New Zealand Nurses Organisation

Submission to the 2025 Taskforce

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ABOUT NZNO

The New Zealand Nurses Organisation (NZNO) is the leading professional body of nurses and nursing union in Aotearoa New Zealand, representing over 46,000 nurses, midwives, students, kaimahi hauroa and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.

The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to contribute to the 2025 Taskforce Committee’s deliberations on ways to improve Aotearoa’s productivity in order to close the income gap with Australia by 2025.

2. NZNO has consulted with its members and staff, particularly professional nursing, policy, research and industrial advisers and members of our 23 specialist colleges and Sections. We have also consulted with other health professional groups.

3. As a member of the New Zealand Council of Trade Unions, we endorse the NZCTU submission and, in particular, the conclusions to be drawn from the consequences of neo-liberalist policies pursued in the 1980’s and 1990’s
which, globally, led to economic disaster and, nationally, transformed our traditionally egalitarian, socially responsible, fair kiwi society into one with growing disparities, where wealth and opportunity are concentrated in fewer hands.

4. As the leading professional body of nurses, the largest sector of the health workforce delivering frontline health services in residential, hospital and community settings, our submission focuses on the health sector and the potential of nursing services to provide skilled and cost effective health care to improve the health, and the productivity, of all New Zealanders.

5. NZNO strongly rejects the Taskforce’s short-sighted recommendations for Health in the first Report, namely:

   - “A funder-provider model should be reintroduced in the hospital sector, allowing much greater private sector involvement in the provision of taxpayer-funded services.
   - Universal (unrelated to income or health status) subsidies for doctors’ visits should be abolished.
   - Subsidies for prescription pharmaceuticals should be substantially reduced, with those in generally good health and not on low incomes paying the full price up to a cap”

6. We believe the Taskforce has failed to grasp the importance of investment in health as a means of increasing productivity and reducing demand for services, in spite of acknowledging “the very large number of people of working age currently receiving welfare benefits”. We advise that even small improvements in health (a decline in disability rates of 0.5 percent per year across all age groups in New Zealand, for example) could offset about one-third of the projected extra health care costs from population ageing; faster
declines would produce a larger offset.  That is a large return on a small investment.

7. Our members, most of whom have been working in the health sector in New Zealand for the past twenty years, have experienced the results of privatisation, deregulation and ‘user pays’ in the health sector and believes that the Taskforce’s recommendations will only serve to increase disparities, put more pressure on the overloaded public health system, and ensure that more people do not have access to the services they need to manage their health care needs and continue to function as contributing members of society.

8. We strongly dispute the concept that greater private sector involvement will increase either health service quality or productivity because our experience with the largely privatised aged care sector proves quite the opposite: privatisation has increased the burden on the public health sector, undermined the health workforce, particularly the nursing workforce, and compromised the equitable pay and employment conditions of a developed economy, encouraging outward migration of New Zealand trained health professionals and inward, very temporary, migration of overseas health workers.

9. We note that most health workforce education and training and complex care is publicly funded; yet private providers, who benefit from a ready trained workforce, and, increasingly, from providing a wide range of publicly funded services do not contribute to either.

10. Accessible, quality public health services are fundamental to improving productivity across the population and reducing demand for expensive remedial services.

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11. NZNO would like the opportunity to make an oral submission to the Taskforce, in particular to detail some recommendations regarding more effective and safe use of limited health workforce resources.

12. A monograph by Teresa O'Connor, co-editor *Kai Tiaki Nursing New Zealand*, discussing Nursing’s contribution to productivity is appended (Appendix One).

**DISCUSSION**

13. The majority of New Zealand’s nurses are in the latter half of their careers - the Nursing Council of New Zealand (NCNZ) 2009 Annual Report gives the average age for RNs as 46.44 years, with nurses aged 46-55 being the largest age category, and some nurses working past the age of retirement. Thus within the staff and members of NZNO, there is extensive first hand experience of the effect that globalisation and major health restructuring over the past twenty or so years has had on health outcomes, and the quality and sustainability of New Zealand’s health workforce.

14. We have seen gains with the major shift towards primary care with the goal of increasing the health status of all New Zealanders and reducing health disparities. This was a sensible response to the change in health needs over the past century from acute emergency care and infection control services to preventing and managing chronic diseases. District Health Board funding is tied to the provision of health and disability services for all people in their regions and has prompted initiatives to reduce the incidence of cancer, obesity, diabetes and cardiovascular disease, manage care of chronic disease and promote wellness.

15. The Taskforce’s recommendations in the first Report do not recognise the value of increasing community levels of health and wellness; the recommendations focus solely on a medical disease-focused model – seeing GPs, getting surgery, buying drugs, all of which are exclusive by means of cost or access to a significant number of people. There are areas in Aotearoa where are no GPs to register with; to be eligible for elective surgery one must
hat least have accessed primary care, yet we know there are many who do not or cannot – adolescents, ethnic minorities, the poor, unemployed, and elderly, those with mobility issues. These people are invisible until they turn up in emergency departments, where the care they must be given is vastly more expensive and often more disabling in the long term than it needed to be. Untreated diabetes can lead to amputation, for example; a chronic asthma attack means a hospital stay and many days off work. It is simply and obviously cost effective to ensure that people are kept as healthy as possible by ensuring they have timely access to affordable care which, for many chronic diseases can be provided safety and effectively by skilled and qualified registered nurses. An excellent example is the nurse-led respiratory clinic at Hutt Hospital\(^2\) which within a short space of time reduced waiting times to see a specialist from two years to zero and has provided a greatly improved service to much larger numbers of patients.

16. However there are still regulatory and legislative barriers which prevent sensible utilisation of practitioners and the Taskforce would do well to concentrate on these.

**Reducing disparities**

17. Aotearoa is not the only country to question the effect of the monetarist policies implemented in the 1980’s and 1990’s, which the Taskforce, with its focus on deregulation, reducing government spending on public health education and infrastructure, and increasing privatisation seems intent on

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\(^2\) **Nurse-led Respiratory Clinics at Hutt Hospital** Before 2000, Hutt Hospital had a physician-led respiratory service, providing four clinics a week. Its one- to two-year waiting list consisted predominantly of Chronic Obstructive Airways Disease (COPD) patients awaiting assessment. Many of these patients could not afford to travel to Wellington Hospital. After the resignation of the respiratory physician, a suitable replacement could not be found. An initial pilot was developed and launched in which a respiratory project nurse pre-assessed and reviewed wait-listed patients. Three years on, there are three part-time nurses providing assessment and education clinics in hospital wards, outpatient clinics and patients’ homes. The assessment clinics provide immediate access to diagnostic tools such as blood tests, chest X-rays and scans, allowing for quicker diagnosis and more timely management.
pursuing. We draw your attention to a recent paper from the Canadian Centre for Policy Alternatives which identifies similar adverse outcomes for the majority of the Canadian population\(^3\) which did not deliver prosperity, or increased productivity, but instead brought, for example:

- “a huge tax shift -- from corporations to households, from richer people to poorer ones; from taxing incomes to taxing spending; from taxing income flows from savings and capital gains to shielding those forms of income;
- a vastly smaller safety net, and more expensive basic services like education and housing;
- greater inequality: the bottom 40% of Canadian families raising kids are worse off now than their predecessors 30 years ago, though they are better educated and working more; only the top 10% have seen significant gains;
- record household indebtedness;
- less regulation and oversight on investments and credit creation;
- more foreign ownership of our enterprises; and
- economic collapse.”

18. Enhanced disparities created by such misguided policies as these are not only barriers to productivity, they are antithetical to the egalitarian principles of fairness and social responsibility embedded in our political and social structures and are perhaps most clearly articulated in the Woodhouse principles upon which the world-leading ACC social contract was based.

19. It is notable that ‘reducing disparities’ seems to have disappeared from the Ministry of health’s lexicon, yet clearly the provision of “better, sooner more convenient” health services should not be aimed just at those who can afford them? The very arguments used to justify health spending cuts – that there

are too few working people to meet the growing cost of health care with a larger elderly population – support increased health spending and equitable public provision of health services to ensure that those that are working, whether they have asthma, diabetes, or heart diseases, are supported to work, and those that are not working are kept as healthy as possible for as long as possible.

20. NZNO recommends that the Taskforce re-examine the Woodhouse principles and advocate policies based on them.

**Government investment in health**

21. Just as good employment practices such as investing in employer training, safety, and retention strategies are good for business (Department of Labour, 2003); investment in public health enhances productivity, while failure to invest reduces it.

22. We draw the Taskforce’s attention to a paper by Lyndon Keene (2010) which cites World Health Organisation (WHO) data which, in general, points to a correspondence between a 1.1 year gain in healthy life expectancy corresponding to a every $100 (“international $”) per capita spent on health. “Furthermore, as average levels of health expenditure per capita increase, healthy life expectancy increases at a greater rate than total life expectancy. In New Zealand’s case, according to the WHO, total life expectancy at birth increased by two years between 2000 and 2007, while healthy life expectancy increased by nearly three years. (Ministry of Health figures show a similar trend, though at lesser rates)4.

23. A Ministry of Health study published last year shows that about a third of the increase in life expectancy is a direct result of better health care, especially for diseases such as stroke, diabetes, heart disease and certain cancers.5

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24. Recent health figures show, for example, that:

- improvements in diabetes management have resulted in a drop in the number of people with diabetes admitted to hospital with acute coronary syndromes since 2002, in spite of marked increases in the number of people with diabetes, who are all at increased risk of cardiovascular disease;\(^6\)

- deaths from cardiovascular disease (heart, blood vessel disease and stroke, which is the greatest cause of disability in older people) fell by 35% between 1996 and 2006;\(^7\)

- five-year cancer survival rates, a direct measure of the effectiveness of the health system in treating cancer, have increased by 5%-6% percent for colorectal, breast and cervical cancers and nearly 13% for prostate cancer between 1997/98 and 2005/06; and

- from 2001 to 2006 self-reported disability (through illness and injury) fell by 8% for New Zealanders aged 65 and over and by 11% for all age groups.\(^8\)

25. While New Zealanders are getting older, we also appear to be getting healthier and less dependent in older age, and this is attributable in part to the increased investment in health. This is an important development in the debate about today’s health expenditure and meeting the challenges of an ageing population, given the widespread consensus that projected future health care costs can be mitigated by keeping individuals in good health.\(^9\) It has been estimated that even small improvements in health (a decline in disability rates of 0.5% per year across all age groups in New Zealand) could offset about one-third of the projected extra health care costs resulting from

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\(^7\) Annual Report 2009. Ministry of Health

\(^8\) 2006 Disability Survey, Statistics New Zealand.

population ageing. Faster declines would produce a larger offset\(^{10}\) (Keene, 2010).

26. The greatest benefit from healthcare spending comes from that directed at the young because of the increased life over which the benefits are gained (Cutler et al, 2006); note that changes to health in this dependent age group have to be mediated through public health strategies and addressing the social determinants of health.

27. While there are cuts to publicly funded primary health care services, cuts to Accident Compensation Corporation (ACC) limiting prevention of injury and rehabilitation programmes, barriers to the efficient use of skilled health practitioners and poorly integrated health, education and social support services, more New Zealanders, particularly young ones, will simply fail to reach their potential or worse, unnecessarily populate hospitals and prisons.

28. The evidence indicates that the Taskforce should be recommending increased investment in health spending, especially on the young.

**Privatisation**

29. We strongly dispute the concept that greater private sector involvement will increase either quality or productivity because our experience with the largely privatised aged care sector proves quite the opposite. (Note our submission to the Health Select committee on the Report of the office of the Auditor-General on the Effectiveness of Standards of Care for Rest Homes)

30. Certainly privatisation has increased overseas interest in ‘investing’ in aged care facilities, and taking the profits from publicly, as well as privately, funded residents and patients offshore. At the same time, however, they have refused to staff such facilities with the right numbers and skill-mix to meet even the minimum voluntary standards (NZ Standards Minimum indicators for Safe Aged Care and Dementia Care for New Zealand Consumers), the consequences of which are clearly reflected in the numerous high profile

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reports from Coroners, the Health and Disability Commissioner and in the media. Public safety has clearly been compromised.

31. Less obvious is:

- the undermining of the New Zealand nursing workforce, virtually excluded from caring for a significant sector of the population;
- the recruitment and, at times, exploitation of migrant nurses who fail New Zealand registration, and work as health care assistants (HCAs) for $13.00 p hr which has adversely affected industrial relations; and
- the pressure put on *publicly funded* emergency departments and hospital wards dealing with medication errors, pressure sores, and other problems resulting from inadequate care due to inadequate staffing.

32. Privatisation of aged care, without adequate regulation for standards of care and protection, has benefited shareholders but at a huge cost to some individuals and risk to the public health system and our employment environment.

33. Many aged facilities are staffed by overseas trained nurses often working as HCAs, undervaluing their skills and that of New Zealand nurses, who often choose not to work in aged care facilities because they are paid less for vastly more responsibility. RNS in aged care facilities in charge of the care of as many as 60+ patients, and direction of several enrolled nurses and supervision of HCAs. Under the HPCAA, the RN is responsible for the work of the latter; however s/he doesn’t even have to be on site. Many facilities advertise they have an RN on site 24 hours and hospital facilities; few actually live up to that promise.

34. We strongly suggest the Taskforce examine what has happened in the Aged care sector over the past 30 years and how the standards of care, employment, and safety compare with the public health counterparts, before recommending increased privatisation.
35. We note that most health workforce education and training and the bulk of services for the management of chronic care and complex treatment are publicly funded. Elective procedures (though we hesitate to use the term when treatment for a prolapsed uterus can be deemed ‘elective’) are generally more straightforward and amenable to planning and it is hardly surprising that such low risk, large volume procedures are increasingly performed by private providers whose surgeons are generally publicly trained, but are not available. However, by definition, they are only available to those who already have access to primary care; this is scarcely equitable and yet current policy is to increase funding for ‘elective’ surgery.

36. Similarly we strongly recommend that the Taskforce advocates for an even playing field in health with private providers:

- contributing to education of health professionals that service their facilities;
- Having to offer at least the same standards of care including appropriate staffing levels and mix for consumers and equal remuneration and conditions for employees as in the public sector.

**Health workforce**

37. Though New Zealand’s population health needs have changed dramatically, as have clinical interventions, models of care, and workforce education, health benefits, including better access, better health outcomes and reduced spending have not been maximised. Various factors such as outdated medicines legislation, traditional GP-centred funding models in primary care, and lack of coordination between government and health agencies have stifled innovation and the sensible utilisation of the health practitioners regulated under the 2003 Health Practitioners Competence Assurance Act (HPCAA).

38. Medicines legislation, which is one of the major barriers to the use of Nurse Practitioners, for instance, has been reviewed 4 times in the past 14 years
and reform is still years away. We recommend the Taskforce advise removing such barriers to the regulated health workforce innovation immediately.

39. Aotearoa’s continued heavy reliance on overseas trained health professionals, a result of myopic and inadequate workforce planning, puts the entire health system at risk. The newly formed Health Workforce New Zealand (HWNZ), however, plans to introduce more non-regulated roles, including advanced clinical roles, (‘deregulation by stealth’) which will exacerbate and hasten that breakdown, including the outflow of New Zealand trained and regulated health practitioners.

40. We note that the language requirements for overseas trained health professionals (and indeed for all those entering Aotearoa as a ‘skilled worker’) are neither occupationally nor culturally appropriate, being largely predicated on the patented Cambridge International English Language Testing System (IELTS). Through years of experience with the individual cases of hundreds of members, NZNO has gained a profound understanding of the failings of the IELTS: the level of pass does not give a robust indication of the level of understanding or communication competence in a New Zealand health setting; it unfairly penalises many for whom it is a second language but who may have been educated in or mainly speak English; it is inconsistent, culturally inappropriate and, at times, unethically administered; and it imposes additional costs on the migrant and regulatory authority with no regard for public safety. Although it is often held up as the “International Gold Standard” for English language communication, there is, in fact, no evidence that the IELTS is an effective discriminant or predictor of success for migrants in any country or occupation. That is hardly surprising because it was not developed for such a purpose.

41. As we have detailed elsewhere the IELTS is expensive, flawed, inappropriate and unsafe; its requirement for registration has ensured that

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11 Notably in our submission to Nursing council on English Language Policy, see http://www.nzno.org.nz/LinkClick.aspx?fileticket=CSlozxNi07A%3d&amp;tabid=511
many competent nurses’ skills have not been utilised, or have been utilised in a discriminatory way when they are employed as HCAs. Equally it has failed to identify those whose communication skills are inadequate in New Zealand health settings.

42. The IELTS is owned, developed and delivered through the partnership of the British Council and University of Cambridge ESOL Examinations (IELTS Annual Review, 2003). We strongly recommend that the Taskforce examine the language requirements for entry of skilled workers to New Zealand and advocates the development of culturally appropriate ones by our internationally recognised ESL teachers, as other countries, recognising the failure of the IELTS, are starting to do.

43. Although nursing comprises the largest proportion of the health workforce, there is an abysmal and longstanding shortage of nursing representation in the Ministry of Health (3 positions) which, in conjunction with the overt medical focus – for example “The current (Government-directed) focus is on medical practitioners, and will [be] for two years, so it is not the right time to incorporate nursing into the Workforce Group” (Ministry of Health, 2010) – indicates that the potential of nursing to deliver innovative, cost effective health care will continue to be ignored.

44. In spite of the HPCAA, the Ministry’s Health Workforce planning team Health Workforce New Zealand (HWNZ) is planning to introduce unregulated clinical roles (in addition to the huge expansion of the unregulated HCA role) at advanced nursing level. Nurses are the only health professionals with experience of the direct interface between regulated/unregulated roles and have a very good idea of what the consequences of this will be for the regulated nursing and medical workforce. Such actions undermine the raison d’être of the HPCAA – public safety. While regulated practitioners will continue to bear full responsibility and the significant financial, professional development and regulatory costs imposed by the HCPA, in many cases
employers will undoubtedly opt to pick up unregulated practitioners who, like unregistered migrant nurses, will probably be cheaper recruits from overseas who are not restricted by a scope of practice. This will undermine training and employment for the already extremely fragile New Zealand health professional workforce.

45. Again, we urge the Taskforce to turn its attention to the ‘bigger picture’ of recommendations which will secure and strengthen a sustainable productive regulated workforce delivering safe health services to improve the health of all New Zealanders.

CONCLUSION

46. We recommend that the Taskforce:

- **Agree** that health spending is a sound investment rather than a negative cost;

- **Agree** that increasing health status of all New Zealanders and reducing health disparities will boost and sustain a productive economy;

- **Agree** that the costs of ill health are unsustainable and impact negatively on productivity;

- **Agree** that New Zealand’s regulated health workforce, and in particular the nursing workforce, must be enabled to deliver innovative and cost effective health care;

- **Note** we strongly reject the Taskforce’s health recommendations for health in the first Report especially increased privatization of health care, increased costs to consumers;

- **Agree** that where care is privatized, it should meet the accepted standards of care for consumers and employees;
• **Agree** that making mandatory appropriate staffing levels and skill mix in private aged care facilities would improve the quality of care for the elderly; reduce costs to public health; reduce exploitation of migrant workers; and increase employment opportunities for New Zealanders;

• **Note** we recommend the Taskforce adopt the Woodhouse principles for social policy recommendations;

• **Note** we would like to make an oral submission; and

• **Note** Appendix One: “Productivity: Nursing’s Contribution” Monograph.

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**REFERENCES**


APPENDIX ONE


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Purpose of paper: This paper is designed to provide a nursing perspective on the productivity debate in the health sector. Nursing’s contribution to productivity cannot be easily measured, because of the nature and focus of nursing work. The nature of nursing work is, to a significant extent, about building therapeutic relationships and the focus of nursing work is on quality health outcomes for the patients/clients nurses care for. Such concepts do not fit neatly into a paradigm focused on inputs and outputs.

“Individuals and their families do better with support and education from visiting nurses than do those who receive more hospitalisation, more physician visits and more long-term care institutionalisation.” 1

A casual observer of the debates about creating a more efficient health service – and when have there not been such debates? – could be forgiven for assuming that elective surgery volumes, child immunisation rates, emergency department and cancer treatment waiting times, and patient discharges, were the sum of our health system. Such is the attention paid to a very narrow range of health “outputs”, one could be forgiven for believing that health was simply what happened in hospitals; that health was simply about treating disease or dysfunction; and that creating a “better, faster, more convenient” health system was simply about more treatments, more operations and getting people out of hospital more quickly; that such increases necessarily equate to a more “productive” health system. But the numbers game is just one small part of the productivity debate in the health system. An over focus on it is detrimental to nursing and to those they care for.

There is growing international research which shows that having more registered nurses in hospital wards is linked with lower mortality rates in a variety of clinical settings.2,3 Thus productivity in the health system does not simply equate to throughput which fails to capture, for example, lives saved through skilled nursing intervention or lives lost because a complication developed into a fatality because there were too few nurses on too many successive shifts, or re-admission to hospital rates because a patient was discharged too soon.

A narrow focus on inputs and outputs does not serve the public well and largely ignores the clinicians who have the numbers, knowledge, skills and ability to make the most significant impact on productivity in health care – nurses. Nurses’ ability to make the most profound impact on productivity in health care is predicated on a number of factors:

- Nurses make up the vast bulk of the New Zealand health workforce. According to Nursing Council figures, in October last year there were 43,780 nurses with annual practising certificates.4 This compares to 12,493 doctors with annual practising certificates, as at June 30, 2009.5
The focus of nurses’ work is on meeting human need: the prevention of illness; care, in hospital and in the community, of those who are sick and assisting them in rehabilitation and restoration of full or partial independence; and assisting people to a peaceful death. This is in contrast to the focus of physicians on disease processes and curative functions.

Director of DHBNZ’s Safe Staffing and Healthy Workplaces Unit Jane Lawless defines productivity within health as “the quality of the outcome for the amount of resources needed to achieve it.”

Nursing productivity, with its focus on quality patient outcomes, cannot be easily measured. In an era of instant responses and pithy sound bites, combined with the need to maintain patient confidentiality, that presents a dilemma for the profession. How does one measure the prevention of a teenage pregnancy by sound nursing advice at a sexual health clinic? How does one measure a skilled surgical nurse picking up a deviation from the normal recovery pattern and preventing it developing into a full-blown post-operative complication, requiring a longer hospital stay? How does one measure the therapeutic support offered by a skilled nurse to a patient suffering a psychotic episode? How does one measure a relationship which evokes sufficient trust for a woman to confide to a practice nurse the violence she endures at home? How does one measure the impact of an elderly man feeling sufficiently comfortable to visit an iwi-based health clinic about his diabetes, after years of avoiding mainstream health services? How does one measure the value of a district nurse visiting an incapacitated person in their own home and providing treatment which ensures that person stays out of hospital? How does one measure a palliative care nurse’s input into enabling a person with terminal cancer to die pain free, with dignity and with their family around them?

This is the stuff of nursing productivity – quality patient outcomes. Attempting to measure nursing productivity is a difficult and fraught exercise, because of the complexity of the services nurses provide, the intellectual capital and knowledge nurses require to do their work, and the systems within which they operate. There is also the difficulty of imposing an essentially fragmentary approach, focused on inputs and outputs, on an inherently holistic profession, focused on quality patient outcomes. What is measured is, increasingly, only that which can be measured easily and, as can be seen from the above examples, that approach fails to capture the totality of nursing’s contribution to quality patient outcomes. It also risks incomplete information informing decision-making. It pays to remember that however nursing input to patient care is measured and however nursing interventions are analysed, nursing will always be more than the sum of its parts.
Be that as it may, in a political context which demands the best value for every health dollar spent, the profession has to be able to show how its interventions enhance productivity. There is ample international evidence showing that when nurse numbers fall, patient mortality and morbidity rise; that when a nurse has a patient load of more than five, 30-day mortality increases.2,7 Thus nurses’ input to prevent death has been measured and found to be very significant. Needleman’s research showed a significant association between higher proportions of RNs on medical and surgical units, lower lengths of stay, and lower “failure-to-rescue” indicators in 799 US hospitals.3 There is also new research which suggests that increasing the numbers of RNs in the workforce might be the most cost-effective way to expand the nursing workforce. 7

United States research shows the worst time to have a heart attack in hospitals is at the weekend or during night shift, when nursing numbers are at their lowest.8 “Failure to rescue” statistics back up the importance of having enough “educated eyes” on patients, enough of the time, to ensure that complications do not develop into fatalities. And educated eyes are nurses’ eyes - those health professionals who are on the wards, with the patients, 24/7.

Various nursing productivity measures have been developed. All have their shortcomings, because of the previously mentioned dichotomy between the fragmentation inherent in measurement and the holism inherent in nursing. Another factor which makes measuring nursing productivity a haphazard exercise at best is New Zealand’s woefully inadequate health workforce information. Two New Zealand researchers refer to the long period of poor medical and nursing workforce planning that began in the late 1980s, with the disestablishment of relevant Ministry of Health directorates. The Medical Training Board (MTB) believes the impact of this poor planning will continue for perhaps 15 years.9

A direct result of this poor health workforce planning is that DHBs do not have robust systems to estimate patient flow and nursing workload and adjust staffing to match, although the Safe Staffing Healthy Workplaces Unit’s demonstration sites at three DHBs are attempting to develop such systems.

Thus attempts to quantify nursing productivity are made against a background of insufficient information, within a simplistic paradigm focused on inputs and outputs and within an historical context of undervaluing nurses’ input to quality patient care.

Be that as it may, some nursing productivity tools have been developed. These include:

1) Nursing hours per patient day (HPPD), sometimes further factored by patient acuity. A weighting is applied for the complexity of the nursing input required, related to the frailty or complexity of the patient. It is worth noting
that hours nurses work beyond their contracted hours are not included in the measure. NZNO figures show that, on average, nurses work seven hours per week in excess of their agreed hours. If this input were removed, it would add an extra shift per week per worker. Thus significant nursing input is not captured under this model.

2) Percentage bed occupancy is one measure of hospital-based nursing care activity. Research shows that pushing bed occupancy reduces patient health outcomes.

3) Customised productivity reports are regular summaries of unit staffing costs by staffing mix, HPPD and a patient classification system based on unit census and patient acuity. Comparison with similar units supposedly drives change through competition and peer pressure.

4) Professional practice models (PPM) give increased responsibility and control over work process and content. These models include quality assurance and staff development, leading to re-engineering of tasks and processes, led by nurses. These PPMs promised much, but studies have failed to demonstrate efficiency savings.

5) Interdisciplinary productivity measurement is a whole-systems approach aimed at improving communications and incentives, thus reducing costs across departments. It also usually includes patient acuity measures.

6) Nursing knowledge information systems, eg the Nursing Intervention Classifications (NIC) system. This attempts to put a value on the temporal, educational and skill competency requirements of 486 taxonomic nursing interventions, to assign costs more accurately. Nursing knowledge is accounted for as a capital asset, i.e. human intellectual capital. This must be measured through knowledge work classification systems, interdisciplinary informatics and productivity index.

It is important to factor in costs due to training, burn out, turnover, recruitment and re-employment into productivity models that push nursing care beyond safe or sustainable limits.

Another system of analysing nursing input to boost productivity, which is gaining a foothold in New Zealand, is the productive ward. This National Health Service (NHS)-developed initiative is a patient-centred approach to improving the quality of care on acute nursing units by freeing up nurses’ time for more direct patient care. It also has the potential to be used to free up community nurses’ time as well. Funded by the Ministry of Health, 15 DHBs are involved in the programme to varying degrees, but Waitemata DHB will have all its in-patient wards under the programme by early 2010. Some of the gains so far reported by Bay of Plenty DHB are improved organisation at ward level, leading to a ten percent reduction
in the amount of time nurses spend walking from one place to another to fetch and carry what they need for patient care and an 18 percent increase in direct care time to 57 percent of a nurse’s time per shift. DHBs are reporting increased staff satisfaction and morale and there is a suggestion that the programme may be having an impact on improving recruitment and retention. But an acknowledged risk of this programme is that initial short-term gains may not be sustained.

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If the health sector is serious about productivity in its most complete sense, ie all the resources, including staffing required for quality patient/health outcomes, it is time to develop and adopt genuine indicators/measures of nursing activity, output and quality. Rather than seeing nurses as the biggest liability on their books, health providers should move to valuing nurses as their biggest asset in both human and intellectual capital. From that shift in mindset, will inevitably flow a greater understanding and valuing of the work of nurses and a culture that empowers nurses and gives them the authority to make the changes necessary to ensure quality patient outcomes.

Where nurses are allowed the freedom and given the authority to be innovative in their practice, they will come up with more efficient ways of providing care – not primarily motivated by a desire to save money, but by a desire to provide the most efficient, effective care to patients, which inevitably costs less. More than 80 percent of cost reduction opportunities in health care rests with clinical decision making, so it makes perfect sense to empower all clinicians to make the decisions that will improve patient outcomes, while also reducing costs.

Thus productivity in health care, particularly nursing productivity, is a many-faceted concept. To focus on just one facet, be it nursing numbers or toting up elective surgery procedures, is to devalue the complexity of the work of all health professionals and to undermine the importance of quality patient outcomes. Health productivity is an amalgam of the skilled work and innovation of empowered health professionals, the understanding and competence of health managers, accurate and accessible information on patient numbers and acuity and the nursing staff required to meet patient needs, and the availability of necessary resources, all honed to producing quality patient outcomes in the most efficient and effective way. And it is vital that whole systems are included in productivity measures – omitting mental health or care in the community or health promotion, while concentrating on easy-to-measure outputs such as discharge rates or numbers of elective surgery procedures is both misleading and disingenuous. Any system used to determine productivity within the health system must capture all these facets and not just focus on those which are easily measured. Only then will the true value of nursing’s contribution to health care be fully understood.

*I would like to acknowledge the input of NZNO researcher Dr Leonie Walker in preparing this paper.
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