PAY JOLT?

THE IMPACT OF THE 2004/5 NEW ZEALAND NURSES EMPLOYMENT AGREEMENT

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1. Introduction

This report examines the impact of a national multi- employer collective agreement (MECA) for nurses, hospital midwives and healthcare assistants in New Zealand. The 2004 MECA covering these staff groups employed by District Health Boards (DHBs) marked a significant stage in nurses' and midwives' pay determination. One of the management negotiators at the time highlighted the MECA as "good for nursing and very good for the DHB sector…. People will always remember the time when nurses pay got to where it ought to be" (O'Connor, 2005). The chief executive of the New Zealand Nurses Organisation (NZNO) heralded the MECA as a "ground breaking achievement" (Annals, 2005). It achieved pay scales which, it was claimed, would bring the pay of these groups in line with other professional groups with similar skills and responsibilities. The agreement covered a two and a half year term, ending in December 2006.

The new pay scale had the potential to have a significant impact on labour market behaviour within the public sector District Health Boards, as well as impacting on the broader dynamics across the various other sectors (private, non-Government, charitable) in which nurses, midwives and healthcare assistants were employed in New Zealand.

This report provides an overview assessment of the impact of the MECA, in order to identify any key trends and impact on nurse labour market behaviour evident at this stage, to assess any additional impact on the workforce, to report on any unforeseen outcomes and knock-on effects in other sectors, and to assess the utility of available nurse/midwifery workforce/ labour market indicators to track future changes.

Aims and methods

The aim of the report is to contextualise and undertake a rapid initial assessment of the impact of the MECA. It uses a a rapid assessment approach based on a document and literature review, a review of available data on the New Zealand nurse labour market, and detailed information from case studies with managers and staff in two District Health Boards. In addition perspectives of non-government employers of

nurses and information on trends in application rates to schools of nursing were assessed. The research for this report was conducted between August 2007 and January 2008. As such it provides a retrospective assessment of the impact of the MECA . The study protocol was approved by the Multi-Region Ethics Committee (one of the Ministry of Health's Health and Disability Ethics Committees) [approved 31 August 2007 (MEC/07/51/EXP)].

2. The Background to the 2004 MECA

In New Zealand the final decade of the 20th century was characterised by extensive hospital restructuring, health system reform and labour market reform. A reported consequence for nursing was the loss of leadership structure and career pathways. This was highlighted in a critical report by the Health and Disability Commissioner (1998), precipitated by organisational stress and patient deaths, which covered a wide range of concerns, and which commented on low nursing morale, increased casualisation of nursing, inappropriate staffing levels and skill mix, lack of professional leadership and an associated reported decline in quality of patient care.

Other reports from that period highlight minimal annual change in actively practising nurses; rising median age of nurses; a decline in the proportion working fulltime compared to part time; and a rise in the percent working casually (New Zealand Health Information Service 1997). Reflecting concerns over the gap between the potential of nursing and what was delivered, a taskforce was established charged with identifying barriers that prevent registered nurses from improving the services to patients, and to devise strategies to remove those barriers (Ministry of Health, 1998). The taskforce reported that the working conditions of nurses were limiting nursing's potential. The report also concluded that the Employment Contracts Act in 1993 had led to nurses' income dropping in real terms, compounding the existing gender income gap affecting a predominantly female workforce. There was compression of pay scales which was associated with lack of reward for nurses with higher educational levels and responsibility.

A survey of non practising nurses and midwives by the New Zealand Health Information Service (2000) identified reasons for not practising: parental or childcare responsibilities; working hours don't suit; and pay that was not attractive. Three quarters of respondents indicted they would consider a return to practice, and the most frequently reported factors that would assist registered nurses and midwives to return to clinical practice were: more flexible hours of work; availability of return to work programmes; salary increases; and provision of child care facilities.

Concerns about nurses' employment conditions were also reflected by the Health Workforce Advisory Committee (2002) in its stocktake of the New Zealand health workforce. Along with a range of reported concerns about professional issues, the report identified remuneration, inflexible hours, physical demands, increased patient acuity, and high workload as reasons for reduced numbers of New Zealand trained RNs being active in the workforce.

These reports agree that nurses' employment conditions had deteriorated by the end of the twentieth century, leading to increased nurse shortages and dissociation of some nurses from working in the profession.

Shortages of "willing nurses"

The nursing workforce and nursing labour market situation in New Zealand in the run up to the negotiation and implementation of the 2004 MECA was characterized as one of staff shortages, with growing concerns about long term supply into the profession. A labour market report conducted by the New Zealand Department of Labour, based on data as at 2004, reported that "Available data suggests that the growth in the employment of registered nurses has remained weak over the past four years. The Department of Labour expects that employment growth for nurses will remain moderate in the short term. In the long term, however, there is likely to be strong growth in the demand for nurses, with the ageing of the New Zealand population." (Department of Labour, 2005, para. 3.3.1).

The Department of Labour also reported that the number of new nursing graduates had fallen strongly in the late 1990s, and that more New Zealand trained nurses were leaving New Zealand soon after qualification, for better paid jobs in Australia and elsewhere in order to pay off loans more quickly (Department of Labour, 2005, para. 4.4.2). The report also highlighted 'occupational detachment' (employees who voluntarily leave an occupation) as a key issue for nursing, given that a significant number of registered nurses were exiting from active employment in the profession. The Department reported that the percentage of registered nurses and midwives remaining active in the profession in the first three years after initial registration had declined to 60% in 1998 from 81% in 1990, and highlighted that in 2003, there were 4,452 registered nurses and midwives in New Zealand holding annual practising

certificates who were not actively employed as nurses or midwives (Department of Labour 2005, para. 4.4.1). (Note: This indicator cannot be used in later years. The 2005 implementation of the Health Practitioner Competency Assurance Act 2004, requiring demonstration of competence, including active practice, for issue of annual practising certificates means that non practising nurses will not now be on the register.) .

The Department also argued that "there does not appear to be a shortfall in the number of trained nurses in New Zealand. Rather, there is a shortage in the number of registered nurses who want to take up work as nurses under current pay and employment conditions. This condition is thus described as a recruitment and retention difficulty rather than a genuine skill shortage" (Department of Labour 2005, para. 5 .3 .1).

The Department reported that "Salaries and working conditions are factors which have been identified as influencing decisions to remain active in the profession" but that "Recruitment and retention difficulties for nurses are expected to ease somewhat over the next few years as more nurses are encouraged to take up active employment in the profession. A key factor affecting this is likely to be the increase in pay (up to 20%) for registered nurses employed by District Health Boards, following the recent pay settlement between the District Health Boards and the New Zealand Nurses Organisation" (Department of Labour, 2005, para. 6.1).

Securing a new deal on pay: the case for change

The 2004 MECA was therefore negotiated at a time of increasing concern about supply-demand imbalances in the New Zealand nursing labour market; it was also the result of a long term strategy by NZNO to shift the focus of nurses' and midwives' pay determination to national level. The labour market and political situation at the time of the negotiation were enabling factors in the union achieving its objective.

From the early 1990's pay determination for nurses and midwives working in the public sector in New Zealand was mainly focused at District Health Board (DHB) level. As part of the process of radical reform in the New Zealand health system, and enabled by labour law reform, in the early 1990s nurses' and midwives' public sector

pay bargaining was devolved down to local ("Crown Health Enterprise") level. Collective bargaining was later consolidated into regional agreements, and at the beginning of this decade there were four regional MECA's (South Island, Lower North Island, Auckland and Northern), while Canterbury for a time continued to bargain separately (NZNO, 2003).

In the earlier part of this decade NZNO developed a strategy of moving first to regional MECA's, with the ultimate goal being national bargaining. One of the lead negotiators on the NZNO team for the 2004 MECA argued that the key rationale for a shift to a national MECA were to achieve "fair pay and safe staffing" (Alexander, 2004).

The NZNO aim for "fair pay" was set out in a 2003 document (NZNO 2003) which put the case for pay equity, citing job evaluation results, pay comparisons with other occupations within New Zealand and pay comparisons with nurses' pay rates in other countries. The document argued that "NZNO will be seeking tripartite agreement (government, DHB employers and NZNO) to a process and timetable for the implementation of a fair pay pathway" (NZNO 2003, p1). The same document highlighted that the "government estimates that it spends $100 million each year on nursing turnover. There is a nationwide shortage of nurses – or at least of nurses prepared to nurse. Overseas employment is becoming increasingly attractive as pay and workload issues are tackled elsewhere" (NZNO 2003, Foreword).

The 2003 document set out the main inter-related objectives of NZNO in the run up to negotiation on the 2004 MECA:-

- consistent national approach to pay bargaining
- pay equity arguments for pay uplift
- recruitment and retention arguments for pay uplift
- related focus on staffing and workload issues

The NZNO aim was to use the pay equity argument to prepare the ground for bargaining. The objective was to create an environment for national bargaining and to overcome piecemeal localised bargaining – as one NZNO negotiator noted "we had to

create solidarity between groups that had absolutely no contact for 15 years". They also had to overcome what some regarded as "protectionist" interests (e.g. groups in high cost urban areas where pay rates were at the time relatively higher), so the union had to ensure the pay rise was sufficient so no group felt they had lost out. The objective was to secure a "pay jolt" of significant magnitude to enable a levelling up of pay rates to a national standard.

The focus on NZNO represented nurses and midwives and related staff employed by DHB's gave a focus that covered the majority, but not all employed staff in these occupational groups. Others were employed in primary care, NGO's, etc. Once having secured a national agreement in the DHB sector, NZNO had the intention to "roll out the basic elements of the settlement to nurses in the primary care, aged care and private sectors."(Annals, 2005) (see also NZNO 2005)

Local or National?

The evidence base on nurses' and midwives' pay and labour market behaviour is limited, fragmented and context specific. There is unresolved debate about the research evidence of the impact of pay on nurses' labour market behaviour (particularly in comparison to other non pay interventions). Some academics have argued that registered nurse labour supply "is fairly unresponsive to wage changes" (see e.g. Sheilds 2004), while others have argued the opposite (e.g. Buerhaus 1991). Some have argued that increases in pay have a more significant effect in attracting more new entrants to the profession than in increasing the hours of those already in employment (Chiha and Link, 2003); and others have even argued that there is evidence of a "backward bending supply curve" in nursing- with nurses substituting more hours of non work activity when their hourly wages increase (see e.g. Lin, 2003).

The academic evidence base, such as it is, is not particularly helpful to this study in New Zealand - most English language research in this area has been conducted in the United States, where labour market dynamics and health system characteristics are very different from those in New Zealand (and from other developed countries), with low unionisation, localised pay determination, limited collective bargaining, and very different labour laws. Many of the published studies have methodological weaknesses

(for a discussion see Buchan, 1992; Antonazzo et al, 2003). Furthermore, most of these studies examine pay rates of individual nurses; they do not assess the impact on labour market behaviour of an award such as MECA, which also includes other significant elements of relevance to working nurses and midwives, such as the safe staffing commitments. Finally, the interdependence between nurses' pay rates/ pay changes, and the effect of the quality of the practice environment are grossly under-explored. It could be argued that increasing pay if the working environment is unattractive may lead to reduced working hours, whilst the same pay increase intervention in a positive practice environment may have the opposite effect.

There has also been continued debate about the pros and cons of local, regional and national level pay determination (see e.g. Calmfors, 1993; OECD 1997; Wallerstein, 1999; Bender and Elliot 2003). Within public sector health systems, health sector reform has sometimes included attempts to shift the locus of pay determination from national to local level on the grounds of greater managerial "flexibility"- as was the case in New Zealand in the early 1990's and in the National Health Service (NHS) in the United Kingdom in the early/ mid 1990's (see e.g. Catton, 1998). Counter arguments have been that national pay is simpler to operate, less time consuming, and may be appropriate for monopsony labour markets such as those for the health professions (see e.g. Buchan 1992; Grimshaw 2000; Buchan 2000)

Trade unions tend to favour national bargaining as it enables them to focus their efforts and maintain consistency across their membership. Where there is fragmented local bargaining unions will usually attempt to "ratchet up" pay rates by targeting their pay bargaining efforts initially on relatively weaker managed units to secure pay increases, and then use these gains as the benchmark to achieve increases in other units. This is enabled if unions can maintain a national overview of pay rates and local labour market variations. However local pay determination can also lead to a range of "local issues" occupying disproportionate time and effort at multiple bargaining tables.

There is often a mixed view from public sector management about the pros and cons of local pay- for example, the "voluntary" nature of the option to move to local pay determination in the UK NHS in the 1990's led to few employers attempting to shift

away from national pay determination, because of perceptions about costs and complexity of handling all pay issues locally; they also were aware that localising the focus carried some illusion of increase power, because there was no increase in the availability of financial resources. More recently, a new national pay system for the UK NHS has been established which includes some local flexibilities, but within a structure that is nationally agreed and negotiated (Buchan and Evans, 2007). The attraction of national pay determination for some public sector managers is that it distances them from the time and resource intensive active participation in the process; it can also create a more stable intra-organisational climate. The NZNO/DHBs MECA was the first example in New Zealand of the shift back to national focus.

One of the issues that makes New Zealand unique is that it has retained a public sector system, but has over the last twenty years shifted from national to local pay determination, and then reversed this trend, moving back to a national focus for pay determination. This has created a situation where many of the stakeholders in the process have detailed experience of the pros and cons of actual involvement in different models- not just a theoretical understanding.

One DHB representative summarised some of the pros and cons of local versus national pay determination, in the context of the MECA: "the advantage of a national MECA is that it avoids the ratcheting of local awards. Employers need a collective approach, otherwise they get picked off. The downside is that it has taken too long nationally to reach agreement – and there are knock-on effects to other groups".

As noted above, by 2003/4 the nursing labour market situation in New Zealand was becoming increasingly problematic. One key element in the NZNO approach, as noted by a DHBNZ representative at the time, was to establish "a view of nursing as a national labour market, with New Zealand having to compete internationally", and that the DHB's should accept that "a nurse is a nurse is a nurse" (i.e. that there should be equal treatment throughout the country). Another DHB representative noted that at the time "there had been a loss of attractiveness" in nursing as a career.

Political change also created a more favourable set of conditions for a new approach to nurses' pay determination, including the prospect of central funding. One NZNO representative noted that the change of government in 1999 "opened the door to change". A DHB representative highlighted that in their view, at least some of the negotiators on both sides "knew that the off stage message from government was that funding was available". Another DHB representative noted: "Negotiations were helped by the fact that the quantum was already known …", while another person involved in the national negotiations commented that "we were aware that the government had made money available for the pay jolt and a three year agreement – it [the national MECA] was seen almost as national policy". In spite of this, and the acknowledgement that the ground was well prepared before "we sat down at the table", a DHB representative noted that "it was really difficult to keep 21 DHB's on side". One of the reported lessons learnt in the MECA negotiations was the need to set up a joint action committee at national level "to keep the momentum going after agreement reached, to keep it live …".

Another issue raised by some commentators was the broader government agenda to reduce the gender pay gap-it could be argued that addressing low pay for nurses could be seen as a big step in this direction. However NZNO sources indicate that the government response to their proposals in 2003 on moving forward to close the gender pay gap had not been encouraging, leading NZNO to alter its strategy and focus on an industrial approach to achieving pay equity.

3. The 2004 MECA between District Health Boards and the New Zealand Nurses Organisation

After negotiations, the 2004 MECA was agreed between the employers (i.e. all 21 District Health Boards – see Appendix 1 for a list) and the New Zealand Nurses Organisation (NZNO), with lead signatories signing off on the agreement at the end of February 2005, and full ratification happening in the following month. Whilst coming into force on 1 April 2005, the main provisions of the MECA were back- dated to take effect from 1 July 2004. The MECA expired on 31 December 2006.

The agreement covered a range of issues including pay rates, hours of work, leave entitlement, etc (see Appendix 2 for details of the agreed pay scales). Whilst much of the content of the agreement could be characterized as a "normal" pay bargaining contract, there were two issues that differentiated it from the norm. Firstly, the contract set out a transition timetable to shift the determination of nurses' pay and employment conditions from the existing local/ regional focus towards a national pay system. As such it included a complex agreed timetable for transition and assimilation, to bring together pay rates previously negotiated at DHB level. As noted earlier, the general trend in pay bargaining in recent years had been from national to regional or local, where national bargaining existed. The MECA example is the first example of the focus of nurses' pay bargaining moving in the opposite direction, as a result of NZNO pressure, an enabling government, and perceived inadequacies with the previous system. This was thus a significant change in direction, and reflected a policy turn-a-round from the previous decade, when the shift, virtually overnight, had been from national to local level pay determination.

The second significant and unusual aspect of the MECA was that it included an agreement to establish a safe staffing commission to assess the impact and implications of low staffing levels, nursing workload, and to establish guidelines on safe staffing and healthy workplaces. In particular, there was a commitment to "a programme of regular monitoring of staffing levels and skill mix. Any identified staffing deficiencies shall be addressed. In the event that an acute staffing shortage cannot be alleviated, patient care, and the volume and range of services may be

reduced in accordance with direction by the appropriate manager and employer policies. When an incident occurs related to inappropriate staffing levels and/or skill mix, or a situation arises that a staff member believes may contribute to unsafe practice, it shall be reported to the person in charge and the appropriate incident report submitted. All incidents shall be investigated and an NZNO delegate will be involved in investigations and corrective measures, via mechanisms to be determined at each DHB through consultation with local NZNO". Appendix 3 reports on the terms of reference of the Commission. Appendix 4 gives its main recommendations.

This national commitment to a system of monitoring, reporting and acting on unsafe staffing levels also sets apart the MECA from most nurses and midwives pay negotiations, as it explicitly sets out procedures to deal with staffing inadequacies, and made linkages between staffing safety/ workload, patient care and the more commonly "negotiated" issues of pay and working conditions. The details of the approach to the safe staffing issue is examined in Annexes to this report, but it should be noted that it is the explicit link between safe staffing and pay determination which is one of the key characteristics of the MECA. In focusing on safe staffing, NZNO were addressing one of their priorities, and were making a case of a strong connection to staff retention. In addition NZNO's focus on safe staffing addressed their objective of obtaining a staffing "guarantee" mechanism to ensure that the pay increase was not "paid for" by reducing the number of nurse FTE's. This was stimulated by their knowledge that a pay equity based salary increase in Ontario, Canada, had led to reduced nursing numbers and increased workload per nurse.

There were four steps in the transition to the new pay system:

Step 1 - 1/7/04 – Auckland region pay rates moved - e.g. RN5 move to $47780 (6.2%); at 1/1/2005, all other MECA rates were aligned with the pre-1 July 2004 Auckland region MECA rates (with the exception of all designated senior positions and those paid above RN5 but yet to be scoped).

Step 2 - At 1 April 2005 a percentage increase was applied to all pay scales with the exception of designated senior positions and those paid above RN5. The increase will work as follows for all those except RN5s:

Step 3 - At 1 July 2005 a further standard percentage increase is applied in most cases.

Step 4 - By the time of the next percentage increase (1 July 2006), all employees should be on the stated salary scale rates.
Source: NZNO

The objective across the 4 stages was to end with a national pay system, giving time for the existing regional variations to be phased out in the process; with variable payments being made to different groups of nurses in different DHB's to "level up" to a national system. Inevitably however, some fared better than others in this process of levelling up- this issue will be examined when the situation at DHB level is examined in more detail.

At national level, the effect of the MECA on nurses' and midwives' pay rates was significant. The Department of Labour, in a report on the nursing labour market in 2005, noted that "Under the latest settlement, nurses employed by the DHBs will receive a significant pay increase (up to 20%). This increase will be phased in by July 2006. The new pay rates for registered nurses will range from $40,000 (grade step 1/new graduate nurse) to $54,000 (grade step 5). This compares with a pay scale of around $33,917 to around $45,000 previously. Senior nurses' pay rates will range from $57,330 to $80,000, compared with $54,600 to $74,766 previously" (Department of Labour, 2005, para. 4.6.1).

4. Impact of the MECA 2004-2006

What has been the impact of the MECA? This report takes a retrospective look, building a picture using available labour market data, combined with the reported assessment of stakeholders at national level and within two DHB's. Overall, it is difficult to attribute causality between labour market change and any one factor, and limited data availability also constrains full assessment of the impact of the 2004 MECA. This section provides an incomplete but compelling picture built on the available national data. It should be noted that as the views of only two DHBs are reported in detail, this is only illustrative and cannot be taken as a balanced perspective from all 21 DHBs.

National Indicators of change

Available labour market indicators can be examined to assess trends across the period of implementation of the MECA. Changes across the period cannot be attributed only to the MECA, as a range of other factors- e.g. funding, demographic change, economic conditions, unemployment rates etc- may also have an impact on indicators such as employment rates, turnover and vacancy rates.

Staffing change

Table 1 below shows staffing growth in DHBNZ employment across the period 2001 to 2006. The relatively rapid growth in nurses employed in the year 2003/4 to 2004/5 is highlighted- but in terms of per cent growth across the period, there has been stronger growth in allied health professionals (AHP's) and in doctors (although these latter two groups are smaller in size). Growth in employment of nursing personnel is in any case partly a function of funding availability, assuming that there are additional nurses available to be employed.

Table 1: Trends in DHB employment, selected occupations, 2001/2 to 2006/7

		2001/02	2002/03	2003/04	2004/05	2005/06	2006/07 *
Sector Total	Medical Personnel	4,858	5,022	5,213	5,737	5,638	6,316
	Nursing Personnel	19,447	19,915	20,230	21,282	21,472	22,286
	Allied Health Personnel	8,953	7,655	7,888	9,628	9,978	10,189
	Support Personnel	2,472	3,840	3,723	2,238	2,234	2,279
	Management/Administration Personnel	8,923	8,968	9,252	9,825	9,595	9,804
Sector Total		44,653	45,400	46,306	48,710	48,917	50,875

% Growth	Medical Personnel		3.38%	3.80%	10.05%	(1.72%)	12.03%
	Nursing Personnel		2.41%	1.58%	5.20%	0.89%	3.79%
	Allied Health Personnel		(14.50 %)	3.06%	22.05%	3.64%	2.12%
Sector Total			1.67%	1.99%	5.19%	0.43%	4.00%

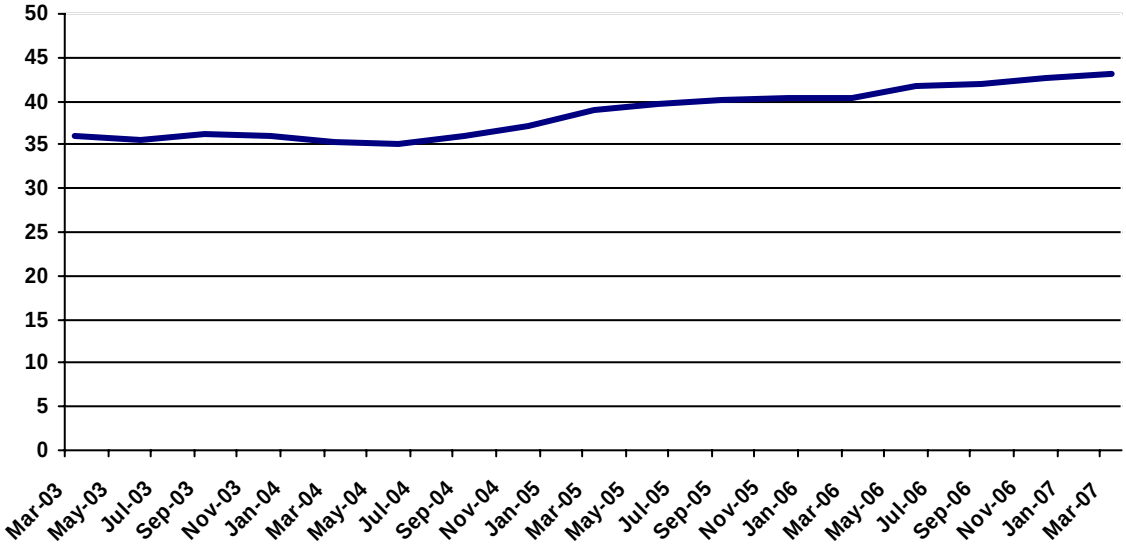
Source: DHBNZ. Data is compiled from rounded figures Information provided above is as at 30 June figure. Outsourced labour is not included.

* A FTE definition change was implemented effective 01 July 2006, therefore data from FY2006/07 forward is not directly comparable to previous years particularly the Medical Personnel.

The definition / recording of FTE for the financial years 2001/02 to 2005/06 are consistent, and therefore data is comparable.

A second source of data on employment trends is the Labour Force Survey. Data from the period between March 2003 and March 2007 is shown in Figure 1.

Figure 1: New Zealand Household Labour Force Survey- annual average number of "nursing and midwifery professionals" in employment, quarterly, March 2003 to March 2007 (thousands).



Source: Statistics New Zealand: Household Labour Force

The data from the labour force survey highlights a static situation in the period between March 2003 and September 2004, followed by constant growth in more recent years. Overall growth for nursing and midwifery professionals across the period was 19.7%, markedly higher than growth for all occupations in the same time period- 11%. (Note that this data covers all sectors, and is a headcount figure.)

A third source of data on employment growth across the period is the Statistics NZ censuses of 2001 and 2006 which gives a rudimentary "before and after" timing for the MECA, and provides some information on nursing numbers in sectors other than DHB. Table 2 below sets out the data (Note: some caution is required in interpreting this data as the occupation classification system changed between the two censuses).

Table 2: Employment change- selected occupational groups, 2001 and 2006, New Zealand

Employment Growth		Census 2001	Census 2006	Employment Growth
NZSCO Code	NZSCO Title			
22311	22311 Principal Nurse	444	1,455	227.7%
22312	22312 Registered Nurse	25,272	27,639	9.4%
22313	22313 Psychiatric Nurse	1,323	1,731	30.8%
22314	22314 Plunket Nurse	501	495	-1.2%
22315	22315 Public Health and District Nurse	1,077	1,326	23.1%
22316	22316 Occupational Health Nurse	213	192	-9.9%
22317	22317 Midwife	2,121	2,313	9.1%

Source: Statistics New Zealand, Census 2001 and 2006

The vast majority of the nursing workforce recorded in the census data were in the registered nurse category, which reported growth of 9.4% across the period 2001-2006. Similar rates of growth were reported for midwives, with higher growth for psychiatric nurses and for public health/ district nurses. In comparison, there was a reduction in Plunket nurses and occupational health nurses. Because this census data covers a range of employers it is not possible to ascertain the actual impact on DHB employment; however it is noticeable that employment dropped in two categories that are not in DHB employment- Plunket nurses and occupational health.

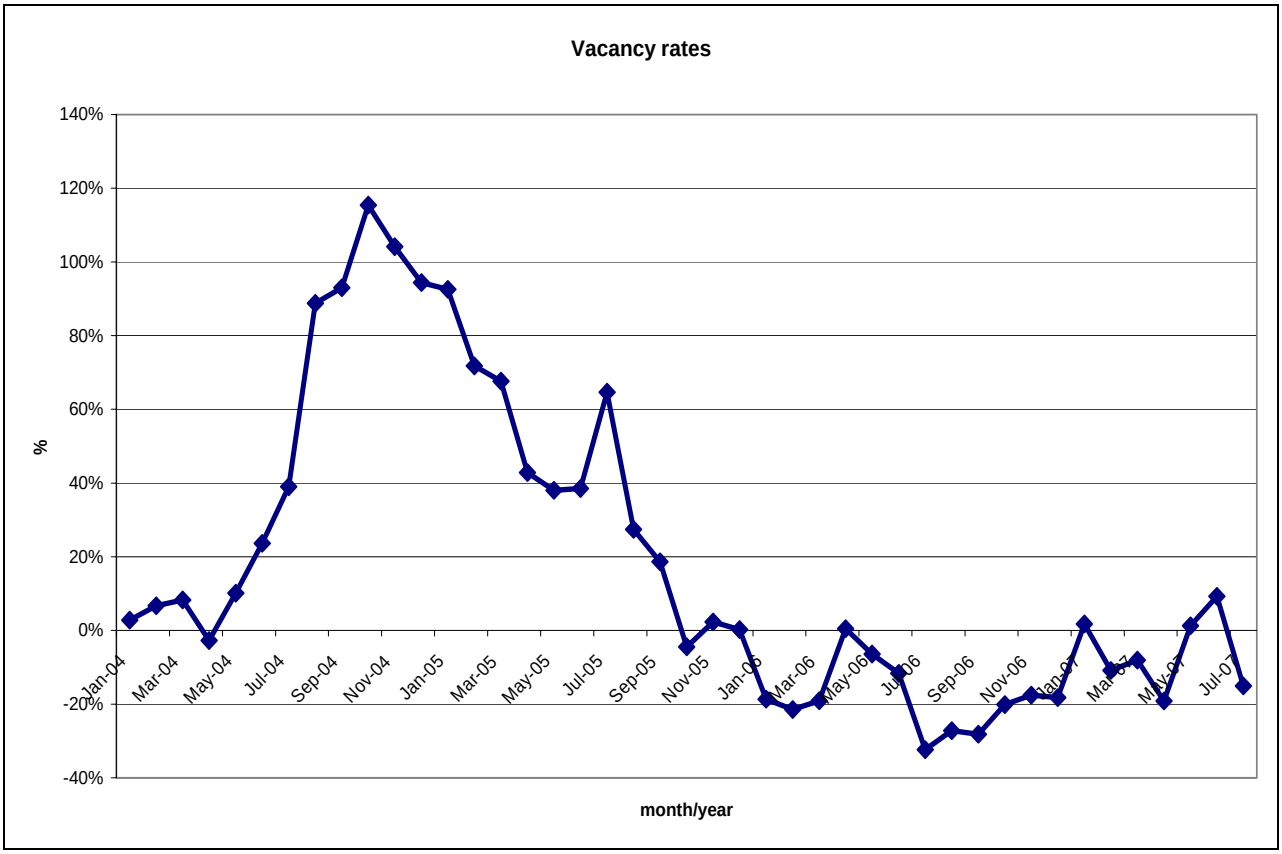
Vacancy rates and shortage indicators

Vacancy rates collated by the Department of Labour give some indication of the relative "tightness" of a labour market. The Job Vacancy Monitor (JVM) compiled by the Department provides estimates of annual vacancy rates, on a monthly basis. This JVM is a monthly analysis of job advertisements published in selected editions of 25 regional newspapers and on two IT websites, which enables monitoring of the number of advertised vacancies in each occupational category over time. The Department note that "Analysis of the JVM suggests that it is an indicator of change in labour market tightness, or change in the degree of difficulty of recruiting staff". (Note: some caution is required in interpreting the JVM data as it is based on a sample. In addition DHB employers use a range of methods to advertise vacancies,

including internal web sites- so the JVM may not be an accurate index of change over time.)

The trend in this rate highlights changes in the prevailing condition of the labour market- the higher the rate, the more likely it is that employers are experiencing difficulty in recruiting staff to fill vacancies that have occurred. The trend in annual rates for nurses, on a month basis over the period from January 2004 to July 2007, shows an increase in the rates up to November 2004, followed by a fairly steady decline in the reported rate up to late 2006 (Figure 2) .

Figure 2: Trend in annual rate of job vacancies for nurses, on a monthly basis over the period January 2005 to July 2007.



Source: Department of Labour: Job Vacancy Monitor

The Department of Labour also provides some data on "shortages" in selected occupations – which has included nurses in the period under examination. The Department notes that "A defining feature of the New Zealand labour market over the past six years has been the rapid growth in demand for labour and skills. This has resulted in a sharp fall in unemployment and an associated rise in skill and labour shortages", which highlights that the period under which the MECA was operating was one of relative tightness across labour markets.

To identify which occupations are currently in shortage, the Department of Labour (the Department) conducts the annual *Survey of Employers who have Recently Advertised* (SERA). The survey collects information on whether employers were able to fill their advertised vacancies, and the number of suitable candidates who applied. The Department notes that the data is very useful for assessing whether skill shortages exist for each occupation, but that the survey does not indicate the type of shortage

that exists, or the reasons for such shortages existing. The "fill rate" data- (the % of advertised vacant posts calculated as having been filled) is available for 2003, 2005 and 2006. Table 3 below highlights that by this measure, there was a reduction in the number of registered nurse vacancies advertised across the period, and that the fill rate in 2005 reduced, suggesting a tighter labour market.

Table 3: Fill Rates for Nursing and Midwifery Occupations, 2003-2006

		2003		2005		2006	
NZSCO	NZSCO Description	No.	% filled	No.	% filled	No.	% filled
22311	Principal Nurse	11	91%	12	58%	30	50%
22312	Registered Nurse	255	66%	143	30%	70	54%
22313	Psychiatric Nurse	-	-	24	13%	25	44%
22315	Public Health and District Nurse	-	-	-	-	14	71%
223	Nursing and Midwifery Professionals subtotal	307	68%	217	30%	155	54%

Source: Department of Labour

The Department reported that "Nurses and midwives moved out of extreme shortage in 2006, but remain difficult for employers to find with a little over half the advertised vacancies being filled". It also pinpointed the MECA as a factor that would improve recruitment and retention:

"The recent pay settlement between the District Health Boards (DHBs) and the NZNO is likely to positively influence nurse retention and encourage trained nurses to return to the labour force. In the longer term, it is expected to encourage more individuals to practice nursing in New Zealand". One DHB representative supported this viewpoint, noting that the DHB where he worked conducted regular "organisational climate" surveys and that ratings from nurses had improved after the MECA was implemented.

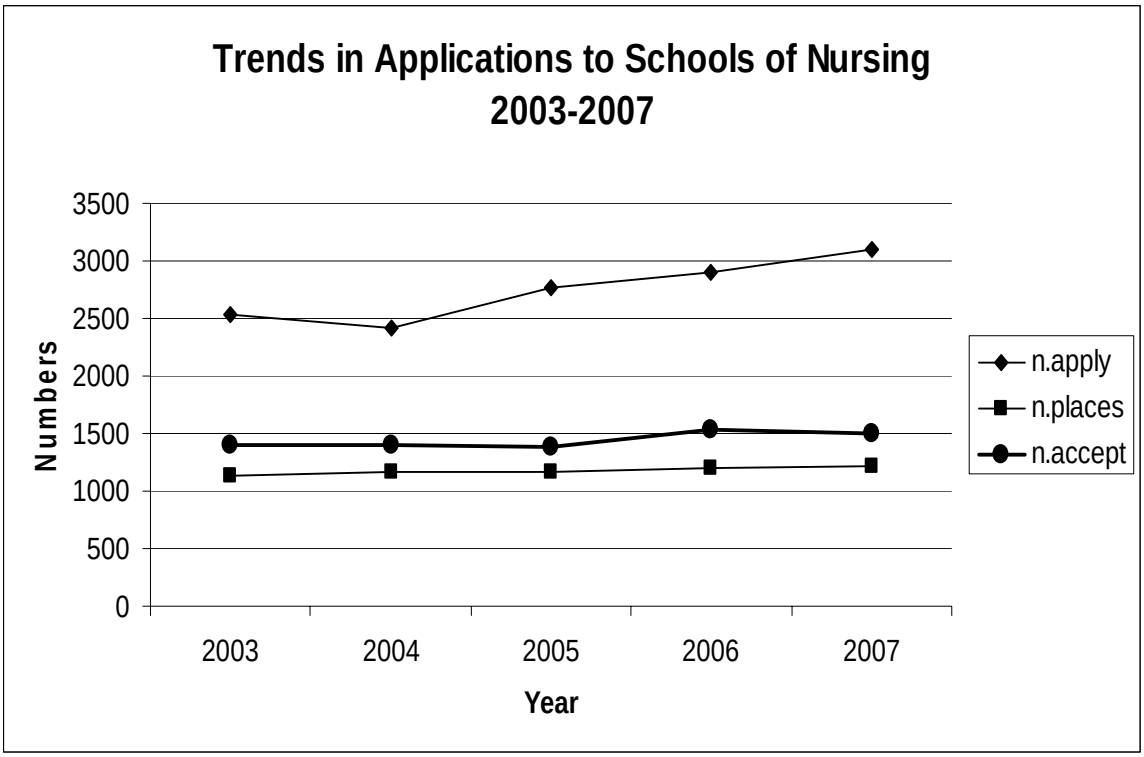
Applications and entrants to pre-registration nurse education.

If nursing was to become more attractive as a career option- either because pay rates become relatively more attractive, or for other reasons, it could be assumed that there would be an increase in applications to undertake pre-registration education. The trend in applications is a better indicator of any change in relative career attraction than is accepted applicants or places. The latter two indicators are primarily a function of funding allocation- assuming there are more suitably qualified applicants than places.

Data on trends in applications, acceptances, and places was requested from all 16 schools of nursing in New Zealand (3 university and the remainder technical institute schools). Responses were received from 14 Schools of Nursing offering undergraduate nursing programmes. Data for most schools in most years were complete, but 2003 data were missing from 4 schools, leaving 11 available for analysis.

The data from those 11 schools were totalled per year, and trends plotted, as shown below in Figure 3. These trends indicate that places available and acceptances are fairly constant, but numbers applying showed an upward trend from 2004/5 after a dip in 2003-2004.

Figure 3: Trends in Applications to Schools of Nursing 2003-2007



Source: Buchan and North, based on data supplied by schools

Additional comments were also received from some of the schools. Allowing for the fact that not all directors of schools commented, and that such comments as these reflect personal experiences and opinions (and are not necessarily representative), the comments do demonstrate that the impacts of MECA on nursing school applications was of interest to nurse educators. Some made an explicit link between application trends and the influence of the MECA:

> "Following public announcement of MECA in 2004 there appeared to be an increase in number of inquiries and an increase in the number of applications for the Bachelor of Nursing. This was not reflected in the number of applications in the years 2005 -2007".

> "The number of places was increased in 2006 due to extra demand and agreement from the local DHB. We had a lot of interest and higher than usual intake in 2006 as you can see. A lot of school leavers in 2007 – more than usual".

> Others were not so sure that there had been a direct link with the MECA: "The increased number of students … is not necessarily the impact of the MECA but an increased effort to grow the programme ... as this was a new programme at the time".
>
> "MECA does not influence applications. Young school leavers do not think about what they will be paid in the future".

The above data indicates that there was an increase in applicants to nurse education at the period after the MECA; what cannot be "proved" or disproved is whether the MECA itself was the cause. However, an increase in applications from well-qualified school leavers was noted. The nursing newspaper New Zealand Nursing Review (Cassie, 2007b, pp1 & 4) has reported that there had been a surge in applications in 2005, followed by another major upswing in 2006, with capacity filled for the first time in many years, and that applications included a high number of school leavers who had achieved well academically. This trend reversed years of reportedly little interest from school leavers, with many (but not all) heads of schools of nursing attributing the renewed interest in nursing to the improved pay and profile of nursing following MECA in 2004. The suggestion is that the 2004 MECA for nurses appears to have had an effect in raising the image of nursing as a profession of choice- but the impact is difficult to assess in any detail. For a complete picture of the influence of the MECA and other factors on candidate choice, primary research covering actual and prospective students would be required.

In summary, an examination of available data over the period 2003 onwards has highlighted the following:

- growth in levels of DHB employment of nurses;
- overall growth in nurse and midwife employment nationally (higher than the average for all occupations across 2003-2007) but a decline in employment of nurses in some non-government sectors (e.g. Plunket, occupational health);
- a significant drop in vacancy rates over the period from late 2004 onwards;
- a reported reduction in vacancies for registered nurses from 2004 to 2006, and decline in fill rate between 2004 and 2005; and

- an increase in numbers of applicants for pre-registration nurse education.

Whilst any one of these changes could be attributed to causes other than the impact of the MECA based award on pay, status and working conditions, it is noticeable that all the labour market indicators point to a tightening labour market for nurses after 2004, with varied growth in different sectors. The data on application trends to a sample of schools of nursing is more compelling, and highlights a significant growth in the number of people considering nursing as a career, coinciding with MECA and reversing a trend in the opposite direction. Taken together, the available data does point to improved attractiveness of nursing as a career and an increase in nurse employment from 2004 on.

5. Impact at DHB level

Based on consultations with key stakeholders and informants in two District Health Boards (DHBs), a further assessment of the impact of the MECA on individual DHBs was conducted. DHBs with contrasting characteristics were selected: one was typical of a large, metropolitan DHB offering regional and national tertiary services in addition to primary and secondary services to its own population; the other was a smaller DHB focused mainly on delivering services to its own population. Both DHBs had participated in regional MECAs on nurses' pay prior to the 2004 national MECA. This section therefore gives more information on impact at DHB level in only two contrasting DHB's; it is illustrative of impact in two contrasting DHB's; it cannot provide detail on ALL DHB's, and should not be taken as representative of the overall impact of MECA on these DHB's.

Informants in the two DHB's were asked to describe relevant contextual issues affecting nurses that were present in the few years preceding 2004. Both highlighted organisational change issues, and both also highlighted increases in difficulties with recruiting and retaining nurses.

Implementation

Respondents in the large DHB reported that they believed that they had a more complex implementation process, than was the case for some small DHBs, because of the size and diversity of their workforce. They highlighted that the translational process was very time consuming, while at the same time regular work needed to continue. The following summarises the level of detail attended to by those working on the translational process:

- automatic annual increments 2004-6 for each grade;
- implementation for senior nurses before and after the scoping exercise;
- movement through and between grades;
- allowances- higher duties, on-call, call back, overtime; provisions for leave- sick leave, shift leave, parental leave;
- minimum hours between shifts;
- provision for Professional Development & Recognition Programme (PDRP);

- removal of some previous allowances, e.g. a shoe and stocking allowance, and a midwifery allowance.

During implementation, management in DHB's also needed to manage expectations and reactions of their respective nursing and midwifery workforces. Management in one DHB noted that implementation of the MECA was made more difficult by the "5 months or so" between agreement and implementation. They reported that communications to staff about when pay rises would actually come through "could have been more strategic". And another DHB reported that it had to manage negative reactions from nurses whose pre-2004 pay was relatively high, compared to other DHBs at that time, and who therefore benefited relatively less from MECA than did nurses in some other regions.

In addition to changes to existing conditions and allowances, another contentious issue reported by managers in both DHB's concerned scoping of senior nurse positions. During the first year of the MECA, a national scoping exercise was to be jointly undertaken by DHBs and NZNO, using one agreed job evaluation tool *(Compers).* The agreed translational principles and scoping process for senior nurses required that senior nursing roles were individually entered into a costing model and translated into the new grades. The 7% increase was then applied to the individual's new base salary and band, or as a lump sum payment. Intended outcomes of the exercise were the defining of generic job titles and consistent salary scales across the country for appropriately graded positions. Comments from one of the DHB's highlighted that "Obtaining an agreed understanding on the principles for translating senior nursing roles onto the new salary grades has been extremely difficult".

Other groups of nurses were reportedly affected more positively. One such group was research nurses- a DHB reported that many of these groups had been employed on individual fixed term contracts attached to clinical trials and had not had pay increases for years. Many moved to the MECA contract and did very well in improved base rates and in receiving back pay.

Impact

The direct financial impact of the MECA on DHB's was off-set to an extent by government contribution to the costs of the nurses' pay increase. However, this contribution does not take into account the opportunity costs of the time spent by management and other staff involved in the translational and implementation process.

Management in both DHBs highlighted an expectation that increased pay for nurses would be associated with productivity increases – in particular, Treasury was seen as driving this expectation. In practice, respondents highlighted that it was difficult to view the productivity of nurses separately from that of other members of the health care team, or indeed separately from the productivity of the organisation as a whole. The difficulty of defining and agreeing a measure of "productivity" in nursing was also noted by respondents.

In relation to any effect of MECA on role redesign or review of skill mix, managers in both DHBs highlighted that redesign and changes to skill mix had already taken place, independent of MECA negotiations, and as such were not attributable directly to MECA.

The main reported negative outcomes of implementation of the MECA award were the contentions over changes to allowances, the impact on senior nurses, and the reported unhappiness in one of the two DHB's when increases in remuneration were low relative to nurses in some other DHBs where the catch-up was greater.

There were also reported fears at the time of the award that higher pay rates may allow DHB employed nurses and midwives who wanted better balance to their lives to reduce their hours while maintaining income (the so called "backward bending supply curve"). There is no national level systematically acquired data for 2004 and 2005 to check if this has occurred. There have been improvements more recently in regular reporting on a range of indicators, including full and part time contracts). One of the DHB's covered as a case study suggested that, anecdotally, there appeared to be no change in the part time/full time ratio of their nursing staff, but management at the other case study DHB reported that they believed there had been some nurses who had reduced their working hours as a result of the pay increase (but they did not have

hard data to substantiate this feeling). It also should be noted that other changes to employment law affecting working conditions which occurred at a similar time, including improved parental leave provision, shift allowances and increased holidays, could also reduce the imperative for nurses to reduce paid hours.

The MECA covering nurses and midwives was also reported to have had knock-on effects on other employee groups. First, not all nurses were covered by MECA, for example some mental health nurses, midwives, public health nurses, were not represented by NZNO. All these groups have subsequently used the NZNO-DHB MECA as the benchmark for their own pay bargaining, leading to a cascade effect of the MECA increases and negotiations with the unions covering those nurses and midwives to, as stated in a memorandum by the CEO of a DHB, "secure nationally consistent terms and conditions for Public Health, Mental Health nurses and midwives". Secondly, the 7 percent increase in senior nurses' base pay was used as a bargaining point by those allied health groups who were formerly paid higher than nurses and sought to regain their advantage. In addition, the argument of affordability ("the employer can afford x percent for nurses") was used to lever their case.

Views on the how best to determine nurses' pay

There were different views on whether national or regional MECA's were better for nurses. Management in the larger DHB highlighted concern that "their" nurses working in a high cost of living region were disadvantaged relative to others during translation to the new system. They also argued that in addition the national MECA had not taken fully into account the differences in skill and responsibility for nurses working in a tertiary hospital. Some continued to question if a "one size fits all" approach was the best for their staff, a view that has persisted as reported by some commentators. It was also argued by these managers that a national MECA was unresponsive to recruitment pressures that differed across DHB's.

Management in the other DHB reported a very different view. They characterised the pre-MECA situation as one where pay rate variations between DHB's which had "caused problems" and that there were "more pronounced" recruitment and retention challenges. They believed that a national MECA was better because "it's ridiculous to have so many different pay rates, based on who could negotiate well … ill feeling

was also caused if a DHB that could pay more wouldn't pay more. The national MECA stabilised this more". They also reported that "national bargaining has raised the status of the profession … it asks the government – how much do you care for your nursing workforce?"

In terms of actual indicators of change over the period, there was only limited evidence available from the two DHBs. This was in part due to changes and only recent improvements in workforce data gathering which meant that it was difficult to obtain standard trends data across the time period. One of the DHBs had data on nursing vacancies, which indicated that between 2004 and2007 there had been a steady increase in both the maximum days to fill each vacancy and the average number of days to fill a vacancy (Table 4). A likely explanation is that the nursing labour market in the region had tightened during the period.

Table 4: Registered nurses vacancies: average time to fill, DHB "A" (number of days)

Year	2003	2004	2004	2006	2007
	40.84	41.94	51.33	53.78	60.80

Source: DHB "A"

Management at the other DHB report declining difficulties with nurse and midwife recruitment and retention (Table 5). Organisational-level turnover rates in nursing had reduced from 17% in 2003 to 13% in 2007, whilst overall turnover rates had not shown the same reduction.

Table 5: Annual turnover rates, DHB "B".

Year	02-03	03-04	04-05	05-06	06-07
					(ytd annualised)
Nursing	16%	17%	16%	12%	13%
DHB average	15%	14%	17%	15%	13%

Source: DHB "B"

Management in DHB “B” stated that the main organisational impact of MECA (along with a strategy of improving organisational culture) had been improved recruitment and retention but there was “clear evidence” locally that the MECA had attracted nurses to the DHB from primary care and aged care. The reported impression of management at DHB “A” was that, anecdotally, nurses’ morale had improved and nurses “certainly felt more valued, recognised and acknowledged”.

6. Other sectors

As noted above, nurses working for employers other than DHBs (such as in private, charitable and non-Government sectors) were not covered by the MECA 2004. In order to provide a broader labour market and policy context, for the report, a range of non-Government organisations (NGOs) were interviewed on the impact on their organisations of the MECA. These organisations included: an umbrella organisation for primary health organisations and general practices; a private hospital; two aged care services; community-based services for mentally and intellectually disabled clients, and a nation-wide child health service.

Some of the employers of nurses not covered by the MECA reported that the MECA had negative impacts on their ability to recruit retain and manage a nursing workforce, while others reported a more positive perspective. An organisation in the primary care sector (that was able to pass on increased costs to users and had lifted the pay rates of the nurses that they employed to match), and an aged care provider (that negotiated its contract after the 2004 MECA and had benchmarked against it), were both positive in their comments on MECA, seeing it as "great to support nurses' remuneration" and "positive as helps retain nurses in NZ". The other aged care provider took a neutral view, stating that MECA had little or no impact on the organisation, partly because the numbers of registered nurses employed were low (they relied mainly on care assistants). However they did remark that MECA had increased staff costs as nurses' pay rates were raised to match MECA rates (and they also commented that they paid caregivers above the agreed base rate).

The views of those in the aged care sector need qualifying. One NGO represents large, long-established institutional facilities with dementia units, while the other is an innovative and recently established organisation. In the more traditional NGO, there was reportedly little opportunity for career development, no non- monetary rewards offered nor study support available. As for many other such providers, recruitment problems were long-standing:

"We have had great difficulty recruiting locally, but fortunately the staff turnover is fairly small. We have a lot of overseas nurses who come here for a year and then apply to go on new graduate programmes or look for a place at the major public hospitals as the career development in a small long term care establishment for older people is very limited."

The lack of career development in that NGO contrasted with the situation in the NGO that was positive about MECA. That NGO described a number of innovative characteristics: a restorative model underpinning the service; investment in professional development of staff, and RN staffing numbers driven by an RN: client ratio, not RN: support worker ratio.

In addition were differences in the way the service was paid for. The standard contract model is based on the number of clients and levels of service needed (based on level of care needed), a model that offers little flexibility or opportunity to introduce innovations. The innovative NGO described a different model:
"The contract is a fee-for service model, with each client visit (episode of service delivery) paid for, and covering all overheads. In addition are donations as this is a charitable organisation."

Others NGO's were less positive. This included a private for-profit hospital that could and did pass on pay increases to customers, but was critical of their lack of scope to influence DHBs on labour market decisions, and who noted that the flow-on pay increases they were forced to make to retain nurses did not take account of differences between small private and large public hospitals in the span and complexity of nurses' jobs.

However it was the not-for-profit NGO's providing publicly-funded services to vulnerable populations, unable to charge fees and pass on increased costs to customers, that reported the most pronounced and often adverse impacts. These impacts need to be considered in the wider context of service contracts. Like aged care providers, many such NGOs deliver community-based services to populations formerly cared for directly by public institutions; these include people with mental health needs and intellectual disability. Service contracts negotiated between funding

organisations, i.e. the DHB's and in some cases the Ministry of Health, and NGO's, are the basis for NGO's to have access to public money to deliver specified services to clients. However, as noted above regarding the traditional aged care provider, service contracts can be very tightly specified (e.g. in relation to numbers and levels of clients and staff), giving the NGO little or no flexibility. To complicate matters, some had just signed a 3 year contract on the eve of MECA in 2004, and were stuck for the duration of their contract in a weak negotiating position and without the means to raise their staff pay or introduce other rewards in response to DHB nurses' pay increases.

The reported impact on NGO's was variable. Several NGO's reported that service contracts did not allow them to match DHB nurses' pay scales, and that the contracts provided little opportunity to offer non-monetary rewards and introduce innovative measures in the contract period to allow NGOs to offset improved DHB pay.

Most, but not all, NGO's had service contracts with DHB funder arms, and they argued strongly that therefore these contracts should reflect the cost impact of the DHB/NZNO MECA. NGO's that held contracts with the Ministry of Health felt they were even more disadvantaged, and unable to bargain based on the MECA. These issues combined to give them a competitive disadvantage in the nursing labour market. One consequence described was an increased ratio of unregulated staff to nurses:

"There have been major changes in skill mix, simply because revenue is fixed and not diversified, and NGOs can buy two support workers for the price of one RN." (A community-based NGO)

They reported that they were not able to compete for nurses in a "level playing field", and described the nursing labour market as one characterised by inequity between bargaining power of different employer blocs. In such a context, even the traditional ways in which NGO's have competed- being innovative, working autonomously with a light regulatory framework governing day to day work, community based, regular hours with no shifts- are under pressure and may be constrained. An NGO observed

that “the gap is far too wide at base for RNs now” and a priority for them was to reduce that gap.

Many of these comments from NGOs do not directly focus on any perceived limitations with the content of the MECA, rather that they are derived from the NGOs perspective that they could not get directly involved in the process of bargaining for nurses pay, whilst having to deal with the labour market consequences of this bargaining.

The large population of practice and primary care nurses was also not covered by the NZNO/DHB MECA in 2004. Prior to the MECA there was a national Practice Nurse Agreement for many years, which NZNO had negotiated. Following the NZNO/DHB MECA, NZNO initiated bargaining for a wider Primary Health Care (PHC) MECA. The decision was then made to split that into two separate MECA's, the PHC MECA and the Maori and Iwi Provider MECA, a separation that would enable different processes to occur and take into account the unique circumstances for health professionals working within the Maori and Iwi Provider organisations. NZNO is involved in a separate bargaining structure process with Maori and Iwi providers.

In 2007 NZNO successfully concluded negotiations of a MECA covering some 2,500 practice nurses and also administrative staff, with the New Zealand Medical Association (NZMA) (Cassie, 2007a), a particularly complex bargaining process because of the very large number of employers (general practitioners) involved. The PHC MECA achieved pay parity with DHB nurses to a large extent, and although complete parity with nurses in DHBs was not reached, improvements were reportedly achieved.

To summarise some of the reported impacts of the NZNO/DHB MECA for NGOs, particularly those unable to raise additional funds except through service contracts, those consulted identified:

- increased negative pay differential compared to DHBs;
- increased staff costs when DHB rates were used as a benchmark;
- increased turnover as nurses left for DHB employment;

- greater recruitment difficulties and time to fill vacancies;
- operating costs increased as they needed to raise nurses' pay (where able) to match MECA so as to retain and recruit nurses;
- in some organisations nurse substitution resulting in an increased ratio of unregulated staff to professional staff;
- nurses feeling undervalued compared with DHB nurses.

In short, the response highlights the "knock on" effect of on the NGO sector of raising pay rates in another part of the New Zealand nursing labour market- the DHB sector.

The contrasts between the views of different NGO's highlighted other issues worthy of further investigation that indirectly affect the nursing labour market. First, the service contract models differed, and a fee for episodes of care model gave the NGO the ability to innovate and reward its nurses, flexibility not offered through the traditional service contract that bulk funds specified services. Second, the NGO using an innovative model of care linked to professional development of nurses, did not report the level of recruitment problems and shortages reported by the "traditional" NGO provider.

Respondents from both for-profit and not-for-profit NGOs reported there were no structured avenues through which to have input or to influence MECA negotiations, and believed that there was a need to develop a different, more inclusive way to determine nurses' pay. However, their underlying theme was that the imbalances characterising the post-MECA labour market for nurses and midwives were unsustainable. They favoured an approach where all employers of nurses were represented, not only DHBs as the major employer, and that there needed to be a benchmarking process to better evaluate nursing jobs, taking into account the diversity of what and where nurses work, and ranges of demand and complexity.

7. Summary and Conclusions

This report has made use of available data and information to assess the labour market and organisational impacts of significant pay increase ("pay jolt") for some, but not all, nurses and midwives working in New Zealand.

There are constraints in making a complete and detailed assessment, which relate to data limitations and to the difficulty of attributing causality in what is a complex and multi-factorial situation. However, it is possible to highlight key changes which have occurred since the 2004 MECA was fully implemented, and to make a rational assessment of its likely contribution to change across the period.

The key findings of this report are as follows:

- **Improvements in DHB employment levels**. There were improvements in recruitment/retention and "return" of nurses to DHB employment in the period immediately after the MECA was implemented.

- **The status of the profession has been raised, and morale of many nurses improved.** Increases in applications to nurse education have been attributed in part to the 2004 pay rise; many commentators have highlighted that morale of many nurses improved.

- **Differential impact during transition to the new system**. In the change from a multiple bargaining sector with different pay rates, to a single national bargaining system, there were inevitable relative "winners and losers" with lower pay increases in some high cost/high pay areas.

- **Knock on effects to other employers of nurses**. DHBs are the main, but not the only, employer of nurses. Some of these other employers, not covered by the MECA (such as some NGOs), reported a negative impact on their ability to compete for nurses.

- **Knock on effects to other employee groups in DHBs**. These include nurses and midwives not represented by NZNO, and allied health who sought to maintain their positive pay differential with nurses, and DHB administrative and clerical workers who attempted to emulate the approach of developing a MECA (PSA 2008).

- **Safe staffing is on the national and local agenda as a result of the 2004 MECA bargaining.** The 2004 agreement included a central drive to secure improvements in safe staffing policies and practices. Ensuring that staffing and pay were dealt with in an aligned way has long term implications. The publication of the Safe Staffing Committee report, a direct result of the 2004 MECA means that the focus on safe staffing will grow in significance ("this will impact as we go forward" commented one DHB representative)

- **There is now greater capacity to support and inform national bargaining.** DHBNZ has improved its resources, and more generally their have been enhancements of the workforce and labour market data available.

- **Tracking change.** Nursing workforce data has improved since the 2004 MECA, particularly in DHBNZ, but there remains scope for improvement. As with many health labour markets, there are multiple employers, and one key improvement would be to agree a national minimum data set that enabled stocks and flows of nurses to be tracked across sectors. The "new" supply of nurses is a critical component and it could be more effectively assessed and understood with a more systematic examination of trends in applications and acceptances to pre-registration nurse education. The impact of pay and other factors on the attitudes and behaviour of individual nurses could be monitored and trended using regular surveys of nurses.

- **There is not universal agreement that the current system of pay determination is "best".** Whilst many respondents reported general satisfaction with the current national MECA approach, others were less happy. Some employers of nurses external to DHBs want to be more directly involved

in national bargaining; whilst management in one of the two DHBs interviewed for this report continue to be concerned about responding to issues of high costs of living and role complexity within a national framework.

Debate about the "best" way to determine nurses pay will continue in New Zealand and elsewhere. As discussed earlier in this report, there have been varying local, regional and national focuses for pay determination in different countries at different times. What is clear from the evidence assessed for this report is that the nursing labour market in New Zealand in the run up to the 2004 MECA was exhibiting deep seated and potentially long terms problems. These related to low levels of participation, concern about staffing levels, and evidence of occupational detachment from nursing employment, and a potential lack of competitiveness in international nursing labour markets. The 2004 MECA addressed some of these inadequacies, for a period at least, and was also instrumental in getting safe staffing on the national agenda.

No pay system is invulnerable to external changes and internal challenges. The pay jolt of 2004 achieved its core objective of enabling public sector nurses' pay to catch up, or move forward (depending on your perspective). It could never be a one-off solution to longer term labour market challenges. Its legacies for New Zealand include more nurses in DHB workplaces, a pay determination system better served by national level capacity and data, and a systematic approach to safe staffing.

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Appendix 1: The 21 District Health Boards:

Auckland District Health Board (Auckland)

Bay of Plenty District Health Board (BOP)

Canterbury District Health Board (Canterbury)

Capital and Coast District Health Board (Capital & Coast)

Counties Manukau District Health Board (Counties Manukau)

Hawkes Bay District Health Board (Hawkes Bay)

Hutt Valley District Health Board (Hutt Valley)

Lakes District Health Board (Lakes)

MidCentral District Health Board (MidCentral)

Nelson Marlborough District Health Board (Nelson Marlborough)

Northland District Health Board (Northland)

Otago District Health Board (Otago)

South Canterbury District Health Board (South Canterbury)

Southland District Health Board (Southland)

Tairawhiti District Health Board (Tairawhiti)

Taranaki District Health Board (Taranaki)

Waikato District Health Board (Waikato)

Wairarapa District Health Board (Wairarapa)

Waitemata District Health Board (Waitemata)

West Coast District Health Board (West Coast)

Whanganui District Health Board (Whanganui)

Appendix 2: Registered Nurse/Midwife/Enrolled Nurse/Health Care Assistants/LMC Salary Scales 2004/5

Registered Nurse / Registered Midwife / DNs / PHN / CMHN Scale	**Auckland "current"**	**Auck DHBs Move effective 1/7/04**	**Other DHBs move effective 1/1/05**	**Other DHBs effective 1/4/05**	**All DHBs effective 1/7/05**	**All DHBs effective 1/7/06**
Step 5	45000	47780	45000	47780	50000	54000
Step 4	42529	44030	42529	44030	46180	48600
Step 3	40336	41750	40336	41750	44000	46000
Step 2	37883	39210	37883	39210	41200	43300
Step 1 (New Grad)	33917	35000	33917	35000	37000	40000
Enrolled/Obstetric/ Nurse Assistant / Karitane Nurses	**Auckland "current"**	**Auck DHBs Move effective 1/7/04**	**Other DHBs move effective 1/1/05**	**Other DHBs effective 1/4/05**	**All DHBs effective 1/7/05**	**All DHBs effective 1/7/06**
Step 4	36291	37380	36291	37380	38501	41000
Step 3	33855	34871	33855	34871	35917	38000
Step 2	31755	32708	31755	32708	33689	36000
Step 1	30476	31390	30476	31390	32332	
Health Care Assistants/ Hospital Aides	Auck Current	Auck DHBs Movt eff 1/7/04	Other DHBs eff 1/1/05	Other DHBs eff 1/4/05	All DHBs eff 1/7/05	All DHBs eff 1/7/06

Progression through the salary scales was by automatic annual increment, except for senior nurses/midwives whose advancement through the steps in their salary grade shall be annual, subject to satisfactory performance.

Appendix 3: Safe Staffing / Healthy Workplaces Inquiry Terms of Reference

The following is a response to the NZNO claim for enforceable fixed nurse/midwife: patient ratios and nursing / midwifery support to be included in the MECA. DHBs have acknowledged the concerns giving rise to this claim, and have undertaken in good faith to address them. Their view is that more sophisticated tools are required to address the issues arising here, and can be developed to meet the DHBs' and NZNO's objectives. The parties agree that in undertaking this Inquiry they are bound by the good faith requirements of the Employment Relations Act to meet its objectives, and that all the remedies available therein to enforce good faith will be available to them in relation to this process.

1. OBJECTIVE:

1.1 To develop and implement a system or systems of nursing/midwifery staffing levels which provide:

- efficient and safe services to patients and consumers
- manageable and safe workloads
- acknowledgement of the professional nature of their practice and time and support to maintain professional standards

1.2 To agree on sustainable solutions to identified issues

1.3 To ensure that evidence-based best practice is used in all DHBs, and avoid duplication of resources and effort

1.4 To address the concerns raised in the MECA negotiations regarding these issues in a way that has the confidence of nurses and midwives and provides a mechanism for nurses and midwives to respond immediately if workloads exceed the determined levels.

2. SCOPE:

2.1 The scope of this Inquiry shall include the following:

- Service provision
- Models of care
- Patient classification systems e.g. acuity measures

- Patient flow
- Skill mix (RN/RM/EN/HCA mix)
- Infrastructure (includes senior nursing / midwifery support)
- Workloads
- Nursing / midwifery care intensity levels / workload measurement
- Work/life balance
- Skills mix (range of RN/RM skills – Levels of Practice)
- Healthy work environment

3. COMMITTEE OF INQUIRY:

3.1 The Committee of Inquiry shall comprise agreed numbers of DHB and NZNO representatives to be determined by each party, plus representatives of the Ministry of Health and advisors to the Committee.

3.2 Total numbers on the Committee of Inquiry shall be jointly determined.

3.3 The Committee of Inquiry shall be chaired by an independent Chairperson agreed by both parties.

4. TIMEFRAMES:

4.1 The Inquiry shall commence within 2 months of settlement of the national NZNO / DHB MECA.

4.2 The Committee of Inquiry shall establish a Project Plan to be agreed by the CEO National appropriate timeframes.

4.3 It shall report every two months thereafter to the CEO National Group through DHBNZ and to NZNO through its Head Office.

4.4 Progress shall be reviewed against the Project Plan and reported at 6 monthly intervals.

4.5 The Inquiry shall be concluded and action commenced on the ratified implementation plan no later than July 2006, or earlier if practicable.

5. SECRETARIAT / BUDGET / SUPPORT SERVICES

5.1 Adequate resources will be provided to the Committee of Inquiry to ensure the efficient and timely operation of the Inquiry and ensure that both employers and employees can be fully involved in it.

5.2 A budget will be established by the Committee of Inquiry along with the Project Plan within the first two months.

6. RATIFICATION PROCESS:

6.1 The recommendations arising from the Inquiry shall be ratified by the CEO National Group and NZNO respectively before implementation. The Committee of Inquiry is not prevented from making recommendations required to meet objectives due to current funding constraints. If DHBs are unable to meet any recommendations from within existing budgets, a joint approach will be made to Government for additional funding

Appendix 4: Key recommendations of the Report of the Safe Staffing/ Health Workplaces Committee

The Committee acknowledged that there was "an urgent need to address the way the nursing and midwifery workforce is currently managed and supported" (exec. Summary) One of the key recommendations was to establish a Safe Staffing/Healthy Workplaces Unit within District Health Boards New Zealand (DHBNZ).The recommendations of the report covered four time periods:

Making it happen (0-3 months)

Endorsement of the work of the Committee, secure funding and begin establishing a Safe Staffing/Healthy Workplaces

Positive change now (0-9 months)

DHBs to ensure that there is adequate access to clinical leadership 24 hours a day, seven days a week, at all levels of the organisation (e.g there is a minimum of one nurse line manager/team leader for a team, unit or service.

When a nurse or midwife providing direct care considers their workload to have reached the limits of safe practice, they will immediately utilise current (and recommended) processes to preserve standards of care while meeting throughput requirements.

Following every instance of unsafe staffing being notified:

- The Nurse or Midwifery Manager or Duty Manager will ensure that a report is provided to the DoN via the DHB's Incident Reporting System.
- The DoN will report to the Chief Executive, including outcomes, analysis, and actions taken for future prevention.
- The DoN will report all unsafe staffing events monthly to the Clinical Board or its equivalent.

All DHBs will have a leadership position for nurses and, where appropriate, a separate position for midwives. These leaders will report to the Chief Executive, and have decision-making responsibility for nursing and midwifery care.

DHBs will support a "no cancellation" policy for any approved training and education leave, unless at least two weeks' notice is given so that all possible alternatives to cancellation can be explored. Training will be scheduled to facilitate staff attendance.

Sustainable change (0-2 years)

DHBs will utilise the Elements (see Chapter 4) in their budgeting and forecasting in 2007/08, and in planning for the 2008/09 District Annual Plan.

DHB management and staff will work specifically on the following:

- developing strategies to improve the quality of the workplace culture
- demonstrating in organisational structures and processes the way in which nursing and midwifery authority and participation in decision-making are aligned to levels of responsibility and accountability
- establishing quality and safety as a principal responsibility of both management and individual nurses and midwives, through shared quality programmes
- working towards generic competencies to enhance staff movement between DHBs
- making provision for education and training to be recognised as work and integrated into everyday activity, requiring protected time and dedicated resources
- nurses and midwives having access to coaching and training regarding quality improvement and systems safety generally
- using all sources of quality and safety data, whether patient- or staff-related, in integrated ways to inform the whole system
- ensuring responsiveness and timeliness of response to identified quality and safety issues, using Incident Reporting Systems
- the DoN reporting on all incidents relating to nurses or midwives and patients to the Clinical Board on a regular basis
- where there are changes in the service (e.g. service reconfiguration, new technology or equipment, or process review), nurses and midwives being involved

in the development of proposals for change and management of that change, with reference to the Management of Change clause in the MECA
- contributing to the work of the SSHW Unit
- implementing the work of the SSHW Unit as this becomes available.

Chief Executives and the National Capital Committee will ensure that there is nursing and midwifery involvement in the planning of capital projects.

Chief Executives of DHBs will ensure the early involvement of nurses and midwives in workplace redesign or refurbishment.

The SSHW Unit will facilitate the development and implementation of:
- best practice guidelines for patient forecasting and patient workload management systems, for roll-out in all DHBs where systems do not meet these guidelines
- a "toolkit" of best practice in nursing and midwifery staffing systems and the management of these systems, including models for providing direct clinical support
- nursing and midwifery leadership and management competencies, which will guide the development of job descriptions, postgraduate and industry-specific training programmes, and on-the-job education and development
- nurse-sensitive, patient-outcome data for inclusion in nationally collected data sets, and DHB performance monitoring, to ascertain the impact of changes in the nursing and midwifery workforce and to benchmark patient outcomes within provider arms and across DHBs
- nationally reportable information on the nursing and midwifery workforce (e.g. turnover, sick leave, qualifi cations, age, distribution) to monitor the health and status of the current and future workforce, in order to track trends, modify strategies and predict future requirements
- processes to audit the DHBs' progress in implementing the Action Plan
- strategies that DHBs will utilise to work with nurses, midwives and others to assess a preferred culture, and to develop and maintain that culture.

DHBs and NZNO, in collaboration with tertiary education providers, the Clinical Training Agency and Regulatory Authorities, will develop a national framework to support post-entry education and clinical teaching in nursing and midwifery. The framework will quantify the direct and indirect costs and resource requirements to support appropriate provision within organisational budgets.

Evaluation and monitoring (0-3 years)

The DHBs will report six-monthly on progress against the Action Plan, to be collated by the SSHW Unit.

Using the processes developed by the SSHW Unit, formal audit will take place of the progress made by all DHBs, individually and collectively, by 30 June 2008, with a report to the parties, the Ministry of Health and the Minister of Health.