforce.
The traditional separation of general and psychiatric hospitals, with the latter under the control of the Department of Health’s Mental Hospitals Division, included separation of general and psychiatric nursing. The training and registration of psychiatric nurses was brought under the control of the Nurses and Midwives Registration Board immediately after World War II, putting such training on the same footing as general nursing. A three year psychopaedic training programme was introduced in 1961, also leading to registration with the Nursing Council (Burgess 1984).

By the early 1970s, the need for a fundamental restructuring of nursing education was widely though certainly not universally accepted. In 1971, the year in which the Nursing Council was established and in which the Nurses’ Association launched “Operation Nursing Education”, the landmark Carpenter Report (Carpenter 1971) recommended transfer of basic nursing training from hospital schools to educational colleges. With government support, a long term transition process was begun in which the hospital schools were phased out to be succeeded by a system of comprehensive nursing education, rather than training, (Campbell 1997) which was established in polytechnics across the country.

While the nursing profession supported the change, some hospital boards did not. In a strongly worded rejoinder to criticism of the polytechnic programmes by a hospital board Chairman, the National Executive of the 18,000 member NZ Nurses Association asserted that “Some hospital board members might fear what they see as the loss of a cheaper and captive work force, rather than welcome an opportunity to improve the quality of patient care which could be provided in their institutions” (NZNA National Executive 1982, 4). The last Hospital School of Nursing closed in 1989.
The shift of pre-registration nursing training from a hospital based apprenticeship programme, funded through Vote Health, to the inclusion of nursing within the tertiary education sector, represented a fundamental shift in nursing education, philosophy and policy. Developments in post-registration nursing education were equally significant. The Wellington based Postgraduate School set up in 1928, later renamed the School of Advanced Nursing Studies, was closed in 1978, and replaced by the Advanced Diploma in Nursing, offered through the polytechnics. Of greater significance, for long-term and strategic development of postgraduate nursing education, was the commencement in 1973, at Victoria and Massey universities, of post-registration courses for nurses.

A possible university role in nursing education in New Zealand had been considered in 1928, by which time university nursing schools were well established overseas, particularly in the United States. In New Zealand, however, with a centrally controlled University of New Zealand until 1961, with its constituent colleges in the four main centres, and with Otago Medical Faculty domination of all tertiary education sector health discussions, the prospect of university based nursing education proved short lived. This prospect was raised again in the 1950s and the 1960s foreshadowing the initiatives taken in the less restrictive university environment of the 1970s (Kinross 2001; Wood 2001). The Victoria and Massey programmes were followed by the introduction of further nursing courses in other New Zealand universities.

**A rapidly evolving health sector**

For nurses and health professionals in general, the working environment of the 1980s and 1990s was that of a rapidly evolving and frequently restructured health system (French 2001a). The cover of the NZ Health Review (1983) depicted the then Minister of Health as having three trays, “In”, “Out”, and “Shake it all about”, the first two empty, the third piled high with
reorganization proposals, the Minister sitting on top of the pile, smiling broadly, cup of tea in hand. After a decade of proposals and changes, a radical and market oriented restructuring of the health sector was introduced in the early 1990s with little consultation. The reforms failed, leaving a legacy of demoralization in the health workforce and ongoing conflict between clinical and management cultures (Hornblow & Barnett 2000). Further restructuring followed with a Labour led government championing a return to earlier health sector structures and principles; though with some significant changes including capitation based funding in primary care.

A positive outcome of the turbulence of the 1990s was a re-emphasis on workforce development (Health Workforce Advisory Committee 2002, 2003), including a reopening of longstanding debates about professional roles, boundaries and accountabilities. Rethinking the roles and accountabilities of nurses led to the introduction of the Nurse Practitioner role in 2004 under the Health Practitioners Competence Assurance Act (HPCA). The Act allows autonomous practice by nurses with appropriate Masters level expertise. Introduction of the HPCA required the repealing or amendment of 25 earlier Acts, to provide an overarching framework for the regulated health workforce to be flexible enough to meet changing roles and scopes of practice.

**Challenges and opportunities**

In our rapidly evolving health sector nurses play a pivotal role. A century on from its colonial origins, New Zealand nursing again has opportunities to develop areas of independent practice, to emphasise collaborative rather than a subordinate relationships with medicine, and to contribute nursing expertise to scientific knowledge and research. The nursing workforce of 35,000 comprises about a third of the total health workforce, and medical practitioners less than a tenth (Health Workforce Advisory Committee 2002). The nursing profession is recognized as being at the forefront of health sector innovation and leadership (King 2004). There are many
opportunities for nurses to assume new roles as leaders in healthcare delivery. This poses several challenges to the nursing profession, which is in the process of developing a comprehensive body of scientific knowledge that can describe and explain the complexities of nursing practice.

The first challenge therefore, is to continue to develop a nursing focused knowledge culture as a necessary complement to professional practice. Historically, nurses have not been expected to articulate the unique attributes of nursing that make a difference to the health status of individuals, families, and communities, nor have they expected this of themselves. This presents immediate opportunities to critically examine philosophical, theoretical and practical components of nursing. New Zealand nurses have the potential to contribute to the current body of international nursing knowledge by identifying and articulating phenomena that are unique to our own cultural, structural, and environmental contexts. Acknowledging these opportunities, French (2001b) also cautioned nurses to beware of contemporary controls over knowledge development such as managerialism and quality assurance policies within institutions.

A second challenge is to strengthen nursing research capacity. The priority of research might once again be described as “an act of survival” as it was in 1977 by educationalist Erihapeti Murchie, then Maori Women’s Welfare League President (Sargison 1993, 76). A recent education sector policy change established the Performance Based Research Fund (PBRF) through which tertiary organizations will be progressively funded on the basis of their research performance. In the initial PBRF assessments in 2003, nursing performed poorly compared to all other subject areas. Although some nurses have developed programmes of research (Papps 2002), building further on these existing contributions to nursing knowledge will provide nurses with significant opportunities to ask crucial questions about the nature of nursing and its role in facilitating health improvement. Of the current nursing workforce, 7000 nurses are estimated to
be engaged in postgraduate education (Carryer 2004). Unlike the past, masters and doctoral qualifications now present new opportunities for academic careers and allow nurses to position themselves at the forefront of health sector innovation and leadership.

A third significant challenge is the dissemination of nursing knowledge. Knowledge generated but not disseminated will be of little use to growing a body of science. Sharing nursing knowledge through publication, conference presentation and the like encourages discussion and debate, often stimulated by peer review. The informed practitioner brings valuable information to collaborative initiatives with other health professionals. This may also equip more nurses to contribute to multidisciplinary and interdisciplinary research initiatives as health professionals in their own right.

In response to health workforce initiatives nurses are again at a crossroads of professional development as they re-examine professional roles and culture. Workforce initiatives pose significant challenges to the structure and functions of nursing, but also provide exciting opportunities to build on a rich and complex history. If nurses are to continue to play a pivotal role in a rapidly evolving health sector they must meet these challenges and take advantage of opportunities to demonstrate professional maturity and leadership.
References


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