EDITORIAL

Reflections on politics, policy and power

He whakaaro mō te ao tōrangapū, ngā kaupapa here, me te mana

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In early 2017, I started work as a Chief Advisor in the Office of the Chief Nursing Officer (the Office) at the Ministry of Health (MoH). The role of a Chief Advisor is to provide high quality, strategic and operational advice, leadership, analysis and recommendations in support of the design, delivery and implementation of policies, priorities, service delivery and programmes of work. In the Office this advice is, naturally, related to nursing. In early 2018, I stepped up to act as the Chief Nursing Officer while the Ministry went through a period of change including the appointment of a new Director General and a restructure of the senior leadership team at the Ministry of Health. During my time as Acting Chief Nursing Officer, nursing in New Zealand went through a period of intense turmoil due to a prolonged period of negotiation for a new multi-employer collective agreement (MECA) for District Health Boards (DHBs) culminating in strike action. Because MECA negotiations are between DHBs and the New Zealand Nurses Organisation (NZNO), the Office can have no involvement. However, two aspects of the fallout from the negotiations did fall to the Office. The response of the Office to these, while only one of the many facets of the work undertaken by the Office, does make an interesting case study of the complexities of the work the Office does. In this editorial, I thought I would share some of what happened and what some of the learnings from this were.

During the protracted period of negotiations, and after two failed settlement offers, an Independent Panel was established to help the negotiating Parties (the NZNO and DHBs) to reach an agreement. The Independent Panel identified a range of issues including the need for immediate funding for additional nurses to meet current workload pressures and leadership, commitment and additional resources to support implementation of the Care Capacity Demand Management Programme (CCDM) (Independent Panel Process, 2018).

Following the Panel process, then Acting Director General of Health, Stephen McKernan, made a commitment to the Chair of the DHB Employment Relations Sector Group, Ashley Bloomfield, to make available $38 million to ensure DHBs had the nursing workforce capacity to deliver required patient services (immediate relief of staffing issues) and a further $10 million to engage staff dedicated to the implementation and development of the CCDM programme (S. McKernan, personal communication, May 28, 2018).[1] This commitment was also subsequently referred to in the Offer for Settlement and Terms of Settlement of the MECA (J. Ryan, personal communication, July 24, 2018).[2]

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The Office was given responsibility for ensuring the $38 + $10 million was appropriately distributed with fair accountability mechanisms. To achieve this, guidance was written in collaboration with NZNO, DHB Chief Executives and the Chair of the Directors of Nursing Group.

Following a third and fourth rejection of an offer for settlement and a 24-hour national strike by DHB nurses and midwives, the Labour government signed an Accord between DHBs, the Ministry of Health and NZNO. The Accord committed the parties to:

a. Explore options for providing employment and training for all New Zealand nursing and midwifery graduates, taking into account the current model for doctors, and report to the Minister of Health by the end of November 2018;
b. Develop any accountability mechanisms that the Parties believe are necessary (over and above those already agreed) to ensure DHBs implement the additional staffing needs identified by CCDM within the agreed timeframe (June 2021) and report to the Minister of Health by the end of February 2019; and
c. Develop a strategy for the retention of the existing nursing and midwifery workforce and the re-employment of those who have left the workforce, and report to the Minister of Health by the end of May 2019 (NZNO, DHBs & MoH, 2018).

While the government did not openly admit that the timing of the signing of the Accord was intended to coincide with voting by nurses on the fifth offer, it was clearly their intention that this would help push nurses to ratify the offer. While we may never know if the reason for nurses finally accepting the offer was the signing of the Accord or that they were just simply tired of a long and drawn out industrial process, the fact is, the fifth offer was ratified, and settlement achieved. In the meantime, the Office was tasked with leading the response to the signing of the Accord as well as facilitating the distribution of the $38 + $10 million.

The two processes were quite separate, but all involved a tripartite approach to achieving outcomes. One of the requirements for DHBs wishing to access their share of the $38 + $10 million was to produce a plan for how it would be spent that was initially signed off by the DHB and NZNO and eventually by the Ministry of Health. This was difficult for some as it meant working in true partnership in order to obtain agreement from both parties. To further complicate discussions between DHBs and their NZNO partners, NZNO was adamant the funding could only be used to relieve immediate pressures on NZNO staff, not staff that may have been members of other unions such as the Public Service Association (mental health and public health nurses) or MERAS (midwives). Although the $38 + $10 million-dollar figure was determined based on 2% of the total national cost of the DHB employed nursing and midwifery workforce (S. McKernan, personal communication, May 28, 2018),[1] because the funding was referred to in the terms of settlement this became a grey area. The Ministry was unable to give definitive advice either way, relying on DHBs to develop plans that matched the needs of their district and that all parties could agree to. The separate but related Accord work is currently underway with an operational group comprising representatives from all three tripartite signatories: NZNO, DHBs and the Ministry of Health.

The challenge with tripartite work is that it is inherently political, with each of the players coming to the table with their own agenda, interpretation, understanding, philosophy, perspective and need for power. Each of the participants is seeking to continuously balance the requirements of their respective organisations with the work that needs to be done, and sometimes, these

[1] Letter from Stephen McKernan to Ashley Bloomfield, 28 May 2018.
[2] Letter from Julie Ryan (DHB Advocate for NZNO Bargaining) to Lesley Harry (Industrial Advisor, NZNO), 24 July 2018.

competing elements do not align – as was the case with NZNO's interpretation of the $38 + $10 million. In such a tripartite scenario, the role of the Office is to represent the interests of the government of the day and to provide advice and support to the Minister and the Ministry of Health. Despite a focus on nursing, the Office cannot advocate for nursing it can only advise on what particular course of action may achieve what outcome. Within any of the clinical or professional advisory units across the ministries of government, there is always a tension between advocacy and advice and in 2018, this tension within the Office had never been more strongly felt – we were, after all, all nurses.

As the sector recovers from the turmoil of 2018, we can reflect on what was achieved and what was lost. While there are likely to be some significant gains from the signing of the Accord and the distribution of funding to address immediate staffing pressures and support CCDM implementation, nursing has significant work to do to rebuild trust and the professional image of nursing. The Office should play a role in this through support, guidance and leadership of the sector and advising the government on the professional role of nursing. But it is the nursing profession itself that needs to play the key role. We need to be more politically savvy and advocate for change from a professional lens, speaking with politicians on all sides of the fence about the practice of nursing and demonstrating our value through evidence-based case studies supported by strong client narratives. We have to stop complaining about not being around the table and find ways to demonstrate what happens when we are not at the table, so we become indispensable.

Nearly two years at the Ministry has taught me many things, not the least has been patience, diplomacy and a little bit of political nous. Change takes time and sometimes we just have to keep tapping away at things to achieve what we need to. While sometimes it seems we are making no progress at all, we still need to celebrate the small wins and think about the cumulative effect of those small wins – they do create the bigger wins that we can often only see in hindsight.

References

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