ICN WORKFORCE FORUM 2015

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Finnish Nurses Association

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Overview Paper

Introduction

This report presents an analysis of key trends presented in eight country reports provided by colleagues in Australia, Canada, Denmark, Finland, Ireland, Japan, New Zealand and Sweden. The report highlights key developments in these countries noting topics of interest to the ICN Workforce Forum discussions.

The participating countries have submitted written reports on the following themes:

1. Environmental Scan
2. Nursing Data
3. Changes to Labour Conditions
4. Universal Health Coverage (UHC) and Human Resources for Health (HRH)
5. Campaigning Activities
6. Retention
7. Lobbying
8. Getting nurses involved in political action-ratification of ILO Convention 149

The report is organised according to the above themes. Not all countries commented on all the agenda topics.

1. Environmental Scan

1.1 Developments in nurses' working conditions

Australia reports that over 60% of nurses in Australia are employed in facilities that are funded, managed or operated by state and territory governments. A number of states and territories have shed nurses and the majority have placed severe restrictions on future improvements in wages and conditions either through legislation or bargaining. Nurses employed in residential aged care facilities continue to receive wages and employment conditions at levels below comparable classifications in our hospitals sectors. Employers in the private hospitals sectors continue to follow the market for nursing wages and conditions established in the public sectors.

In **Canada** CNA and CFNU have developed an evidence-based safe-nurse staffing toolkit to promote safe-nurse staffing practices and is key to the quality and safety of patient care to the maximizing of positive outcomes for patients, nurses and organizations.
CNA has undertaken a number of activities to help optimize the scope of nursing practice, including the following:

- Developing a RN prescribing framework.
- Revising the *Framework for the Practice of Registered Nurses in Canada*.

- Participation in a federal government consultation and an academic summit to discuss optimizing scopes of practice and promote a common understanding of the nursing scope of practice.

Denmark reports that the latest round of collective bargaining in the spring of 2015 resulted in changes in the general agreements in the period from 2015 – 2018. In the after-math of the economic crisis and the tight fiscal policies on the part of the Government there are still limits to the possibilities of improving the conditions of public employees. DNO (and other Danish Unions) has fought hard to prevent a worsening of the employees' working conditions especially since 2009. However, there were some improvements at the latest round of collective bargaining this spring.

In **Finland** the shortage of RNs and physicians has eased during the past few years, although the regional workforce shortage exists. The main reason for improvement is the economic situation; the prolonged financial crisis has seriously affected the municipality's and nation's economy. During economic downturn, employers consider carefully whether or not to recruit temporary and permanent staff. When considering RNs labour market situation in a following five year time frame, the prospects are good. It has been estimated, that there is going to be lack of 2 741 RNs in year 2017 in Finland.

Ireland reports that the negotiations took place in May 2015. The pay proposals of the Public Service Stability Agreement 2013-2018, known as the Landsdown Road Agreement will see the majority of public servants receiving approximately €2,000 extra over three phases between January 2016 and September 2017. The non-pay elements of the agreement include the proposal to freeze the Nursing and Midwifery Board retention fee at the current level of €100 for the lifetime of the agreement. The INMO also secured agreement to have the actual working time of nurses and midwives measured over a 9-month period. The agreement also provides for an intensive three month engagement with employers, and a 2-month engagement on nurse/midwife management structures.

In **Japan** the Japanese government has launched an initiative called "Training System for Nurses to Perform Specific Medical Interventions." Upon the completion of this training program, nurses can conduct a part of physician's medical interventions. This training system was initiated to promote team-based care to respond to diversified care needs in Japan.
Retaining healthcare workforce is a big challenge in developing a healthcare provision system to respond to needs of super aging and low fertility society. Due to the enactment of the amended Act on Assurance of Work Forces of Nurses and other Medical Expert (Nurse Recruitment Act), nurses now have their effort-obligation to notify their prefecture nurse center of their name, address, and license number. The notification will start in October, 2015.

New Zealand reports that District Health Boards (DHBs) in public sector are making good progress in implementing TrendCare™, an accredited patient acuity and workload management system, and have committed to funding the Safe Staffing Healthy Workplace Unit for a further three years.
Settlement of the DHB Multi-Employer Collective Agreement (MECA) (2% this year and next) is likely to include a wage increase above inflation (0.1%, Statistics NZ) Wages and wage increases in aged residential and community care (mostly privatised), are, in general, significantly lower (i.e. between ~7% - 1.5% lower) than those in DHBs. Significant funding and wage disparities remain between Māori and iwi providers compared with the DHBs.
NZNO's survey exposed the increasing uncertainty in nursing employment, partly as a result of continued structural and organisational change in the health system. About a quarter of respondents reported reductions of more senior nursing positions, and 23%, changes to skill mix. Regionalisation and privatisation of specialist services, and merger / acquisitions in the aged- care sector were also

recorded. Heavier workloads, higher patient acuity, restructuring and the financial climate were cited frequently; morale has been affected, with 45% of those affected (vs 24% of those not affected) questioning their nursing future.
There has been some unemployment among new graduate nurses, with supported nurse entry into practice (NEtP) positions available for only 64% of the new graduate cohort. Mental Health and Aged Care are targeted areas of practice for the Voluntary Bonding Scheme for new graduates, and for nursing categories on Immigration New Zealand's (INZ) Essential Skills in Demand (ESID) lists. Almost half of new nursing registrations are of internationally qualified nurses (IQN) and Aotearoa New Zealand remains heavily reliant on immigration to fill nursing shortages.

Sweden reports that the proportion of female employees in health and social care with stress-related health problems has increased from 10.9 percent in year 2012 to almost 16 percent in year 2014. The stress-related sick-leaves have also increased dramatically 2014. A large part of the nurses are working part time to manage the high stress and for Critical Care Nurses also the inconvenient working hours. The shortage of nurses and specialist nurses in particular is a big problem for patient safety and nurses working conditions in Sweden at the moment. Several hospitals have been forced to close down parts of or sometimes entire wards because of the nurses' shortage.
The Swedish government has announced several new initiatives related to work environment and women's working conditions specifically. A new strategy for improving the work environment will be developed in 2015 and the government earmarked funding for research about women's work environment.

1.2 Developments outside nursing

Australia reports as follows:

- ***Health funding cuts***. A new conservative Federal Government is in the process of trying to implement a raft of budget cuts and other measures that will severely undermine Australia's universal health system and reduce access to primary health care services to the low paid and sick. Other budget measures will result in a loss of future funding to the States and Territories previously committed to assist public hospitals meet the growing demand for services. The new Government has also withdrawn funding directed at reducing the substantial wages gap between nurses working in residential aged care and the public sector.
- ***Aged care reform.*** The Federal Government continues to drive major reform to deliver a more consumer-driven, market-based aged care system in Australia.
- ***National Code of Conduct for health care workers.*** The code of conduct was developed to provide occupational standards for assessing safe and ethical practice for all health care workers who are not registered under the National Registration and Accreditation Scheme for health practitioners.
- ***6th Pharmacy Agreement.*** The Federal Government reached an in-principle agreement with community pharmacists for a new $18.8 billion agreement over 5 years to provide community pharmacy services. A key focus of the new agreement is supporting the role of pharmacists to provide professional services with greater integration with Australia's primary health care system.
- ***Electronic health record.*** A national individual electronic health record system has been under consideration and development for many years. However, since implementation its uptake has been low. Following a review of the existing system, in May this year the Federal Government announced its intention to reform the system by changing its enrollment model to opt-out rather than opt-in. Known as the Personally Controlled Electronic Health Record (PCEHR), fewer than 10% Australians had signed up to the system undermining its potential effectiveness.

Canada reports as follows:

Federal government: This year's federal budget included targeting small amounts for those with autism spectrum disorder, a renewal of funding for the Mental Health Commission of Canada, support for innovation in health care, and a Home Accessibility Tax Credit for seniors and others with disabilities. The federal government has proposed reductions in health care spending transfers to the provinces/territories, starting in 2017 — reductions which CFNU's new economic analysis sets at $43.5 billion over an eight-year period. The proposed cuts significantly limit the ability of the provinces/territories to keep hospitals properly staffed, provide beds in long-term care facilities and offer quality care and health services for patients and their families in the community and across the continuum.

The federal government launched an advisory panel to identify five areas of innovation to reduce health spending and improve the quality and accessibility of care for Canadians. The panel's report, *Unleashing Innovation: Excellent Healthcare for Canada*, includes recommendations for the federal government under many themes. Three of these themes, family-centred care, health promotion and disease prevention, could be a turning point toward the adoption of a primary health care approach in Canada.

The Supreme Court of Canada heard an appeal in *Carter v*. *Canada*, which challenged the constitutionality of section 241 of the Criminal Code making suicide a criminal offence. The absolute ban was unanimously struck down, giving Canadian adults who are mentally competent "with a grievous and irremediable medical condition . . . that causes enduring suffering that is intolerable" the ability to seek physician's assistance in dying. The court suspended this ruling for one year, giving the government time to amend its laws. CNA, CFNU and other organizations have convened to start working on a framework around this issue.

The federal government has moved forward on legislation in areas such as mandatory reporting of drug reactions, reviewing e-cigarettes and the health risks of marijuana. As well, the several other legislations have passed into law in 2014-2015.

The federal government has a mandated responsibility to ensure availability and access to health services for First Nations and Inuit communities. Chronic disease continues to challenge the health-care system.

Provincial/territorial governments

CFNU featured a presentation by economist Hugh Mackenzie, the author of a new report that re-evaluates the effects of the forthcoming cuts to federal Canada Health Transfers (CHT) to provincial/territorial governments. Moving from a 6 per cent annual growth rate that began in 2011, the federal government will reduce the CHT to the rate of nominal GDP growth beginning in 2017. Mackenzie's report, *The Canada Health Transfer Disconnect: An Aging Population*, *Rising Health Care Costs and a Shrinking Federal Role in Funding*, shows that the shortfall from the new GDP-linked transfer will be $43.5 billion (rather than the widely cited $36 billion), and that it will result in a steady fall in federal health-care funding.

CFNU released a new report calling for a safe seniors plan, *Before It's Too Late: A National Plan for Safe Seniors' Care*. The seniors care experts who authored the report recommend federal continuing care legislation and a national seniors care standard to address the need for integrated continuing care across the continuum. The report also includes specific measures to implement the federal plan at the provincial/territorial level, with recommendations on staffing levels, staff composition, training and care continuity. And it highlights the disparities in cost and quality between for profit, not for profit and public long-term care facilities while calling for a public system, without for-profit delivery of health-care services.

CFNU and CNA have a long-standing history of advocating for a national pharmacare strategy that includes access to affordable medicines.

- CFNU's report *A Roadmap to a Rational Pharmacare Policy in Canada*, 2014
- a pharmacare roundtable for provincial/territorial health ministers, 2015

- development of a national pharmacare program
- A new report called *The Future of Drug Coverage in Canada, 2015*

In **Denmark** one of the most distinct dividing lines in Danish politics in the past years has been the ongoing discussion as to whether and to what extent there should be an increase in public expenditure, or whether Denmark should install growth rates at 0 per cent for the foreseeable future. The development of the public sector and thus also the development of the Public Health Service reflects restraint and budgets under pressure since the financial crisis. There is a need for more economic reforms towards 2020.

Finland reports of **the parliament election in April 2014**. Because of the **financial downturn**, there are presented **number of austerity measures** in a new Finnish government program. Aim of the new government is example to lower the educational requirements of the health care workforce, especially in elderly care. Regulation aimed to be reduced. Nurse-to-patient ratios is also aimed to be reduced in elderly care. Digitalisation will increase in the social welfare and health care sector. In child care, there is going to be more children in groups and less nannies and teachers to take care of them. Also the length of vocational and university education is aimed to be reduced. One of the Government Programme's main objectives includes raising the employment rate to 72% and increasing the number of people in employment by 110,000. The Government also seeks to achieve a situation where investment exceeds depreciation. Achievement of these objectives calls for structural reforms, with a special emphasis on efforts to reform working life. With **a social contract**, the Government aims to achieve a 5% improvement in competitiveness. In June, the Government held discussions with the social partners. The aim was to assess their readiness to conclude a social contract. By 21 August 2015 the social partners did not agree on social contract. Due to fail in the negotiations the Government set so-called **mandatory labour laws** that were widely objected. The new deadline for the social partners' new proposal is 28th September.
One of the main goals of the new government is to reform the social and healthcare services system in Finland (**the SOTE-reform**). The aim of the reform is to guarantee the provision and financing of welfare services and to reduce unnecessary administration and overlapping services. The reform has already been in a preparation for few years by civil servants in the Ministry of Social Affairs and Health and also in political decision-making process.

In **Ireland** the economy continues to improve and grow, being the fastest growing economy in the EU. This growth is having a real impact on unemployment: the current unemployment rate at 9.7% is the lowest it has been in six years, in 2011 the rate was 14.9%.
The general election will take place in early 2016.
The long awaited ending of the moratorium on recruitment in the public service was announced by Government at the end of 2014. As a result of recruitment embargo the country is severe short of the required number of nurses, as large number of nurses left to work overseas.
Irish report highlights also three other issues: Health Reform Programme, New Health Funding System and Emergency Department Overcrowding.

Japan reports a follows:

1) **Review of Settings for Care Delivery" and "Redistribution of Resources for Health and Long-term Care**

Super aging society with mass mortality is imminent in Japan. The country is developing a care delivery system suitable for super aging population. The national government has directed the country's healthcare system to transform from traditional institutional care to home based care. Yet there are a number of problems to be addressed. The country is right now initiating two major strategies as follows:

・Building a system for efficient and quality healthcare provision

・Establishing a structure for community-based integrated care.

“Building a System for Efficient and Quality Healthcare Provision”

This strategy is specifically to clarify and to demarcate functions among healthcare and long-term care facilities. The national health administration cannot control all beds and their functions. Most hospital beds are managed by private healthcare facilities in Japan. As a result, the Japanese care provision does not necessarily meet local care demand. In order to address the situation, “Promoting the Demarcation and Collaboration of Functions among Hospital Beds” is positioned as a core strategy. In the strategy, prefecture governments have to determine their local healthcare provision, referred to as “Local Healthcare Vision,” clarifying the care needs according to hospital functions. And then in line with the vision, local governments must develop their healthcare provision scheme.

Establishing a Structure for Community-based Integrated Care System

This strategy means to establish a structure for seamless provision of healthcare in a local community so that the seniors can keep living without anxiety in their familiar community to the end of their life. The new structure will support independence and protect dignity of the elderly (service users)

2) Newly Developed Support Fund

The Government of Japan developed a new financial support mechanism (fund) for the policy mentioned in 1) “Review of settings for care provision” and “Redistribution of resources” for health and long-term care. This fund is financed from a rise in consumption tax which was initiated in April, 2014. Prefecture governments apply for and then receive the fund for projects to develop better health and long-term care, and to recruit and retain their health and long-term care professionals. The year 2015 Fund amounts to 90.4 billion for healthcare and 72.4 billion yen for long-term care, paid 2/3 by the national government and 1/3 by prefecture governments.

3) Better Working Conditions for Healthcare Professionals”

The amended Medical Care Act imposes on healthcare facilities ‘effort obligation’ to improve working conditions for their employees. Better working conditions are considered for a long time, as a big issue for the healthcare field to address. In fact, there have often been violations of the Labor Standards Law in healthcare facilities. Japan now recognizes that the government supervision and guidance alone are not enough. The country is trying to introduce a system for prefecture governments and relevant organizations to jointly support healthcare facilities in their independent initiatives for better working conditions. 44 prefecture governments have already set up a ‘Support Center to Improve the Working Conditions of Healthcare Professionals.’ Local nursing associations and other relevant healthcare organizations are involved in the management of the support centers.

4) Rise in the Number of Foreign Workers in Healthcare and Welfare

The number of workers from overseas has been growing every year in Japan. The year 2014 marked the record high in their numbers, 9.8% higher than the previous year. In healthcare and welfare settings, the number of overseas workers was not large, amounting to around 12,000, 1.5% of all workers from overseas. Particularly among overseas nurses, Japan has seen a rise in the number of foreign educated nurses who applied to and passed the Japanese national nurse licensing examination. But there is no accurate data including their nationalities etc.

New Zealand reports that along with increasing preventable chronic disease - diabetes, CVD etc., Aotearoa New Zealand continues to face the resurgence of diseases of poverty eg rheumatic fever, rickets. However, there has been an improvement in New Zealand’s already high rate of immunisation, increased participation in the extended breast screening programme for women aged 45-69, and a reduction in waiting times for elective surgery, first specialist appointments and cancer treatment. An expansion of the school-based programmes in the Youth Mental Health Project included extended funding for school nurses or school-based health services in decile 3 schools, as well as decile 1 and 2. Free GP fees for children under 6 years have been extended to children under 13 years. Health outcomes for Māori and Pacific peoples remain lower than average across almost all health indicators, including access to healthcare.

A change of direction back towards the primary health care focus of the New Zealand Health (2000) has been signalled by the new Minister of Health.
A new Director-General of Health has identified wellness, integrating government services, communicating with communities, whānau (families) and individuals, and information and communication technologies (ICT) as the key focus areas for the Ministry of Health. Currently there are several major Ministry of Health reviews underway.
A plan for the development of the rapidly expanding unregulated care and support workforce (Kaiāwhina), the Kaiāwhina Workforce Action Plan, is underway, alongside the development of a national education framework for Health and Wellbeing training and qualifications, which overlaps that of the level 5 Diploma of Enrolled Nursing.
Health funding has fallen as a proportion of GDP for the past six years, and is not keeping pace with growing costs, population pressures and health demand. Analysis suggests a shortfall of around $1 billion has accumulated since 2009 In general, trends are towards increased outsourcing of services eg elective surgery, and service provision in communities, through primary health organisation (PHOs) (mainly GP practices), pharmacies, and integrated family service provision through Whānau Ora, a Māori-led cross government integrated health, education and social services programme.
Moves to reduce the number of DHBs though regional mergers and to centralise administrative and other services, including finance, laundry and food services continue. However, Health Benefits Limited, which was to have delivered significant efficiencies to DHBs through centralised purchasing of financial and other services has been disestablished, having failed to deliver the expected return on substantial DHB investment. Some regional clinical hubs have been established. PHARMAC, Aotearoa New Zealand's pharmaceutical purchasing agency, is now responsible for the procurement of medicines and medical devices for both hospital and community health services.
Significant progress has been by the IT Health Board in developing standards for and implementing shared health information platforms to secure access to health information electronically for patients and their treatment providers regardless of the setting.
Most DHB have eReferrals and eDischarges, GP2GP is fully implemented and a quarter of DHBs are using the new Maternity Clinical information system. Through the Health Identity Programme, the 20-year-old technology supporting the two main health identity databases – the National Health Index (NHI) and the Health Practitioner Index (HPI) – has been replaced with a single integrated system. Patient portals have been introduced in some primary health practices and general practices are allowing some emergency departments and after hours practices to access information held in primary care. Implementation of electronic administration of medicines in hospitals, including prescribing and reconciliation is underway. The New Zealand ePrescription Service (NZePS) for community prescribing has been rolled out almost all community pharmacies and has been installed in some general practices.
Major social concerns include child poverty, inequity and chronic housing shortages, particularly in the largest and economically dominant city of Auckland.
Delivering better public services (BPS) within tight financial constraints is one of the Government's four priorities for this term. A strong fiscal focus is reflected in programmes targeted at reducing long term welfare dependency and strengthening work expectations.

Sweden reports that the **new government**, elected in 2014, voted for a budget which, among other things, included **more money to maternal care**. The government initiated also **a project to fasten newly arrived immigrants integration to the labor market**. The unions, representatives for the employers and Arbetsförmedlingen (the National Agency for Job Matching) are part of the project. Vårdförbundet has applied for project money to improve Biomedical Scientists integration to the Swedish labor market. The government assigned a commission of inquiry to investigate how **to limit profits in private welfare companies**. A completely new law, **the Patients Act**, came into force on 1 January 2015. The purpose of the Act is to strengthen and clarify the position of the patient and promote the privacy, self-determination and participation of the patient.

1.3 National Nursing Association (NNA)

Australia reports as follows:

- ***Australian College of Nursing's (ACN) leadership agenda*** In 2014, ACN set a new strategic direction as the national organisation advancing nursing leadership for the purpose of improving the health care of all Australians. ACN's new vision will see it promote the unique role and perspective nurse leaders, and those aspiring to leadership, can play in providing solutions to healthcare challenges. This will be achieved by providing nurses, at all stages of their career, with learning experiences and opportunities to prepare and enable them to lead change and contribute to a range of policy issues, equipping them with economic as well as health outcome perspectives. ACN will also continue to provide leadership in the policy arena on key nursing and health issues.
- ***FGM learning portal*** In 2014, ACN and the Australian College of Midwives launched an online portal, FGM Learning, for the dissemination of professional resources related to female genital mutilation (FMG). FGM Learning is a national hub where nurses, midwives and other health professionals can access reliable sources of information about FGM in order to inform the care they provide to women and girls affected by the practice. The website also includes a forum for health professionals to network with each other and identify gaps in current knowledge and opportunities for collaboration.
- ***Australian Nursing and Midwifery Federation*** (Collaborating partner) Elections were held in the last six months and saw Lee Thomas returned as Federal Secretary by a significant margin.

Canada reports that the last administration of the Canadian Registered Nurse Examination (CRNE) took place in October 2014. The ten provincial/territorial RN regulators have chosen the National Council of State Boards of Nursing (NCSBN) as the provider of the Canadian RN entry-to-practice exam. The new exam is called the National Council Licensure Examination—Registered Nurse (NCLEX-RN).

To ensure CNA's compliance with the new *Canada Not-for-profit Corporations Act*, and to maintain long-term sustainability, CNA's board determines what is relevant to its membership and the current health-care system. The board has recently done the following:

- Add two new membership classes (retired and independent RNs) under the new Family of Nursing group.
- Create a new class C membership group, which means student nurses are now able to vote.
- Recently approve CNA's strategic plan for 2015-2019 and named primary health care as the focus for the next five year planning cycle.
- Vote on and pass universal membership at this year's meeting of members. Details to be further discussed at next board meeting.
- Welcome new directors Marc Bourgeois (public affairs and member engagement), Carolyn Pullen (policy, advocacy and strategy) and Joanne Lauzon (finance and administration), and new executive lead Patricia Elliot-Miller (certification and professional development).

Denmark reports that in connection with the general election to the Danish Parliament 2015 DNO focused on the economically stressed Public Health Service in which the nurses' working environment is challenged by the lack of coherency between tasks and resources. During the election campaign DNO focused on four concrete proposals for a more sustainable Public Health Service:

- ***Investment in quality time between patient and nurse – time for intimacy, safety and involving of the patient.*** DNO suggests that an economic boost to support a development focusing on quality and safety of patients is ensured. DNO stated that such developments are already going on in many units of the Public Health Sector. But there is also a need for additional funds to the most strained units in order to be able to raise quality.

- **A focused and ambitious effort against chronic disease.** DNO stated that in recent years different programmes and setting up of quality standards have aimed to raise the quality of nursing and treatment of citizens with chronic diseases. But that the next steps should more focused on tailored procedures. DNO suggests that a specialist-education in chronic diseases is established for nurses. This kind of education would ensure a homogeneous and highly professional level and support a significant lift of quality in a targeted effort towards citizens with chronic diseases.
- **One patient – one co-operative Public Health Service.** DNO suggests a strategic and integrated plan for the present Public Health Service, to support the national plan for establishing a future structure for hospitals in the regional sector.
- **Health is more than what happens within the Public Health Service.** DNO suggest that an overall plan is made for a healthy life for children and young people so that they all will meet a coherent, integrated and inter-professional effort for health and well-being.

Finland reports as follows:

- ***90th Anniversary.*** This year 2015 the Association celebrates its' 90th anniversary. 16 regional associations have celebrated the anniversary by organizing festive occasions along the year, but mainly during the International Nurses Day.
- ***Advanced practice nursing.*** Advanced roles for registered nurses have been developed since the early 2000s. According to a recent survey, Finnish nurses view advanced roles and clinical career prospects as an important way of increasing the appeal of nursing. The Finnish Nurses Association has established the preparatory group of experts to examine APN roles and educational issues. This report will be released in fall 2015.
- ***Suvake project***
  The Suvake project is implemented together with five polytechnics, one university and FNA. It aims to produce a common, reliable, cost-effective and national entrance examination for nursing students. At the moment the polytechnics are able to organize the entrance examinations on their own way.

Ireland reports of

- ***Survey on Health and Wellbeing of Nurses/Midwives***
  The survey found that the incidence of presenteeism, which is the opposite of absenteeism is growing. The report found significant difference between the ages.
- ***Survey on Workplace Bullying***
  Over the past four years there has been an increase of over 13% in perceived incidences of bullying. Almost 6% of nurses and midwives report that they are bullied on almost daily basis the percentage of non-union members who experience almost daily bullying is almost double that the union members.
- ***INMO wins Landmark European Commission pay case***
  In 2011 the Government reduced salary and allowances of 10% of those entering the public service for the first time, and applied the reduced scale to workers who had previous pubic service in another EU country. The Commission concluded that comparable employment in other EU member state must be similarly recognized.

Japan reports as follows

JNA Announces "Future Vision for Nursing

Japan is reforming its social security system for the year 2025 when baby boomers will be 75 or older. Nurses are facing big challenges to meet healthcare and welfare needs of society with low birthrate, super aging and mass mortality. The coming ten years are the time for change. As the major nursing professional organization in Japan, JNA announced at its Annual General Convention held in June 2015, the association's action policy for coming 10 years: "Future Vision for Nursing –

Nursing Supporting Human Life, Living and Dignity," pointing to how nursing and nurses should be in Japan for the next decade.
The perspective of nursing covers not only disease-based care but the whole of people's lives. The JNA's Future Vision for Nursing values nursing profession's view of people's lives, raising the vision for 2025: "Nursing supporting Human Life, Living and Dignity," "Nursing linking life, health, healthcare, and welfare over people's lifetime." In order to achieve the Future Vision for Nursing, JNA will develop and implement the concrete mid- and long-term action programs based on the following directions:
1. Transforming the nation's health, healthcare and welfare system in a way to emphasize importance of people's place of living
2. Disseminating quality nursing to link people's living into health, healthcare and welfare
3. Building quality and sustainable nursing care provision system
4. Promoting nursing policy and strengthening the organization of nursing associations

JNA's Main Policies and Projects in 2015
JNA has developed the following four main policies and projects for this fiscal year in order to achieve "Future Vision for Nursing" mentioned above. Particularly the association has put top priority on "Establishment and promotion of the community-based integrated care system." Nurses in Japan must further demonstrate professional expertise as the country is promoting healthcare and long-term care reform.
1. Establishment and promotion of the community-based integrated care system
2. Enhancement of positive practice environments for nurses
3. Promotion of the role expansion of nurses
4. Development of nursing human resources capable of meeting the needs of the super-aged society with fewer children

Promoting Nurse Staffing to Sustain Advanced Acute Care
Nurse staffing standards are linked to the hospital admission fee schedule of the National Health Insurance (NHI) system in Japan. Better the nurse staffing ratio is attained by a hospital, bigger the amount of admission fee is paid to the facility by the NHI system. The nurse staffing ratio of 7 to 1 introduced in 2006, means that one nurse assigned to 7 patients should be maintained for 24 hours. 7 to 1 staffing ratio is better than the previous best possible limit of 10 to 1.
Japan is reforming its social security system by clarifying and strengthening functions and roles of acute care hospital beds. Some point out that the present 7 to 1 staffing is not sufficient to provide advanced acute care, and yet the country needs safer and better quality nursing care provision. Thus, JNA is requesting the Government of Japan to set up better nurse staffing standards adequate to build up advanced care provision.
Right now, 400,000 beds have notified to have 7 to 1 ratio, representing 40% of general beds in Japan (as of July, 2013). As for the skill mix of nurses and licensed practical nurses, it is regulated that 70% or more should be nurses (registered nurses) in the nurse staffing ratio of 7 to 1, 10 to 1, and 13 to 1. ICUs, CCUs, NICUs, convalescent care units always have 2 to 1 and 5 to 1 staffing ratio according to the severity of patients, responding advanced acute care conditions.

In **New Zealand** NZNO is finalising its next five year strategic plan, which has four key objectives: improved health outcomes, skilled nurses, a strong workforce and effective organisations. The 2014 Manifesto *Nursing Matters* identified seven priorities for health: a sustainable, fully utilised nursing workforce, investment in public health, a primary health care approach to population health improvement, best start for children, safe clinical environments, social and health equity, and safe and fair employment.
NZNO was influential in securing a united nursing voice advocating for nursing workforce planning, retention and graduate employment noted in the *NNO Report to Health Workforce New Zealand.* The

NNO is Aotearoa New Zealand's key nursing stakeholder group comprising representatives from employers, educators, professional bodies, the regulator, and the OCN.
NZNO has developed a suite of specific policy frameworks to progress the vision articulated in its 2011 document *2020 and Beyond: A Vision for Nursing*.
NCNZ has developed guidelines for two types of nurse prescribing: community and specialist nurse prescribing, and prescribing is now a mandatory component of the nurse practitioners scope of practice. A number of position statements have been developed, including one on care rationing, following NZNO's observation that the balance between available funding and health-care need is at risk, and that care rationing, as a result of unsafe staffing levels and inappropriate skill mix, is occurring in Aotearoa New Zealand.

In **Sweden** the extra congress of Vårdförbundet voted yes to **two new political documents; one about healthcare politics and one on healthy work environment.** Vårdförbundet will continue working with the ideas in practice through action plans, strategies and competence development for members and union representatives.

2. Nursing Data

2.1 Nursing Workforce Profile

Specific data on nursing workforce profiles in Australia, Canada, Denmark, Finland, Iceland, Ireland, Japan, New Zealand, Sweden and USA can be found in their specific *Nursing Workforce Profile, Database Summary.* Below is additional information that was reported by some countries.

Australia's nursing profile:

- Total number of nurses registered in the country in March 2015: 333,964
- 264,238 RNs and 60,306 ENs
- Average age for RNs was 44.2 and 46.2 for ENs in 2013, of RNs 37.7% were over 50 years in 2013 and 46.9% of ENs were over 50 years in 2013.
- In 2013, 44.7% of RNs and 57.4% of ENs worked part time hours
- Average number of hours worked per week in 2013 is 34.3
- In 2016 there will be an estimated shortage of nurses (13,162 RNs and 6,918 ENs).

In **Canada** according to the latest nursing workforce data from the Canadian Institute for Health Information (CIHI), for the first time in two decades, more regulated nurses in Canada left the profession than entered it. The supply of regulated nurses (licensed) declined by 0.3 per cent between 2013 and 2014. The supply of RNs, who make up the majority of Canada's nursing workforce, declined by a full percentage point. This equates to a net loss of 2,360 regulated nurses.
The CIHI report also notes the following:

- Since 2009-2010, the number of students admitted to entry-to-practice RN programs has been declining.
- Despite a tightening labour market, the proportion of the regulated nursing workforce actually employed in the profession in 2014 continued to grow, reaching 383,949 regulated nurses (which translates to a 97 per cent employment rate for RNs and NPs)

- 156,457 RNs (58.5%) reported to work in full-time positions, 78,050 RNs (29.2%) reported to work in part-time positions and 32,850 RNs (12.3%) reported to work in casual positions.

CFNU published its fourth biennial Quick Facts report, entitled *Trends in Own Illness- or Disability-Related Absenteeism and Overtime Among Publicly-Employed Registered Nurses*. The 2015 edition

illustrates the toll excessive workloads are taking on Canada's nurses — which contributes to a decline in patient care.

3. Changes to Labour Conditions

3.1 Legislation, regulation, terms and conditions, custom and practice

Australia reports that in the national jurisdiction, enterprise agreements must leave nurses better off than they would be under the Nurses Award 2010 and the National Employment Standard (NES) which, combined, provide the safety net for wages and conditions. The Fair Work Commission (the national tribunal) is currently undertaking a review of all Awards where employer bodies are seeking to reduce and remove award provisions that set minimum standards for hours of work, overtime, shift allowances, weekend and public holiday rates of pay and annual leave. The review into the Nurses Award is due to commence later this year.

Enterprise bargaining in the public sector has been significantly impacted by stringent budget measures at the state/territory level capping wage increases from 2% to 2.5% per annum and requiring productivity offsets for any improvements in conditions. The Tasmanian State Government has gone further and imposed a 12 month legislated wage freeze on public sector employees including a freeze on incremental progression within the salary scale.

Several State Government budget cuts have also resulted in the loss of nursing jobs in the public sector (1300 in Queensland and the loss of several hundred positions in Tasmania). Job opportunities for new graduates are also decreasing with a significant increase in the number of new graduates unable to find work and many others underemployed in part time or casual positions.

The new Federal Government is seeking to reduce workers' rights and working conditions. It has announced several reviews in 2014 including:

- a root and branch review of the Fair Work Act;
- a review of Penalty rates;
- the role and the regulation of trade unions;
- industry superannuation funds; and
- the need to increase labour mobility.

The principal law covering the employment of nurses and midwives in Australia continues to be the Fair Work Act 2009. Over the 2014/15 period there have been a number of changes to the minimum employment standards that apply to all employees covered by the Act. These include changes in relation to:

1. Parental and pregnancy leave entitlements;
2. Requests for flexible work arrangements; and
3. Anti-bullying regulations.

Over this period the Commonwealth Government also introduced a number of legislative Bills into Parliament.

Canada reports that the Supreme Court of Canada ruled that a blanket ban on public servants' right to strike is unconstitutional and infringes on freedom of association guaranteed under the Canadian Charter of Rights and Freedoms, striking down Saskatchewan's essential service legislation. This will have implications for unions in Newfoundland and Labrador, Nova Scotia and British Columbia, which also have essential service legislation. The United Nurses of Alberta and other unions brought forward Alberta's 40-year-old ban on the right for all public servants to strike. The ban was deemed invalid and the province was given 12 months to come up with a new approach. Alberta also went to court to ensure that Alberta Health Services enforces provincial legislation and regulations pertaining to adequate staffing in long-term care facilities. Under the nursing homes regulation, facilities are required to have an RN on staff at all times. If that isn't possible, an RN must be

available to be on call at all times (some Alberta nursing home operators had been failing to ensure levels of staffing required by law).
In February 2015, 3,000 RNs and health professionals from Ontario Community Care Access Centres, members of the Ontario Nurses' Association, went on strike. After 17 days, the dispute was sent to an arbitrator, who ruled in favour of the workers and awarded a 1.4 per cent increase to nurses in each of two years.
Many CFNU member organizations continued their bargaining efforts. The Nova Scotia Nurses' Union (NSNU), Saskatchewan Union of Nurses (SUN) and New Brunswick Nurses Union (NBNU) are currently in negotiations. In April 2015, the Prince Edward Island Nurses' Union (PEINU) ratified a four-year contract with wage increases of 9.9 per cent, compounded by the end of the contract.

Denmark reports that the latest round of collective bargaining in the spring of 2015 resulted in a number of changes in the general agreements in the period from 2015 – 2018.

- ***Wages***

  The nurses working in hospitals and municipalities get annual wage increases of approximately 2 % from 2015-2018. It is possible to negotiate additional wage increases at local level, e.g. at the workplace.

  To DNO it was important to emphasise the relationship between additional education and the wage level. Nurses with an academic education and nurses with formal educational qualifications – the specialists – were a priority and received additional wage increases during the last round of collective bargaining.

- **Regulatory wage system**

  Reguleringsordningen is an agreed Regulatory Wage System with respect to the different wage increases in the public and the private sectors. The agreed regulation mechanism will for the period 2015-18 continue to ensure an almost parallel wage development between the sectors. But the system is tightened, though compared to previous rounds of collective bargaining. New is a so called "*private wages-defense*" which involves an automatic regulation of the wages of the employees in the public sector, with full impact, in case of wage increases in the public labour market having been higher than increases in the private labour market in the previous period.

- **Pension**

  The contribution rate to publicly employed nurses' labour market pensions fund will be improved from approximately 13.37 % to 13.51 % by April 1st, 2016. This was an important improvement for DNO to prioritize, because nurses generally have lower contribution rates to their labour market pensions fund than other occupational groups in the public sector. The contribution rate for nurses with an academic education were increased from 13.37 % to 18.46 % which corresponds to the pension contributions for other academic groups in the public sector. Also, head nurses with a relatively low contribution rate received an increase from 13.39 % to 15.04 %, although some head nurses already have a 16.59% contribution rate. Hence the contribution rates were not fully levelled for the head nurses.

- **Nurses with a supplementary academic degree**

  In the 2013 round of collective bargaining it was further specified that the agreements now cover nurses who complete an additional academic education at university level degree. This is an important result to DNO because more and more nurses choose to proceed with an academic degree on top of their nursing degree.

There are now nine academic degrees for covered by the collective agreements for the municipalities – including cand.cur. and cand.scient.san.

- **Nurses with an approved specialist education**

  Education should be worth the effort which is why DNO and the employers have made a new agreement for nurses with a specialist education about a wage supplement for experience. This only applies for approved degrees which are regulated by the national health authorities.

  Nurses employed in the regional sector (hospitals) with at least 10 years of experience have a

monthly wage supplement of a little more than 1,100 DKR and it is agreed that for specialist nurses the supplement will be raised by an additional 550 DKR per month.
In the municipalities there is an agreement that nurses with a relevant specialisation are to have the same wages as health visitors and that both nurses and health visitors with a relevant specialisation and a minimum of four years of experience are to receive a bonus of a little more than 550 DKR per month.

Other improvements and results of agreements 2015

Collective contributory influence – Adjustments of the competences of the local negotiating bodies and committees and a promising renewal of central dialogues between public employers and employees

In the public sector in Denmark there is a long tradition of agreements on the so called *MED-system* a complex and widespread system collective contributory influence. The structure is an integral and fundamental part of *The Danish Model*.

1 week of extra paternal leave for fathers

The Collective Agreement offers an additional week of paternal leave with full pay to fathers, so that the fathers from now on have 7 weeks of earmarked paternal leave with full pay. The scheme also applies to couples of the same sex. Should the father decide not to make use of his week, the mother has the possibility of making use of it and receiving maternitity benefit at the same time.

Absence at children's hospitalisation

Parents with a child who is hospitalised have the right to five extra days of personal leave and pay so that the parents all together have the right to 10 days. The personal leave does not apply to ambulant treatment.

Job Security and Safety Fund

The fund offers nurses who are dismissed due to general changes in the municipal organisation – e.g. reductions of staff, budget cuts, restructuring etc. – an opportunity of applying for up to 10,000 DKR. The funds apply both at mass dismissals and dismissal of individuals due to general criteria such as the ones mentioned above. The money can be used for financing of skill development and further education, career sparring advice and clarification, assessment of competences and individual guidance regarding both personal and occupational challenges in connection with the dismissal.

Right to two hours guidance at dismissals

Nurses who are dismissed due to the municipality's state of affairs e.g. changes in organisation or budget cuts, have the right to guidance and advice for up to two hours in her/his trade union or unemployment fund.

Agreement on employees with reduced work capacity

The parties have concluded an agreement on conditions of employment and wages for employees with reduced work capacity who has been employed as of June 1st 2015 or later. The new agreement is established because of changes in legislation for employees with reduced work capacity. This will be included as a new chapter in the general framework agreement on social chapter. Compared with the current legislation the agreement e.g. offers following news:

- Wage conditions will also in the future follow the collective agreements in every case. However, wages and supplements will be calculated in proportion to the individuals' work capacity (work intensity) as provided by the new changes of the legislation.
- In future it is mandatory to involve the local union representative before the employment. Today the employer is not obliged to involve the union representative when employing for these kinds of jobs.

Occupational development

It is agreed to allocate 14 million DKR to the previously established Research and Development Fund for Public Health Service in the regional sector. All groups within the Danish Health Confederation

can apply for funds to develop new knowledge within the professions. Likewise there will be an intensified focus on rehabilitation and dementia on the municipal sector.

Equal opportunity and local wage development

The parties have agreed to make new, updated joint guidelines on the centrally agreed framework on local wage development. Amongst other subject is it also agreed to focus on equal opportunity and equal pay with respect to local wage development and the guide will offer ways to avoid further wage gaps between men and women.

Information to union representatives in case of employing of substitutes via temporary employment agencies

At request a municipality or the regional authority is obliged to inform the union representative on which kind of agreements apply for the field of activity of a substitute from a temporary employment agency and which the region/municipality intends to employ. This is a new initiative to reduce social dumping and in the after-math of some scandals in the press with respects to public works.

Finland reports as follows:

- ***New law.*** Professional practice rights in the social work - new law is coming into effect in 1.3.2016
- ***The agreement on a salary.*** The labour organizations reached an outcome of the negotiations for Employment and Growth agreement in 15.6.2015. This agreement is raising the salaries of 16 € per month (a minimum of 0.43%) in year 2016.
- ***Hepatitis vaccination for nursing students.*** There are nursing students that are in risk of getting hepatitis infection in their clinical practice training period. This group will receive the vaccine free of charge, from August 2015 onwards.

Ireland reports of two changes to labour conditions:

Workplace Relation Act 2015

The Act reforms employment rights and industrial relations bodies and is a major piece of public service reform which will see the existing five employment rights bodies merged into two bodies. The Act also provides for a number of changes to a range of employment laws and for new compliance measures.

Industrial Relations (Amendment) Bill 2015

Trade unions have welcomed draft legislation on collective bargaining which will allow them to represent members at the Labour Court where employers refuse to recognize unions.

Japan reports as follws:

1) Enactment of Karoshi (Death from Overwork) Prevention Act

Recent years have witnessed a number of Karoshi (death from overwork) cases in Japan. Karoshi has become a big social issue in the country. In November 2014, the Act to Promote Karoshi-Prevention was enacted in order to eliminate death from overwork. This anti-Karoshi Act considers death and suicide from overwork as social loss, and spells out that the national government is responsible for taking actions on Karoshi prevention.

2) Better Mental Health: Stress Check Starts

'The Law to revise part of the Industrial Safety and Health Act' promulgated on Jun 25, 2014, has produced a new system, which requires employers to provide their employees with opportunity to receive a stress check test and interview guidance by public health nurses and physicians. The stress check test is designed to reduce the risk to develop poor mental conditions by regularly examining the stress level of employees, sending the test results to them, and making them aware of their stress condition. The new system will begin to be implemented in December, 2015.

3) To Prevent Violation of Labor Standards Law: Countering Long Hour Work

Japan has a big problem of 'Black Companies,' companies which force their employees to work with heavy burden in poor working conditions. As a part of its action against the Black Companies the

Ministry of Health, Labour and Welfare (MHLW) has determined to give guidance to and release the name of companies which keep their employees to work illegally long hours.

In **New Zealand** changing employment patterns, with increased contracted, casual, and part-time work, have increased the risk of 'precarious' employment; a substantial proportion of families receiving social assistance (benefits) have someone in paid employment.
The most significant labour development has been the upholding of the Employment Relations court decision in the claim made by health care assistant Kristine Bartlett against Terra Nova Homes (aged care), which economically empower those who work in low wage, female dominated occupations. Bartlett argued her $14.46 hourly wage was less than would be paid to men with the same, or substantially similar, skills, and that it was a breach of the Equal Pay Act. The principal case is yet to be heard.
The *Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill* has been introduced to Parliament. This will amend legislation to increase the range of regulated health practitioners authorised to undertake certain functions.
NZNO campaigned strongly against further amendments to the ***Employment Relations Act*** which have weakened collective bargaining and removed some protections for employees around rest and meal breaks, but has given all employees the right to ask for flexible working hours.
The Health and Safety Reform Bill, introduces major reforms to workplace health and safety, but also reduces employee participation and elected representation, removing the requirement for Health and Safety representatives for organisations with fewer than 20 employees. A significant gap in the regulations is the absence of provision for a national workforce monitoring and surveillance scheme to identify and mitigate long-term occupational disease. In addition, proposed changes to the Accident Compensation Corporation (ACC) levies, do not allow for adequate provision for funding occupational disease (*Accident Compensation (Financial Responsibility and Transparency) Amendment Bill*).
Regulations implementing the ***Vulnerable Children's Act*** have imposed substantial vetting and screening requirements for people working with children, including regulated health practitioners. Despite a vigorous campaign for 26 weeks of paid parental leave ('26 for babies') paid parental leave was extended from 14 to 16 weeks this year and will be 18 weeks after April 1, 2016. Eligibility has also been extended to include non-standard workers (part-time, casual) and 'primary carers' (eg grandparents, whāngai (family adoption), etc.).

In **Sweden** wage statistics for 2014 show an average individual wage increase in the County council sector of 4 % and in the Municipalities of 3.4 %. In the private sector (Care Providers) and the State was wage growth 3.5 and 3.3 %. The County Council is the sector that received the highest individual wage, but it is also the sector where the median wages are lowest.
At local government levels we can see a rising trend in the number of long-term sick leave cases. From the beginning of 2000 there was a decrease in the number of long-term sick leave cases. This continued until 2009. From then, there has been a continuous increase in the number of long-term sick leave cases. Occupational groups with the highest risk of long-term sick leave in 2012 were nurses, auxiliary nurses and ambulance drivers. Within these groups, more than 35 of 1,000 people employed are on prolonged sick leave. The cases of sick leave among nurses, midwives and others (medical technical assistants) increased from 22.8 cases per 1000 employees to 24.5 cases per 1000 employees among women between 2011 and 2012. For men, the corresponding figures were 11.1 and 15.8 cases per 1000 employees.
The risk of ill-health generally increases with age. In all age groups the risk is also higher for women than for men. Women working in municipalities or county councils also have a higher risk of chronic illness in all age groups compared with women working in the private sector.

3.2 Working hours: shift work patterns/breaks, flexible hours/work life balance

Australia reports that Full time hours of work are 38 hours per week. Part time hours are less than 35 hours per week (44.7% RNs and 54.4 ENs worked part time). Nurses regularly miss rest breaks and regularly work unpaid overtime. Overtime (if claimed and authorised) generally 50% loading on first 2 hours and 100% loading thereafter.

In **Canada** CFNU held a series of focus groups with early career and mid- to late-career nurses. This fall, the intergenerational report, *Generational Diversity in the Workplace: Exploring Career Experiences*, *Needs and Expectations of Early and Mid-Late Career Nurses*, by Sheri Price and Linda McGillis-Hall, will be published and presented at the federal health ministers' annual meeting. Based on their research results, Price will present a series of recommendations aimed at contributing to a retention and recruitment plan as part of a larger health human resources strategy.

Denmark reports as follows:

- **A good psychological working environment**

  The Trade Unions and the employers agree that a good psychological working environment is an important prerequisite to productivity and quality. Therefore, a joint flying squad will be established for the municipal sector - and in the regions expert assistance – in order to assist, guide and inspire local units to make an extra effort for a better psychological working environment.

  Working hours in the municipalities

  For the municipal sector DNO together with a large number of other trade unions has met the employers' demands on more homogenous regulations in the field of working nights and weekends. At the same time the unions managed to stave off the worst demands of worsening of conditions from the part of the employers. The new agreement for working hours implies that e.g. a special Saturday-supplement of 28 % will apply from 8 a.m. instead of previously at 11 and that an evening-supplement of 27 % will be effectuated from 5 p.m. instead of 6. Furthermore, there will be a 3 % pension bonus of the most common special services such as the evening and night supplements. At the same time the special days off, such as May 1st, Constitution Day, Christmas Eve and New Year's Eve, will be reorganised.

  With the changes the trade unions contribute to simplify the managerial planning of working hours and look forward to the effect of this. Namely that it is also aimed to free managerial resources to focus more on profession, quality and a good working environment.

  Working hours in the regions

  For the regional sector it is agreed to gather experiences and examples of how the agreed regulations on working hours is functioning in practice. Also the parties will jointly test new ways of organising working hours.

In **Finland**

New period work model. This new work model came into force June 1, 2015

- The most essential changes and improvements for RNs working in three shifts:
- So called formal period work is dismissed, only one period work remains.
- The double periods (3+3 weeks) exists no longer. The length of the period is 2, 3 or in exceptional cases 4 weeks.
- The several rosters can still be planned ahead.
- Extra work will be paid as overwork. Overwork is paid faster as the period is shorter than before.
- The value for the beforehand known interruption is always 7h 39min.

- Before it was possible that if a person was attending paid education during Monday-Friday, she/he had to work still 16 hours to get the list full.
- No more than 7 shifts can be planned in a row.
- The rosters cannot be overbooked, the compensation given as day offs have to be included to the roster.
- ● The period work regulation will be applied for those working in formal period until May 31, 2015.

Japan reports of Dissemination of *Guidelines on Night-shift and Shift Work for Nurses.* The JNA published guidelines in 2013. JNA proposed '11 Standards for Making a Nurse Shiftwork Roster' in order to help nurses ease the impact of night and shift work on their health, safety and lives. Those eleven standards were developed based on the latest labor science knowledge. *The Guidelines* also suggest effective ways to take rest and nap during a night shift work.
Following the last year, we have conducted this year a survey for 8,563 hospitals in order to how *the Guidelines* were penetrated in the country (response rate: 37.5%). In Japan, 60% of hospitals have adopted two shift work system. As for 90% among those hospitals, nurses were working longer than 15 hours. The JNA's *Guidelines* propose that the total hours spent at work should be within 13 hours. Respondent hospitals which 'have adopted' this standard mark 19.6% with 4.8 point increase from the previous year. Hospitals which said that they were 'planning to adopt' make a big rise to 17%. On the other hand, the problem of three shift work is a short break between shifts. There are only four hours between shifts, excluding overtime work and commuting time. Respondent hospitals which have adopted 'break between shifts should be 11 hours or longer' mark 42% with 6 point increase from the previous year's rate of 36%.

New Zealand reports that eight hour shifts continue to be standard for most nurses. 10 and 12 hours shifts are included in the DHB MECA, but their use tends to be localised. NZNO completed research into this area in 2014 (Clendon & Gibbons, 2015).12 hour shifts may be phased out as information about patient safety data in relation to shift hours emerges. NZNO is in the process of collaborating on research into the relationship between hours of work and nursing fatigue.
WorkSafe New Zealand, the regulatory agency responsible for workplace health and safety, is undertaking a systematic review of all workplace regulations and guidelines many of which are outdated, to ensure that they are relevant and reflect best practice. An evaluation of the guidelines for *Preventing and Addressing Workplace Bullying* (WorkSafe New Zealand, 2014) is underway with a representative sample of employers (Auckland University of Technology).
NZNO's employment survey revealed a 10 per cent increase in time off work for workplace-acquired infections and injury compared with the 2013 survey. The commonest causes were back, knee, wrist and shoulder injuries relating mostly to slips and lifting, and flu or norovirus infections. Nineteen per cent reported having some problems with performing their usual work, study, housework, family or leisure activities, and 34.9 per cent reported moderate pain or discomfort. There were some very disturbing accounts of violence towards nurses, especially in the fields of mental health and aged care.

Sweden reports of initiating local negotiations about the conditions and the compensation when working at night. Vårdförbundet wants the time for rest and recovery to be included in the schedule when employees are working at night. Vårdförbundet also wants it to apply to all members - regardless of employer or where in the country they live. Despite many long conversations with SALAR about a central collective agreement, this has so far not led to any results. Therefore Vårdförbundet now take an initiative to sign local collective agreements. For the future, the goal is still a central collective agreement.

3.3 Health and safety particularly in relation to bullying

In **Australia** a worker who "reasonably believes" they have been bullied in the workplace will be able to apply to the Fair Work Commission and seek orders against the perpetrator and their employer requiring them to stop the bullying. Upon application, the Fair Work Commission is now able to take serious steps to stop of prevent bullying at the workplace if:
-the worker has been bullied at work by an individual or group of individuals; and
-there is a risk that the worker will continue to be bullied at work by that same individual or group

In **Canada** CNA and CNFU have released two joint position statements on quality workplaces:

- *Practice Environments: Maximizing Outcomes for Clients, Nurses and Organizations*
- *Workplace Violence and Bullying*

In September 2014, the first diagnosed case of the Ebola virus disease was confirmed in North America, at a Texas hospital. Public Health Agency of Canada's (PHAC) protocols around Ebola needed updating to protect health-care workers and ensure the safety of patients and communities. CNA and CFNU communicated directly with the chief public health officer at PHAC, and with other health and infection, prevention and control experts, to ensure that current information and guidance documents were timely, evidence based, appropriate and safe for nurses, care providers, decision-makers and patients. Both CNA and CFNU informed the public and media as concerns and new information emerged. CFNU released a policy directive on Ebola, as an occupational health and safety guidance document for nurses, and worked with its provincial affiliates on developing a provincial response.

In **Denmark**, one in every 10 nurses has been victim of bullying. This corresponds to appr. 5,600 nurses per year being subject to bullying. Colleagues are primarily the ones who bully.
In 2008 the social partners agreed to implement EU's framework agreement on bullying in working places. Due to this, since then all public working places have had to develop guidelines to identify, prevent and handle problems related to bullying. But as the mentioned figures from DNO indicate, the problem is not yet solved.
Initiatives have been taken at national level and within the social dialogue to support workplaces in preventing bullying. E.g. in a co-operation between the National Research Centre for the Working Environment and the social partners a campaign focusing on bullying has been conducted. The campaign communicates understanding of bullying and how it can be avoided. Furthermore, sharing of good experiences across working places is especially emphasized. In the context of the Danish Working Environment Authority a 'bullying'-hotline has been established through which you can get advice and guidance on bullying, by phone.

In **Finland** the Union of Health and Social Care Professionals, Tehy arranged a seminar 28.5.2015 against bullying. Over 100 shop steward, occupational safety delegate and managers participated this seminar. It was also possible to look the seminar through the Tehy's website.

Japan reports as follows:
1) Workplace Power Harassment: Rise in the number of a work-related mental disorder claims
In recent years workplace power harassment cases have increased in the consultation services provided by prefecture labour bureaus. More cases have received workers' compensation benefit due to mental problems caused by bulling or serious harassment in workplaces. That reveals power harassment as an important social issue. The breakdown of individual civil labour dispute cases in 2014 illustrates that there were the 'bulling and harassment' cases of 62,191 (21.40％), marking the first position for three consecutive years.

According to “the 2014 state of worker’s compensation for brain and heart diseases and mental disorder,” health care workers were in the second position of the number of claims and benefit provision. (Long-term care workers were in the first position.) As for the number of approved cases broken down by events, the majority were in “events which generated a (big) change on their job description and workload” and in “serious harassment, bulling, or violence.
The MHLW conducted a fact-finding survey of power harassment for all professionals in 2012. 80% or more companies thought that the development of anti-power harassment measures was an important management challenge. Yet, only 45.5% of companies implemented actions to prevent and to address harassment in workplaces. Responding to those conditions, the MHLW has started anti-power harassment seminars throughout Japan, promoting actions to prevent and address workplace harassment, and has developed this year for the first time “*the Manual for introducing Anti-Power Harassment Initiatives: Support Guide from Prevention to Post-Harassment Response*.”

2) Harassment in relation to Nurses

According to a survey in 2013, the number of nurses who have experienced power harassment was 8,670 out of 32,000 respondents, exceeding 1/4 of the whole responses. As for who did harassment, a superior of the nursing department marked the highest percentage of 55.2%, followed by physicians, 44.3%, patients, 17.9%, and colleagues, 17.4%. Among those who had faced power harassment from their superior of the nursing department, a higher percentage was in younger nurses. That suggests that a superior’s power harassment may cause young nurses to leave their job.
Even though team-based care is recently promoted in healthcare settings, the fact is that a hierarchy structure still exists, placing physicians at the top of the pyramid. If unsocial verbal statement is expressed at the time of emergency such as patient’s sudden deterioration, then that statement is often considered as a part of a series of patient safety action, not a harassment case. That is a nature of healthcare organizations. Responding to the situation, a national government-affiliated organization has published an awareness raising brochure to make the public understand the state and characteristics of harassment in healthcare and long-term care settings and to show the direction of anti-harassment initiatives at workplace. It is expected this year to hold seminars and deploy instructors in order to promote anti-harassment initiatives.

In **Sweden** ill-health in the community and among members is high and has increased since last year. It is the psychosocial diagnoses that have increased the most, though the underlying causes are not yet described sufficiently. Structural problems and lack of clarity in the organization of work can probably be parts of the causes.
In recent years, attention around the issue has increased. Partly it is because of a notable court case in Sweden, where two top executives in a municipality have been sentenced guilty for causing a social secretary’s illness and suicide (but later acquitted in higher court). The judgment can in the future have major consequences for the employer's responsibility in individual bullying cases and can lead to an altered picture of risks for occupational diseases and the employer's liability for them when it comes to dealing with issues around bullying in the workplace.
On-going research has also highlighted problems with bullying which involves manager's difficulties handling bullying among its employees. Therefore, there are probably also many cases of unreported acts of bullying. Instead of handling the problem of bullying, there are various solutions to buy-outs or to relocate employees. The issue of bullying has also been emphasised by The Swedish Work Environment Authority, who wants a new regulation that widens the employer's responsibility for how to act proactively and how issues should be taken care of in the event of a bullying situation.

4 Universal Health Coverage (UHC) and Human Resources for Health (HRH)

4.1 Impact of UHC

In **Australia** the health care system is multi-faceted and highly complex. It is comprised of public and

private services, service providers and systems infrastructure. Public health services are provided by all levels of government and are underpinned by principles of UHC. The Federal Government funds the "Medicare" system, Australia's universal public health insurance scheme. Medicare was established in 1984 to fund free and/or subsidised treatment by health professionals and free treatment for public patients in public hospitals. Medicare also funds the subsidisation of the costs of approved prescription medicines. A person can opt to have private health insurance in addition to Medicare or just Medicare.

In **Canada**, successful human resources for health planning for achieving universal health coverage specific to the nursing role must consider that

- effective nursing HRH planning is paramount to meeting population health-care needs with universal health coverage;
- an expansion of universal health coverage will increase the demand for health services, given that many services will now be paid for by government, and persons who could not previously afford health services will seek health care; and
- a robust, responsive and stable nursing workforce is essential for ensuring an expansion of health services provided under universal health coverage.

In **Denmark** the Danish Public Health Service is characterised by free and equal access to public health benefits and services but in spite of this, inequality in health is noted as a growing problem. There are significant differences in life expectancy, mortality and illnesses. These differences vary significantly with the length of education, income, profession, social position etc.
With a political proposal DNO especially focuses on this issue. Among other things we suggest that action should be taken to strengthen the efforts to promote health in the field of children and young people in order to be able to intervene at an earlier stage. Furthermore, we work on behalf of more social nurses in hospitals throughout Denmark, as the social nurses in particular are good at bridge-building between the Public Health Service and the rest of the public service and system.

Finland reports that there are socio-economic challenges e.g. inequality seems to increase, public healthcare suffers with long queues and occupational health care is available only for those who are working.

Ireland reports that six years of cutbacks, both in terms of financial and human resources imposed upon the public health service has resulted in dysfunctional health service where emergency department overcrowding, inordinately long delays in accessing healthcare, and intolerable working environments for frontline staff, are the norm.
The Government's proposal for Universal Health Insurance has been recently re-evaluated and revealed to be too expensive and unworkable. It is recognized that no form of UHC is possible unless the financial and human resources are in place to deliver wider access to safer, higher quality health care. As a first step in delivery of UHC, the Minister recently introduced free GP care for children under six years old which will soon be extended to the over 70s.

Japan achieved its universal public insurance system in 1961. Since then, all the people have been able to access necessary healthcare and to choose care facility anytime and anywhere in Japan. As a result the country has attained the longest life expectancy and the lowest infant mortality rate in the world. Healthcare spending is, however, growing in recent years. Particularly, healthcare costs for the elderly over 75 make up 70% of all healthcare expenses with bigger burden on people in productive ages.
For a long time in Japan, the population aging rate was higher in rural areas due to depopulation and lower in Tokyo and other urban cities than average. However, the estimation of growth of the elderly for the next 10 years indicates that the aging population is declining in rural areas while

rapidly rising in urban cities. Local areas are losing population and health human resources as well. On the other hand, urban areas are rapidly gaining aging population, and are facing serious shortage of health and long-term care services including care facilities. Taking into the conditions so far mentioned, Japan is making efforts to remodel the healthcare and long-term care delivery system according to the needs of local regions.

New Zealand reports that NZNO is a member of Action for Children and Youth in Aotearoa (ACYA), which presents the national coalition civil society periodic shadow reports to the UN Committee on the Rights of the Child (UNCROC); 2015 was the 5th periodic review of the UN Committee on the Rights of the Child (UNCROC). Family violence, child poverty and children with disabilities were key themes of the shadow report.
NZNO contributed to *Aotearoa New Zealand's National Plan of Action for the Promotion and Protection of Human Rights* (Human Rights Commission, 2015) specifically in relation to health workforce planning for Māori and Pacific peoples. The Plan was a government commitment arising from the 2013 universal periodic review (UPR).
A high court case taken by Lecretia Searles, a terminally ill human rights lawyer, has prompted widespread civil debate about the right to die and assisted suicide. A parliamentary inquiry seems likely.
The Ministry of Health published its first annual update of the health and disability workforce The Health of the Health Workforce 2013 to 2014 (November, 2014) and a companion document on The Role of Health Workforce Aotearoa NZHWNZ (2014) The former highlighted the need to drastically increase the nursing workforce by 2017, and the latter highlighted HWNZ's role as a workforce facilitator, supporting and leading health sector responses to workforce planning and development (NZNO italics).
A taskforce and work programme has been developed for each of the key workforces – doctors, nurses, midwives, allied health workers, non-regulated workers (kaiāwhina), and those in leadership and managerial roles, with additional projects underway on mental health and the Māori and Pacific workforces. The focus is expected to shift to new models for aged, primary and cancer care, and how individual workforces can combine and align their efforts.
The Ministry of Health does not appear to share NZNO's and the NNO's concern with the high level of dependence on immigration to meet its nursing workforce needs. However, NZNO's research highlighting the need to retain (young) IQN to reduce churn and predicted skills shortages due to retirement, (ref) have resonated with both the Nursing Council of New Zealand (NCNZ) and Immigration New Zealand. NZNO is liaising with both to enhance IQN retention.

Sweden reports that it formally enacted UHC in 1955. The Healthcare system is tax payer- funded and the patient fee is only a small fraction of the actual costs. The fee is largely set by each county or municipality. The fees are however quite similar. People in need of a lot of health care are covered by high-cost protection. When the patient paid a total sum of 1 100 SEK they received a free pass that is valid for the remainder of the 12-month period.
According to the OECD-report "Health at glance" 2013 Sweden had 11.1 practising nurses per 1000 population in year 2011. That was higher than average but still not top 10. Sweden had 34.4 nursing graduates per 1000 nurses in 2011. The OECD-average was 53.7. There is however differences in the country data that is reported to OECD which should be taken into account when comparing countries with each other.
According to SCB (Statistics Sweden) Sweden had 113 860 nurses in year 2012. Less than half, 49 600, were specialist nurses. The agency´s projection shows that the total number of nurses in Sweden will increase to about 138 400 in 2035. The number of specialist nurses will however stay about the same according to the projection. Since mid-1990s the percentage of nurses with specialist education has decreased in Sweden. If nothing is made to prevent this development the percentage of specialist nurses will keep decreasing even more.

SCB´s latest report (2014) also shows there is a shortage of Biomedical Scientists, Doctors, Nurses, Specialist Nurses and Midwives in Sweden. In some healthcare professions there is only a shortage of experienced applicants for example physiotherapists and occupational therapists. The shortage of nurses in Swedish healthcare is the worst in years. Media is regularly reporting about how this affects quality of care, patient safety and the work environment.

4.2 Activities at country level to address UHC & HRH

Australia reports of Abolishment of the proposed GP co-payment**.** While global efforts are being made to encourage nations to develop UHC, the Australian Federal Government has formed a policy platform to introduce co-payments for fully subsidised visits to general practitioners. These intentions, announced as part of the 2014 Federal Budget, would undermine the principles of UHC in Australia. However, in March 2015 the Government dropped its proposed co-payment scheme after significant public backlash including heavy campaigning against it from health professionals.

In **Canada** the Canadian Health Workforce Conference brings together policy-makers, academics, researchers, practitioners and students from across the country with responsibility for and interest in health workforce issues. The goal of the conference is to provide an opportunity to engage in knowledge exchange and meaningful discussion on a range of health workforce issues and showcase the latest research, technology and innovation for health workforce policy, planning and management. The theme of the upcoming 2016 conference is Optimizing the Canadian Health Workforce. CNA is on the planning committee for this conference.
In 2012, there were cuts to the Interim Federal Health Program (IFHP) which provides temporary, basic health care for refugees, protected persons and refugee claimants who are not covered by provincial/territorial health insurance plans. In 2014, the federal court struck down the cuts as unconstitutional, claiming they were a form of "cruel and unusual" treatment. The federal immigration minister was forced to reinstate benefits to these targeted refugees, at least until the government's appeal is heard in October 2015. CNA and CFNU have joined with other concerned groups to demand that the government respect the ruling and drop its appeal, so that refugee claimants would get the health care they require. CNA participated in this year's fourth National Day of Action against the IFHP cuts and press conference.
The Conference Board of Canada released a report, *Understanding Health and Social Services for Seniors in Canada*. Noting that Canada's seniors' population will double between 2009 and 2036, it provides a comprehensive demographic overview and outlines the resulting health-care challenges seniors are facing. The report focused on issues such as wellness and health promotion as well as the huge variation across Canada in health services outside of primary and acute care, including home care, pharmacare, long-term care and palliative care. As documented in CFNU's new report, *Before it's Too Late: A National Plan for Safe Seniors' Care*, the board also describes coverage of some of these health services as "patchy and uncoordinated." This view reinforces CNA's call for the federal government to coordinate the discussion on home care standards across the country while ensuring that all Canadians benefit from an equitable level of home care. It also reinforces CFNU's call for national standards across the continuing care spectrum, recognizing the need for an integrated approach to continuing care.

Denmark: DNO focuses on HRH through two primary fields: Ensuring of the best possible training of nurses and the development of allocating increased competences to more nurses.
The nursing education is at the moment in a revision process synchronously with the other educations of health professionals. It is highly prioritized which is why DNO together with the other trade unions and in co-operation with a consulting bureau and a university has made an extensive report which shows the development and the challenges within the Public Health Service and the future needs for training and competences. It works as a solid basis in the current debate with many

interested parties on how future training should be organised. At the same time the report offers a basis for discussions of the ongoing development of competences and a systematic further training etc.
At the same time DNO continues our targeted work regarding further training and development of competences for nurses – inclusive especially in order to implement more functions for nurses with expanded competences. Within the regional sector there are nurses with expanded competences within almost all specialities. In the municipal sector the number is more limited. In Denmark we have almost no Advanced Nurse Practitioners, but DNO's aim is to achieve a Danish version of Advanced Nurse Practitioners within the whole Public Health Service. At the moment our special focus areas are in the fields of cancer and chronic diseases.
Analysis by the regional authorities indicates that we might experience a lack of nurses in Denmark in 10-15 years which is why the dimensioning of the nurses' training is boosted as from 2015.

Finland: The new social and healthcare service reform is under way. There is also a goal to reduce 300 million euros from the elderly care.

Japan: The attainment of universal public insurance system brought about big benefits to the Japanese people. Hospital beds increased due to the construction rush of new facilities. Yet the country has failed to increase healthcare professionals including physicians and nurses. Consequently, Japan now faces a shortage of healthcare professionals.
While the nurse workforce is growing year by year, Japan is expected to need more nurses with fewer children and population aging. The country is trying to build a quality healthcare provision system and a community-based integrated care structure. Nevertheless, not a large number of nurses (ca.190,000) are working for community-based care settings such as visiting nursing stations, elderly health facilities, special nursing homes, social welfare facilities, and home-based services. They represent only around 13% of entire nurse workforce (including public health nurses and midwives)

Sweden reports as follows:
Commission on Equal Health
The Swedish government has initiated a commission on Equal Health. The Commission will develop strategies to reduce health inequalities in society. The main focus will be health differences connected to socio-economic factors. Gender differences will also be part of the commission's work. The commission shall present its proposals to the government in spring 2017.
Earmarked funds for educating more nurses and midwifes
The Swedish government has announced that they will earmark funding for an expansion of the education for nurses, specialist nurses and midwifes. Normally, it's up to each university to decide how many students they accept after consulting with local employers. When it comes to educating enough people for the healthcare sector the government has found that the decentralised system has not been satisfying.
National initiative for HRH
The government has initiated a national forum for discussion about how to handle the challenges of staff shortage in the healthcare sector. The gatherings will include unions, such as Vårdförbundet, patient organisations and Swedish Association of Local Authorities and Regions among others.

4.3 Organisational activities regarding HRH

Canada reports that in general, where RNs work remains unchanged: 62.4 per cent are employed in hospitals, 15.2 per cent in community health and 8.8 per cent in long-term care. This distribution, however, is not aligned with Canada's health-care needs (i.e., seniors, chronic diseases and community care). CNA believes health services must be shifted to the community and has advocated for such change.

Finland reports that there is a goal to reduce long sick leaves of employees.

In **Japan** *The Future Vision of Nursing* published this year, specifies the JNA's direction for qualitative and quantitative increase of nursing care in communities. JNA expects that a big transformation from institutional care to community-based care will occur. Efforts are necessary to substantially increase nursing workforce in communities by 2025, attracting more nurses into community care.

In **Sweden** Vårdförbundet has developed a concept for nurses´ specialist education where the nurse is employed during the entire education. In brief, the education programme is given by universities on advanced level, with academic progress in nursing throughout the programme. Education goals are regulated by the state. The education itself is designed so that a large part of it takes place on the job, in what is known as 'activity-integrated learning'. The education employments are regulated in collective agreements for the sector.
Vårdförbundet (The Swedish Association of Health Professionals) published a report with an analysis of the staff shortage in the health sector. The report was presented at a seminar where politicians, healthcare leaders and healthcare staff took part in a panel discussion on the issue.

5 Campaigning Activities

5.1 What is happening in your country?

Canada reports that its 42nd federal election must occur by October 19, 2015. However, Prime Minister Stephen Harper can call the election at any time.

In **Finland** citizens have demonstrated against government's aim to reduce fundings related to education and day care and recently against the Government's mandatory labour laws.

In **Denmark** DNO launched a campaign prior to the general elections in the spring of 2015 called *Time for Quality*. The campaign has successfully created a political focus on the fact that the past years of economical pressure on the Public Health Service now also presses the quality of nursing and treatment.
A special effort has been made to support DNO's 5 regional districts in following up the national contact with the press in the local and regional media.
The campaign is not over yet, but we can already note that it has had a great impact, as already during the election campaign a wide range of political parties took up the premise of the campaign that the nurses' enormous pressure of work puts a strain on the quality within the Public Health Service. Central politicians took up the rhetoric of the campaign about a close linkage between time and quality. Both the government and the leading opposition launched extraordinary health proposals including more money and promises to improve e.g. over-crowding in hospitals. Pressure of work in the Public Health Service was the most dominating topic of debate in the election campaign.
Another new campaign *Men can also be Nurses* aims at boosting the awareness among young and grown up Danes that healthcare can also be a trade for men. The target is to break down the prejudice about male nurses and to stimulate more young men to choose healthcare for their career.

5.2 Sharing of successful campaigning activities

Campaigns in Australia
National Campaigns
There are a range of national campaigns of significance to health and the nursing profession being

pursued in Australia. These include:

- ***Australian Border Force Act 2015:*** This year the Federal Government introduced the Australian Border Force Act 2015 that threatens jail for up to two years for health care professionals who disclose information that is deemed 'protected information' under the Act.
- ***Never Alone Campaign against family violence*****:** A campaign to support women and children who have experienced domestic violence.
- ***Penalty Rates Campaign:*** A broad campaign to protect and, where possible, improve penalty rates, allowances and loadings for nurses and midwives.
- ***Lies, cuts and broken promises:*** An ongoing campaign to oppose Federal Government budget cuts of $50 billion and impose new costs to consumers for basic health services
- ***Grad nurses need jobs:*** An ongoing campaign to promote the employment of graduate nurses and midwives.

State Campaigns

There are a range of national campaigns of significance to health and the nursing profession being pursued in Australia. These include:

- **Victoria: *Fight for Our Rights:*** A campaign against nurses and midwives working conditions.
- ***Care before KPIs:*** A campaign to air the grave concerns of Victorian nurses and midwives about care standards being sacrificed in favour of productivity targets.
- **Queensland: *Ratios Save Lives***: A campaign to introduce safe nurse/midwife-to-patient ratios and skill mixes.

Campaigns in Canada CNA's 2015 federal election campaign aims to encourage federal parties and candidates to promote CNA's *Health Is Where the Home Is* approach, which focuses on home care and healthy aging. According to a public opinion poll, nearly 90 per cent of Canadians say it's important that they are able to age at home and have access to health care in a home setting. To meet this goal, CNA aims to galvanize support for three federal recommendations:

- Establish common standards for home health care
- Give more support to family caregivers
- Improve community and home-based health promotion

CNA is using a number of strategies to promote the campaign, including

- hosting town halls in federal ridings that were focused on home health care and healthy aging;
- launching a federal election website; and
- sending a federal election questionnaire to the leaders of the five main federal parties, inquiring about their commitment to home care and healthy aging.

CFNU and all eight of its provincial member affiliates will be registering as third-party advertisers during the election to urge federal candidates to make health care a priority. Working with these members, CFNU is committed to engaging nurses and Canadians to Vote for the Health Care We Deserve. CFNU will call for action by the federal government on four distinct issues, which will all help create a sustainable health-care system that puts patients first:

- A safe seniors' strategy
- A national prescription drug program
- A health human resources plan
- A policy that moves the federal government toward a commitment to fund 25 per cent of the cost of health care by 2025

Across the country, CFNU members have been engaged in various campaigning efforts to raise awareness on issues of importance to nurses and health care.

Campaigns in Finland:

- ***FNA's proposal for the Government Program*.** Before the parliamentary election FNA came out with the own proposal for the Government Program.
- ***Thank nurses campaign.*** During the Nurses Day FNA launched Thank nurses campaign where everyone could thank nurses.
- **SuomiAreena**
  SuomiAreena is a political conversation forum. FNA participated the event by organizing the debate over robotics in healthcare, taking part in the discussions and holding a booth at the civil market where anyone could pop up and had their blood pressure or blood sugar tested.

Campaigns in Ireland:

NMBI – Retention Free Campaign

In 2014, the NMBI announced that with effect from 2014 the annual retention fee for nurses and midwives would be increased by 50%. In 2015, following a six-month long campaign led by the INMO, the NMBI board decided to reverse its previous decision and restore the €100 fee.

Safe Staffing Campaign

In 2014, as a direct result of the INMO Safe Staffing Campaign, the Minister for Health established a special Taskforce on nurse staffing and skill-mix. The report of the Taskforce will issue shortly. The critical shortage of midwives has also been highlighted by the INMO. The current maternity services require over 500 extra midwives to bring our staffing levels up to international norms.

Patients First Campaign

The INMO was active throughout 2014 in activating patient groups to lobby to end the constant underfunding of health services and to push for a period of investment to meet public demand for healthcare.

Campaigns in Japan:

- **Awareness Raising for Dementia Care**
  In relation to the New Orange Plan, the national measures against dementia described in the section 1-2, the JNA took up dementia care as a topic for a session at the JNA's Annual General Convention in 2015, presenting a lecture titled "JNA Initiatives for the Future of Dementia Nursing." In the presentation, the JNA called out to nurses throughout Japan as follows:
  Nurses' sustainable support is critical for people with dementia.With initiatives for dementia nursing, JNA aims to create a society in which people with dementia and their families can continue to live their lives comfortably in their familiar communities. Provision of quality dementia care in community requires the creation of more robust nursing structures for dementia and collaboration with other healthcare professionals.
- **Awareness Raising for Nursing**
  JNA has been conducting a variety of events on Nursing Day, May 12 under the main theme "Heart of Nursing to Heart of Everyone." The Events are both for the general public and for nurses throughout Japan. On the Nursing Day every year, JNA sells a Nurse Kitty (a stuffy animal). A Nurse Kitty is made with the theme relevant to the year's nursing events. The 2015 Nurse Kitty is based on the theme of a midwife: The ICM Asia Pacific Regional Conference was held in Japan (Yokohama) in July. And in August, JNA has started the Clinical Ladder of Competencies for Midwifery Practice (CLoCMiP) to certify clinical competencies of midwifery.
- **Initiatives for Work Life Balance (WLB) Promotion**
  JNA has been running WLB promotion initiatives. One of them has a costume of the WLB symbol character Kango-zaurus to be used by prefecture nursing associations for their PR activities. The association has also held an award ceremony of "Kango-zaurus Prize,"

commending healthcare facilities which attended the Nurse WLB Promotion Workshops for three consecutive years and made efforts to promote WLB in their workplace.

Campaigns in New Zealand:

- **All the Way with Equal Pay** – a joint litigation campaign with the Service and Food Workers Union in support of Kristine Bartlett's case for equal pay and pay equity; 2745 legal claims have been filed with the Employment Relations Authority. A supplementary web based campaign directed primarily at women MPs *We're relying on you* to support "pay for jobs not gender" is being developed.
- **Trans Pacific Partnership Agreement** – a broadly based civil, union and health sector campaign to oppose the TPPA because of the risks it poses to PHARMAC, national tobacco regulations, regulations governing the emergence of generic drugs and controls over food imports by transnational corporations. A number of national protests marches and rallies have been held, along with consistent government and political party lobbying, media engagement etc.
- **Care Point** – an NZNO campaign to implement care capacity demand management (CCDM) in all DHBs, using the TrendCare™ tool. A significant focus of the campaign has been on optimising the new DHB MECA provisions around the environment of CCDM, including building strong partnerships with stakeholder groups, influencing leadership development, and building our own capacity by upskilling staff, delegates and members.
- **Health and safety** – a cross union campaign against proposed changes to the Health and Safety Reform Bill which reduce the participation and representation of employees on health and safety committees. The campaign is strongly focused on lobbying, with member delegations seeing government and political representatives.
- **New Grads** - Full employment for nurse graduates. This highly successful online social media campaign garnered 8000 member signatures (15% NZNO membership) within 8 days for a petition, subsequently presented to parliament. The media impact was significant, and increased funding for the nursing graduates entry into practice programme was made available soon after. The campaign was very strongly supported by young nurses, and was the first 'political' action for some.
- **Go Purple** – NZNO's DHB MECA campaign engaging members in the process of improving their pay and working conditions. The DHB MECA sets the employment standards for nurses which are referenced by other CAs.

Campaigns in Sweden:

- **The "two musts in healthcare policy"**
  In Sweden, Vårdförbundet has continued lobbying for "two musts in healthcare policy" in order to articulate what is necessary in order to create better, safer, and more effective health care. The "two musts in healthcare policy" are the following:
  - Safeguarding the supply of skills - addressing the staff shortages in the health and social care sector.
  - Combining the care for each person - decreasing the number of individual services that people need to access when they are suffering from complex conditions and creating a more person-centred healthcare system.
- **Refer a colleague**
  During May we conducted the campaign "Refer a colleague". All members were invited to speak to colleagues who are not yet members and to offer them membership. Both those who refer a member and the ones which becomes a member receive a cinema ticket. The campaign is spread via our magazine, Facebook, Instagram, newsletters and posters in the workplace.

- **Health care managers**
  In recent years, Vårdförbundet has worked to shape, concretize and develop our offer to members who work as managers and leaders in healthcare. From initially being a project, we have from 2015 formed an own sub organization for managers.

6 Retention

6.1 Initiatives to keep nurses in the profession

In **Australia** the retention of nurses in the health workforce continues to be identified by Health Workforce Australia (HWA) as a key factor in abating potential workforce shortages. This includes student retention, as the current estimated overall student attrition rate for RN students in Australia is 34%, which ranges between 18% to 54%. In their 2014 report, HWA reiterate that key strategies to support nurse retention need to involve supporting and enhancing nursing leadership, professional satisfaction and professional development.

Canada reports that nursing retention in Canada is influenced by many factors such as age, supply (absenteeism and overtime), geography, contract flexibility, educational support and career expectations related to generational experiences. Between 2005 and 2014 more than 80 per cent of regulated nurses remained in the same workplace setting from one year to the next. The highest retention rates were in the hospital setting, at close to 90 per cent for regulated nurses. This figure included of RNs/NPs (87 per cent), LPNs (85 per cent) and RPNs (more than 80 per cent). Retention in community health and nursing home/long-term care settings was lower but typically remained above 80 per cent.
The nursing workforce in Canada is aging. 40 per cent of RNs are 50 or older and nearing retirement while almost 26 per cent are 55 and older and on the cusp of retirement. The number of nurses not renewing their licence is greater than those obtaining one, which means that there are fewer nurses in the supply for employers to draw from. In light of this data on aging and the tightening nursing supply, CFNU has renewed its call for a national health human resources plan.
In response to having more nurses nearing retirement, a tighter labour market and increased rates of absenteeism and overtime — coupled with a 46 per cent higher vacancy rate in Canada's rural and remote communities — it is also paramount that nursing retention and recruitment initiatives include educational support. Improving educational support for nurses, specifically in First Nations communities and for aboriginal post-secondary learners, could strengthen the retention and recruitment of aboriginal nurses in remote communities. In response to increasing vacancy rates in the North, the federal government implemented a nursing retention and recruitment strategy. This strategy seeks to provide a stable nursing workforce and increase the government's capacity to access training opportunities while ensuring that the needs of the communities are met. Among its elements is the federal First Nations and Inuit Health Branch's new nursing careers web content, which highlights links and resources for nurses looking for a career in remote and/or isolated communities.

In **Denmark** DNO does not currently have major specific and special initiatives in order to keep nurses in the profession. However, the many already mentioned priorities with respect to work conditions, wage strategies and others in the 2015-rounds of general agreements are of importance with respect to the retention in the profession and as members of DNO. We have a relatively high proportion of organised membership but are also continuously focusing heavily on the maintenance thereof. The nursing profession is popular as ever, but the regional authorities now expect a shortage of nurses in 10-15 years. In the annex on nursing data DNO is on the same line with judgements of short term balance combined with shortages in 5-10 years.
DNO in general aims at being close to the members and their problems at work and in their daily life.

As an example DNO in springtime this year has launched a new campaign concerning individual career advisory and consultations to members on possibilities and development in job functions or in further education and training for nurses. DNO expects that the campaign will be successful but it is still too early to give a precise picture of how much it will be used by our members.

In **Finland** those who are able to work only partly are trying to keep at work. Pension reform will enter into force in 2017. The current system is valid in all respects until the end of 2016. Changes in the pension reform agreement are:

- Pension will rise by 2027 progressively to 65 years of age (from 2018).
- The current part-time pension will disappear and will be replaced by a partial early retirement pension. Old-age pension can be taken to pay either 25% or 50% of the accumulated pension as early as 61 years of age.
- Pension accrues after a transitional period for all ages 1.5 per cent per annum from 17 years of age. Pension accrues full salary and the employee pension contribution will no longer be deducted from the pensionable earnings.
- Each comes with its own target retirement age, which compensates for the effect of the life expectancy coefficient.
- Working after the minimum retirement age to increase the achievement of the pension by 0.4 percent per month (postponement increase).
- Heavy-employed people can retire before the official retirement age of 63 years of age, if they are behind at least 38 years of work physically or mentally heavy work and their ability to work is impaired (working lives of the pension).
-

Ireland reports that over last six years, no initiatives have been put in place to retain nurses and midwives. Since the acknowledgement by the Department of Health and HSE that there is a chronic nursing and midwifery shortage several initiatives have been put in place to retain and recruit nurses and midwives. The graduate programme which saw newly qualified nurses and midwives on reduced salaries has been shelved; the HSE has converted fixed-term and agency staff to permanent posts; and an international recruitment campaign is due to commence in the foreseeable future.

Japan reports that it is dispensable to create positive practice environments in order for nurses to continue to work in good health. Right now the nation-wide efforts are progressing on the bases of the Medical Care Act amended in 2014. Ahead of actions led by the national government, JNA initiated in 2007, a project 'Nurse WLB (Work Life Balance) Promotion Workshop.' JNA published *Guidelines on Night-shift and Shift Work for Nurses* in 2013. Since then, JNA has been making efforts to disseminate *the Guidelines* in order to help nurses ease their shift work burden.
As the average age of nurse workforce exceeds 40, more nurses are expected to work with long-term care duties for their family. JNA is requesting the national government to require employers to allow their employees to work shorter hours when they have to handle both their work and family nursing care duties ('Measures to Shorten Work Hours for Family Nursing Care').
Many nurses leave their job because of childbirth and childcare duties in Japan. Once resigned, it is hard to find a new work place where they can handle both their work and childcare duties. Out of 2 million qualified nurses around 710,000 are voluntarily unemployed. When the notification system will start nurses are supposed to notify their employment status to their nurse center. The system is expected to prevent nurses to be voluntarily unemployed by extending them easier access to job placement information.

In **New Zealand** retention, of both locally and internationally qualified nurses, is a significant issue for Aotearoa New Zealand, which finds it difficult to compete in the global market for health professionals, particularly with the proximity of Australia. The NNO suggests that implementing new

models of care (including education) that fully utilise nursing skills, and ensuring safe healthy workplaces are necessary to improve nurse retention.

Sweden reports that nurses themselves are expected to fund their specialist training has led to a decreasing number of specialist nurses in Sweden during the last 20 years. Vårdförbundet has therefore proposed and are lobbying for the introduction of a model that can secure the supply of expertise and make healthcare better, safer and more efficient.

7 Lobbying

7.1 Strategies and skills

Australia reports that the intent of lobbying and advocacy activity will vary greatly depending on context. However, regardless of its purposes, the effectiveness of lobbying and advocacy activity will be dependent on activists having a sound strategy, a comprehensive knowledge base and well-honed communication skills.
Effective lobbying and/or advocacy require activists to have a strong subject knowledge base. Nurses seeking reform or change must have a comprehensive understanding of the facts of the problem or issue they seek to address.
An understanding of the people or groups who are the target of lobbying and/or advocacy is essential. Knowing who the decision makers, stakeholders, opinion makers, potential collaborators and proponents are will positively inform the development of strategies and plans. Also important is targeting those most opposed to change to encourage their flexibility around the issue.

Canada reports that CNA and CFNU are pleased to report that Canada's nurses have shown a greater willingness to become engaged in political discussions, particularly around protecting our public health-care system, which faces ever-increasing threats. The Ontario provincial election was a good example of nurses unions engaging directly with their members to work for better health care. ONA worked both collectively with organizations and directly with their members to raise the issue of nurse shortages and potential cuts to health-care services.
CFNU produced and presented three expert reports to the federal leadership candidates for the three major parties and to provincial/territorial leadership:

- *Before It's Too Late: A National Plan for Safe Seniors' Care*
- *A Roadmap to a Rational Pharmacare Policy*
- *The Canada Health Transfer Disconnect: An Aging Population, Rising Health Care Costs, and a Shrinking Federal Role in Funding*

CFNU has offered a members' workshop to help train nurses on effectively lobbying their local federal candidates on health-care issues, and CNA is engaging governments and RNs in a number of ways, including conducting an annual CNA Lobby Day on Parliament Hill, attending meet and greets, visiting candidates and members of Parliament, holding pre-election meetings with key parliamentarians and staff, hosting town hall meetings to both promote and ensure that CNA recommendations are considered in party platforms, making formal submissions for party platforms, launching an election campaign website, using of print and social media vehicles to promote election issues, publishing articles in *Canadian Nurse* magazine and in CNA Now before and during the election campaign, participating in a press conference and in joint op-ed/media opportunities with CFNU and other associations and stakeholders and promoting its Health in All Policies online toolkit, designed to help people systematically consider how policy decisions may affect the health of a population.

Denmark reports that DNO have succeeded in involving members in the political development work. DNO has held workshops in order to involve the members prior to our political work in the field of

health policy, e.g. dementia, psychiatry and urgency functions at hospitals.

In **Finland** during the parliamentary elections both FNA and Tehy supported nurse candidates by publishing their advertisements. FNA and Tehy came out with their proposals for the Government Program.

Ireland reports that from September 1st the Irish Government will require all people involved in lobbying to register with the Standards Commission. People who register will be required to provide the Standards Commission with records of all lobbying activities from 1st September to 31st December 2015. By 21st January 2016 it will be compulsory to be registered with the commission if you are engaged in lobbying activity and you must provide returns of your activities for the first three months of operation of the Act.
The INMO has been engaged in forms of lobbying throughout the years. The lobbying conducted is usually at two levels. Firstly, as part of the campaigning on particular issues, the organization often calls on members to lobby their local politicians. The second level of lobbying, which the organization engages in, is at General Secretary level where the General Secretary would have access, on a regular basis, to the Minister for Health's senior Civil Servants.
Finally, nursing organisations probably need to invest greater resources internationally into lobbying activities.

Japan reports that the basic position of JNA is to realize nursing policies through a ruling party in the Japanese national politics. The association is lobbying both ruling and opposition parties. JNA is lobbying in the national politics while prefecture nursing associations in local politics. In lobbying activities, the Japanese Nursing Federation (JNF) collaborates with its local organizations when necessary. JNA developed JNF in 1959 as JNA's political body. We are lobbying the Diet members of not only ruling but also opposition parties when they will deliberate bills relevant to nursing and nurses in the national government. Yet it is effective for local members of prefecture nursing associations and JNF's local organizations to try to influence on politicians elected in their constituencies.

New Zealand reports that NZNO lobbies formally through submissions, and oral submissions, regular meetings with the Minister of Health, Director-General of Health; and issues based meetings with various Ministries, the national health board, and political parties. NZNO has a strong focus on advocacy and support of nursing representatives across the sector and at all levels.
NZNO is an affiliate of the New Zealand Council of Trade Unions, T*e Kauae Kaimahi* (CTU) and is active member of the CTU Women's, Health, health and Safety and Environmental Committees. NZNO also works through the formal structured relationships between unions, the government and DHBs i.e. Health Sector Relationship Agreement and Bipartite Action Group.
NZNO enjoys strong and productive relationships with other health practitioner groups, the Public Health Association, and NGOs such as Public Good, Aged Concern, and the Child Action Poverty Group, which often leads to collective action.

7.2 How to get nurses involved in politics

Australia reports that engaging nurses in politics hinges on inviting them to participate in collective action on matters of personal and professional relevance to them. While nurses globally are the most numerous of health professionals, their political influence tends not to reflect their predominance across health systems. Nurses can be encouraged to: write letters; undertake professional representation; contribute to submission development; seek stakeholder meetings and to participate in various ways to support campaigns. Nurses can take direct or indirect action to get involved in politics. Direct action could take the form of writing to a local government official or representative

in relation to an issue. Indirect action could be providing information to inform the work of a nursing organisation such as data or research on frontline professional activity.

In **Canada** CNA uses various communications vehicles to get nurses involved in politics such as *Canadian Nurse* magazine*,* CNA Now, the *CNA Now e-Update*, Twitter and Facebook. In addition, the organization collaborates regularly with its speciality nursing group members and invites them to contribute or present to various political committees as external representatives. CNA also monitors government bills and research studies and notifies its jurisdictional members of political issues pertinent to nurses, the profession and the health of Canadians.

Denmark reports that DNO is in an ongoing dialogue with nurses organised in DNO's subsectors which are organised in a long range of specialised fields within healthcare and nursing. They function as sparring partners and bridge-builders between the health professional problems that our members meet and the political work of the organisation.
DNO has used the members' personal stories as part of the input in the public debate on the pressure of work on the personnel in the Danish hospitals. Thus, we have succeeded in communicating the personal experiences of the members from their working lives, directly to the politicians.

Japan reports that they need to generate nurse-politicians in both national and local politics. Now there are four nurse national Diet members: one male and three female members as of July, 2015. JNA nominated them as candidates and JNF led their election campaigns. Then they were elected as nurse-Diet lawmakers. All those are also LDP members. One of those nurse-politicians elected in the last general election in December 2014 was a former policy secretary for JNA.
Nurse-politicians' role is to contribute to the realization of nursing policy. The challenge is how to give the organizational support for them to succeed in policy making relevant to nursing and nurses. JNA is also required to build further its own political power as well as capacity for policy development. At the same time the association needs to train human resources who are involved in policy development/ recommendation.

7.3 When to get nurses involved in politics

Australia reports that to maintain influence in constantly evolving health systems, nurses need to be engaged with politics and policy development on an ongoing basis. It is essential that the nursing profession is constantly attuned to political activity through political monitoring as well as through direct action when required. This is particularly crucial to ensuring nurses have a say in how the profession is shaped and its place in the health care system. The profession should continuously participate in the political arena through making submissions to government and other relevant organisations and by seeking to build relationships with government representatives and decision influencers. Nurses also need to be prepared to take more immediate action in response to emerging and unpredicted political and/or social events of a high level of interest and concern to the profession. This may be in the form of a strategic campaign.

Canada reports that it is important to get nurses involved in politics early and continuously. Engaging nursing students creates an essential foundation for later participation in such events as election campaigns, the discussion and passage of government bills, and responses to media coverage and current events.

Denmark reports that members continuously participate in the organisational work, e.g. at our congress where we establish the strategy, targets and political direction of the organisation. In addition, every year a broad delegation of the members represent the DNO at democratic events as

the yearly *Folkemøde* on the island of Bornholm – a political festival for citizens, NGO's and politicians. Also many Danish nurses and members participated with DNO at the ICN Conference in Seoul.

8 Getting nurses involved in political action- ratification of ILO Convention 149

8.1 Actions taken or history regarding Attempts to ratify C149

Canada reports that it has been a member of the International Labour Organization (ILO) since 1919. In Geneva, at the 63rd session (21 Jun 1977) the ILO adopted C149-Nursing Personnel Convention, 1977 (No. 149) *Convention concerning Employment and Conditions of Work and Life of Nursing Personnel (Entry into force: 11 Jul 1979).* Out of the 41 ratifications of C149 to date, Canada has not ratified.

Finland reports that it became a member of the International Labour Organization (ILO) in 1920. In 1979 Finland was one of the countries that ratified ILO Convention 149. Convention concerned Employment and Conditions of Work and Life of Nursing Personnel.

In **Japan** JNA had high hopes for C149, the association sent to the International Council of Nurses (ICN) as well as the International Labour Organization (ILO) its opinion in 1976 one year before C149 was adopted. After the convention was adopted in 1977, JNA actively engaged a variety of campaigns including dialogue meetings with citizens and signature collection. Although the campaigns for the ratification of C149 continued to the 1990s, over 20 years had already passed without actual ratification. At that time there was concern that the staggering ratification campaign would lead to eroding the entire movement for nurses' better working conditions. JNA decided at the 2000 General Convention, to change its action policy to remove 'promoting the ratification of C149,' shifting its course toward actions to solve individual and concrete labour issues. The Government of Japan is stating why Japan has not ratified C149 as follows:
"As C149 says that 'nursing personnel shall enjoy conditions at least equivalent to those of other workers in the country concerned,' Japan has almost realized the condition by the provisions of the Labor Standards Law and other relevant legal acts. However the country allows for nurses to work under less favorable conditions than other workers: for example health and medical care facilities are exempted from the rules for Simultaneous Rest Periods, and small workplaces with fewer than ten workers such as clinics, birth centres and visiting nursing stations have a 44 hour week as legal working hour."
The Japanese government has a position that international conventions should be ratified after the domestic working conditions have become ready. Therefore, we cannot expect that the ratification of C149 will come in a short period of time.

In **Sweden** the Convention was adopted at ILO IN 1977 by 332 votes for, non against and 64 abstentions. The Recommendations were adopted by 363 votes, non against and 36 abstentions. The Swedish ILO Committee, with representation in the same way as in ILO gave their recommendations to the government. Vårdförbundet was invited to give the point of view as well as the Confederation we belong to, namely TCO. The National Board of Health and Welfare considered the Convention already to be fully functioning as it is. Both the employer side as the employee agreed without any major objections. It was ratified by the Swedish Government 10 July 1978.

If Successful what enabled the ratification
Japan reports that they are not able to do the assessment. JNA has suspended the campaign for the

ratification of C149. If JNA will start the campaign again, there is a need to discuss the cost and expected outcomes.