Voluntary Bonding Scheme

Submission to the Health Workforce New Zealand, Ministry of Health

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Contact

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Voluntary Bonding Scheme (VBS).

2. The Survey was circulated to all NZNO member groups, including members of the National Student Unit (NSU), Colleges, Sections, midwives, Te Rūnanga o Aotearoa, directors of nursing and nurse educators, and professional nursing, policy, and research advisers. Their feedback informs this submission.

3. The format of the survey was problematic for an organisation such as ours.

4. In general we have found that, for nurses, the VBS:

    - provides a comparatively small, but welcome, financial benefit and opportunity to a very small number of new graduate nurses and midwives whose interests generally coincide with, rather than are incentivised by, the areas covered by the VBS;

    - is limited in the contribution it makes to addressing skills shortages over time because it does not address issues of skill mix and experience, which are critical factors in ensuring workforce safety and retention in hard-to-staff specialties;

    - does not encourage relocation of graduate nurses to hard-to-staff communities areas because of the very limited choice on

offer - Wairoa District, West Coast DHB or South Canterbury DHB - and because it does not contribute to the immediate or ongoing costs of relocation;

- is of minor influence/consequence in the current employment environment where hundreds of nursing graduates remain unemployed months, and even some years, after graduation, and where employment post Nurse Entry to Practice programme (NETP) is not assured;

- is inappropriately targeted at specialty areas which are hard to staff because of inferior wages and conditions, (which the VBS does not compensate for) eg Māori and iwi providers, aged care; and

- includes speciality areas which are not necessarily difficult to staff such as tamariki ora/well child (Plunket) services.

5. In the current employment and health funding environment, we consider it unlikely that the limited and poorly resourced VBS can make much difference to shoring up nursing skills gaps in core health services throughout the country.

6. Moreover we suggest that the alignment of the VBS with new graduates may not be the best way of addressing skills shortages in specific areas; for nurses, its impact on supplementary problems such as new graduate employment and loan repayment is minor.

7. Accordingly, we make a number of recommendations to improve the effectiveness of the VBS and outcomes for the nursing workforce, including:

    - extending the entry timeframe to 4 or 5 years to better address the skill mix and experience requirements of staffing needs in complex, hard to staff areas;

    - increasing the number of hard-to-staff locations for nurses to reflect health need;

    - adding Capital and Coast DHB (CCDHB) to hard-to- staff locations for midwives;

    - removing aged care and tamariki ora from hard to staff areas

    - increasing the size of the incentive relative to nursing/midwifery student debt;

    - extending the VBS to all nurses including nurse practitioners (NPs) and enrolled nurses (ENs);

- extending the VBS to psychologists who are an integral part of the mental health team; and
- making the VBS available to more midwives and have a higher reimbursement payment.

8. We suggest that the VBS is promoted more widely and made more flexible to encourage higher participation.

9. We also strongly recommend that priority be given to resourcing entry to practice programmes for all nurse and midwifery graduates.

10. Finally we suggest that the VBS could be used to incentivise practitioners into emerging fields/expanded practice/new models of care eg colonoscopy nurses to support the national bowel screening programme and expanded practice.

DISCUSSION

11. NZNO's view is that that the only context within which a VBS constitutes a rational use of resources and a fair incentive for new graduates, is one in which there is sound workforce planning for a self-sustainable workforce. Ie it should be part of a comprehensive health and workforce strategy rather than a crisis management tool.

12. The priority for the nursing and midwifery workforces is to ensure that all graduates are supported into practice through an Entry to Practice programme, as is the case with the apprenticeship model for medical practitioners[1]. Currently only 60% of registered nurse (RN) graduates are supported into practice, a similar scheme is only just starting for ENs and entry to practice positions for midwives in some services have been cut.

13. In the current context of continued unemployment of new nursing graduates, and skills shortages/high turnover in under-resourced health services with vulnerable clients, we question the safety and cost effectiveness of incentivising inexperienced practitioners to work in complex areas, where the elements of safe staffing/healthy workplaces[2] (ie the right number of appropriately skilled and experienced staff, in the right place, at the right time, with appropriate resources) are not met.

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[1] Eg New Zealand Medical Association Position Statement on Medical Education and Training, 2013. Retrieved July 2017 from https://www.nzma.org.nz/__data/assets/pdf_file/0015/1455/Medical-education-and-training-2013.pdf

[2] Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry. 2006. Wellington.

14. Our experience with new graduates is that they do not want to go to, or stay in, services where the safety of both patients and practitioners is compromised because there are not enough staff with the right knowledge and experience to assure the delivery of safe effective care.

15. First experiences can be critical to graduates' decision to remain in the profession itself; delayed employment and stressful, unsafe conditions increase the risk of graduates leaving the profession[3].

16. Extending the VBS to more experienced nurses and midwives would mitigate the risk to public safety of the most vulnerable services being staffed by the least experienced practitioners, and reduce the significant personal and public costs of losing qualified practitioners early in their careers.

17. It is also possible that experienced practitioners may be more confident about practising in isolated, and/or professionally isolated areas, than newly-qualified graduates.

18. All regulated nurses - RNs, ENs and NPs - should be eligible for the VBS and the numbers and remuneration increased.

19. We are also astonished, given the workforce challenges in mental health and increased community provision of mental health services, that psychologists are not eligible for the VBS. We strongly recommend that this group of practitioners is added.

20. Finally, notwithstanding the quite cynical indication that there will be no change in funding despite increases in population, aging and health demand, we recommend that you consider making the VBS to all new graduates in their chosen field and location. As former NZNO President, Marion Guy, said when the VBS was introduced[4]:

> "The fact is we have a real problem retaining our graduates right across the spectrum of nursing. We would prefer to see the scheme open to every graduate who establishes their nursing career in New Zealand, not just a targeted few. "

21. Similarly former chair of the NZNO National Student Unit noted:

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[3] Bowles, Cheryl; Candela, Lori. First Job Experiences of Recent RN Graduates: Improving the Work Environment. *Journal of Nursing Administration*: March 2005. Volume 35, Issue 3, pp130–137.

[4] NZNO Media Release *Nationals Bonding Measures Not a Long Term Solution* Retrieved July 2017 http://www.nzno.org.nz/about_us/media_releases/articletype/articleview/articleid/72/categoryid/16/nationals-bonding-measures-not-a-long-term-solution

> The chairperson of the, Michelle Wipiiti is concerned that the policy does not go far enough "Student debt is a tremendous concern to student nurses and to those recently graduated. There is merit in what the Government has proposed but more needs to be done to ensure that more young people are attracted to the nursing profession and establish their nursing careers in New Zealand. Nurses should not have to incur significant debt in order to deliver care to our communities. Helping graduates pay off debt is appreciated but we also have to make it possible for nurses to train without taking on a huge personal debt in the first place."

Hard to staff locations

22. It is difficult to see why only three locations have been singled out for nurses. We note that Northland has similar characteristics to the West Coast and *many* areas in Gisborne, (not just Wairoa) which make it difficult to attract staff ie rural, remote, high Māori population, poor.

23. However, virtually all DHBs have areas of deprivation where there are high health needs and inadequate staffing, and these may change eg in response to a natural disaster, or retirement of a specialist, or a large-scale exodus of practitioners.

24. The arbitrary and very limited range of locations (especially in comparison to those eligible to other professions) disadvantages nurses and other hard to staff areas, including those with high Māori and rural populations. Māori, Pacific peoples and those living in the most deprived areas generally report poorer health than others. Asian health is generally good.

25. Alternative criteria to those currently used to identify hard-to-staff areas are needed and we strongly recommend that they are informed by evidence for unmet health need, which is currently lacking. We take this opportunity to recommend a definitive national survey of unmet secondary healthcare conducted by an independent expert group is undertaken.

26. Resources, including the VBS, should be directed to the areas of highest need (throughout the country and to specific population groups). The enactment of te Tiriti o Waitangi articles would ensure that Māori experience the same health outcomes as the rest of the population; clearly, they do not [5].

27. As noted above, only one small area (Wairoa) of one high Māori population location was included for nurses, which begs the question of

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[5] "Māori report poorer outcomes Ministry of Health. 2016. Annual Update of Key Results 2015/16:
New Zealand Health Survey. Wellington: Ministry of Health.

what the VBS is trying to achieve, if it is not prioritising staffing in deprived areas with substantial Māori populations.

28. NZNO midwife members advise that CCDHB should be identified as a hard-to-staff location for midwives and that in general more midwives should be eligible for the VBS.

Hard to staff specialties for nurses

Aged Care (aged residential care and older persons' health services)

29. NZNO does not support the VBS being used to incentivise staff to go to specialties which are understaffed primarily because of poor wages and conditions, including, critically, a lack of professional peer support.

30. Immigration Aotearoa New Zealand 2016 PIERS report indicates that the average RN wage in privatised aged care was $40,000, considerably below the ~$49,000 starting salary for DHB-employed RNs.

31. NZNO's professional advisers who have experience and expertise in aged care, are reluctant to recommend new graduates accept positions in aged care unless they are on a NEtP programme. There are very few of these available and staffing challenges in aged care, including high turnover of nurse mentors, means that they are often insecure.

32. New graduates have sometimes had to leave these positions because they were not able to access the NEtP training/education required, even where it was offered in partnership with DHBs. If new graduates supported into practice find it difficult, we see no reason to encourage new graduates who don't have access to the same mentorship.

33. We also note that many (not all) aged care facilities have substituted ENs with unregulated health care assistants, reducing the pool of clinically trained regulated staff.

34. While there is abundant evidence showcasing the value of nurses in aged care[6], there is not the same support for NPs despite a successful demonstration coordinated by Health Workforce New Zealand some years ago[7]. We note that the latter is particularly relevant, since the demonstration utilising NPs in response to a GP shortage in the MidCentral region.

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[6] Ministry of Health webpage: Showcasing nursing in aged care. Retrieved July 2017 http://www.health.govt.nz/our-work/nursing/developments-nursing/showcasing-aged-care-nursing

[7] Peri K., Boyd M., Foster S. and Stillwell Y. 2013. Evaluation of the Nurse Practitioner in Aged Care. Palmerston North: MidCentral District Health Board.

35. Ensuring both ENs and NPs were eligible for the VBS (and note our points below with regard to the timeframe for repayment of student debt) could address some skills shortages in aged care.

36. However, we suggest that addressing the systemic causes of why it is hard to attract staff to aged care is the priority. We take this opportunity to recommend urgent attention is given to development of mandatory staffing levels in aged care, and that pay and safe staffing/health workplace conditions in all Aged-related Residential Care (ARRC) service agreements are aligned with the DHB MECA.

Mental Health (hospital and community, including addiction services)

37. NZNO has the same reservations about new graduates going directly into mental health services without being supported into practice as in aged care.

38. Staff shortages *are* acute in some areas, including Canterbury DHB where the effect of the earthquakes has given rise to predictably high levels of stress and mental health issues.

39. In addition, progressive policy changes relating to seclusion and restraint without the resources needed to implement have had an adverse impact on patient and staff safety[8].

40. Again our experience is that new graduates going into mental health services that are under pressure are at risk themselves and much less likely to stay in both the service and the profession.

41. Mental health nurses work closely with doctors, social workers *and* psychologists. Those working in community services, including drug and addiction services, report significant delays in accessing psychologists which compromises the quality of health care available to clients.

Community Care (including practice nurses, public health nurses, well child (Tamariki Ora) nurses, district nurses and Māori and Pacific provider nurses)

42. We understand that*, in general*, Well child/Tamariki ora services do not have the same difficulties with recruitment of nurses as other specialities where shift work is required, and they do have very good training and support.

43. The same is true, for practice nurses and district nurses though, as indicated, there are individual services and regions in all DHBs that can

[8] *Kai Tiaki Nursing Journal*. September 2016. NZNO: Wellington.

be difficult to staff, especially where there are heavy workloads and poorer pay.

44. It has been well documented for over a decade that the level of funding for Māori and iwi health providers is inadequate and does not support fair levels of remuneration for health practitioners which remain up to 25% less than their DHB counterparts. Addressing funding shortfalls, ie removing structural barriers to health equity would improve staff recruitment and retention levels in hard-to-staff these specialties.

45. We agree that there are not enough public health nurses – indeed the public health nursing workforce has declined alarmingly and steadily over the past few decades. However, again we suggest that there is a need for broader systemic intervention to support and grow the public health nursing workforce than the VBS.

46. The fact that public health nurses have been selected to act as lead professionals on (vulnerable) Children's Teams may indicate that more public health (and tamariki ora?) nurses may be needed in the future. However, these roles require experienced nurses, not new graduates.

47. We suggest you may want to consider using the VBS to incentivise nurses moving into areas where there will be increased demand eg colonoscopy, to support the national bowel screening project.

Student debt and repayment period

48. The value of the VBS ($2800 per year for nurses and slightly more for midwives) must be considered in relation to student debt. We submit the amount is so low, it is not an incentive, and question why it is less than a third of that for doctors when the difference in fees and years before earning is hardly on that scale.

49. The average cost of fees for a three year bachelor degree in nursing (BN) is around $21,000. Most students face additional costs with course materials and living costs and many do not qualify for student loans that they do not have to pay back. We estimate that the average nursing student debt is between $40- $50,000, based on a 2013 survey which found that 71% of student nurses emerged with debts of between $30,000 and $40,000[9] and anecdotal evidence.

50. A 2017 survey of nursing students found that: "Financial difficulties can be particularly problematic in a nursing context, due to factors like

[9] Walker, Léonie. 2013. *NSU National Student Survey,* NZNO Retrieved July 2017 from *http://www.nzno.org.nz/Portals/0/publications/NSU%202013%20-%20National%20nursing%20student%20survey.pdf*

spending a lot of time on placement (unpaid), and having 33% having responsibility for children/whānau."[10].

51. Very few nursing or midwifery students will be free of student debt within the VBS entry timeframe of 2 years post-graduation and less than half of *all* students, not just nurses and midwives, will have finished repayments at the end of the bonding period according to the latest Student Loan Scheme Report (Ministry of Education, 2016).

52. Repayment times vary, but the report indicates that most take between 8 and 14 years to pay off a Bachelor's degree, almost 18 years to pay off a Diploma (eg Enrolled Nursing) and around 13.5 years to pay for post graduate education. A high proportion of nurses (38% of RNs, 100% NPs and 12% of ENs) hold post registration qualifications[11].

53. Females, who constitute the overwhelming majority of nurses and midwives, make up a greater proportion of borrowers than males and take slightly longer to repay their debt.

54. If the VBS is to incentivise nurses and midwives, the payments will have to increase, and be proportionate between professions.

CONCLUSION

55. The priority for hard to staff specialties and locations is to ensure that staffing numbers and skill-mix support safe and sustainable nursing and midwifery workforces.

56. While we recommend that priority be given to resourcing entry to practice programmes for all nurse and midwifery graduates, and to addressing systemic issues such as pay disparities, student debt, lack of coordinated planning and structural discrimination we suggest that the VBS could be more effective if you:

    - extend the entry timeframe to 4 or 5 years to better address the skill mix and experience requirements in complex, hard to staff areas;
    - increase the payment;
    - increase the number of hard to staff locations for nurses to reflect health need;

[10] In press NZNO, NSU Student Survey 2017. NZNO: Wellington.
[11] Nursing Council of New Zealand. (2015).*The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses* 2014¬2015. Wellington: Author.

- add Capital and Coast DHB (CCDHB) to hard-to-staff locations for midwives;
- remove aged care and tamariki ora from hard to staff areas
- increase the size of the incentive relative to nursing/midwifery student debt;
- extend the VBS to all nurses including nurse practitioners (NPs) and enrolled nurses (ENs);
- extend the VBS to psychologists who are an integral part of the mental health team;
- make the VBS available to more midwives and
- use it to incentivise practitioners into emerging fields and new scopes of practice/models of care eg colonoscopy nurses to support the national bowel screening programme; utilising NPs etc.

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