Reforming the cost of care

Te tārei anō i te utu o te taurima tangata

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In her editorial to *Nursing Praxis* three years ago, Rhonda McKelvie reflected on the nursing strike of 2018, the first of its kind in Aotearoa New Zealand for over 30 years (McKelvie, 2018). Whilst appropriate pay was one motivator, the need for a safely staffed environment delivering quality care was a strong driver of nursing angst. Nurses claimed that the health care system had failed to live up to its promise in 2009 to deliver a Care Capacity Demand Management (CCDM) programme to respond to excessive nursing workloads, which placed patient safety at risk. The CCDM was a partnership endeavour between the union - the New Zealand Nurses Organisation (NZNO), and the employers - the district health boards (DHBs), developed on the back of a national inquiry (Safe Staffing/Healthy Workplaces Committee of Inquiry, 2006). McKelvie, herself, played a significant role in developing the CCDM infrastructure. Yet, she too had to conclude that despite the best efforts of nurses to input data on the patient care needed and the nursing capability required to deliver it, nursing workforce gaps were not fully addressed, leading to ongoing deficits.

I now offer my editorial in the immediacy of a further national strike of some 30,000 DHB employed nurses, preceded by two strikes of an estimated 3,400 nurses working within the primary health care sector (NZNO, 2021, 2020). In the aftermath of the 2018 strike, the so-called *Safer Staffing Accord* was agreed between the

Ministry of Health (MoH), NZNO, and the DHBs (MoH, 2019). This Accord, which “committ[ed] the parties to there being sufficient nurses and midwives in our public hospitals to ensure both their own and their patients’ safety” (MoH, 2019, para 1), had seemingly failed to deliver, with an increasing demand for improved pay and conditions fomenting the new wave of industrial action.

There is irrefutable international research as to the significant savings in patient care costs and enhanced quality of care provided when sufficient nurses are deployed. For example, a leading commentator in this field, Linda Aitken, recently testified to the New York legislature reassuring them of this fact as they moved to endorse a state statute mandating numbers of nurses required (Aitken, 2021). Why is it then, in the face of such evidence, we cannot get the right numbers of nurses on the ground here in Aotearoa New Zealand?

The challenge for the nursing workforce in determining appropriate pay, safe staffing and healthy workplaces is its sheer size. Nurses represent 39% of the DHB workforce and \$2.2 billion is spent annually on their wages, which is 36% of DHB total salary costs (MoH, 2020). Yet \$1.1 billion (half of the nurses’ wage bill) is spent on senior medical officers who are just 7% of the DHB workforce (MoH, 2020). Historical notions of poor remuneration and conditions continue to curtail the value ascribed to nursing.

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Perhaps surprisingly, during this period of workplace dispute together with the perceived need for restraint to manage COVID-19 associated costs (Te Kawa Mataaho, 2021), our central health agency, the MoH, is on point in confirming Aitken's thesis. Toward the end of last year, the MoH's Workforce Directorate produced a report entitled, *The cost and value of employment in the health and disability sector* (MoH, 2020). The report identified the benefits to not only patient care outcomes, with a properly educated and deployed workforce, but also to social capital and adhesion inherent in such a workforce (MoH, 2020). The report anchors its premise on the United Nations High Level Commission on Employment and Economic Growth (2016):

The Commission hoped to change the mindset of political leaders, policy makers and economists who view health employment as a burden on the economy (as it is considered to be inefficient, resistant to gains in productivity and an expense to be stringently controlled). The Commission wanted to shift the focus of health employment as 'consumption' to health employment as an 'investment' (MoH, 2020, p. 2).

The Health Workforce Directorate provides evidence on the economic and social returns of investing in the health and disability workforce to provide a basis for health and financial decision makers to work together around shared goals and public finance objectives. The intent is to enable a stronger dialogue with the Minister of Finance and Treasury about the contribution made by health systems to reducing social and economic exclusion and to growing the economy, and, by implication, investment in the health workforce.

Disjointed policy making was identified by the Health and Disability System Review (HDSR, 2020), chaired by Heather Simpson. The HDSR report describes multiple instances of disjointed planning in the regulation, education, and deployment of the workforce with a lack of robust data giving any real sense of the current status, let alone being a foundation for ensuring future

fitness for purpose. The lack of connectivity between the 20 public DHB employers, primary health organisations (PHOs), non-governmental organisations (NGOs), and private enterprise, all involved in health care delivery, impede the development of a workforce to meet population health care needs and reduce health inequity. Significantly, despite decades of intent to target the growth of the Māori and Pacific workforce, endemic racism is often at the root of recruitment and retention failures (HDSR, 2020).

The Minister for Health has taken the Simpson findings on board, in actuality outlining a future health and disability framework more radical than recommended (Department of Prime Minister and Cabinet, 2021), which may well provide an answer to nurse workforce problems. Included in the reforms is the replacement of all 20 DHBs with overarching commissioning agencies in the shape of Health NZ and the Māori Health Authority. However, we cannot afford to drop the ball on ensuring national workforce planning systems are in place. Centralisation may not be the only key but bringing decision makers together and closer to the point of delivery, as they make those decisions, could stimulate action.

The New Zealand health reforms, due to begin to be enacted in July 2022, will hopefully recognise the answer to nursing's plight is not more industrial action, but a recognition of those tenets that investment in health, and our profession within that, is an investment in the future of the nation. Meanwhile, nurses have voted to strike three more times as their pay dispute with DHBs continues (Burrows, 2021). Surely, sometime quite soon, the honest question has to be asked (regardless of the best evidence in the world), "How much are we willing to spend on nursing?" In turn, the answer needs to be equally honest with a national agreement through transparent decision making that the number we decide upon is truly the most we can afford and the best outcome for our health, and indeed our economy. Go figure - the time is right to reform the cost of care.

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