Clarifying Funding for Post-Registration Nursing Education

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Preface

Nursing is the largest health professional workforce, both in number and by geographic distribution. As a result nursing has the furthest reaching arm, giving patients access to responsive health care. The single most effective way to achieve improved access to health care for all is to shape, educate and deploy our nursing resource wisely so that the profession’s capabilities can be realised. Until now the funding process may best be described by words like ‘chaotic’ and ‘haphazard’, and a move towards rational, prioritised allocation based on needs is long overdue.

The purpose of this document is to place context around the way post-registration education has been determined and funded over the past two decades. It aims to provide an historical perspective, current context and guiding principles for improving the synergy between nursing education and practice. There is much we can learn in this way and is essential the lessons from the past inform today's decisions so as to ensure a better future.

As we move into better informed and collaborative national health forums we need to take lessons from the past and apply them to our policy making if we are to move in directions that will improve the health of our nation and our communities. Whatever our particular roles and perspectives on health and nursing, patient health and safety sits at the centre of our national health objectives. This must be the driver for decision-making and will lead to sustainably effective nursing education programmes.

The messages for us all, in partnership with the Ministries of Health and Education, are to look towards an open, equitable and encouraging system of education funding for health professionals.

We must help establish new collegial trails where open, well reasoned and informed education funding decisions are made. This discussion document will help give nurses and those charged with responsibility for health workforce planning and funding an historical perspective, the current context and guiding principles for strengthening the engagement between nursing education and practice.

Geoff Annals
CEO
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February 2010
Executive Summary

- Comprehensive population health need analysis must underpin workforce planning and education. Physical aspects of conditions are currently measured (e.g., diabetes, heart disease and asthma) yet other components of health – e.g., psychological and emotional – warrant closer attention in the District Health Boards’ Annual Plans (DAPs) to inform nursing workforce and education needs’ planning.

- Inadequate and inequitable funding of nursing education for many years has reduced the contribution that nursing can and could make towards meeting the individual and population health needs of New Zealanders.

- Nursing forms the largest group of health professionals so its reach for the provision of health care is particularly significant.

- With both the Ministry of Health (Clinical Training Agency) and Ministry of Education are pivotal in the funding of post-registration nursing education. The relationships between the DHBs and the tertiary education organisations (TEOs) are vital to success. Communication and co-ordination between all stakeholders is essential.

- The CTA was formed in 1993 following the Government funding split for health professionals’ education between Vote Health and Vote Education. It has evolved over the past 17 years with a historically weighted funding priority being given largely to medical education. Nursing, despite its size in the health workforce, is awarded only fifteen percent of CTA funding.

- Having an educated, competent and confident nursing workforce needs high priority in order to realise the profession’s capabilities especially given the 2009 call (Gorman, Horsburgh & Abbott) to work collaboratively with other health professionals.

- The 1998 Ministerial Taskforce on Nursing was charged with finding strategies to remove the barriers to providing nursing services more effectively. The Taskforce recommended that “funding decisions are made with a national focus”, and that a “funding formula similar to that currently [then] used by the CTA be developed.”

- By 2006 the CTA had three models of funding for postgraduate nursing training. These were: nursing entry to practice (NETP); Ex-deficit nursing; and national nursing training programmes. A new funding model was introduced from December 2006 to be administered by DHBs. The funding provided for postgraduate (level 800) nursing education to all the DHB or Ministry of Health funded health services nursing workforce.
• NETP Programmes for graduate nurses are funded 50 percent by the DHB and 50 percent by the CTA (total of $12,000 per graduate). This contrasts with the first year House Surgeons who are funded 100 percent by the CTA during their year of provisional registration.

• In 2009 the CTA commissioned the Health Workforce Information Programme (HWIP) in conjunction with the Nursing and Midwifery Workforce Strategy Group (DHBNZ), to undertake a series of modelling and forecasting exercises on the current regulated nursing workforce in NZ to provide a robust basis for current and future workforce planning.

• The Minister of Health established a Committee on Strategic Oversight for Nursing Education in 2009 which comprised one member, Len Cook. He wrote to the need for leadership and decision-making to occur at a consistent, system-wide level.

• The Clinical Training Agency Board (CTAB) was established in 2009 under section 11 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act) to provide advice to oversee the rationalisation of workforce planning, training, education and purchasing within the health sector. The CTAB is now called Health Workforce New Zealand (HWNZ).

• NZNO proposes seven guiding principles for taking post-registration nursing education forward. These are that the education content and processes be: Appropriate; Acceptable; Affordable; Accessible; Relevant; Supported and Evaluated in order to effectively meet the informed and agreed outcomes.

• If nursing in New Zealand is to be adequately educated to work to its potential, it is essential that post-registration nursing education, fit for purpose and adhering to these principles, is put in place and funded.
Introduction

Over recent decades the health sector has changed rapidly, with large and sometimes seemingly haphazard policy shifts testing the ability of health professionals to produce consistent, patient-focused outcomes. Responses to continuing change have been mixed, with some staff easily flexing to what is new and significant, and others strongly resisting letting go of systems they know, and – at the extreme - reacting by leaving their job or New Zealand.

Is it possible, through education, to shift our response to change as health professionals so it is positive and proactive? How can we best devise a way forward that will lead to the players feeling valued and engaged? That is our current challenge and the basis of this paper, which examines the evolution of funding structures affecting post-registration nursing education and the impact of changing approaches to funding allocations. Ultimately, the way the political process handles the allocation of resources, while responding to pressures from competing interests, determines how far-reaching changes in the health sector will be, and whether outcomes will be beneficial or disruptive to the agencies and the people – including patients - involved. Using influence through lobbying and networking is integral to the political process, and our education must raise our political awareness so we are better able to achieve the health service and patient outcomes we need and want.

The so called “Shock Doctrine” has become a familiar element of reform strategies, with sudden seismic policy shifts being used by forceful proponents to shake up established processes, and to get past the entrenched ability of organisations to absorb incremental reforms without changing appreciably (Klein, 2007). In parts of the health system (and certainly in nursing) this has had a bewildering impact at times, with grand visions imposed from above creating varying mixes of chaos, bottlenecks and alienation in the workplace. At a managerial level there is an understandable tendency to make the changes work rather than to report or remedy their inadequacies – since 1980 there have been four major attempts at reforming the public health service by changing the model (Cook & Hughes, 2009, p. 7). The authors write that, “the nature of hospital treatment and where health services are delivered and resources placed have typified how the public health service may have changed more significantly than any other complex part of the public sector (ibid, p. 10)”.

It becomes very hard to distinguish between valid criticism and reactionary negativism when changes are enforced and variably understood at operational levels. If the health system is to make the best of new, emerging designs, then it follows that time spent supporting and inspiring people, through education, in adapting to the ongoing process of change must be a good investment.

As professionals and members of the public, we are embedded in the change process. Our responsibility lies in contributing to the design of health systems that make sense and make a difference. That means: knowing which data is worth recording and collecting based on a holistic assessment of health needs; analysing the information so it is able to be functionally
applied regionally and nationally; implementing those findings on an operational basis; evaluating the consequent effect(s) to understand what works and what doesn’t. Most importantly, it also means projecting this knowledge into policy-making, and also communicating effectively with the wider public and our politicians. This process can be enhanced when interaction among the professionals and the stakeholders receiving health care, -ie, the patient, their family/whānau, and community – is sought and respected.

Post-registration Education

Nursing has the potential to greatly influence those health outcomes. In responding to the 2009 call (Gorman et al, p. 19) to rally and work collaboratively with other health professionals, our educational opportunities need to be appropriate, affordable, accessible, and relevant to best reflect health needs, realities and the environment that surrounds us. They also need to be stimulating, promoting the ability to question and to communicate.

In particular, the resourcing (both intellectually and financially) of post-registration nursing education will be explored in this paper. It is our aim to have tax dollars used towards educating competent and confident nurses who are able to contribute fully to the spectrum of health care.

The Learning Process

Can we enhance the exchange/transmission that occurs between teaching and learning in order to get it right and raise its efficacy? It’s recognised that learning can involve taking risks, and the process itself needs be at least as important as the content. Having a ‘safe’ learning environment (both classroom and clinical) demands adequate resourcing, with money and supportive teaching time, to allow students to take those learning risks.

Studies have shown that 90 – 95 percent of learners can master a subject with a high degree of success, if given sufficient time and assistance (Bloom, 1968; Bruner, 1966; Carroll, 1963; Skinner, 1954 as cited in Jarvis, 2004). Resources are needed at all levels of education - from curriculum design, implementation and support, through to the evaluation of outcomes.

Health, education and funding

Under the current system, the CTA funding streams are intended to encompass education needs that reflect health strategy outcomes. Whether or not education funding meets health needs effectively across the 20 DHBs is a moot point. For example, how well are mental health (not just mental illness) needs currently integrated into under graduate nursing
curricula setting the baseline for further development in post-registration courses/programmes?

Within health and education policy, synergies for programme development are able to be created between tertiary education organisations (TEOs) and stakeholders such as a DHB, but these synergies are often dependent on nursing leaders’ abilities and understandings and the personalities that underpin such relationships. From the DHB perspective, strategies, staff surveys, patient satisfaction surveys, and discussions among the director of nursing / nursing development unit, nursing staff and patients can serve as the guiding posts for determining educational needs that most closely align with health strategies. From the TEO perspective, strategic, well-informed and well-networked relationships can be enhanced through dialogue between the schools of nursing and nursing leaders and clinicians. Having the clinicians involved in all stages of those relationships is crucial. The development of a responsive curriculum/programme is dependent on these increasing strengths being facilitated by forward-thinking nursing leaders.

Workforce Needs and Information Delivery

DHBs are expected to plan services and forecast future workforce needs for the health of their populations. In contrast, the CTA postgraduate nursing training (PNT) funding is designed to assist DHBs develop their nursing workforce, according to their planned needs in response to Government policy. While these contrasting drivers in part reflect the inevitable tensions between Government funders and the needs of funded agencies, a key determinant is the varying impacts that different parts of the health sector have on the development and application of Government policy.

The different models of nursing care used across the DHBs are difficult to measure for their effectiveness, and even harder to compare. Finding supportive literature regarding successful models of care is frustrated because of “a lack of systematic, evaluative research on the models of care delivery, and most existing studies are flawed (Tiedeman & Lookinland, 2004, p. 296)”.

One of the key challenges facing the sector, including the CTA, is to prioritise competing demands for the limited training funds available. As well, there is the need for clear accountability streams to be in place, so improved developments can be ongoing. Bovens (2006) suggests that accountability is the post-mortem of action and, certainly, there are many signs that health funding would benefit greatly if it could incorporate balanced accountabilities into its delivery mechanisms, rather than continue to rely on processes after the event. Having set evaluative criteria at the start would give focus to desired outcomes.

CTA funding involves the accepted responsibilities of the agency as well as those of the stakeholders, and accountability should therefore reflect this and mustn’t become diluted in wider systems where pools of shared government funding streams are in place. This risk of diluting accountability/responsibility is very real when a multitude of stakeholders (e.g.
Health and Education) play a part in the health needs, workforce planning and nursing education needs. Applying a direct party/counterparty approach to funding accountability does not threaten the development of broad collegiate planning. Rather, it is an adjunct to such planning, needed to ensure that (the desired) integrated resource allocation results in targeted resourcing and effective outcomes.

As an example of lost accountabilities, Cook & Hughes (2009) refer to the long period of poor medical and nursing workforce planning that began in the late 1980s with the disestablishment of relevant Ministry of Health directorates. These authors cite the Medical Training Board’s (MTB) 2009 conclusion that the impact of this poor planning will continue for perhaps 15 years (ibid, p. 11). Managed workforce capacity has turned from being possible to being an endless tangle of vested groups staking their claims against a blurred background of missing, patchy national information. These authors lament “the seemingly poor strategic level and managerial use of analysis of long term demographic, social and health trends (ibid, p. 11).”

Accurate assessment of health needs is pivotal to the success of understanding the learning needs of health professionals. The DHBs’ district annual plans (DAPs) are intended to analyse those health needs and set the baseline for planning health services required in the district. If the DAPs are not comprehensive enough – with tangible aspects of care currently being the primary consideration – then the ensuing education planning formulae used will be faulty as well, so it is vital to understand the range of health needs of the given population from the start. For example, a survey of the experiences of 3525 people (68% response rate) seeking outpatient cancer treatment in NZ describes the areas for improvement in current services from the patients’ perspective (Cancer Control Council of New Zealand, 2009). These are:

- Provision of information about possible changes in relationships, sexual activity and emotion (50 – 69% - depending on which topic - did not receive enough information)
- Explanations for any delays in treatment (67% did not receive adequate explanations)
- Help with anxiety and fears (about their diagnosis and treatment) (53% did not feel the cancer care team did enough)
- Taking into account patients’ living situations when planning treatment – including travel concerns (51% did not feel staff had done this)

These areas for improvement in meeting patient need could well be applicable to other areas of the health services but remain largely untested (Ministry of Health, 2008). As well, another recent example would be around the New Zealand suicide rate - in the year ending June 2008 there were 511 suicides reported to coroners, whereas there were 422 road deaths (http:www.stuff.xo.nz/dominion-post/archive/national.-news/689095). There is no evidence that this ratio has had a significant impact on relative education priorities for health professionals. Are we accurately focusing on the comprehensive areas of health need, and
the consequent issues that arise from illness that patients and their family/whānau are faced with on a daily basis? Having sound health needs assessments as the foundation for planning for nursing (and other health professionals’) education programmes represents the only way forward in establishing priorities for responsive care.

Finding and establishing the relevant data and information is a skilled process. The New Zealand Health Survey (Ministry of Health, 2006/07) asked over 17,000 New Zealanders (children and adults) about their health and yet the information provided does not appear to be presented within DHB boundaries. Had this research been designed to reflect the health needs of DHB populations, then its utility would be considerably raised.

Similarly, data necessary for workforce planning has only recently begun to emerge in a form that complements broad collegial planning. The composition of aspects of the NZ health workforce is detailed in Figures 1, 2, and 3. Nursing remains the largest group of health professionals in the workforce though data on its composition is only being analysed and released now with more specific data on nursing specialties yet to be determined.

Calls for innovation in health care, including new ways of working and training in a more collaborative manner, have been made (Gorman, Horsburgh & Abbott, 2009). Yet, before those more collegial Boards were designated, the number of future medical students was increased from 365 to 565 per annum, with the first 60 of the extra 200 students starting in 2010. Those extra 200 students represent a significant increase (55%) to medicine and sit alongside the recently announced pilot study of American Physician Assistants to be launched in 2010.

**Figure 1 - Workforce composition, DHBs only - HWIP, Q4, 2008**
**Figure 2** - Nurse employment - Nursing Council of New Zealand data, 2008

![Pie chart showing nurse employment by sector](image)

- Public hospital: 58%
- Primary care: 13%
- Rest homes: 11%
- Private hospital: 9%
- Public Community: 9%

**Figure 3** - Regulated Nursing Workforce data
Nursing Council of New Zealand data, 2008

![Pie chart showing regulated nursing workforce](image)

- RN: 93%
- EN: 7%
- NP: <1%
- NA: <1%

RN = Registered Nurse; NP = Nurse Practitioner; EN = Enrolled Nurse; NA = Nurse Assistant
There is a need for intra-collegial innovation to be fostered in order to deliver services in
diverse circumstances and to a national standard. Cook & Hughes (2009) advocate for
innovation from a responsive system, with recognised incentives, that has effective processes
for defining best practice in the context of the New Zealand health service.

**Nursing Outcomes**

Compounding difficulties in understanding health needs is the baseline requirement for
nurses to develop and use tools that measure the quality/nature of the actual nursing care
provided. There is a paucity of tools of this type, and this is a global issue (Finkler, 2008). It
reflects the sometimes nebulous nature of nursing, where therapeutic discussion with a
patient can make just as much, if not more, difference to the patient’s overall health as a good
physical catharsis. The problems with establishing valid and reliable measurement tools are
confounded by dynamics beyond the tangible aspects of care that nurses deal with on a daily
basis. Given informed data/knowledge about the difference nursing can and does make
would, in turn, help to define why, how and when nurses deliver the cares they do to meet the
health needs of patients. If parts of this equation are weak or missing, then it follows that the
process of determining how nurses will continue to be educated in order to meet health needs
is compromised. We need to quantify nursing’s impact – this is a worldwide issue and is a
very real issue in New Zealand with the Safe Staffing Health Workforce project currently
seeking answers to this complex problem (Lawless, 2009/2010).

In contrast, medicine appears better resourced in determining its workforce and learning
needs. For example, in January 2007, the CTA completed a review of the vocational training
for general practitioners (GPs). It had been noted that the number of GPs in New Zealand
had declined from 3191 in 1999 to 3006 in 2003 (the year the PHC Strategy was introduced)
whereas, over the same period, the number of specialists increased from 2647 to 2873. 34
percent of GPs in New Zealand were trained overseas. Ageing and attrition through
retirement were noted as adding to the potential shortage (Ministry of Health, 2007b).

The GP Review recommended an immediate increase in the GP registrar programme from 69
to 104 (51% increase) trainees in the 2008 academic year and 154 (48% increase) in the 2009
academic year. These changes represent 123% total increase in numbers in the GP registrar
programme over these two years.

GPs were given extensive support to define their programmes and the registrar programme
was declared the most effective form of GP training, with the recommendation that the
seminar/vocational programme be discontinued. The GP Review was funded by the CTA,
and developed in consultation with the RNZCGP. Supporting this effort, the CTA
commissioned the New Zealand Institute of Economic Research (NZIER) to forecast the
number of GP registrars needed to meet demand to 2016. NZIER modeled a number of
scenarios and, under the most likely circumstances and with the then current intake of 54
registrar trainees, predicted a shortfall of 973 GPs by 2016. As well, the GP Review included
a literature review (completed by New Zealand Health Technology Assessments), and incorporated key informant research and focus groups with key stakeholders (contracted to Research First). Resulting from the review, with a crisis in GP supply being predicted, changes to GP training model and numbers were quickly implemented (Ministry of Health, 2006b, 2007b).

This focused, research-backed approach contrasts sharply with the approach taken at the same time to nursing. In 2006 an expert advisory group (EAG) basically made its own (anecdotal) decisions, without a commensurately funded rigorous process behind its expedited consultation processes.

Viewing this positively, these deficits in planning can serve as a red flag marking one of the missing essential components in our current nursing education – ie, systems analysis and political positioning. Being equipped to take the details of nursing care and its delivery through to the bigger picture, and into negotiations for securing appropriate levels of funding for nursing education, is crucial to health and education outcomes.

Nursing needs to revisit its priorities so the importance of political positioning in securing money/funding can be recognised. Such positioning is a very familiar tool for most other professions. For nursing, the cascading pressures of the past two decades to hold down costs have tended to deny our educational processes the resources needed to underwrite the purchase of necessary time (and all that that ‘time’ means) to convey to students what nursing is all about. In turn, this will have an ongoing detrimental impact on patient outcomes (Brinkman, 2009). The need for competent negotiating for adequate (at the minimum) resourcing applies to both the health and education negotiating tables.

The CTA, 1993 through to 2008

Understanding the CTA, as a critical funding agency of post-graduate nursing education, is important in developing strategies to ensure fair and realistic future resource allocation. The CTA’s main evolutionary issues are summarised here with further details to be provided in the unabridged companion edition of this document.

In 1993 there was a seminal move to change the public health service model to reflect other State sector restructuring patterns. This resulted in the separation of purchaser from provider, with the creation of four Regional Health Authorities (RHAs) and 23 Crown Health Enterprises (CHEs) for these respective purposes.

Following on from the 1993 health reforms, the Government split funding for health professional education between Vote Health and Vote Education. The Advisory Group on the Funding of Clinical Training met in 1993, initiating a process that gave rise to the CTA, intended to be an independent organisation to plan and purchase post-entry clinical training for health professionals in NZ. Policy changes determined that the CTA would fund post-
entry and postgraduate programmes with a clinical component of more than 30 percent, fitting with the then Ministry of Health’s priorities; while the Ministry of Education would fund all pre-entry qualifications, and postgraduate qualifications with less than 30 percent clinical component (eg, academic or research-based) (EAG, 2004). Post-entry clinical training was defined then as “training which is post graduation, substantially vocational and clinical in nature, and involving formal training which leads to a nationally recognised qualification (p. 2).”

While it would seem very reasonable for registered nurse training to have been incorporated into the new regime, it was considered that nursing did not meet the funding criteria set for “nationally recognised qualification[s]”, as the profession did not have agreed post-registration/specialty clinical/education pathways. The dispersed nature of nursing around the country had counted against national consensus being sought or reached. Therefore, the initial CTA funding allocation policies took shape without nursing’s participation. Unfortunately, this lack of professional education definition still requires (urgent) resolution today.

The following bullet points capture the basic evolution of the CTA, from nursing’s perspective, through to its current place as the New Zealand Health Workforce/CTAB body.

- In 1993 government funding of clinical training came from three sources – Area Health Board (AHB) operating grants; other direct grants from Vote: Health (Department of Health); and Equivalent Full Time Student (EFTS) funding of health professional courses by the Ministry of Education with the result of blurred accountabilities across the intersecting streams.

- In 1996, three pilot training programmes for tertiary nursing education programmes were developed but proved unsustainable in the longer-term as student demand diminished.

- The Mason Report, 1996, found that mental health services had been chronically underfunded, with low morale in the workforce but did not address structural deficiencies in any critical way (Oliver, 1996; Cottingham, 1996). Following on from the Mason Report the CTA increased PECT purchases in mental health in 1997 for mental health workforce development. The new graduate mental health nursing had 86 “new purchases” made, and a further 79 for advanced mental health nursing. As well, there was the stated intention to look at the possibility of providing clinical training specifically targeted for Maori Mental Health nurses (CTA, 1997a, p. 4).

- From 1998 onwards, the CTA indicated that “a significant move from historical to needs-based purchase and provision” would occur. This meant that 70 – 80 percent of the current contracts (then) would be reviewed (CTA, 1995, p. 5). “Ex-deficit funds” were then “unbundled” through to the CTA, within this review process.

Table 1 demonstrates the spectrum of Ex-deficit Nursing Funding that was reported in 1998 (Ministry of Health, 2007a).
Table 1 - Ex-deficit Nursing Funding by DHB in 1998

<table>
<thead>
<tr>
<th>District Health Boards</th>
<th>DHB Nurse FTE</th>
<th>Ex-deficit Base Allocation</th>
<th>Price per FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auckland</td>
<td>2,800</td>
<td>$486,837</td>
<td>$173.87</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>915</td>
<td>$139,411</td>
<td>$152.36</td>
</tr>
<tr>
<td>Canterbury</td>
<td>2,857</td>
<td>$305,763</td>
<td>$107.02</td>
</tr>
<tr>
<td>Capital &amp; Coast</td>
<td>1,494</td>
<td>$448,190</td>
<td>$299.99</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>1,874</td>
<td>$350,000</td>
<td>$186.77</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>758</td>
<td>$46,971</td>
<td>$61.97</td>
</tr>
<tr>
<td>Hutt Valley</td>
<td>652</td>
<td>$169,695</td>
<td>$260.27</td>
</tr>
<tr>
<td>Lakes</td>
<td>408</td>
<td>$388,475</td>
<td>$952.14</td>
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<tr>
<td>MidCentral</td>
<td>1,148</td>
<td>$412,674</td>
<td>$359.47</td>
</tr>
<tr>
<td>Nelson Marlborough</td>
<td>613</td>
<td>$136,159</td>
<td>$222.12</td>
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<tr>
<td>Northland</td>
<td>750</td>
<td>$40,268</td>
<td>$53.69</td>
</tr>
<tr>
<td>Otago</td>
<td>1,041</td>
<td>$129,060</td>
<td>$123.98</td>
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<tr>
<td>South Canterbury</td>
<td>275</td>
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<tr>
<td>Southland</td>
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<tr>
<td>Tairawhiti</td>
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<td>Taranaki</td>
<td>488</td>
<td>$48,000</td>
<td>$98.36</td>
</tr>
<tr>
<td>Waikato</td>
<td>1,840</td>
<td>$324,365</td>
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<tr>
<td>Wairarapa</td>
<td>169</td>
<td>$50,000</td>
<td>$295.86</td>
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<tr>
<td>Waitemata</td>
<td>1,909</td>
<td>$55,000</td>
<td>$28.81</td>
</tr>
<tr>
<td>West Coast</td>
<td>224</td>
<td>$105,000</td>
<td>$468.75</td>
</tr>
<tr>
<td>Whanganui</td>
<td>414</td>
<td>$81,315</td>
<td>$196.41</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>21,271</strong></td>
<td><strong>$3,852,072</strong></td>
<td><strong>Average = $223</strong></td>
</tr>
</tbody>
</table>

- The Ministerial Taskforce on Nursing (MToN) was established in February 1998. Its terms of reference were focused on finding strategies to remove the barriers to providing nursing services more effectively. The government resourced the taskforce with a view to improving nursing services. The taskforce did ‘supersede’ the CTA in terms of its mandate, with the CTA expected to follow on from the taskforce recommendations.

- The taskforce recommended that “funding decisions are made with a national focus”, and that a “funding formula similar to that currently [then] used by the CTA be developed (MToN, 1998, p. 63)”. Implicitly, this funding formula was intended to reflect that provided for other health professionals. Nursing leaders at the time were aware of the need for nationally relevant courses to be offered but it was a formidable task for nursing to determine those synergies with the information (lack of data), professional drivers, funding and other resources available at the time.

- In June 1999, the intention was signaled by the Ministry for developing a paper on the framework and purchasing strategies for the first year of nursing practice, for
reviewing post entry clinical training (PECT) funding. It was stated that the CTA nursing steering group was examining the level and prioritisation of funding with regard to nursing post-entry education (Ministry of Health, 1999, p. 1).

- From 2001, the CTA funded several national nursing PECT programmes at level 8 on the NZ Qualifications Framework, referred to as national nursing training (NNT) programmes. These programmes were developed in response to government strategies at the time (EAG, 2004). However, from 2007 they were no longer awarded funding due to falling student numbers. And, unlike the Ex-deficit model, the NNT programmes were purchased on a lead provider basis and had limited capacity to respond to and meet local needs.

- In March 2001, the Ministry of Health began work on a national purchasing and prioritisation strategy for funding PECT for nurses. The project was developed because there was no robust, transparent framework to ensure consistent decision-making and sustainable funding for PECT for nurses. The project ultimately resulted in the report, *Purchasing Post-Entry Clinical Nurse Training Programmes* (EAG, 2004). It concluded that “findings highlight the need for measures such as the development of national training specifications to increase the consistency for PECT for nurses (ibid, p. 32)” is sound.

- In 2004, Nursing’s expert advisory group’s (EAG) recommendations indicated that CTA funds should be directed towards a first year of clinical practice programme and 800-level papers that may later lead to a master’s level education and to the development of the nurse practitioner (NP) role. There was a particular focus on the NP, at the expense of the development of other advanced nursing practices.

- These recommendations for postgraduate education would require a transfer of CTA funding from the ex-deficit and miscellaneous specialty programmes to nationally specified programmes that enable nurses to better meet population health needs. The supporting evidence for the projected effects of offering funded level-800-only focus was weak (EAG, 2004, p. 3). The implications for the nurses who did not have undergraduate nursing qualifications as a result of the CTA decision to fund level-800 only are real, involving opportunity costs for patient outcomes.

- In 2002, pilot programmes for the first year of nursing clinical practice were launched. The aim was to consolidate practice in DHB-based programmes rather than hospital-based ones, as graduates emerged from the tertiary institutes. Following on from the pilot programmes an evaluation report was published in 2004.

- The rural primary health care programme (see Table 2) introduced in 2004 seemed to provide necessary training for nurses in rural areas where workforce availability is tighter than in urban situations. The programme’s success was presumably at least partly due to the greater resourcing made available through the comparatively very generous Rural PHC Scholarships (Ministry of Health, 2007a).
Table 2 - Primary Health Care Nursing (Rural) – CTN40

<table>
<thead>
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<td>Intake 1</td>
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<td>16</td>
<td>16</td>
<td>13</td>
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<td>13</td>
</tr>
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<td>34</td>
<td>30</td>
<td>30</td>
<td>25</td>
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<tr>
<td>Intake 3</td>
<td></td>
<td></td>
<td>25</td>
<td>25</td>
<td></td>
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</tr>
</tbody>
</table>

- The first intake of NETP trainees for participating DHBs began in August 2006 and was designed to improve nurse retention and recruitment. All DHBs offered NETP programmes during 2007. The CTA specification for the Nursing Entry to Practice (NETP) programmes was that the CTA pay $6000 per graduate as a contribution to the DHBs’ costs of offering the programme. It was estimated the programme would cost $12,000 per graduate, although each DHB’s costs may vary (DHBNZ, 2008).

- In 2006, the CTA had three models of funding for postgraduate nursing training. These were: nursing entry to practice (NETP); Ex-deficit nursing; and national nursing training programmes. The CTA established an expert advisory group (EAG) during 2006 to review the distribution of nursing education funding between DHBs and to consider appropriate parameters to which this funding should be applied.

- From the EAG recommendation, ex-deficit nursing education funding was discontinued from December 2006, and replaced by a new funding model to be administered by DHB. The EAG’s wider consultation for this change spanned 41 days from formal notice of the consultation (18 October 2006) through to the Ministry finalising the CTA specification (27 November 2006) for postgraduate nursing training (PNT) funds. Each DHB was to be allocated a maximum amount per annum, based on the population based funding formula (PBFF).

- Since 2006 the EAG has devolved into the nursing advisory group (NAG). NAG has continued to uphold the mandate for CTA funding for PNT to be dedicated to level 800 studies that are approved by the Nursing Council of New Zealand (NCNZ) (Watson, 2006).

- Analysis and monitoring of the uptake of the PNT has been unavailable. Information on student numbers applying, numbers accepted for CTA funding, retention and pass rates would be useful, comparative information. This data would provide a national perspective to nursing education need and provision and help inform prospective nursing staff members of benefits sought and supported by DHBs.

Finding perspective in 2010

Everyone involved in health needs to be aware of the inequitable education funding among the different health professions. Priorities have to be set based on robust processes that reflect informed discussions about the varying roles and perspectives of health professionals. The following pie chart illustrates the inequitable distribution of funding that has occurred between the health professions (Clinical Training Agency, 2008a).
Figure 1 - Clinical Training Agency training budget 2007/2008

Critical Training Agency training budget 2007/08

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Nursing (9.86%)</td>
<td>$11,100,498</td>
</tr>
<tr>
<td>Nursing - NETP (5.33%)</td>
<td>$5,999,323</td>
</tr>
<tr>
<td>Non vocational medical (19.4%)</td>
<td>$21,801,247</td>
</tr>
<tr>
<td>Vocational medical (50.1%)</td>
<td>$56,441,862</td>
</tr>
<tr>
<td>Psychiatry (8.20%)</td>
<td>$9,241,432</td>
</tr>
<tr>
<td>Mental health (0.268%)</td>
<td>$302,481</td>
</tr>
<tr>
<td>Pacific peoples health (0.0000245%)</td>
<td>$2,760</td>
</tr>
<tr>
<td>Disability support (0.269%)</td>
<td>$303,535</td>
</tr>
<tr>
<td>Maori (2.25%)</td>
<td>$2,536,677</td>
</tr>
<tr>
<td>Midwifery (1.78%)</td>
<td>$2,000,000</td>
</tr>
<tr>
<td>Other (2.55%)</td>
<td>$2,875,187</td>
</tr>
<tr>
<td>Total</td>
<td>$112,605,002</td>
</tr>
</tbody>
</table>
Current Developments: are nursing education needs emerging from the shadows?

HWIP 2009

The CTA commissioned the Health Workforce Information Programme (HWIP) in conjunction with DHBNZ, to undertake a series of modeling and forecasting exercises on the current regulated nursing workforce in NZ to provide a robust basis for current and future workforce planning (Ministry of Health, 2009).

This project is a national initiative, undertaking a series of forecasting and modeling exercises on the nursing workforce to provide a robust basis for workforce planning.

This CTA initiated project has developed in response to the widespread need to understand health nursing workforce demand, supply and training requirements. The project requested the services of the DHBNZ Health Workforce Information Programme (HWIP) and the Nursing and Midwifery Workforce Strategy Group (DHBNZ), to develop workforce projections for the national nursing workforce, and to build a picture of the nursing workforce. The shared costings have not been sourced to include here.

The ‘projections’ are intended to be the first part of the project and underpin future ‘planning’, as accurate workforce information is fundamental to the effective management and planning of health and disability services. This information is recognised as being essential to adequate planning for undergraduate, post-graduate and post-entry clinical training.

Nursing Education Developments 2009

The Minister of Health established a Committee on Strategic Oversight for Nursing Education which comprised one member, Len Cook (the former National Statistician for the United Kingdom and prior to that the Government Statistician for New Zealand). Cook’s paper states that “Bottom up planning at the local DHB/Tertiary Institute level needs increasingly to be tempered by leadership and decision-making at a system-wide level, as local demands for nurses by DHBs may be simultaneously affected by resource constraints, the severity of which necessitates short- term adjustments that add up to change that is unsustainable at a national level” (Cook, 2009, p. 32).

Having national consistency is vital to the success of nursing education in order to meet health needs. Cook writes that, “The accumulation of these decisions at a national level can result in inconsistencies in how short and long term benefits are compared. They usually ignore the relative scale of local and national capacities to manage change, and the considerable differences in the capacity of single institutions to influence system change, compared to national organisations” (ibid, pp. 32-3).
The Clinical Training Agency Board (CTA Board) was established in 2009 under section 11 of the New Zealand Public Health and Disability Act 2000 (NZPHD Act) to provide advice to oversee the rationalisation of workforce planning, training, education and purchasing within the health sector. It is seen an interim measure to drive immediate change while advice is developed on the longer-term placement of a health sector workforce agency. The CTA Board is designed to be larger than the mandate and work programme of the previous CTA (Ministry of Health, 2009). The CTA board is now referred to as Health Workforce New Zealand (HWNZ) (to save confusion will be referred to as HWNZ/CTAB further in this document, as appropriate).

There has been an increase in the HWNZ/CTAB budget from $121.5 million in 2008/09 to $125 million in 2009/10 largely due to fund increases for general practice, postgraduate midwifery and nursing entry to practice (NETP) expansion.

In late 2009, the HWNZ/CTAB is reported as planning to set up an “innovations fund” using the estimated $4 million “underspend” by DHB providers unable to fill all nursing training places in the 2009–2010 year.

In February 2010, the HWNZ/CTAB continues to be based in Christchurch and has 11 Ministry of Health employees. The unit consists of a group manager, four managers, an administrator, an accountant, an executive assistant and three analysts. The operating budget for this group is less than $1 million per annum (Gorman, Horsburgh & Abbott, 2009).

**Moving Forward**

Some of the reasons why nursing has not been able to fulfill its capacity and work to its potential within the health sector have been detailed in this document. In particular it needs to overcome the historically entrenched barriers to/for nursing education, and to play a role commensurate with its position in promoting a more effective health service based on robust workforce analysis and planning.

NZNO’s policy on education speaks to nursing education being responsive to the changing social and technological context of health care, in order to provide for current and future health care needs of society. As well, the need for curricula to meet the health needs of society and be determined collaboratively from across the profession, the tangata whenua and representatives from society is articulated. Accountability to the profession, society, the education institution and the learners can only be achieved through (local and national) evaluation (of outcomes) and the subsequent adjustment of nursing education options being offered (1993, p. 14).

The following framework incorporates the synergistic guiding principles for nursing education and forms the basis for future guidance for effective nursing education.
Recommended principles for post-registration nursing education for realising nursing capability

**Appropriate** — based on health needs and the consequent learning needs for developing competent and confident nursing care.

- Health care needs must be set alongside the clear determination of health needs on national, regional and local baselines in order to subsequently meet strategically determined health goals. Quantitative methodologies can be augmented by qualitative methods (e.g. focus groups) to this purpose.

- The patients and their family/whānau have a right to expect a health environment which delivers safe, effective care through well-crafted systems based on sound information and decision-making. Prioritising, that includes reasonable stakeholder input, will necessarily reduce health risks.
• Limiting the nationally funded mechanisms to level 800 in the tertiary system remains unsubstantiated as to its singular dominance and/or effect given the dearth of analysis available. Other education programmes/courses (e.g. level 700) are currently meeting needs and effectively deliver to those attending (Manchester, 2006). A more open approach to funding distribution needs to occur so that appropriate outcomes can be realised.

• Evaluating the quality of care, and the contributing factors to that quality, is vital for nursing education needs to be appropriately determined. For example, studies in hospital wards describe the “quality of care and nurse and patient satisfaction may be related more to factors such as educational preparation, dedication, and competency of the nurse; nature of the support systems; and the motivation, attitude, and leadership qualities of the charge nurse (Tiedeman & Lookinland, 2004, pp. 296-297).”

**Acceptable** – is culturally appropriate to the recipients of nursing care. As well, political competence needs to be developed beyond basic political awareness, so nurses can better advocate for the patients and their families/whānau for a just distribution of scarce resources.

• Being a multicultural, post-modern society brings with it social and psychological complexities that require sophisticated and informed responses in order to meet health needs. Nursing education needs to increase its capacity for addressing the many shortfalls that affect the health of individuals and populations.

• Nurses need to know they are receiving a consistent standard of education across the country in order to work competently in different settings and regions. National understandings and priorities need be reflected in nursing curricula.

**Affordable** – is effectively managed on a national basis to make the best use of scarce health and education resources.

• New Zealand is not a wealthy country within the Organisation for Economic Co-operation and Development (OECD). Households’ indebtedness has reached 160% of disposable income (OECD, 2009, pp. 2-3). Since around 2001, public health care spending has grown at more than double the pace of Gross Domestic Product (GDP) (ibid, p. 9). Recognising the potentially exponential demands that could exist for health care, priorities of care (and the commensurate costs) have to be explored and decided through public discussion, informed by applied research.

• The opportunity cost of not systematically working through the prioritisation and costing issues is too great for health professionals to avoid any longer.

• That individual nurses are able to afford education essential to their competence in the workplace.
**Accessible** – flexible delivery and adequately resourced to ease the nurse’s individual loading in the context of the work environment.

- The cumulative effect of having barriers in place (intentionally or not) which mitigate against nurses having fair and reasonable access to education, are debilitating to the effectiveness of the health workforce as a whole (Brinkman, Wilson-Salt & Walker, 2008; Walker, 2009). Medicine, on the other hand, has negotiated rights and funding within their employment contracts (Appendix 2).

- The wider health needs that call for nursing capabilities to be realised in order to penetrate real areas of dysfunction and distrust for the individual and parts of our population is very real (Litchfield, 2004, 2007). Some people have trouble accessing the healthcare they need due to perceived barriers that have nothing to do with physical proximity to the healthcare sites. We can no longer afford to have funds not allocated to nursing due to entrenched historical patterns amongst health professionals. The time for genuine collaboration between health professionals is now.

**Relevant** – flexible design of programmes so they are responsive to current and evolving health needs.

- Firstly, it is vital that the education programmes are appropriate to health needs. Integral to the programmes’ success in meeting nursing education outcomes is the requirement that teaching strategies ensure the capacity of the learner(s) are catered for through inspiring, engaging methods and approaches.

- Programmes/courses are based on the analysis of health needs, with stakeholders and educators working collaboratively to develop relevant learning processes and outcomes.

- Clinical teaching must be delivered by competent and confident teachers and preceptors who are clearly knowledgeable about the curriculum and programme design, in order to integrate theory with practice. This is a crucial link in the value chain (Cook, 2009).

- Whether or not having the Nursing Council as the agency to accredit/approve the courses that are made available for funding is a moot point (see Appendix One). The HPCA Act provides for that possibility but is not necessarily best met through current processes where individual educators are contracted to evaluate programmes, in contrast to medicine where vocational colleges are delegated that responsibility.
There is a gap in nursing’s specialty mandate and this requires urgent definition by the profession as a whole so that there is ONE national voice about specialty practice (at a number of levels) and preparation. Nurse clinicians are the ones most appropriately versed in the needs and competencies of their specialty practice(s) so must lead the process.

**Supported** – in the workplace for release time that is planned for and delivered in order to maximise learning opportunities.

- The opportunity to gain the necessary clinical competence in the areas covered by the programmes on offer be resourced and consistently provided to an acceptable standard.

- On a wider scale, education and research funding systems have proven to be particularly challenging for nursing, as the profession adjusts to these added academic demands (Brinkman, 2008, Watson, 2006). Better supportive mechanisms and systems need to be explored and applied to augment the standard of nursing’s national education and research standing. The education and health sectors have competing philosophies and goals which do not lead to fluid synergies. This difference must be addressed in order to move forward with confidence (ibid).

- For individuals and groups of nurses, health systems and structures have whittled back staffing levels and skill mixes so nurses are expected, in some DHBs, to take LWOP or annual leave in order to attend education courses. Again, other health professionals are not faced with the same barriers (see Appendix Two).

- Funding needs to be awarded to the applicants upon acceptance into an education course so individuals are not burdened with these costs in the interim, when payment to DHBs has already been made. This only increases pressures on individuals which can work against success and purpose.

- Without having access to nationally monitored data comparisons and evaluations between education outcomes for DHBs, and the tertiary institutions, analysis for difference cannot be made. More work needs to be done on determining the successful models of support that do exist, at least in pockets, across the country (Brinkman & Wilson-Salt, 2008).
**Evaluated** – Defined learning outcomes are used as the tool of measurement for ensuring learning outcomes are met. As well, consistent national templates for relevant data collection and analysis are monitored, with evaluation information made available on a regular, sector-wide basis.

- Individually, nurses are assessed throughout (formative) and on completion (summative) of the programme, to ensure learning outcomes have been achieved (NZNO Critical Care Nurses’ Section, 2010, p.7).

- The Ministries of Health and Education need to initiate and maintain synergies and processes which are conducive to effective nursing education (and funding) meeting health needs (Brinkman, 2008).

- The evaluation of current and future models of care will require strong partnerships and relationships. The need to establish and maintain trust between the government agencies, and those they contract with, must be achieved in order to establish nationally cohesive approaches (Cook & Hughes, 2009).

- Nurses themselves need to accept the varying forces that have led to our current position, as well as the responsibilities we have or haven’t taken, that have contributed to this evolution. Now, our collective wisdom can and should underwrite the paths we are set to blaze, discover and enjoy. Through well-informed analysis and evaluation, a positive difference to the health of the nursing profession will be palpable through better collegial understandings of our capabilities and capacity.
Conclusion

In this newly emerging era of collegial, interdisciplinary and collaborative effort designed to meet our collective learning needs, it is imperative that nurses come to the negotiating tables with an understanding of the decision-making processes supported by the necessary data, structures and systems. The ‘infrastructures’ of the health system must be defined through recognition of the roles we can and do play, the education we need to optimise our contribution, and the numbers and skills required for a capable and supported health workforce to come to fruition. Until this happens, we will continue to flounder while searching for elusive national data on our ‘needs’, and for the cohesive systems necessary to drive forward our goals for health.

So, yes, changes to the health system propelled by successive governments should, in part, reflect issues raised through the varying avenues open to us through our professional work, analysis and lobbying. Like other essential, knowledgeable and respected professionals comprising our health system, nurses should respect, and make use of, public pressure, as well as direct representations to policymakers. However, we should also keep sight of our professionalism: slogan shouting, bad analysis and chronic negativity will damage our cause. Any objectives set for/by the government must be based on a sound understanding of health and the priorities that NZ can (and cannot) afford. In order to influence the government and the public effectively, we should not lose sight of our strengths. Nurses have a well-deserved image as reasonable and caring professionals, and this is a major asset that should be supported through sound analysis and active, informed participation in policy development.

We all have to build the momentum to be both assertive and generous as health professionals, to realise our collective capabilities to serve our society better. Leaving the disenfranchised behind – for whatever health reason – unnoticed and unwell is not acceptable. Nurses’ capacities as health professionals speak to a potential that has yet to be realised and awaits a more informed, dynamic and engaging health system.

Recognising that we are locked into a dynamic of constant change in the wider health system, nursing education must develop and provide skills that enable nurses to recognise and seize opportunities from policy shifts, to generate and support sound ideas emerging from within their ranks, and to challenge the poor allocation decisions that have dogged our profession through successive ‘reforms’ of the funding mechanisms.

Meaningful, responsive post-registration education can only occur through processes that provide robust information on which to base decisions in order to meet health needs. Inequitable funding of nursing education for many years has resulted in significant opportunity costs, frustrating the capacity and capability of the contribution that nursing can and could make to health care. There is a strong need for a greater political awareness and action by nurses to determine their own destiny in terms of their education requirements, within the newly appointed inter-collegial environment, towards meeting the individual and population health needs of New Zealand.
Appendix One

Legal analysis of the role of the Nursing Council of New Zealand (NCNZ) under the HPCAA (2003) in overseeing nursing education
(Margaret Barnett-Davidson, NZNO lawyer, 18 May 2009).

The Nursing Council of New Zealand, like all other regulatory authorities operating under the HPCA Act 2003, operates under the primary principle of protection of the health and safety of the public. The NCNZ’s role in nurses’ education is very fundamental under the Act. The Council sets the scopes of practice for nurses, prescribes their qualifications, designates what the qualifications are and the institutions accredited to deliver them.

The relevant provisions that specify the above are section 11 (1) of the Act which describes the contents of the profession in the scopes of practice; then section 12 (1) which prescribes the qualifications for the scopes of practice. Section 12 (2) of the Act provides for the NCNZ to designate the types of qualifications required for the scopes of practice. The NCNZ under section 12 (2) of the Act is also responsible for accrediting the educational institution that delivers the qualifications.

In providing for the above, the NCNZ must be guided by the principles under section 13, which require that:

- (a) qualifications must protect the public,
- (b) qualifications may not unnecessarily restrict the registration of health practitioners, and
- (c) qualifications may not impose undue costs on nurses and the public.

The language of the latter two is less imperative than the public health and safety principle at s. 13 (a).

In relation to registration fitness, the NCNZ is charged under section 16 (a) and (b) with ensuring that an applicant for registration can communicate effectively in order to practise, and can speak and understand English sufficiently to protect the health and safety of the public.

The NCNZ’s role and responsibility in the ongoing education of a registered nurse is summarised under section 118 of the Act and includes the monitoring of institutions that it has accredited. Under the language of section 118, the role of the NCNZ once the qualifications and scopes of practice are prescribed, is one of overseeing that the standard is maintained.

Section 118 of the Act also provides for the NCNZ to review and promote the competence of nurses, and to recognise, accredit and set programmes to ensure the ongoing competence of health practitioners. This role is in relation to the maintenance of competence through the competence review process outlined in the Act.
Under section 118 of the Act the NCNZ is also charged with the function of setting standards of clinical competence, cultural competence, and ethical conduct to be observed by nurses, and promoting education and training in the profession.

In summary, the NCNZ’s role in nursing education is based on the overriding principle of ensuring public health and safety. It relates firstly to describing the scope of practice for nurses and secondly, to setting up the framework for education, from prescribing the qualifications through to accrediting and monitoring the standard of the qualification and the institution delivering the qualification.
Appendix Two

Medical NZRDA and ASMS contracts' sections regarding training

a. NZRDA and NZ DHBs MECA, 29 August 2008 – 31 December 2009

26.1 In recognition of the importance of ongoing medical education a minimum number of hours rostered duty per week will be set aside for the purpose of medical learning which is not directly derived from clinical work. The number of hours of rostered duty per week in each DHB shall be set out in schedule three and need not necessarily be provided in one continuous period.

26.2 All employees in their second and subsequent years of service shall be entitled to five days medical education leave in each full year of service for the purposes of study towards their vocational training and/or to attend interviews for vocational training positions.

28.3 The employing DHB shall reimburse the actual and reasonable costs of the training undertaken in the pathway to obtain vocational scope of practice, on the production of receipts.

Costs for the purposes of this clause shall include course, examination, modules and clinical assessments and other fees where they are incurred as a direct result of training required for achieving vocational scopes of practice. Costs also include reimbursement for required texts, travel and accommodation.

b. ASMS National DHB MECA, 2007 – 2010

36.1 (a) The employer requires employees to be fully informed, and where possible, practised in developments within their profession. To facilitate this, employees will be entitled to leave for 10 working days (pro rata for part-time employees) continuing education each calendar year, plus the agreed reasonable travelling time. This provision may be accumulated for three years entitlement.

(b) Employees, shall be reimbursed actual and reasonable expenses of up to $8,000 per annum (GST exclusive) increasing to $12,000 per annum (GST exclusive) from 1 January 2008 increasing to a maximum of $16,000 from 1 January 2009 and accumulated on the same basis as the working days (a) above. This reimbursement is pro rata for part-time employees except that part-time employees whose only income from medical or dental practice is derived from their employment with one employer shall be entitled to the full reimbursement.
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