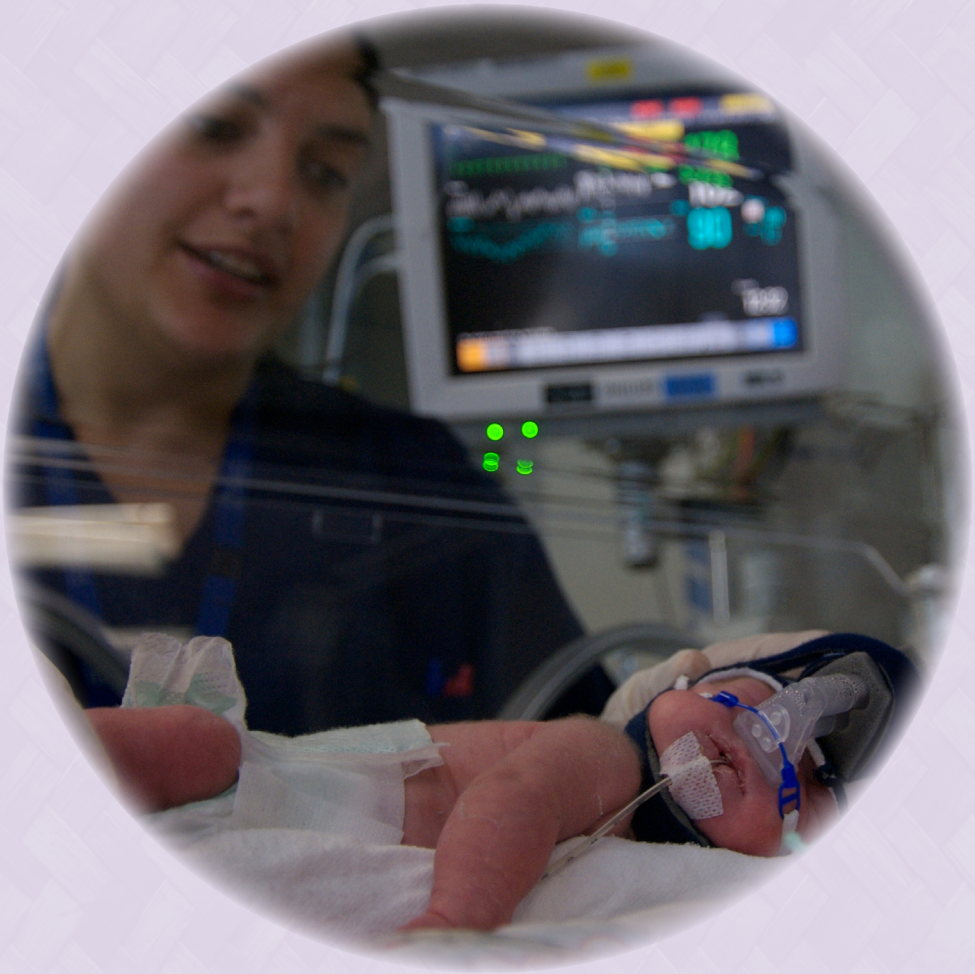
Towards improving health outcomes in New Zealand

Clarifying Nursing Education Funding Issues



NEW ZEALAND NURSES ORGANISATION

Unabridged Version
August 2010
ISBN number: 978-1-877-461-21-7

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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. It 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 that will lead to sustainably effective nursing education programmes.

The message for us all, in partnership with the Ministries of Health and Education, is 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, and the current context and guiding principles for strengthening the engagement between nursing education and practice.

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CEO
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August 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.
- 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' costs for graduate nurses are shared by the DHB and the CTA (total of $12,000 only per graduate up until 2010). These costs do not cover salary costs of days worked in the ward/ services/ practices. This contrasts with the first year house surgeons (PG Y1) who are funded 100 percent by the CTA during their year of probation 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 (Nursing Projections Project) 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). 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 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 national 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, acceptable, affordable, accessible, relevant, supported and evaluated (see Figure 5) to best reflect health needs, realities and the environments that surrounds us. These same opportunities 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 undergraduate nursing curricula setting the baseline for further development in post-registration courses/programmes? Is this process of integration reliant on the nurse educators being 'comprehensively' prepared in order to at least adequately transmit the spectrum of patients' health needs to the students?

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 those 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 requirements that most closely align with health needs. 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 varying drivers in part reflect the inevitable tensions between Government funders and the needs of funded agencies, a key determinant is the varying political influence 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 (2005) 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 across ministries 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 (Hillman & Goldsmith, 2010). 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. Therefore 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.

We must ask if we are 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 for assessing health needs 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 (DHBNZ, 2009).

Figure 1 - Workforce composition, DHBs only - HWIP, Q4, 2008

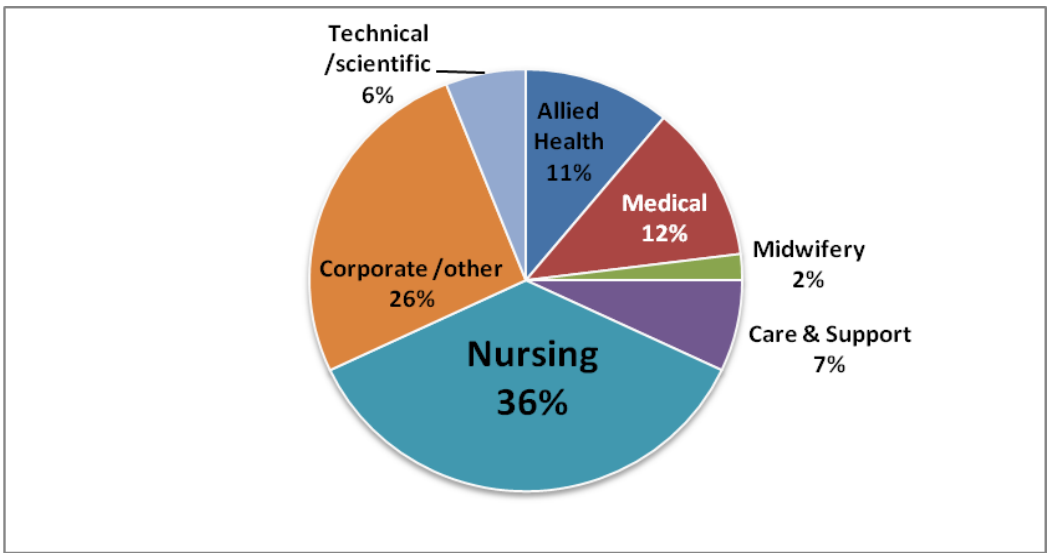


Figure 2 - Nurse employment - Nursing Council of New Zealand data, 2008

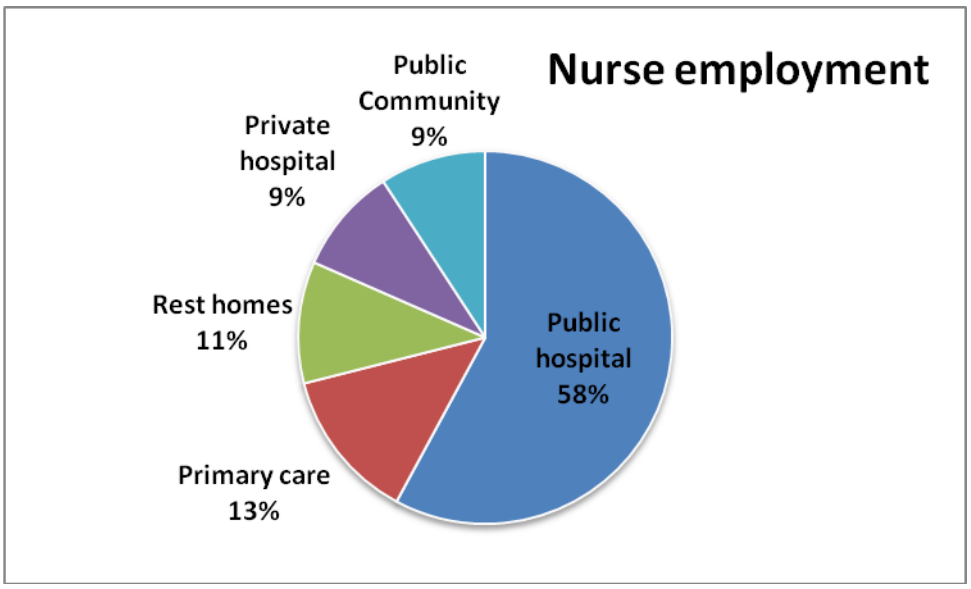
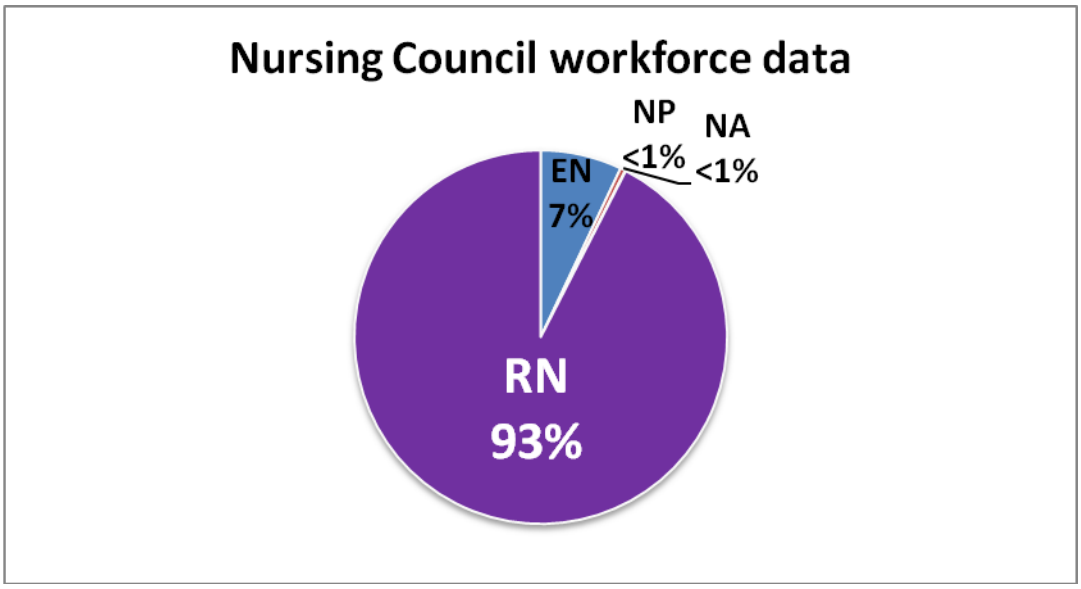


Figure 3 - Regulated Nursing Workforce data
Nursing Council of New Zealand data, 2008



RN = Registered Nurse; NP = Nurse Practitioner; EN = Enrolled Nurse; NA = Nurse Assistant

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 with the implications for clinical placement availability fully realised by 2018. As well, the recently announced pilot study of Physician Assistants from the States (two candidates only) is to be launched in 2010 with yet-to-be-defined benefits for the New Zealand health system.

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 how, why 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 problem and is a very real issue in New Zealand with the Safe Staffing Health Workforce project (SSHW) currently seeking answers to this complex dynamic (Lawless, 2009/2010). Again, limited funding has circumscribed the potential of the SSHW project.

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. As well, 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 trainees (51% increase) in the 2008 academic year and to 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.

It is interesting to note, that in 2006 it was proposed that each medical registrar on the GP training programme (GPEP1) be funded a bursary of $39,008 (excl GST) through the Royal New Zealand College of General Practice (RNZCGP). The RNZCGP funded $17, 418 (excl GST) per registrar for the training programme. The total per registrar would then be $56,426 (excl GST). Therefore, the planned increase of 15 new places on the programme would cost $846,390 (excl GST) per training year (Ministry of Health, 2006, p. 5).

GPs were given extensive support to define their programmes. 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. NZEIR 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 recognized and put into effect. 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 necessarily has an ongoing detrimental impact on patient outcomes (Brinkman, 2009). The need for competent negotiating for adequate (at the minimum) resourcing applies at both the health and education negotiating tables.

Who are the CTA and how did they evolve

Understanding the CTA, as a critical funding agency for nursing education, is important in developing strategies to ensure fair and realistic future resource allocation. The following section takes a fairly exhaustive look at the evolution of the agency and parallel funding bodies. There are clear lessons apparent in these processes about the manner in which policies aimed at improving efficiencies tend to become subsumed by competing interests. Unfortunately, the frequent ad hoc changes that have occurred, coupled with the tendency for nursing to be treated as an adjunct (or an afterthought) to the wider health sector, means there is no clear structure to build this review around, other than chronology.

The key element in those health reforms – introduced on July 1, 1993 - was the separation of purchaser from provider of taxpayer-funded health services. Personal health services, be they primary or secondary, were to be purchased by the new (then) Regional Health Authorities (RHAs) while, for population health services, the purchaser was the Public Health Commission. The providers included the new (then) Crown Health Enterprises (CHEs), community trusts and independent or private institutions and other agencies (Health Reforms Directorate, 1993).

Following on from the health reforms of 1991-93, the Government split funding for health professional education between Vote Health and Vote Education. This change took effect from the 1995 academic year. The split in funding was based on policy from a Cabinet decision made in 1994. This policy determined that the CTA would fund post-entry and postgraduate programmes with a clinical component of more than 30 percent which fitted 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).

It was anticipated that bids for programmes from the limited clinical training funding would be inevitable. The document states that "arguably the determining factor in ranking the priorities for support will be the perceived needs for future recruitment in the health sector". (p.2)

Can it be assumed that these "perceived needs" would have been based on robust health needs assessment, or were the structures to be based on other, less patient-focused needs, such as political perceptions that 'we need to train and retain more doctors', say?

The CTA was the product of submissions made to the Advisory Group on the Funding of Clinical Training in 1993 within the context of the proposed reforms in the health sector at the time. The Government had signalled its commitment to maintain a highly qualified and well-trained health workforce through explicit contracts for the provision of clinical training (Ministry of Health, 1991, p. 118). The three questions asked within this submission process were:

1. Should the funding of clinical training be linked with other aspects of workforce development, eg ongoing workforce planning?

2. How should those excess costs of teaching hospitals, not attributable to clinical training, be funded in the new health systems?

3. Which of the proposed options is most likely to provide a structure which meets the criteria listed in Section 8.1? (These options included: Minimum change; A block grant from Vote: Health to teaching hospital CHEs; Fund clinical training through RHAs from their population based allocation; Establish a purchasing agency for Vote: Health funded education and training; Transfer the funding of all education and training of health professionals to Vote: Education; Some combination of two or more of the above).

The Advisory Group, within this submission process, identified the following evaluation criteria when considering the six broad options being posed for consultation and feedback:

- Effectiveness; the ability to deliver the required outputs
- Efficiency; obtaining optimal value for the investment of taxpayer funds
- Quality assurance; ensuring that appropriate standards of training are maintained
- Accountability; ensuring that funds are applied to the purposes for which they have been granted
- Continuity; ensuring that present training programmes are not disrupted in the transition to the new structures on 1 July 1993
- Adaptability; the ability to modify the system to meet changing needs and new directions in Government policy

The glossary of terms in this Health Reforms document defines *clinical training* as "the component of education and training which necessarily occurs in the presence of consumers of health care or of activities directly relating to the health care of clients (ibid, p. 11)". Amplifying this definition is the observation that clinical training does not include "the formal or classroom components of health professional education or, for the purposes of this exercise, activities associated with staff development or continuing education (ibid, p. 2)".

Was it assumed, then, that staff development and continuing education needs in 1993 would be picked up by the Area Health Boards through the delivery of responsive, on-site education options?

In 1993, the 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.

The authors acknowledged, too, the "unquantified private funding including costs borne by host practices and other private health care providers, and those borne directly by individual students and trainees (ibid, p. 5)". This private funding could well have added up to significant amounts reflecting the well-intentioned providers combined with input by aware, motivated students but those figures are not apparent.

The "teaching supplement" covered the additional costs of clinical training within the Population Based Funding Formula (PBFF) used at that time, with the allocation to each AHB adjusted to reflect teaching costs incurred. However, because no part of the AHB operating grants was specifically tagged for teaching it was difficult to determine the actual amount used for this purpose, including (let alone) the indirect costs. The National Interim Provider Board was charged with trying to define these costs more precisely, "with the difficulty of the exercise being acknowledged (ibid, p. 5)".

The Ministry of Education provided funding of more than $140 million in support of health professional courses in 1993. This funding was designed to cover the costs of all classroom teaching and made a contribution (indeterminate/unknown amounts?) to "covering the costs of clinical training for most of those courses (ibid, p. 6)".

In 1993, the Ministry of Health commissioned accountants Coopers and Lybrand to undertake a national resource identification project to identify the net costs of clinical training provided in Crown Health Enterprises, using 1992 as the "base year". The findings of this project (called *Estimates of the Costs and Benefits of Clinical Training,* completed in January 1994) provided the basis for the Ministry of Health's later unbundling of the net costs of post-entry clinical training from health service provision (CTA, 1994).

The CTA, following the acceptance of this report, is described as being "an independent organisation established to coordinate the planning and explicit purchase of post-entry clinical training for health professionals in NZ. The Agency has been established through a legal partnership agreed amongst the four Regional Health Authorities (RHAs) (CTA, 1994, p. 2)". It was envisaged that the CTA would act as an independent organisation which co-ordinated the planning and explicit purchasing of post-entry clinical training for health professionals in New Zealand. The Board of the CTA comprised a representative from each of the RHAs as partners, and an independent Chairperson. For some (unclear) reason, the Agency was to be "based in Christchurch (ibid, p. 3)".

At the time the net cost of clinical training was estimated to be $52.345 m, GST inclusive or $46.531m, GST exclusive. The monies were ring-fenced for the purchase of post-entry clinical training (PECT) in the 18-month period January 1, 1995 – June 30, 1996 (ibid). These parameters were set according to the initial guidelines for the CTA, largely based on the Coopers and Lybrand resource

identification project (1994). As well, there was some additional funding that was being directed to post-entry clinical training by the RHAs. This additional funding was desirable but clouded funding streams and educational prioritising. Accountabilities were inevitably blurred between the "systems" of health and education funding.

It was acknowledged at the time that “there are issues in regard to the definition of post-entry clinical training and the resource unbundling which the Agency will work with others to resolve over the coming months (ibid)”.

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).” As it happened, nursing’s tertiary-based courses were not funded, as they didn’t meet the ‘nationally recognised qualification’ criteria within the definition.

How well equipped - in terms of time and money were nursing leaders back then - to focus on resolving this issue, so more success could be secured in future funding rounds? Or, alternatively, was lobbying and influencing for change in the defined funding policy considered to be an appropriate priority, given nursing’s academic emphasis over clinical focus in many tertiary education programmes?

At some stage in its evolution, the CTA was a Crown Entity. A mitigating factor that later led to the CTA being absorbed into the Ministry of Health was possibly that there were “problems in linking the external Crown Entity to policy processes within the Ministry” (Gorman, Horsburgh & Abbott, 2009, p. 15).

Following from CTA Business Plan 1996 – 1997

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 (CTA, 1997a, p. 4).

Did the 1997 mental health and aged-care programmes meet their stated aims and how were they evaluated for their effectiveness and sustainability?

In the 1996 calendar year, three “new initiative” pilot training programmes were purchased in mental health and specialised care of the elderly. The mental health programme was designed so that skills in community-focused mental health, crisis management, clinical supervision and policy analysis of mental health care nationally and internationally would be provided. It was expected that a “high proportion of students in the programme will be Maori” (CTA, 1996, p. 2) of the 79 places purchased.

The aged-care post registration certificate aimed to develop registered nurses with “expertise to contribute to professional judgement, research, critical reflection,

decision making, exploration of innovative practice, collegial support, team leadership and ward management" (ibid).

There seems to have been varying levels of funded assistance to the different health professional groupings for evaluation by the CTA. This inequitable funding towards reviews was/is puzzling given the need for quality information and outcomes.

Within the same CTA newsletter, details are provided about the review of the Diploma in Obstetrics (medicine) which was charged with identifying the benefits and outcomes of the training programmes for primary care, as well as the relevant involvement in secondary care. It was to look at training needs and how the existing training programmes met those needs. Additionally, the role of the GP, skills required, scope of practice and linkages with other health providers were to be incorporated into the review.

The 1995 CTA Business Plan refers to the Agency's investment in new initiative training programmes (ie training programmes previously not provided) which were to increase over the 1997 and 1998 calendar years. It states that, "It is acknowledged that the necessary resource for this increased investment may derive from reducing volumes in low priority areas and/or the implementation of optimal prices. From 1998 onwards, there will be a significant move from historical to needs-based purchase and provision. This will entail the Agency reviewing 70 – 80 percent of currently contracted training by the 1998/99 year (CTA, 1995, p. 5)".

It would seem that nursing's resourcing would continue to be limited despite intentions for "needs-based" purchase and provision.

For medicine, in 1997, the CTA's Prioritisation Working Group, chaired by Neil Woodhams, entered Phase 2 of its business. A series of national consultation forums were held in Auckland, Wellington and Christchurch in November of that year with written submissions due by 28 November 1997. The consultation paper was centred around the six principles for prioritization outlined which were:

1. Training which is consistent with the aims and principles of the Transitional Health Authority (THA) and its successor the National Funding Agency.
2. Training which will support the New Zealand public health system in achieving personal and population health gain.
3. Training programmes which will support the New Zealand public health system to address the Government's Health Gain Priority Areas (currently identified as Maori Health, Mental Health, and Child Health).
4. Training which contributes to an evidence-based approach to health and disability service delivery.
5. Quality training programmes which demonstrate explicit and measurable training outcomes.
6. Training programmes which represent the best value for money.

The proposed Framework was needed to guide the 1999 contracting decisions (CTA, 1997b). Nursing does not seem to have been included in those fora.

Background to more CTA nursing funding development

Funding for post entry nursing training programmes initially came from the 1998 unbundling exercise over to the PECT funding. Nursing training funding historically was based (and capped) on the amount of clinical training hospitals reported they were providing for nurses. The (reported?) funding varied considerably between the DHBs, with no national monitoring process in place at the time (see Table 1).

In 1998 the then Crown Health Enterprises (CHEs) were running deficits and claimed that one reason for this was the unfunded training being provided. CHEs then estimated the monies spent on nursing training, and these funds were transferred to the CTA. To ensure separation (and protection) of nursing training and service funding, the CTA contracted with CHEs for their stated spend. In 1998, the aim of the government was to get the CHEs out of the red, based on the data they provided by the deadlines given. By 1999, there was some room for negotiation, it seems, that would have reflected understandings and negotiating skills of the involved parties to influence the amount of funding awarded. Subsequent contracting of these funds directed similar amounts back to individual hospitals, regardless of overall need. The new model enabled DHBs to respond to local nurse training needs (there were varying ideas/interpretations of what those needs might be). This information resulted in a variable distribution of funding between DHBs (see Table 1).

This siloed funding did not benefit nursing on a consistent national basis, and there doesn't seem to have been any groundswell against the inequitable distribution of funds happening at the time.

The question we need to ask ourselves today, in order to learn from this process, is what information and analysis was required in 1996 that would have prevented this disparity in funding allocation from becoming entrenched? Of course, nursing not speaking from 'one voice' has been a long-term hazard and risk, limiting our political influence and consequent resourcing.

It was often insufficient for actual DHB nursing training requirements, although it's unclear to what extent, if any, it reflected what was asked/negotiated for. This funding was only available to nurses employed in hospital-based services (DHB provider-arm employees), preventing access to nurses outside of this setting (eg primary health care, NGOs) – an approach that clearly illustrated the need for comprehensive assessments of individual and population health with the subsequent flow-on effect to nursing learning needs.

Bearing in mind that the overall CTA budget for 1996 was estimated to be over $52 million, the amount of money spent on nursing was insignificant ($3.8m, or less than eight percent).

Table 1- Ex-deficit Nursing Funding by DHB in 1998

District Health Boards	DHB Nurse FTE	Ex-deficit Base Allocation	Price per FTE
Auckland	2,800	$486,837	$173.87
Bay of Plenty	915	$139,411	$152.36
Canterbury	2,857	$305,763	$107.02
Capital & Coast	1,494	$448,190	$299.99
Counties Manukau	1,874	$350,000	$186.77
Hawke's Bay	758	$46,971	$61.97
Hutt Valley	652	$169,695	$260.27
Lakes	408	$388,475	$952.14
MidCentral	1,148	$412,674	$359.47
Nelson Marlborough	613	$136,159	$222.12
Northland	750	$40,268	$53.69
Otago	1,041	$129,060	$123.98
South Canterbury	275	$40,000	$145.45
Southland	419	$50,000	$119.33
Tairawhiti	223	$44,889	$201.30
Taranaki	488	$48,000	$98.36
Waikato	1,840	$324,365	$176.29
Wairarapa	169	$50,000	$295.86
Waitemata	1,909	$55,000	$28.81
West Coast	224	$105,000	$468.75
Whanganui	414	$81,315	$196.41
Total	**21,271**	$3,852,072	Average = **$223**

It is not clear why the differences in ex-deficit nursing funding among DHBs was so spectacular – was it based on the strength of the case (hampered by there not being a nationally agreed costing methodology) put forward by the then Directors of Nursing? Was national comparison and analysis of these differences and their implications considered by the CTA and the Ministry? Or was it a lack of analysis and reporting back to the CTA by the then Directors of Nursing? Were the implications of these flawed processes for nursing education and nursing competence understood?

Table 1 demonstrates that the price per FTE for each DHB's spend ranged from $28.81 through to $952.14. All but two of the Price per FTE allocations were below $400.

The Ministerial Taskforce on Nursing

The Taskforce was established in February 1998 with a five month report back time to the Minister, including recommendations. The terms of reference were focused on finding strategies to remove the barriers to providing nursing services more effectively. There was controversy which arose around the consultation processes used and outcomes settled on for determining the ten recommendations. These professional differences amongst the main players in nursing at the time affected its acceptance by the nursing profession as a congruent whole with residual effects still apparent in 2010.

It is worth noting that these points of historical difference amongst nursing leaders and the professional groupings they represented from 12 years ago are not the focus here. Whether or not the terms of reference were effectively achieved is not the issue either as this paper is exploring the government resourcing that has occurred towards improving nursing education.

Yet, the nursing profession is still having to deal with problems that the Taskforce process faced around determining the contribution of nursing as the "lack of formal measurement tools to adequately measure the 'nursing difference'" remains central to our seeming inability to define and measure nursing (Ministerial Taskforce, p. 75; SSHW Committee of Inquiry, 2006; Lawless, 2010). As well, whether or not nurses in practice today are a central part of (future) decision-making affecting nursing remains unanswered for a variety of reasons (Oliver, 1998).

Instead, it is important here to acknowledge that the government did resource (funding amount?) 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 recommendation(s) made.

The recommendation made by the Taskforce pertaining to the CTA was to review the [then] current policy that the CTA be responsible for the funding of post-entry programmes in which 30 percent or more of the total programme comprised clinical experience. This was to be done by the Ministry of Health in conjunction with the Ministry of Education and the CTA (Ministerial Taskforce, p. 16).

In June 1999, the Chief Advisor (Nursing) released a sector update about the implementation of the Taskforce report which spoke to two tasks taken on by the CTA. One was for developing a paper on the framework and purchasing strategies for the first year of nursing practice. The other was that of reviewing the Post Entry Clinical Training (PECT) funding. It stated that the CTA Nursing Steering Group was examining the level and prioritization of funding with regard to nursing post entry education (Ministry of Health, 1999).

The Continuing Emergence of Today's Funding Structures

The initial bundling of PECT funding from various sources to Vote Health resulted in only one programme for nursing staff – the graduate certificate in specialty nursing practice. In 1998 the CTA received additional funding through the 'deficit switch' project (which was estimated based on the amount of clinical training that hospitals reported they were providing for nurses). The intention was that the arrangement would be changed as nationally provided programmes became available. However, nursing was not able to rise cohesively to this challenge for nationally provided programmes, for a variety of reasons, so funding was not allocated on a sustainable basis. Additional funding from the base CTA budget and the Mason allocation was also directed towards nursing training (CTA, 2003).

This process provided three streams of funding for nurse training (ibid):

- Ex-deficit funds, used to access mainly academic programmes at a mixture of 700 and 800 level for DHBs nurses only.
- The base CTA budget, with purchasing focused on advanced national PECT programmes, including Emergency Nursing, Palliative Care, and Child and Family.
- Ex-Mason funding, with two programmes purchased in mental health nursing – the CTA administered these programmes in line with the Ministry's *Mental Health (Alcohol and Other Drugs) Workforce Development Framework*.

Nursing leaders at the time were aware of the need for "nationally recognised qualifications" but it was a formidable task to galvanise the needed synergies without the information, data, and funding required for meetings, analysis and untangling of the professional drivers.

The Ministerial Taskforce on nursing 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 (1998, p. 63)". Implicitly, the funding formula alluded to was intended to reflect ones provided by the CTA for other health professionals, particularly medicine.

In March 2001 the Ministry of Health commenced 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 (Expert Advisory Group on Post Entry Clinical Nursing Programmes (EAG), 2004). The CTA stated that;

> *Funding for post entry clinical training in nursing is limited. In addition, in the past, the allocation of any funding available has lacked a clear direction because the sector has been fragmented. However, a strategy for training will be developed in the near future, and the CTA will work with the sector to implement priority training (CTA, 2001, p. xiv).*

The Ministry of Health, via the CTA, funded identified PECT programmes where 30 percent or more of a programme was clinically based and was required to meet health service needs nationally. Funding of these programmes was from a contestable pool of limited resources. Total CTA expenditure on nursing PECT programmes for the 2001/02 contract year was $7.9 million (excluding funding for mental health programmes) from a total PECT budget of $80 million. Of the 35,100 actively practicing nurses in New Zealand, the CTA funded approximately 1333 FTEs on at least a part-time basis (CTA 2001; EAG, 2004).

The CTA (2001) was aware of the issues that were facing nursing at the time and noted that,

> *Post entry clinical training for nursing lacks an overall strategy. As a result, the CTA has funded nursing training through a variety of funding streams to meet national need (for example, emergency nursing) through new funds, or local need through deficit funds. There is a growing perception that New Zealand has a growing shortage of adequately skilled nurses. This perceived shortage may relate to the amount of training that is offered and undertaken (CTA, 2001, p. 112).*

Strategies developed by the Taskforce on Nursing and sector reference group (comprising representatives from DHBs, the education sector, Maori and Pacific communities, and the Ministry of Health) in obtaining information included literature searches to "see if there were links between registered nurses prepared at an advanced level and patient outcomes, and to provide an overview of funding mechanisms and priorities for postgraduate education internationally (EAG, 2004, p. 3)". The analysis of these searches outlines four references only from four separate countries as the findings, a spread that would be difficult to apply directly to the NZ environment and climate. Having a number of confounding factors in measuring the links between education and nursing outcomes would cloud the process and thereby hinder the possible research options available (Gijbels, O'Connell, Dalton-O'Connor & O'Donovan, 2009).

As well, the DHB Directors of Nursing were surveyed with an overall response rate of "approximately 50%" (CTA, 2001, p. 31) in order to identify the costs incurred by health service providers in terms of the clinical component of nursing PECT programmes. It was "noted that at the onset of the survey that as there are no national specifications for the majority of post-entry clinical nurse training programmes, it was likely that the comparison of data between programmes would be limited, and would not provide financially accurate information" (ibid). The Report also stated that "a survey conducted among DHBs revealed a large variation in the cost of providing these clinical components (related to the education programmes), so no reliable data on average costs

The lack of systems thinking and the lack of political analysis in nursing education continues to undermine the profession in its development and positioning.

could be included in the model (ibid, p. 4)". This lack of common costing methodology added to the resulting variations.

Other information was sought from tertiary institutions on the range of programmes for registered nurses yet this is not discussed with the other "methods used to collect information on PECT for Nurses" (ibid, p. 29). Combined, a robust platform from which to make decisions that would effect national levels and programmes of nursing education was not apparent.

However, the conclusion that the Report's "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. Given the recommendations made, it is also noted that in the Report's findings providers had indicated that the CTA should consider funding the costs of "guest lecturers, books, accreditation and credentialing costs, and any additional course fees" (ibid, p. 32), all having a cumulative effect on the delivery and quality of education received.

The group's 2004 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 role. There was a driven focus on the Nurse Practitioner role which has affected the development of other advanced nursing practices - roles and possible scopes (Cumming, 2008). Regrettably, there have been opportunity costs – beyond the financial – that are associated with the development of the Nurse Practitioner scope as the role's genesis had not been fully supported by the wider health sector, thus blocking the it's realisation. Gorman recently commented on the NP model not having had a fluid, sustaining transition into the health sector stating that the underlying problems have been around: health needs targeted for NPs from the start not being strategic enough; the nursing voice continuing to be divided; and the medical profession not being adequately converted to the role's value - from the start - thereby resisting its 'bedding down' (Gorman, 2010).

The profession's lack of agreed educational levels and frameworks, from registration to specialty to advanced training, continues to erode our standing in the health arena.

The EAG's directions 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 (though the supporting evidence for the projected effects of a level-800-only focus were questionable). The focus was intended to support nurses in training at a level equivalent to 800 on the NZQA Framework and to be consistent with the recommendations included in the *National Strategy for Purchasing Post-Entry Clinical Nurse Training Programmes* report (EAG, 2004).

Nursing needs to be adequately resourced in order to untangle and define what it does, what it can do (add value), and then achieve the learning required to do just that.

The discussion in the report (EAG, 2004) around the need for postgraduate education is tenuous because there is minimal analysis of the outcomes desired from postgraduate education other than as a buffer against recruitment and retention problems. The discussion presented is further weakened as it does not explore comparisons with level 700 education programmes, nor attempt to evaluate its impact, in contrast to that of level 800, on the effectiveness of nursing knowledge, skills and care, particularly given the number of nurses in the workforce without degree education (level 700).

This same problem of measuring effectiveness has still not been eased in 2010. A recent (2009) systematic review evaluating the impact of post-registration nursing and midwifery education on practice, focused on recognised academic awards, and excluded continuous professional development and in-service training programmes and activities. The authors conclude that there is limited evidence of the direct impact of post-registration education on organisational and service delivery changes, and on benefits to patients and carers. They recommend that the impact on practice has yet to be fully explored and realised through a more systematic and coherent programme evaluation approach. (Gijbels et al., 2009).

In the 2004 report, individual employers were expected to fund the continuing education of staff development programmes. These are defined as "programmes that are less than six months (FTE) in length, provide skills and expertise that meet employers' or the individual's specific needs rather than health service requirements nationally, and/or do not lead to a national qualification (EAG, 2004, p.10)". However, if the health needs were clearly identified and measured initially then the process for meeting the ensuing educational needs for competent nursing care would be more straightforward.

Additionally, for level 800 programmes, the tertiary education sector's Performance Based Research Funding (PBRF) processes introduce other dimensions and drivers that can work against the clinically focused disciplines (Brinkman, 2008).

The dynamics of meeting professional teaching, clinical practice and research demands within the tertiary education system generate significant difficulties when pitted against disciplines free of 'practical application' within their training.

During 2003 the EAG project was completed despite concerns raised over the lack of information provided regarding potential funding structures and their impact (CTA, 2004). There was concern that the process was premature and needed further analysis for an open, transparent and informed consultation to take place. Concern was also expressed about the limited nursing representation (from across the spectrum) on the Expert Advisory Group. It seemed that seminal points of information were not being shared, or lacked analysis, or both.

For example, NZNO's submission for this 2002/03 consultation spoke to:

- nursing/training programmes needed to be prioritised in accordance with national health goals and strategies and should be patient/consumer needs driven;
- the funding of nursing training and education is/was inequitable and insufficient;
- insufficient information was given in the consultation document regarding the funding of post-entry clinical nursing training;
- further work is/be undertaken in developing policy options followed by an appropriate consultation process;
- level 700 courses should be retained to ensure competency and skills;
- NZNO supported the 'staircase' model of education and training that allows flexibility given the variety of demands placed on nurses in their wider life;
- NZNO does not support a shift to funding only level 800 post-graduate clinical education; did express support for strengthening the opportunities for nurses to achieve nurse practitioner status;
- lack of recognition had been given to the needs of nurses working in the private aged-care sector;
- concern that new graduates might receive a reduced salary in exchange for attendance on a first year of practice programme;
- enrolled nurses and their learning needs had not been mentioned;
- the representation on the Expert Advisory Panel should be wider and include nurses working in clinical practice.

Following on from this strategy development, the CTA declared that "In future years CTA funding will be directed towards 800-level programmes that are focused on priority areas and will provide nurses with a stepping stone towards Nurse Practitioner status." (EAG, 2004, p. 18; CTA Strategic Intentions 2004 – 2013, p. 15) Was rigourous analysis of health needs and the consequent education needs for nurses carried out by the EAG or was opinion and general feedback the best we as a nation could afford to follow given the (limited) resources allocated? In contrast, the CTA provided resourced analysis for the Public Health Medicine Training Programme which included re-costing the revised specification and estimating the required numbers of this group for future years (CTA, 2008).

Nursing Post Entry Clinical Training programmes

From 2001, the CTA also funded several national nursing Post Entry Clinical Training (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), and included:

- Child and Family Nursing
- Palliative care
- Advanced Emergency Nursing
- Rural Primary Health Care

The CTA budgeted $91.274 million for the financial year ending 2004/05 for post-entry clinical training, and around 3200 health professionals received training funded through CTA contracts (Ministry of Health, 2006, p.10). Nurses, and other health professional groupings, comprised a significantly insignificant percentage of those 3200 health professionals receiving funding in the 2004 academic year. The lion's share of funding continued to be awarded to medicine.

An independent evaluation (March 2006) of the Child and Family, and Emergency programmes recommended that the CTA review the funding model for nursing PECT, as the national nursing PECT programmes appeared to no longer be meeting the needs of employers due to the decline in trainee enrolments over the previous three academic years (see Table 2).

As a result the CTA did not contract directly for these programmes in the 2007 year. Again, the modelling done seems to have been based on perceived needs rather than actual needs, weakening the longer-term gains as is demonstrated by the following figures.

Table 2 - Modelling

Child and Family Nursing - CTN33

2001 Cont. Act.	2002 Cont. Act.	2003 Cont. Act.	2004 Cont. Act.	2005 Cont. Act.	2006* Cont. Act.
41 39	93 84	76 70	90 51	50 15	35 21

Advanced Nursing (Emergency) – CTN44

2001 Cont. Act.	2002 Cont. Act.	2003 Cont. Act.	2004 Cont. Act.	2005 Cont. Act.	2006* Cont. Act.
40 34	53 32	35 34	40 21	40 20	26 25

Advanced Nursing (Palliative Care) – CTN55

2001 Cont. Act.	2002 Cont. Act.	2003 Cont. Act.	2004 Cont. Act.	2005 Cont. Act.	2006* Cont. Act.
0 0	0 0	40 38	40 26	40 27	33 33

Key: Cont. = Contracted volumes, Act.=Actual volumes, 2006*= Volumes to June 06

Unlike the Ex-deficit model, the National Nursing Training (NNT) programmes had limited capacity to respond to and meet local needs so might have worked against employer commitment. The NNT programmes were purchased on a lead provider basis. This meant that an academic provider held the contract for the academic component and then subcontracted the clinical learning and clinical release/supervision components (usually with the trainee's employer). The implications for this contracting process are that the quality of that supervision was variable for the trainees within the programme, impacting on the wider learning objectives being sought.

From 2001, there seems to have been a split between nationally determined NNT programmes (based on defined need?) and the employers' willingness to support nurses. Would the NNT have been sustained if the profession had clearly defined nurses' education requirements necessary for competent post-registration practice?

Another limitation of the lead provider model was that the providers are (necessarily) not situated in all the main centres. As a result nurses have had to travel to other centres, which can be a significant barrier for some to ongoing nursing training/education – the level of resourcing would be felt by some individuals (Brinkman, Wilson-Salt & Walker, 2008). The Travel band funding introduced in 2006 addressed this and was positive for nurses from the (smaller) DHBs in order to attend programmes in the larger centres. (Yet, no doubt, there were those nurses who would have travelled outside their large urban areas to study in another city at the tertiary institution of their choice).

In contrast to these three NNT programmes, the Rural Primary Health Care programme (see Table 3) was introduced in 2004 and seemed to provide necessary training for nurses in rural areas where workforce availability is less than in the urban environments. 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 3 - Primary Health Care Nursing (Rural) – CTN40

	2004 Contracted	2004 Actual	2005 Contracted	2005 Actual	2006 Contracted	2006 Actual
Intake 1	20	16	16	13	13	13
Intake 2			34	30	30	25
Intake 3					25	25

Within the Ministry of Health, postgraduate nursing training was funded by a number of directorates using different funding models.

Why was the national lead and process taken by the Ministry so dispersed and variable across its own departments?

The 2006 consultation process

In 2006, the Ministry of Health's Clinical Training Agency unit was

appointed as the business unit responsible for post-entry clinical training charged with the aim of ensuring that training funds were targeted appropriately and effectively. From there it was decided that the CTA should lead the postgraduate nursing training funding purchasing strategy.

The aim of providing nurses with the ability to match training requirements with workforce need, in a fair and equitable fashion, was logical but was nursing allocated the resources needed for it to be put into effect?

Within the Ministry of Health Directorates these changes were intended to result in a fiscally neutral transfer of funds from the Health Services Funding NDE (Primary Healthcare Funding Path) to the National Services NDE (CTA funding). This move signified the changes in responsibilities between these Directorates.

The CTA had three models of funding for postgraduate nursing training in place in 2006. These were: Nursing Entry to Practice (NETP); Ex-deficit Nursing; and National Nursing Training programmes.

The CTA established the Expert Advisory Group (EAG) during 2006 to review the distribution of nursing training funding between DHBs and to consider appropriate parameters to which this funding should be applied. The Ministry's CTA and Clinical Services Directorate (CSD) recognised the need to move from the fragmented and centrally driven system of the ex-deficit funding, to one which would potentially be more comprehensive and congruent. A nationally agreed specification was required to meet CTA funding processes.

When compared with the rigorous attention afforded to the GP Review processes it is puzzling why neither the CTA nor the EAG recognised the complexities required for determining how health needs could best be served through an appropriately educated nursing workforce.

Ex-deficit nursing training funding was discontinued from December 2006, and replaced by the model recommended by the appointed (Nursing) Expert Advisory Group (EAG) to the CTA and the Clinical Services Directorate. This new funding model to be administered by DHBs was set in place following the expediently run 2006 EAG consultation process, which spanned only 41 days from formal notice of the consultation (18 October 2006) through to the Ministry finalising the specification (27 November 2006).

There were 37 submissions received as a result of the EAG consultation, from a range of organisations and individuals. These submissions were found to be "positive about the move to a single equitable funding model and generally supportive of the specification", (CTA, 2006) although any analysis made of the submissions is seemingly unavailable. NZNO had to deploy the Official Information Act's (OIA) processes with the CTA on two occasions in 2008 in an effort to secure this information with only a compilation (without analysis) of the submissions being sent to NZNO. Was a robust analysis of the submissions even carried out?

The 27 November 2006 specification outlined the parameters for the application of CTA postgraduate nursing training funds to all the DHB or MoH funded health services nursing workforce (including the DHB provider arm, the DHB non-provider

arm and Ministry of Health funded nursing workforces). The non-provider-arm healthcare services were detailed as being Non Government Organisation/Primary Health Organisation/Maori/Pacific/Aged Care etc healthcare services delivered via the DHB Planning and Funding contracts, within the DHBs' specific geographic areas. Each DHB was to be allocated a maximum amount per annum, based on the Population Based Funding Formula (PBFF) through Vote Health.

The move to the single funding model by the CTA and CSD was designed to enhance the accountability and transparency of the funding process and enable DHBs to determine and prioritise the training needs of their nursing workforce with direct reference to their District Annual Plans (DAP). The actual distribution of the funds (percentages allocated) among the DHB provider arm, the DHB non-provider arm and Ministry of Health funded nursing workforces was not clear at the time, and this has since been addressed with PHC funding being rolled out nationally for 2010, although the DHB arm often commands the more significant portion of the overall funding.

It would be highly useful to have had access to the national data that has been collected by the CTA from the DHBs (CTA monthly funding payouts only occur following receipt of the date). Elements of the CTA funding process for nursing are described as being "inflexible and the related monitoring is both punitive and overly bureaucratic (Gorman, Horsburgh & Abbott, 2009, p. 15)". It is puzzling why these results regarding student numbers applying, numbers accepted for CTA funding, retention and pass rates haven't been available on a regular, national basis. This data would have provided a nation-wide perspective to nursing education need and provision and help inform prospective nursing staff members of benefits sought and supported by DHBs. The data has now been released for the first time in April 2010.

The accountability of the CTA and DHBs in distributing and taking, respectively, government monies should be clearly set out and transparent as is ideally described by Cordery (2008) in determining the processes for PHOs in the PHC sector.

Since 2006 the Expert Advisory Group (EAG) has devolved into the Nursing Advisory Group (NAG) (see Appendix 4). NAG has continued to uphold the mandate for CTA funding to be dedicated to level 800 studies that are approved by the Nursing Council (NCNZ).

In late 2009, the CTA is reported as planning to set up an "innovations fund" using the estimated $4 million "under-spend" by providers unable to fill all training places in the 2009 – 2010 year. If national data were available about the uptake, or not, of the CTA funding for postgraduate studies would this situation of "under-spend" be lessened through awareness and drivers to match standards set by other DHBs? Is it the job of the CTA to monitor and encourage Directors of Nursing and their professional units to access these resources equitably on a national basis? Does the cost of having an "innovations fund" come at the cost of some nurses in some

areas not being supported to access further education through usual CTA funding channels?

It is interesting to note that the recently announced (23 December 2009) pilot programme to test the role of physician assistants is the first of the "innovative" health role trials being supported by the new CTA board (Nursing Review, Jan 2010, p. 3).

The NCNZ does have a role in the setting of education standards and competencies under the HPCA (see Appendix 2) but like the Medical Council it has neither the "mandate nor establishment expertise to be involved in curricula and pedagogical debates (Gorman et al, 2009, p. 13)". Nursing, unlike medicine, has not given this educational mandate to the professional clinical groupings whereby curricula and their implementation are accredited by external (to the Medical Council) professional bodies.

In order to establish and maintain effective undergraduate, post-registration and postgraduate programmes, it is the clinical nursing leaders and nurse clinicians who are best placed to inform and articulate the profession's expectations for achieving levels of expertise and the necessary pathways to be taken. Programmes must be responsive to clinical need and it is vital that clinicians and educators work together.

Primary Health Care (Rural) Funding

In 2007, the new Ministry structure was established, and reflected some further changes in the configuration of the directorates. The CTA moved to become part of a new Directorate, called Health and Disability National Services (HDNS). Under this next line of leadership, the CTA anticipated further improvements to contracting processes over time, and the alignment of processes across the new Directorate.

September 2007 saw funding being ring-fenced by the CTA, with the DHBs, for Rural and Primary Health Care (PHC) Nursing transferred from the former Rural and Primary Health Nursing scholarship funding. To illustrate this, the six PHC Nurse Practitioner (Rural) Scholarships required a funding commitment of $140,000 from July to December 2007.

A criticism in 2005 of these rural scholarships was the limited/restricted course or study options. Specifically, the exclusion of courses that are appropriate to PHC but are not NCNZ approved meant the focus of the education was narrowed. This lack of NCNZ approval for interdisciplinary programmes and courses was not presented with supporting evidence confirming their seeming irrelevance to a nurse's postgraduate education. This issue has been somewhat eased from 2009 with up to two interdisciplinary courses being transferable to a Nursing Council approved masters degree depending on each institution's degree criteria.

Due to the PBRF processes, tertiary institutions have been increasingly driven to support programmes that engendered high research output from suitably qualified, motivated staff. Staff teaching within the tertiary institutions are recruited and supported for their research activity. This emphasis has repercussions for the quality of teaching.

This research driver has a direct effect on clinical aspects of education, as short-term, casual clinical teaching contracts are frequently offered to clinicians who may or may not be familiar with the curriculum, particularly at the undergraduate level.

Requiring flexible roles that meet health needs is a priority for the diverse primary health care sector. Gorman et al (2009) state that the PHC Strategy has "resulted in a per capita loss of doctor productivity and has not resulted in any substantial diversification of health professional roles (p. 8)". Many PHC nurses are frustrated, particularly by PHO governance systems, limiting their ability to extend their practice and better meet patient need. More dialogue and critical analysis will tease out the issues which are behind this resistance to change causing unnecessary barriers to professional practice affecting patient access and outcomes.

Nursing Entry to Practice (NETP) Programme

Pilot programmes for the first year of nursing clinical practice were launched in February 2002. The aim was to consolidate practice in DHB-based programs rather than hospital-based ones as graduates emerged from the tertiary institutes. This is in comparison with doctors, who in their first year of clinical practice must work under designated supervision within their probationary registration. This year of their medical training (PGY1) is accredited by the Medical Council, has a national specification, and is 100% funded by the CTA – as is the postgraduate year two (PGY2). Having met the appropriate standards, the graduate is then awarded general registration by the Medical Council following PGY1.

This begs the question about which system of education towards professional registration – nursing's or medicine's - serves the public better?

It is also significant to ask why the NETPs costs are shared by the DHB and the CTA ($6,000 each only) in direct contrast to medicine with its system attracting the significant 100% funding by the CTA.

Following on from the pilot programmes for the first year of nursing clinical practice an Evaluation Report was published. Recommendations were made which resulted in the development of a national Specification. The first intake of NETP trainees for participating DHBs began in August 2006, with the programme designed to improve nurse retention and recruitment. All DHBs offered NETP programmes during 2007.

Whether or not the focus on academic input is desirable in what is a year of consolidation with the focus on clinical experience and expertise, is a moot point that warrants closer study.

The CTA commissioned an evaluation of the NETP programme, contracting independent evaluators, with the report being released in December, 2009 (Haggerty, McEldowney, Wilson & Holloway, 2009). The CTA report states that more than 90 percent of new nurses are successfully completing NETP programmes. However, due to low response rates to the report's survey findings around wider issues for both the graduates and preceptors mean the conclusions reached are thereby weakened.

The Report states that the number of programmes where trainees found the teaching "not directly applicable to the clinical setting" is reported to have decreased substantially from 14.3 per cent in 2007 to 3.8 per cent to date in 2008. The issue of theoretical workload had fluctuated but was still viewed as a problem by 38.5 percent of programmes in mid-2008. This area of discontent could well be related to the new nurses having academic courses (level 800) being required within some DHBs' NETP programme. If all NETP participants are funded for level 800 study then this will cut across available HWNZ funding for other nurses unless new monies are allocated.

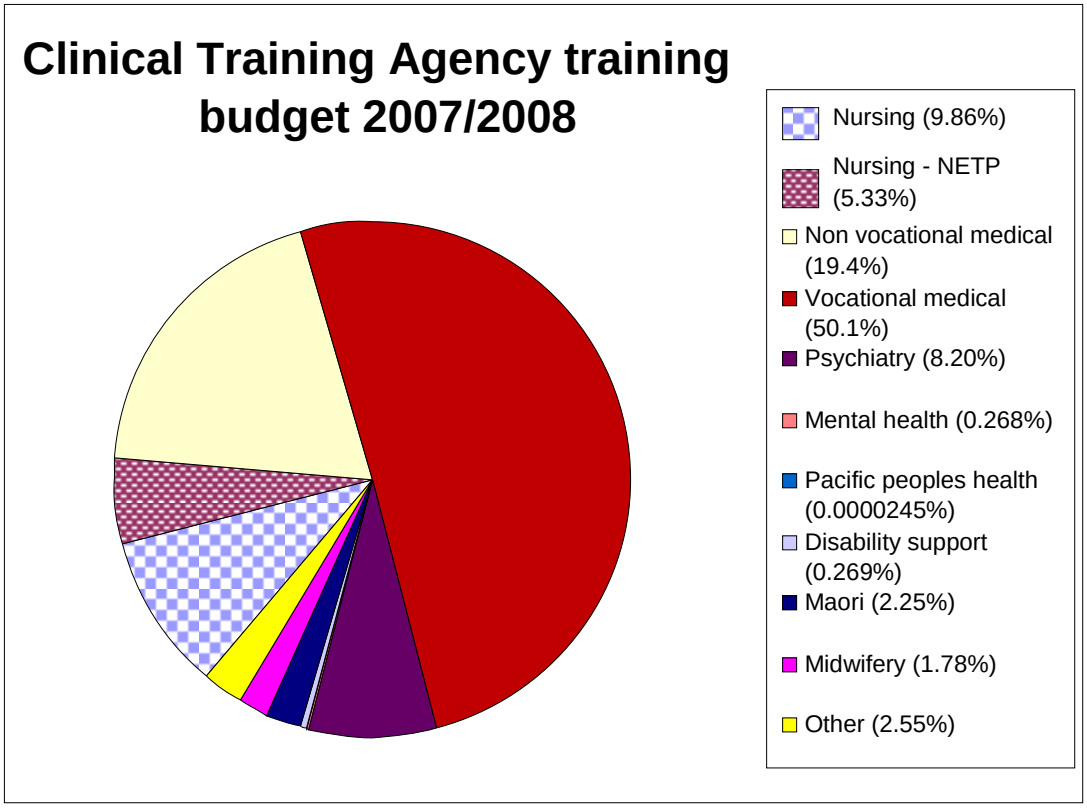
The next review of the NETP programmes is scheduled for 2012, with revised specifications and costings to be in place for 2011 from the 2009 review (Nursing Review, 2010).

For mental health, there will be four providers of new graduate programmes in 2010. Te Pou administers the mental health clinical training funding not the CTA. Te Pou funds about 260 new graduate and postgraduate places in 2010 with up to 182 places dedicated to nursing with the remainder open to nurses and allied mental health professionals. The new graduate programmes for mental health will be offered by four providers. 25 more new graduate places will be offered in 2010 and a new clinical leadership programme providing a pathway to a master's qualification will be available, too. Three universities will provide the new clinical leadership programme with up to 42 places available (Nursing Review, 2010).

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 4- Clinical Training Agency training budget 2007/2008



Critical Training Agency training budget 2007/08

Nursing (9.86%)	$11,100,498
Nursing - NETP (5.33%)	$5,999,323
Non vocational medical (19.4%)	$21,801,247
Vocational medical (50.1%)	$56,441,862
Psychiatry (8.20%)	$9,241,432
Mental health (0.268%)	$302,481
Pacific peoples health (0.0000245%)	$2,760
Disability support (0.269%)	$303,535
Maori (2.25%)	$2,536,677
Midwifery (1.78%)	$2,000,000
Other (2.55%)	$2,875,187
Total	$112,605,002

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 as 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). By July 2010 the Christchurch office was to be disestablished with services being relocated to the Ministry of Health offices in Wellington.

Moving Forward

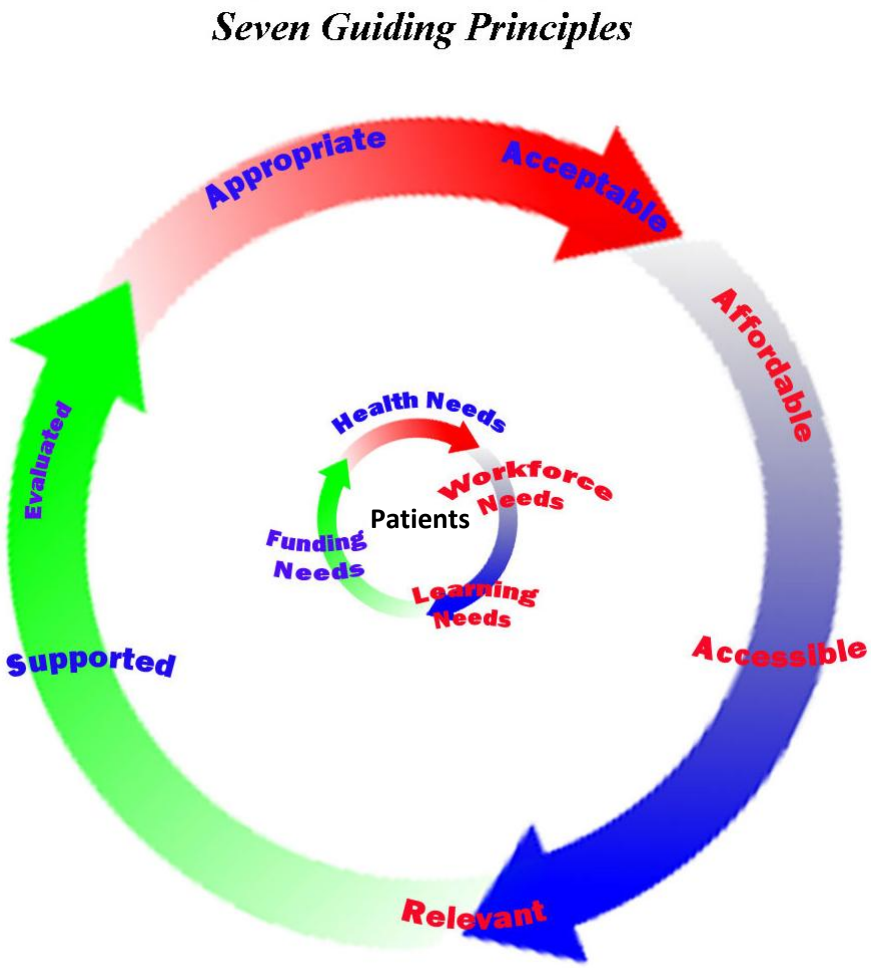
Some of the reasons why nursing has not been able to fulfill its capacity and work to its potential within the health sector have been detailed in this document. In particular it needs to overcome the historically entrenched barriers to/for nursing education, and to play a role commensurate with its 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 institutions 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.

Figure 5 - Post-Registration 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 essential 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.
- Flexible learning delivery is a necessary component to many students' learning. Other modes and processes of learning need to be explored and implemented on a national scale if nurses are to be enabled to gain the determined knowledge, behavior, skills, values and processes for ongoing safe and competent practice (Mende, 2010).
- Another issue to consider is the prioritising of CTA monies to clinical programmes thus demoting research based masters degrees. The consequence of that emphasis is in lessening the overall amount of research activity being pursued as well as the potential quality of nursing research being compromised (CTA, 2009).

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) is/ 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 (Appendix 2). 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.

- The increasing international and national calls for interprofessional education (WHO 2010; McKinlay & Pullon, 2004; Pullon & McKinlay, 2004) are problematic as they do not align with the current HWNZ/CTA funding systems for nurses. Under the current processes a programme must be approved by the Nursing Council to qualify for CTA funding (CTAB, 2009).

  The interprofessional education programmes are located outside of the Schools of Nursing that have gained Nursing Council approval. However, the Nursing Council's approval processes for postgraduate degrees do not stipulate exacting criteria when it comes to the inclusion - or not - of interprofessional courses/programmes (NCNZ, 2004). Confusingly, for students and DHB funders, it is currently left to each education institution's own processes whether or not non-approved courses are accredited towards the approved institution's degree programme.

  An example would be that some institutions with Nursing Council approved degree programmes permit two 'non- Nursing Council approved' courses to be credited towards an approved Masters clinical degree. This is in contrast to the full inter-professional postgraduate programme (from which those courses have been derived) not being NCNZ approved thereby blocking HWNZ/CTAB funding for interested nurses. This is despite the potential relevance of the full programme to the nurses' learning needs in improving health outcomes.

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 (Appendix 3).
- 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 relevant to our learning '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 - Nursing Education Timeline, 1993 - 2010

1993	1994	January 1995 – June 1996	1996	1998	2001	2002	2004
Advisory Group on the Funding of Clinical Training meets Ministry of Education funds over $140 million in support of health professional courses	Split in funding between Vote: Health and Vote: Education made Coopers & Lybrand report, 'Estimates of the Costs and Benefits of Clinical Training' CTA established through a legal partnership amongst the four RHAs.	CTA funding $52.342 million (GST inclusive), plus some added funding from RHAs	Three 'new initiative' pilot training programmes for nurses purchased in mental health and specialised care of the elderly	CTA makes significant move from historical to needs-based purchasing and prioritisation Unbundling (from CHEs) of Post Entry Clinical Training (PECT) funding for nursing The Ministerial Taskforce on Nursing reports	Ministry of Health commenced work on national purchasing and prioritisation strategy for PECT for nurses CTA's budget $7.9 million (excluding mental health funding) from a total PECT budget of $80m Several national nursing PECT programmes at level 800 funded	CTA funded three national pilot Graduate Nurse programmes	Ministry of Health PHC scholarships offered CTA budget $91.274 million for 2004/05 Rural PHC programmes commenced

2004	2006	2007	2009	2010
CTA budget $91.274 million for 2004/05 Rural PHC programmes commenced	PECT courses not funded for 2007 academic year CTA leads the Post graduate Nursing Training funding purchasing strategy Expert Advisory Group established Ex-deficit training funding stopped in December 2006 First intake of NETP trainees for participating DHBs begins in August	Nursing Advisory Group takes over from Expert Advisory Group Rural and Primary Health Nursing Scholarships funding transferred to CTA auspices All DHBs offered NETP programmes during 2007 CTA nursing training budget $16.6 million	CTA contributes to HWIP for robust nursing workforce planning Committee on Strategic Oversight for Nursing Education set up and report published CTA funding in 2008/09 is $121.5 million CTA nursing training budget $18.8 million CTA changes name to CTA Board (CTAB) then to Health Workforce NZ (HWNZ)	CTA budget $125 million for 2009/10 HWNZ, with Des Gorman as Chair, states main focus is on medical education for two years. CTA office in Christchurch moved to Wellington. July – CTA renamed as the Investment Relationships and Purchasing arm of Health Workforce New Zealand

Appendix Two - Legal Analysis

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 Three - Medical NZRDA and ASMS contracts

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.

a. 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 icreasing 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.

Appendix Four - CTA Advisory Groups

Advisory Group on Clinical Training (1992)

Chair - Professor David Stewart*, Assistant vice-Chancellor, Division of Health Sciences, University of Otago*
Ms Lesley Askew, *Professional Advisor, Department of Health*
Professor Don Beaven, *Deputy Commissioner, Canterbury Area Health Board*
Mrs Margaret Horsburgh, *Northern Regional Manager, Open Polytechnic of New Zealand*
Dr Karen Poutasi, *General Manager, Wellington Area Health Board*
Dr Tony Townsend, *General Practitioner, Rotorua*

CTA Steering Group on Nursing (1998)

Chair – Nigel Kee, *CTA Programme Manager for Nursing, President of New Zealand Nurses Organisation*
Frances Hughes, *Chief Advisor (Nursing), Ministry of Health*
Joc Peach, *Director of Nursing and Midwifery, Auckland Healthcare*
Judy Kilpatrick, *Chair, Nursing Council of New Zealand*
Tracy Cadman, *Clinical Nurse Educator, Health Waikato*
Margie Schofield, *Rural Nurse, Castle Point, Masterton*
Shelly Park, *Director of Nursing, Burwood Hospital, Christchurch*
Professor Alison Dixon, *Chair, Department of Nursing and Midwifery, Victoria University of Wellington*
Debbie Penlington, *Director of Nursing Practice, South Auckland Health*
Ron Dunham, *CEO, Eastbay Health, HHS Representative*

Members of the Post-Entry Clinical Nurse Training Expert Advisory Group (2004)

Chair – Frances Hughes, *Chief Advisor Nursing, Ministry of Health*
Pamela Lee (Deputy Chair), *Senior Analyst, Ministry of Health*
Members of Group:
Taima Campbell, *Assistant Director of Nursing (Maori), Auckland DHB*
Mia Carroll, *Former Director of Nursing, Auckland DHB*
Marion Clark, *CEO, Nursing Council of New Zealand*
Mary Finlayson, *Associate Professor of Nursing, University of Auckland*
Jan Grant, *Ministry of Education*
Judy Kilpatrick, *Associate Professor of Nursing, University of Auckland*
Nicolette Sheridan, *Auckland University*
Janette Skiba, *Former Director of Nursing, Christchurch Hospital*
Margaret Southwick, *Whitireia Polytechnic*
Maree Young, *Analyst, CTA*
Stephanie Calder, *Ex-officio, Ministry of Health*

Members of the NETP Establishment Steering Group (September, 2006)

Ministry of Health representatives
Tony Gibling, *Manager, CTA*
Daria Martin, *Portfolio Manager, CTA*
Mark Jones, *Chief Advisor, Nursing*
DHBNZ/DHB representatives
Chair - Sue Hayward, *Director of Nursing, Christchurch Hospital, Canterbury DHB*
Kerry-Ann Adlam, *National NETP Project Co-ordinator, DHBNZ*
Margaret Dotchin, *Nurse Director, Adult Services, Auckland City Hospital, Auckland DHB*
Lindy MacLennan, *Training and Development Manager, Bay of Plenty DHB*
Nursing Council of New Zealand representatives
Annette Huntington, *Council Chair*
Marion Clark, *CEO*
Carolyn Reed, *Education Advisor*

Members of the CTA Nursing Advisory Group (September 2007)

Chair - Sue Hayward, *Director of Nursing, Christchurch Hospital then Waikato DHB*
Daria Martin, *Portfolio Manager, CTA*
Mark Jones, *Chief Advisor, Nursing, Ministry of Health*
Alison Dixon, *Nurse Educators in the Tertiary Sector*
Phillipa Molloy, *Director of Nursing, Marlborough DHB*
Kerry-Ann Adlam, *Director of Nursing, Taranaki DHB*
Margaret Dotchin*, Director of Nursing, Manager, Auckland DHB*
Carolyn Reed, *Education Advisor, Nursing Council of New Zealand*

CTA & HWIP Reference Group members – (April 2009)

Karolyn Kerr, *Project Manager, HWIP*
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Groups outside of CTA

Taskforce on Nursing, 1998

The Hon Dame Ann Hercus, *(Chair from 23 February to 30 June 1998)*
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References:

Bovens, M. (2005). Public Accountability. In A. Ferlie, L. Lynne & C. Pollitt (Eds.), *The Oxford Handbook of Public Management* (pp. 182-208). Oxford: Oxford University Press.

Boyne, G., Gould-Williams, Brinkman, A. (2008). *Collating for collaboration: Tertiary education funding.* NZNO: Wellington. http://www.nzno.org.nz/LinkClick.aspx?fileticket=dHyI1EeMBu4%3D&tabid=437

Brinkman, A., Wilson-Salt, R. & Walker, L. (2008). NZNO Education Survey: Implications for practice. NZNO: Wellington website, Retrieved, 7th October, 2009, from http://www.nzno.org.nz/LinkClick.aspx?fileticket=W0tQ%2ftTCnkg%3d&tabid=179

Brinkman, A. (2009). Marketing nursing to secure the profession's future. *Kai Tiaki Nursing New Zealand.* 15:10, 28 – 29.

Cancer Control Council of New Zealand (2009). *What We Learnt from Patient Experiences – Part One*. Retrieved 18 December, 2009 from http://cancercontrol council.govt.nz/files/Voice%20of%20Experience.pdf

Clinical Training Agency (1994). *Purchasing Direction 1995 - 1998*. Ministry of Health: Wellington.

Clinical Training Agency (1995). *Business Plan 1996 – 1997*. Wellington: Ministry of Health.

Clinical Training Agency (1996). *Newsletter (July).* Wellington: Ministry of Health.

Clinical Training Agency (1997a). *Newsletter (May).* Wellington: Ministry of Health.

Clinical Training Agency (1997b). *Newsletter (November)*. Wellington: Ministry of Health.

Clinical Training Agency (1998). *Newsletter (September).* Ministry of Health: Wellington.

Clinical Training Agency (2001). *The health workforce: a training programme analysis.* Retrieved 10 June, 2010 from: http://www.moh.govt.nz/moh.nsf/82f4780aa066f8d7cc2570bb006b5d4d/42228d5af3b0fc6ccc256b1e000761d6/$FILE/CTA.pdf

Clinical Training Agency (2004). *Clinical Training Agency Strategic Intentions 2004 – 2013.* Ministry of Health: Wellington.

Clinical Training Agency (2008a). *Purchase Intentions.* Wellington: Ministry of Health.

Clinical Training Agency (2008b). *Review of the Purchasing strategy for the Public Health Medicine Training Programme.* Wellington: Ministry of Health.

Clinical Training Agency (2009). CTA Postgraduate Nursing Training Specification. Retrieved 4 November 2009 from: http://www.healthworkforce.govt.nz/sites/all/files/cta-postgrad-nursing-spec-aug09.pdf

Committee on Strategic Oversight for Nursing Education. 2009. *A Nursing Education and Training Board for New Zealand*. Wellington: Ministry of Health. Retrieved 4 December 2009 from: http://www.moh.govt.nz/moh.nsf/indexmh/nursing-education-and-training-board-for-nz-aug09

Cook, L. (2009). *Report to the Minister of Health: An evaluation of the need for a Nurse Education and Training Board for the oversight of nursing education and training in New Zealand.* Minister of Health: Wellington.

Cook, L. & Hughes, R. (2009). Recognising the need for wider public sector reform alongside the new arrangements for leading the public health sector. *Institute of Policy Studies Quarterly.* To be in press.

Coopers and Lybrand (1994). Report to the Ministry of Health, *Estimates of the Costs and Benefits of Clinical Training.* Coopers and Lybrand: Wellington.

Cordery, C.J. (2008). *Dimensions of accountability: voices from New Zealand Primary Health Organisations*. Unpublished doctoral thesis for Victoria University of Wellington. Retrieved 22 June, 2010, from http://www.nzno.org.nz/LinkClick.aspx?fileticket=Fg9tc72EV08%3D&tabid=421

Cottingham, C. (1996). Nurses' needs ignored. *Kai Tiaki: Nursing New Zealand*. 2:6, 17.

Cumming, G. (2008). *From a generic to a gynaecological oncology clinical nurse specialist: an evolving role.* Unpublished masters thesis for the University of Otago.

District Health Boards New Zealand (DHBNZ) (2008). *Frequently Asked Questions.* Retrieved 22 February, 2008, from http://www.dhbnz.org.nz/Site/Future_workforce/NETP/FAQ.aspx

District Health Boards New Zealand (DHBNZ) (2009). *Nursing Projections Project.* Retrieved 3 March, 2010, from http://www.dhbnz.org.nz/Site/Future_Workforce/HWIP/Nursing-Projections-and-Planning/default.aspx

Dominion Post (25 October 2008). *Suicide toll surpasses road deaths.* Retrieved 23 December, 2009, from http://www.stuff.co.nz/dominion-post/archive/national-news/68905

Dowell, A.C., Garrett, S., Collings, S., McBain, L., McKinlay, E. & Stanley, J. (2009). *Evaluation of the Primary Mental Health Initiatives: Summary report 2008.* Wellington: University of Otago and Ministry of Health.

Expert Advisory Group on Post-Entry Clinical Nurse Training Programmes (2004). *Towards a National Strategy for Purchasing Post-Entry Clinical Nurse Training Programmes.* Ministry of Health: Wellington.
Retrieved 9 September, 2009, from: http://www.moh.govt.nz/moh.nsf/pagesmh/3100

Finkler, S.A. (2008). Measuring and accounting for the intensity of nursing care: Is it worthwhile? *Policy, Politics, & Nursing Practice.*
Retrieved 29 November, 2009, from http://ppn.sagepub.com/cgi/content/refs/9/2/112.

Gijbels, H., O'Connell, R., Dalton-O'Connor & O'Donovan, M. (2009). A systematic review evaluating the impact of post-registration nursing and midwifery education on practice. Nursing Education in Practice. In press.

Gorman, D., Horsburgh, M., & Abbott, M. (2009). *A review of how the training of the New Zealand health workforce is planned and funded: a proposal for a reconfiguration of the Clinical Training Agency.* Minister of Health's Taskforce: Wellington.

Gorman, D. (2010). *A vision for the future health workforce.* Presentation at the College of Nurses Aotearoa seminar series. Wellington: Massey University (May 27th).

Haggerty, C., McEldowney, R., Wilson, D. & Holloway, K. (2009). *Growing Our Own: An Evaluation of Nurse Entry to Practice programmes in New Zealand 2006-2009.* Wellington: Author.
Retrieved 3 February, 2010, from
http://www.moh.govt.nz/moh.nsf/Files/ctadocs/$file/growing-our-own-NETP-final-report-Jan2010.pdf

Health Reforms Directorate (1992). *The Clinical Training of Health Professionals: options for funding.* Ministry of Health: Wellington.

Hillman, B.J. & Goldsmith, J.C. (2010. The uncritical use of high-tech medical imaging. *New England Journal of Medicines.* 336 (i), 4-5

Jarvis, P. (2004). *Adult education and lifelong learning (3rd edition).* London: RoutledgeFalmer.

Klein, N. (2007). *The Shock Doctrine.* Penguin Group: Australia.

Lawless, J. (2009/2010). Just keep swimming…just keep swimming. *Kai Tiaki Nursing New Zealand.* 15:11, p. 29.

Lawless, J. (2010). So what's happening with safe staffing and healthy workplaces? *Kai Tiaki Nursing New Zealand.* 16:2. 22-3.

Litchfield, M.C. (2004). *Achieving health in a rural community: A case study of nurse-community partnership.* Hastings: Central Publishing Bureau.

Litchfield, M.C. (2007). *Towards a people-pivotal paradigm for healthcare: An integrative nursing scheme for Turangi with mobile whānau/family nurses to span primary-secondary-tertiary sectors*. A report submitted to the Ministry of Health as part of the primary health care nursing innovation project 2003 – 2006.

MaGPIe Research Group (2003). The nature and prevalence of psychological problems in New Zealand primary healthcare: a report on Mental Health and General Practice Investigation (MaGPIe). *New Zealand Medical Journal.* 116(1171): U379.

Manchester, A. (2006). Certificate programme values nurses in practice: the graduate certificate programme at Christchurch Polytechnic Institute of Technology has found a niche market as it continues to attract students from throughout the country. *Kai Tiaki: Nursing New Zealand, 12: 8, 21.*

McKinlay, E. & Pullon, S. (2004). Professional development in primary care- who is responsible? *Kai Tiaki New Zealand*, 12(5).

Mende, E. (2010). CNnect: The College's online learning environment. *Nursing.aust,* 11(1), 18.

Ministerial Taskforce on Nursing (1998). *Report of the Ministerial Taskforce on Nursing: Releasing the potential of nursing.* Ministry of Health: Wellington.

Ministry of Health (1991). *Your Health and the Public Health*. Ministry of Health: Wellington.

Ministry of Health (1999). *Implementation of the Ministerial Taskforce on Nursing Report: Sector Update*. Ministry of Health: Wellington.

Ministry of Health (2006a). Health Workforce Development: an overview. Wellington: Author.

Ministry of Health (2006b). *Health Report: Increasing General Practitioner Registrars (GPEP1).* Wellington: Author.

Ministry of Health (2007a). *Health Report: Purchase of Postgraduate Nurse Training from 2007 and Beyond.* Wellington: Author.

Ministry of Health (2007b). *Health Report: Implications of the CTA Review of General Practitioner Vocational Training.* Wellington: Author.
Ministry of Health (2008). A Portrait of Health: Key results of the 2006/07 New Zealand Health Survey. Wellington: Author.

Ministry of Health (2009). *Current status of the national regulated nursing workforce*. Retrieved, 3 February, 2009 from http://www.moh.govt.nz/moh.nsf/pagesmh/6795/$File/current-state-nursing.pdf

New Zealand Nurses Organisation (1993). *Nursing Education – Policy and Standards.* NZNO: Wellington.

New Zealand Nurses Organisation Critical Care Nurses' Section (2010). New Zealand standards in critical care nursing education (4th ed.). Retrieved, 24 February, 2010 from http://www.nzno.org.nz/LinkClick.aspx?fileticket=tjjbDYWEJoA%3d&tabid=317

Nursing Council of New Zealand (2004). *Standards for postgraduate programmes with nurse prescribing.* Wellington: Author.

Nursing Review (2010). *CTA outlines its spending on nurses.* 10:9, 4. Tauranga: APN Print.

Oliver, H. (1998). Why NZNO refused to endorse Taskforce report. *Kai Tiaki:Nursing NewZealand*. 4:7, 12-13.

Organisation for Economic co-operation and Development (OECD) (2009). Policy brief: Economic survey of New Zealand, 2009. Retrieved, 3rd February, 2010, from http://www.oecd.org/dataoecd/62/41/42564695.pdf

Pullon, S. & McKinlay, E. (2004). Towards a culture of supporting professional development for primary care professionals. *New Zealand Family Physician*. 31(4), 267-70.

Safe Staffing/Healthy Workplaces Committee of Inquiry (2006). *Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry.* Retrieved 3rd March, 2010, from http://www.nzno.org.nz/LinkClick.aspx?fileticket=B2HW4Hixc24%3d&tabid=228

Tiedeman, M.E. & Lookinland, S. (2004). Traditional models of care delivery: What have we learned? *Journal of Nursing Administration.* 34:6, 291 – 7.

Walker, L. (2009). Holding Up: The first biennial NZNO Employment Survey. Retrieved, 15 December 2009, from http://www.nzno.org.nz/LinkClick.aspx?fileticket=X45apYb%2bMpk%3d&tabid=179

Watson, P. (2006). New directions for postgraduate education. *Kai Tiaki: Nursing New Zealand.* 12:5, pp. 22-23.

World Health Organisation (2010). *Framework for action on interprofessional education & collaborative practice.* World Health Organisation: report by Health Professions Networks Nursing and Midwifery Office. Retrieved 19 July, 2010 from http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.3_eng.pdf

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