The Commodification of Caring:
A search for understanding of the impact of the New Zealand health reforms on nursing practice and the nursing profession.

A Journey of the Heart

Jill Fredryce White

VOLUME TWO
APPENDICES

A thesis submitted to the University of Adelaide in fulfillment of the requirements for the degree of Doctor of Philosophy

in

the Department of Clinical Nursing
Faculty of Medicine
University of Adelaide
April, 2004
APPENDIX I

Materials Associated with the Research Process for this Thesis
APPENDIX I:

Material associated with the research process for this thesis

1. Information sheet
2. Consent form
3. Interview questions
4. Human ethics approvals
5. Examples of summaries of group meetings
6. Examples of N-Vivo Node listings
7. Examples of N-Vivo models
University of New England, Armidale, Australia
Central Regional Health Authority, Wellington Ethics Committee

Title: The Commodification of Caring: Sustaining a nursing ethic of care in an environment of managerialism in the aftermath of the health reforms in New Zealand.

Information Sheet

As you are well aware the health "reforms" in New Zealand have lead to many changes, including increased emphasis on accountability, outcome measures, performance indicators and competitive contracting. This new environment has changed nursing practice and will continue to do so. Nurses appreciate and live daily with the costs of these changes but they also have the capacity to contribute to shaping the future of New Zealand health care. Change is inevitable. Nursing can either choose to be part of change or be buffeted by the decisions of others.

Conversely health care organisations are extremely dependent on nurses and nursing practice for patient/customer satisfaction and with the implementation of change processes. This study aims to facilitate shared understandings between management and nursing of the difficulties and the opportunities of the "reformed" health system.

This study involves the formation of a group of nurses from all levels of practice and managers from the resource manager group and general managers. The group of approximately 12 people will meet together for 3 hours fortnightly for a three month period. The group will be held at the hospital out of work hours in a comfortable environment with food and drink supplied. The group process will be facilitated by me and our aim is to come together as equal contributors to discuss nursing practice within the health reforms to try to gain a better understanding of management and nursing and to seek new possibilities of practice together.

All participants will be interviewed individually for between 30 minutes and 1 hour by me within one month of commencing our group conversations and again within one month following the completion of our group work. You will be given a copy of the transcripts of both of these interviews. The group conversations will be tape recorded and transcribed and a copy of the transcription returned to you within a week so that you will have time to review and reflect on the substance of the last conversation prior to our next meeting together. Copies of the group transcripts will then be destroyed (with the exception of my copy) in the interests of confidentiality.
All discussions within the group must be kept confidential to the group. All participants will enter the group in goodwill, as equal partners and aim to develop an environment of trust which will facilitate sharing of real practice based concerns and possibilities. All participants will be free to leave the study at any time with no fear of negative consequences.

At times some of the conversations may be uncomfortable as sharing stories of practice difficulties often are, but with the support of the group, the outcome should be positive and for some potentially therapeutic.

I am happy to provide you with a copy of the full study proposal or answer any questions you may have about the study at any time. Also, if you have any concerns about the research you may write to the Chairperson, Central RHA, Wellington Ethics Committee, Wellington Hospital, Private Bag 7902, Wellington South ph: (ext. 5185) or fax: As this study represents a component of my PhD you may also contact my supervisor, Professor Alan Pearson, Department of Caring Sciences, School of Health, UNE, Armidale NSW 2351 ph:

Jill White
Department of Nursing and Midwifery
Victoria University of Wellington
Consent Form

Project Title: The Commodification of Caring: Sustaining a nursing ethic of care in an environment of managerialism in the aftermath of the health reforms in New Zealand.

(This project represents part of a PhD being undertaken through the University of New England, School of Health, by Jill White).

Supervisor: Professor Alan Pearson
Department of Caring Sciences
School of Health
University of New England
Armidale, NSW 2351

Venue: Hutt Hospital
Hutt Valley Health
Lower Hutt

Aim of the Investigation:

This study aims to work with a group of nurses and managers to collaboratively explore the goals, opportunities and constraints on management and nursing practice within the New Zealand health "reforms". Through a process of fortnightly meetings for three months it is hoped the group will be able to envisage possibilities of caring innovative nursing practice and ways of constructively influencing the direction of care within the CHE.

Confidentiality:

Confidentiality of all matters discussed within the group must be maintained. Participants will be identified in the study report by pseudonyms chosen by them at the commencement of the study.

I (-------------------) have read the information on the information sheet attached and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I agree the research data gathered for the study may be published, provided my name is not used. I understand that this project has been approved by the Central Regional Health Authority Ethics Committee and by the Human Ethics Committee of the University of New England, Armidale, Australia.

Participant or Authorised Representative .......................................................... Date

Investigator .......................................................... Date

Statement by Witness/Advocate. I have discussed this consent form with the participant and I am satisfied that she/he fully understands it and that her/his consent is freely given.

Signature of Witness/Advocate.......................................................... Date..
INTERVIEW QUESTIONS:

1) What is our understanding of the intent and effect of the post 1991 health reforms?

2) What has been the experience of the patient of the health reforms?

3) What is your understanding of nursing?

4) What is your understanding of an ethic of care?

5) What is your understanding of what patients believe nursing to be? What do they want/expect from nurses/nursing?

6) What has been the effect of the post 1991 health reforms on nursing/for nurses? What part do they play as a professional group in the reform?

7) Do the/should nurses have a voice in the shaping of New Zealand health care?

8) What can facilitate nursing/nurses active participation in change? What prevents nursing/nurses active participation in change?
Ms Jill White
Department of Nursing and Midwifery
Victoria University of Wellington
Wellington
New Zealand

27 October 1994

Dear Ms White,

I have pleasure in advising you that the Research and Higher Degree Studies Committee have approved your PhD Research Proposal and Ethics Form without alteration. I will now submit them to the University's Ethics Committee for approval and advise you when their approval is received.

Yours sincerely,

D V Clifton
TO: Professor Jill White  
Nursing and Midwifery  
FROM: Linda Bowden  
DATE: 17 October 1994  
SUBJECT: ETHICAL APPROVAL - THE COMMODIFICATION OF CARING

The VUW Human Ethics Committee Standing Committee has advised that, as your project has been submitted to the RHA Ethics Committee for approval, it does not require the approval of the HEC Standing Committee. The University has a reciprocal agreement with the RHA Ethics Committee.

The Standing Committee would, however, appreciate receiving notification of approval by the RHA Ethics Committee once this has been received.

Thank you.
21 October, 1994

Professor Jill White
Department of Nursing & Midwifery
Victoria University
PO Box 600
WELLINGTON

Dear Jill

94/109 - The Commodification of Caring

Your application for ethical approval for the above study was considered at a sub-committee meeting of the Ethics Committee on 20 October.

You have Ethics Committee approval for your study subject to providing a satisfactory response to the following:

1. The Committee had some reservations about the capacity for group consent in the context of this study.

2. Please elaborate on what protections are in place for the risk of later use of the information obtained from the transcript by participants.

3. The risk of identifiability of personal information in the reporting document.

4. Approval from the University of New England to proceed with this study for the purposes of your Ph.D. degree.

We look forward to receiving your response. Please contact me if there are any aspects of this letter you wish to discuss with me.

Yours sincerely

Alison Douglass
CHAIRPERSON
23 November 1994

Alison Douglass
Chairperson
Wellington Ethics Committee
Wellington Hospital
Private Bag 7902
Wellington

Dear Alison

94/109 – The Commodification of Caring

Thank you for your letter of October 21 indicating approval of my study subject to providing a satisfactory response to four (4) items.

1. **Group consent in the context of the study**

   I understand the committee's concern in relation to group consent and have removed this clause from the information sheet and consent form. This will no longer be part of the project. The discussions of the group will be kept confidential to the group (see attached revised information sheet and consent form).

2. **Protects for the risk of later use of the information obtained from the transcript by participants**

   The copies of transcripts of the group discussions will be numbered and collected for disposal at the end of the discussion sessions by me. My copy will be the only copy existing at the completion of the group process. Transcripts of individual interviews will be returned to participants. Their later use of this material is considered to be their prerogative as it will contain only their own responses to my questions.

3. **Risk of identifiability of personal information in the reporting document**

   Participants will choose a pseudonym at the beginning of the research process and will be identified only by this assumed name in the report. There will be no information in the final report that would allow identification of participants or other staff members.

4. **Approval from University of New England** – see attached approval.

   Thank you for your consideration. I hope this response meets the committee's requirements. I am most keen to commence data collection and would therefore appreciate your faxing or phoning me with the response of the committee ph: 495-5034 or fax: 496-5442.

Yours sincerely

Jill White

DEPARTMENT OF NURSING AND MIDWIFERY
P.O. Box 600, Wellington, New Zealand, Telephone +64 4 471 5363, Fax +64 4 496 5442
E-mail nursing-midwifery@vw.ac.nz
30 November, 1994

Professor Jill White
Department of Nursing & Midwifery
Victoria University
PO Box 600
WELLINGTON

Dear Jill

94/109 - The Commodification of Caring

Thank you for your letter of 23 November in response to the four issues raised by the Committee.

It still does appear that there is a risk of identifiable information in the reporting document. While it is accepted that you will be using a pseudonym for each participant can you actually guarantee anonymity in the report? We note that there will only be 13 participants and quotes etc. may indirectly identify participants. We therefore suggest you elaborate on the protections of confidentiality you will have in place including reference to the write-up in your final report.

You have our Committee’s approval for this study. We wish you well with your research.

It is a condition of Ethics Committee approval that you provide a brief progress report no later than November 1995.

Yours sincerely

Allison Douglass
CHAIRPERSON
ENVIRONMENT:
Positive Speaking Space

TOPICS FOR DISCUSSION:
- Health Reforms
- CHE
- Commercialism
- Management
- Nursing
- Patient / Client / Customer

MAJOR POINTS FROM DISCUSSION:

Health Reforms different to and separate from the service team restructuring at HVH
Commitment "on paper" and in "talk" to the changes not backed up by resources
necessary to reach the long term vision.
"Do not see an "honest strategic commitment" on behalf of management to the
change".

Hamstrung by budgetary constraint
CNS'S believed 1) commitment to "quality and excellence
2) shared governance
3) business vision / quality vision / improved patient care / ethic of
care were all lined up and interlinked within the management vision when
employed. They want to be part of decision making group.

RHA and Government keep changing direction to the CHE. At what point do
management communicate the constant changes to the staff and remain both
"honest" and responsible?

Paradox: Major changes at macro level with government and RHA and CHE but little
movement at the level of patient care. Nurses feel that they have spent much time
ACCUMODATING the management changes so the patient isn't effected.

Management have a huge problem in moving healthcare from now to the role in 2000
Nurses can fill this vacuum and take the high ground in the reforms if they want.
Nursing can decide what adds value to clinical practice. However nurses do not
speak with one voice - Multiple reasons for working and nursing. Career option
relatively recent. Often work to pay the bills.

Nurses have dealt with continuous and huge change in the last 18mths. They perceive
change as "dumped" on them. - "just give us time to get used to this change before
the next one" (? some sentiments for management with respect to constant
government and RHA changes)

Nurses showing leadership - Is leading from behind = bulldozing?

? Need to work with the people in service team groupings to slowly change the
culture. Need to SLOW DOWN the RATE and SIZE of the change
Problem of communication within the organisation but not just nursing and
management but also within nursing. - challenge to find workable systems.
Who speaks on behalf of nurses at HVH??
New structures, when radical, have a downward spiral for 9mths then next 3mths come up and following year fly.... HVH into the final 3mths of the first year. At the moment in the "chaos"/ "wobbles" and some sections of management getting nervous and looking at moving back to predictable traditional system.

VISION - what is it ? / who can design it? / CEO on white charger -who would follow? Some would as long as the vision was truly a vision and was INSPIRING. Needs to be MACRO and MICRO level with a commitment, reassurance and consultative processes. Nurses want to work with EMT to construct vision and with resource managers to work towards it with service teams NOT going their own way. The "hands off" approach to the CNS group may have been TOO hands off which left them feeling UNSUPPORTED.

KEY WORDS OF THE FINAL ROUND:
* ACCOUNTABILITY  *PARTICIPATION  *"VALUE "OF NURSING
* CULTURE  *COMMUNICATION  *HONESTY / TRUST.

Hope you see this as faithful representation. I'll be interested in your perceptions. Look forward to seeing you on Tuesday  Jill
1. **What is professional leadership in this "crazy environment?"**

- Quality structure not in place despite consultants saying it was at interview. CNS group now developing nursing strategic plan.

- Challenge to sustain best-practice in a "differently driven environment". Hutt issues as pointers to more general health care problems.

- RHA done "wonderful marketing job" leaving community with opinion that CHE should provide all the services they need.

- Selective about "doing what we do best" –
  - does this cut across expectations of clinicians to "practice their craft"?
  - does this cut across public expectations?

- Is the "competitive" element between CHE's a myth?
  - monopoly on common procedures so lower cost
  - collaborative/collegial relationship still between clinicians
  - retain relationships as:
    (1) professional action, or
    (2) to resist change and perpetuate the old system, or is it
    (3) pragmatism "don't know when the boot will be on the other foot".

- Service aims – ? taking clinicians away from their expertise – registrars and CNS's. Huge problems for CNS's to be in 3 places at once leads to feeling "you're not doing things as well as you could". Would a business just "cope" – in whose interest is "just coping"?

2. **Turning the "they" in "but they ........ "into "us". / Who cares? Who manages?**

- Doctors and nurses manage private businesses well outside the CHE – What makes it different in a big CHE?

- (Prof Scott) – physicians and surgeons no longer trusted.

- Perception that management don't "care" about the patient.
  - most managers working in health because they do care about patients – interested in patient outcomes and financial outcomes.
  - "best practice" common focus of clinician and manager.
• Challenge by early discharge to continue to support the patient – "vacuum", phone in, dressing clinics – how to "charge" it? / who pays and how?

• Transport – who, with whom, in what capacity i.e. inpatient and outpatient.

3. Cost/benefit. $$'s and caring

• The change in practice with introduction of talk of "cost/benefit" when dealing with young and vulnerable seriously ill people e.g. is chemo or TPN "worth it" in cost/benefit terms?

• Does the CHE have a disadvantage over private providers in not being able to choose not to take high risk/high cost patients.

• "put the patient first and screw the cost" – maintains the chasm between management and clinician.

• DRG's don't accurately reflect cost of co-morbidity. Nobody wants high cost DRG's e.g. Crohn's.

• ? costs being "shunted" but not changed – "moved sideways".

• Staffing - 50% occupancy - ? does not allow for "unpredictable" nature of practice.

*Need for research based information on best practice and development of clinical pathways – medical resources and faculties.

RESPONSIBLE SUBVERSION – is it "band-aiding". Major theme which holds possibly the key its understanding clinician/manager "trust"/ "mistrust".
- Would be addressed by clinical audit:
  * accountability
  * co-operation
  * trust 
  
challenged between nurses & managers

Overall beginning "to peel of the layers" even though at this stage "lots of stuff we've just touched the surface of".

Group working guidelines

• positive speaking space
• respect for person talking so they feel "heard"
• speaker indicates who speaks next
• leaving time for others to enter who have longer "delay" time.
• personal responsibility to stay part of the circle.

Thanks again. See you Tuesday.
Jill.
NODE LISTING

Nodes in Set: All Tree Nodes

Created: 5/14/01 - 9:15:48 PM
Modified: 7/4/01 - 3:51:23 PM
Number of Nodes: 43

1(1) /Communication
2(1 1) /Communication/direction
3(1 1 1) /Communication/direction/vertical
4(1 1 2) /Communication/direction/horizontal

5(1 2) /Communication/issues
6(1 2 1) /Communication/issues/adequacy
7(1 2 2) /Communication/issues/consistency

8(2) /Perspective of change
9(2 1) /Perspective of change/opportunity
10(2 2) /Perspective of change/treat

11(3) /Health reforms
12(3 1) /Health reforms/intent
13(3 1 1) /Health reforms/intent/contractualism
14(3 1 2) /Health reforms/intent/deregulation

15(3 2) /Health reforms/time
16(3 2 1) /Health reforms/time/pre 1991
17(3 2 2) /Health reforms/time/1991
18(3 2 3) /Health reforms/time/1995

21(4) /Philosophical models
22(4 1) /Philosophical models/medical
23(4 2) /Philosophical models/economic
24(4 3) /Philosophical models/nursing
25(4 3 1) /Philosophical models/nursing/caring
26(4 3 2) /Philosophical models/nursing/technician

27(6) /Language
28(6 1) /Language/customer
29(6 2) /Language/patient
30(6 4) /Language/managerialism-economic

31(7) /Leadership
32(7 1) /Leadership/vision
33(7 1 1) /Leadership/vision/direction
34(7 1 2) /Leadership/vision/identity
35(7 2) /Leadership/issues
36(7 2 1) /Leadership/issues/cohesion

37(8) /Structure
38(8 1) /Structure/workforce
39(8 2) /Structure/practice

40(10) /Responses
41(10 1) /Responses/feelings
42(10 2) /Responses/actions
43 (100) /Search Results
NODE LISTING

Nodes in Set: All Tree Nodes
Created: 14/05/01 - 9:15:48 PM
Modified: 6/02/02 - 11:09:34 AM
Number of Nodes: 87

1 (1)/Communication
2 (1 1)/Communication/direction
3 (1 1 1)/Communication/direction/vertical - them & us
4 (1 1 2)/Communication/direction/horizontal - collaborative
5 (1 1 3)/Communication/direction/horizontal - violence
6 (1 2)/Communication/issues
7 (1 2 1)/Communication/issues/adequacy
8 (1 2 2)/Communication/issues/consistency
9 (1 2 3)/Communication/issues/Trust
10 (1 3)/Communication/the group process
11 (2)/changing work
12 (2 1)/changing work/bed vs patient management
13 (2 2)/changing work/purpose of hosp
14 (2 3)/changing work/nurs vs med work
15 (2 4)/changing work/magnet hospitals
16 (2 5)/changing work/loyalty
17 (2 6)/changing work/copies
18 (2 6 5)/changing work/copies/responsible subversion
19 (2 7)/changing work/accountability
20 (2 8)/changing work/research base for practice
21 (2 9)/changing work/Technology
22 (2 10)/changing work/managers
23 (2 11)/changing work/business units - fragmentation
24 (2 12)/changing work/Information-data
25 (3)/Health reforms
26 (3 1)/Health reforms/intent
27 (3 1 1)/Health reforms/intent/contractualism
28 (3 1 2)/Health reforms/intent/deregulation
29 (3 1 3)/Health reforms/intent/consultants
30 (3 1 4)/Health reforms/intent/competition
31 (3 1 5)/Health reforms/intent/quality and efficiency
32 (3 1 6)/Health reforms/intent/cost control - shifting
33 (3 1 7)/Health reforms/intent/length of stay
34 (3 1 8)/Health reforms/intent/health vs illness
35 (3 1 9)/Health reforms/intent/health professional involvement
36 (3 1 10)/Health reforms/intent/public involvement
37 (3 2)/Health reforms/time
38 (3 2 1)/Health reforms/time/pre 1991
39 (3 2 2)/Health reforms/time/1991
40 (3 2 3)/Health reforms/time/1995
41 (3 3) Health reforms/politics
42 (3 4) Health reforms/pace of change
43 (3 5) Health reforms/public vs private
44 (3 6) Health reforms/public expectations
45 (3 7) Health reforms/reality
46 (3 8) Health reforms/change fatigue
47 (4) Philosophical models
48 (4 1) Philosophical models/medical
49 (4 3) Philosophical models/nursing
50 (4 3 1) Philosophical models/nursing/caring
51 (4 3 2) Philosophical models/nursing/technician
52 (4 3 3) Philosophical models/nursing/Ethics
53 (4 3 4) Philosophical models/nursing/authority
54 (4 3 5) Philosophical models/nursing/visibility
55 (4 3 5 4) Philosophical models/nursing/visibility/rhetoric vs reality
56 (4 3 6) Philosophical models/nursing/career pathway
57 (4 3 7) Philosophical models/nursing/envisioning
58 (4 3 8) Philosophical models/nursing/responsibility
59 (4 3 9) Philosophical models/nursing/economic-management
60 (4 3 10) Philosophical models/nursing/tired/burned out
61 (4 3 11) Philosophical models/nursing/own worst enemy
62 (4 3 12) Philosophical models/nursing/continuity of care
63 (4 3 13) Philosophical models/nursing/motivation
64 (4 3 14) Philosophical models/nursing/translator
65 (4 3 15) Philosophical models/nursing/value
66 (4 3 16) Philosophical models/nursing/skill base
67 (6) Language
68 (6 1) Language/customer
69 (6 2) Language/patient
70 (6 3) Language/best practice
71 (6 4) Language/managerialism-economic
72 (7) Leadership
73 (7 1) Leadership/vision
74 (7 1 1) Leadership/vision/direction
75 (7 1 2) Leadership/vision/identity
76 (7 2) Leadership/issues
77 (7 2 1) Leadership/issues/cohesion
78 (7 2 2) Leadership/issues/Trust
79 (7 2 3) Leadership/issues/educating the next generation
80 (8) Staffing
81 (8 1) Staffing/workforce
82 (8 2) Staffing/practice
83 (10) Responses
84 (10 1) Responses/feelings
85 (10 2) Responses/actions
86 (100) Search Results
87 (111) 111
APPENDIX II

Supplementary Materials Demonstrating the Development of the Thinking Behind this Thesis
APPENDIX II:

Supplementary material demonstrating the development of the thinking behind this thesis.

1. Listing of relevant publications, conference papers and invited addresses within health and education sectors related to the development of this thesis.

2. Seven papers of particular relevance to the development of the thinking of this thesis:
   - Invisibility of nursing in the New Zealand health reforms.
   - Managing to care.
   - Patterns of knowing – review, critique and update.
   - The balance of intuition and research
   - Professional doctorates in nursing and midwifery: unwise indulgence or courageous coming of age?
   - Health services research: what counts and what is valued.
   - Displaying our wares: what do we show, to whom do we show it, and where should we display our wares.
RELEVANT PUBLICATIONS:


RELATED CONFERENCE PAPERS:


White, J. (2002). Displaying our Wares: What do we show, to whom do we show it, and where should our wares be displayed. Invited Keynote. *The We are Able and Artful Nurses – College of Nurses, Aotearoa NZ Conference*, Nelson, New Zealand, September.


**RELEVANT INVITED ADDRESSES WITHIN THE HEALTH AND EDUCATION SECTORS:**

White, J. (2002). *Professional Doctorates – Challenges of supervision*. Professional Doctorates Seminar/Workshop Charles Sturt University, Wagga Wagga (invited presenter)


White, J. (1999) (Opening Address) – *Home is where the Heart Is*. Home is where the Heart Is Conference Sydney, May.


This is a critical paper in the development of this thesis. At the time of the invitation to give this lecture, the first in the series for that year I was very new to New Zealand, new to the Department and University and in the process of redesigning the topic for my doctoral studies. The Hunter Alumni Series is a prestigious pan-university series run for graduates of Victoria University of Wellington and invited guests. It was the first time I had spoken publicly in my new position as Professor of Nursing and Midwifery and decided it was the opportunity to lay down of the nursing gauntlet – we are here and will be taken notice of.
The Invisibility of Nursing in the New Zealand Health Reforms.

Thank you for the opportunity to speak with you this evening. As a relative newcomer to New Zealand and Nursing in New Zealand in particular I am aware of the presumption of speaking on this topic. I have spent a year endeavouring to comprehend what has happened in the last decade to a once very public and very influential profession. Tonight I speak as a nurse and I hold up a mirror, no doubt somewhat flawed and imperfect but one which will never the less provide a reflection of the current picture that may stimulate contemplation. I believe it is important standing in this place, the University, to try to foster contemplation and discussion even if at times the process is uncomfortable.

In trying to create this picture I see the multifaceted nature of the "health reforms".

The picture as I see it shows little evidence of the nursing profession. Little acknowledgement of the existence and contribution of the largest health professional group.

What do I see as part of the picture:
• The invisibility of nursing as a profession within the process of planning and implementation. (This invisibility reflecting non-involvement).

• The invisibility that is related to the nature of the work nurses do. (This invisibility reflects the taken for granted and undervalued nature of this work by those not currently touched by a need for care).

• The professional education reforms.

Opportunity exists and it is a matter of finding the moment of pause in the chaos to enable something different to be proposed and to be able to be heard. We will try towards the end of this evening to explore these opportunities.

1. **Invisibility of nursing within the planning and implementation of the health reforms**

When one looks back over the past decade in New Zealand it is clear the governments of this country, irrespective of political party, have been on a mission of Public Sector Reform. There has been a trajectory of deregulation, first state-owned enterprises and then progressively welfare. There has been rapid-fire legislation that has been at the least dizzying.
This reform agenda was a response to an economic crisis from which overseas observers were sceptical Aotearoa/New Zealand would recover. Whilst possibly excessively aggressive in their execution there would be few who would argue that utilities such as banking, telecommunications, forestry and power could be more efficiently managed.

The pattern that was being set was of "New Public Management" based in a philosophy of "agency theory" (Boston, 1991). The hallmarks of NPM were introduced in the State Sector Act (1988) and the Public Finance Act (1989), these included:

1) emphasis on management rather than policy
2) emphasis on generic management rather than professional direction
3) quantifiable output and performance targets
4) separation of policy advice from policy implementation
5) competitive contracting and contestable provision of public services.
6) deregulation with decreased professional and union power
7) emphasis on the individual, self-interest(as a positive attribute), and autonomy.
8) stress on cost-cutting and efficiency.

(Boston, 1991)
The supposed outcome of this emphasis was increased "public accountability".

Sound familiar???

Public Sector reform using the principles of new public management theory was by no means a Aotearoa/New Zealand phenomenon. It had been an overseas pattern particularly in OECD countries for quite some time but Aotearoa/New Zealand adopted it, as you know and all felt, with a fervour.

Health and welfare had long been targeted for major change. These public services were extraordinarily expensive and the government had little control over price or volume particularly of primary health care services. There was a belief that the sector had been "captured" by the medical profession and that there was little accountability for spending and service developments (Scott, 1994). As with other OECD countries there was a prospect of escalating health costs. Ageing population, increased technological advances, and vastly increased public expectations of health care produced a trilogy resulting in an unaffordable healthcare future. (Blank, 1994)

The introduction of the Social Security Act (1938) had provided Aotearoa/New Zealand with free hospital care and cheap and accessible health care. Private healthcare acted to complement rather than compete with the public sector. There was a firm public expectation of health care as a social right of citizenship.
This expectation remained mostly unchallenged until the economic crisis of the 70's despite increasing costs of the sector through the 50's and 60's. By the early 80's there was tight restraint on health resources and all health professionals and most patients became aware that there was a financial crisis. The Labour Government of the time had recognised something had to be done in the 1970's and they had suggested health care reform in their 1974 "A Health Service for Aotearoa/New Zealand." However, the white paper was vocally rejected by health professionals and was never implemented.

In 1983 the Area Health Board Act rationalised the system somewhat by moving 18 health boards (public health) and 29 hospital boards into 14 Area Health Boards which combined hospital and public health services. These were slow to get organised and were only fully in place in 1989.

The State Sector Act (1988) cut across the plans of the Area Health Boards and generic management structures were introduced to replace the old triumvirate system of Principal Nurse, medical director and administrator.

As a reflection of the government thinking of the time a report on health was commissioned - the Gibbs Report, 1988, "Unshackling the Hospitals". This report had all the hallmarks of NPM however it was not implemented at the time.
With the election of the National Government in 1990 the introduction of NPM into health and welfare was inevitable. In 1991 Simon Upton, The Minister of Health released the document which has become known as the "Green and White Paper" (Upton, 1991). In it is the blueprint for the total reshaping of healthcare, but when one looks closely one sees the major features of the Gibbs report.- What it held, you know and have experienced:

1) integration of primary and secondary care funding (integration also with ACC and continuing care)
2) separation of purchaser and provider with introduction of four Regional Health Authorities (RHA's) and twenty-three Crown Health Enterprises (CHE's) and community trusts.
3) dissolution of the AHB'S and again separation of personal and public health
4) Public Health Commission to purchase and co-ordinate public health services.(recently reconsidered)
5) Health Plans (not as yet implemented)
6) National Advisory Committee on Core Health Services (Core Services Committee) to advise on the core services that should be accessible and affordable to all as a minimum entitlement.
7) Community Services Card targeted to low income groups.

The introduction of these wide ranging "reforms" was to take place in an incredibly tight time frame because of the three year parliamentary term. There was just two years from announcement to implementation.
The RHA's, CHE's, and the CHE boards were made up of senior managers who had often been involved in the earlier restructuring of State-Owned Enterprises. Rarely had they previous experience in the health sector. There were very few general managers involved who had health backgrounds, for those who had their health backgrounds were serendipitous rather than deliberate. Health professional opinion was rarely sought and channels for taking part in decision making were few.

What this meant for nursing will be discussed later.

2) The invisibility of the work of the nurse

The invisibility and undervaluing of the physical and emotional labour of caring has been widely written about in nursing literature (James, 1992; Diers, 1987; Smith, 1993; Parkin, 1995) and whilst this will not be explored in great depth tonight it does require at least the resurfacing as it forms part of the whole contemporary picture.

The cost is often seen only in its absence (OHP Melbourne cup - the gaze of watchful expectancy) - when the hand of experience has been removed and replaced with fragmentation or inexperience. The expert nature of practice is evidenced in what it does not allow to happen and what it prevents. This lack of acknowledgement has always been seen in public health nursing.
It is devalued because it cannot easily be "valued" counted/costed.

One glimpse into this invisibility is eloquently given to us by Rose Bird, former Chief Justice of California in her piece "A Daughter's Story" (Styles, 1994)

Women's work and its invisibility has been comprehensively addressed in Marilyn Waring's (1988) "Counting for Nothing - What men value and what women are worth". Here she draws to our attention the way work is valued - what "counts" in terms of national and international accounting. "I learned that, in the UNSNA (United Nation System of National Accounts), the things that I valued about life in my country - its pollution-free environment; its mountain streams with safe drinking water; the accessibility of national parks, walkways, beaches, lakes, kauri and beech forests; the absence of nuclear power and nuclear energy - all counted for nothing. They were not accounted for in the private consumption expenditure, general government expenditure, or gross domestic capital formation. Yet these accounting systems were used to determine all public policy. Since the environment effectively counted for nothing there could be no "value" on policy measures that would ensure its preservation."(Waring, 1988:1)

She goes on to say "hand in hand with the dismissal of the environment, came evidence of the severe invisibility of women and women's work."(1988:1)
 Whilst Waring does not speak of nursing directly, I believe nurses immediately see the parallels. When accounting for "healthcare", so called, we can easily count numbers of operations, the number of days in hospital, the number of pharmaceuticals dispensed, the number of tasks performed. Less quantifiable is the quality of the care given - largely given by registered nurses. Who counts the intimate connection between nurse and patient in crisis and vulnerability, who counts the expert assessment when we appear to be simply having a conversation or walking along with a patient. Who counts the trust that develops between nurse and patient when the nurse meets the vulnerability of the patient and tenderly and carefully holds it and gives it "safe passage" through the extraordinary events that so often surround illness.

OH5/6 etc. Melbourne cup  
horse and hand of trainer
How do you quantify that? You don't. You help those who are only used to/familiar with numbers to see other forms of "counting". To find ways of judging quality process and outcome, not outputs. Nurse researchers are working on this at the moment.

So we have a system imposed but which has totally disrupted the nature and structure of nursing's work world, and we have "work" and a work world that is only seen by people in glimpses and at times they'd rather not remember. We have become ourselves vulnerable.

3) Professional Education Reforms

We have looked at our health system and our work. What else has been happening with the nursing profession which is interrelated to the present situation.

Educational directions and decisions, whilst in themselves justifiable, have not necessarily helped the position right now to respond from strength and with a single voice.

Over twenty years ago now brave decisions were taken to improve the education of nurses in this country. The move out of the apprenticeship system and into the "new" system of polytechnic education was made. Unfortunately there has been an unexpected cost, not only apparent in Aotearoa/New Zealand but also in Australia. The distance between the education setting and the service setting became more than a geographical one. Many of
the bright, articulate and skilled clinicians left the clinical area to teach in the polytechnics and with fifteen across the country and two university programmes this represents a large drain in a small country. Hospitals were left somewhat vulnerable but could have stayed integrally linked to professional education. The continuation of the dual systems of training may have exacerbated the "them and us" feeling. Whatever the reason educators and clinicians lost sight of each other.

Consistent with international trends in nursing literature the curricula began to increasingly focus on HEALTH rather than ILLNESS care and in doing so inevitably became aware of the socio-political influences on health - its intrinsic links to language, culture, land, education, employment (Chopoorian, 1986; White, 1995).

Students are educated to understand the possibilities of nursing as an autonomous profession with a health focus. The reality they experience when they enter hospitals for clinical practice was until recently hierarchical, rule governed and sickness focused. This has contributed to a service/education dichotomy which has been neither comfortable or productive.

The alienation of service and education could not have come at a worse time for the profession. The dual system, fifteen
polytechnics and a shrinking health workforce in the 1980's led to large unemployment for newly registered nurses. Many left Aotearoa/New Zealand and many left nursing.

4. The Total Picture

When one superimposes on this situation of alienation and lack of shared focus of practice the massive changes to the health care system mentioned in broad brush strokes earlier we see what the situation meant for nurses and nursing.

The formation of AHB's whilst it meant a loss of senior nursing positions was, as I understand it largely supported by nurses who could well understand the need for responsible cost constraint, increasing accountability and co-ordination of services.

The imposition of generic management to health was a blow because it meant even greater loss of senior nursing positions with redundancies, early retirements and movement of nurses into general management. For some it represented opportunity for career advancement and new challenges but overall for Nursing it represented the exacerbation of key developing themes:

- loss of clinical and professional WISDOM, leadership, mentoring and role modelling.
• loss of well understood professional communication channels (within the setting and the profession)

• loss of voice / place-by -right in decision making processes.

The picture is further complicated by the effects of the Employment Contracts Act (1991) with the introduction of generic management contracts for many charge nurses and above, increasing casualisation of the workforce, decreased power of the professional groups and unions, increased employment of cheaper more inexperienced staff, short term contracts with changed conditions and generally fear and a retreat to personal security rather than professional solidarity.

The final cap has been the extraordinary haste and lack of professional input into the latest "reforms". Multi-millions of dollars have been pumped into movement of the "top layers" Ministry, RHA's, CHE's but little has effected the patients level of care. The nurse has been placed in the position of "buffer" to protect the patient from the negative effects of the changes. This
has led in many instances to "moral distress" (Rodney, 1993) and "responsible subversion" (Hutchinson, 1990). Each of which has its personal and professional costs.

We are now left with the position where inpatient facilities have sicker patients, cared for by less experienced and fewer staff, many of whom are casuals who try to shield patients from too early discharge into a community which has had its community nursing resources diminished. The nurses have a fear of speaking out as they fear for the security of their jobs and they have little understanding of how they can influence the situation on behalf of the patient. They no longer have professional communication channels they knew and trusted.

What can be done to take advantage of the situation for nursing and for improved health care?

- (Re) - create the service - education - research links to focus on nursing as the study of "caring in the human health experience" (Newman, Sime & Corcoran-Perry, 1991). The education system has been preparing RN's for this role for years, they need a structure and some experienced role models. Clinical unbundling offers the opportunity to do things differently.

- (Re) - create the communication systems that allows for many voices - guided by experience and with established speaking positions. The communication systems should include professional representation at RHA level and
expanded representation within the Ministry. Expanded networks, like those newly formed between NZNO, College of Nurses, College of Mental Health Nurses, Council of Maori Nurses, Nurse Executives, Nursing Council, NETS. There has recently been a very positive initiative taken in this area with the establishment of the umbrella network linking all of these organisations.

- (Re) - create remuneration systems that take expertise into account rather than years of employment through clinical career structures.

- As the most trusted profession (National Business Review) for the second year running we can stand beside the community to redesign the health system.

HEALTH

HEALTH & ILLNESS CARE

HEALTH CARE PROFESSIONALS

HEALTH CARE AND PROFESSIONALS SUPPORT SYSTEMS
(including Minister, Ministry, RHA's & CHE's)

The quality of any health service depends on its nursing. Managers, nurses and other health professionals have as the focus of their concern as quality care for the recipient of the service
whether they name that the community/patient/client/customer. At least this provides a common point for dialogue.

"Invisibility" assumes something is there but not seen. Many nurses are simply no longer there. The picture may be partially reconstructed but it will never be completely whole again. We have lost WISDOM and we have witnessed and experienced huge human cost. The ends DO NOT justify the means. Let us not forget those who have been caste aside and those who have hung in there through "unhealthy" circumstances, those who are keeping the systems going for the "patient's sake" at an enormous personal cost.

Let's create something better out of the chaos but do it in honour and tribute to these people - not by standing on their bones.
Bibliography


The invisibility of nursing in the New Zealand health reforms

Jill White
Professor of Nursing and Midwifery

The Hallmarks of New Public Management:
- emphasis on management rather than policy;
- emphasis on generic management rather than professional input;
- quantifiable output and performance targets;
- separation of policy advice from policy implementation;
- competitive contracting and non-rival provision of public services;
- deregulation with decreased professional and union power;
- emphasis on the individual, self-interest (as a positive attribute), and autonomy;
- stress on cost-cutting and efficiency.

(Boston, 1994)

Nurses, as trusted peers, are those who hear secrets, especially the ones born of vulnerability. Nurses are treasured when these interchanges are successful, but most often people do not wish to remember their vulnerability or loss of control, and nurses are indefinitely identified with those terrible personal times.

(Fagin & Diers, 1981:116)

"The problems we are facing need to be solved by different thinking than the thinking that created them."

(Einstein)
Almost a year following the invisibility paper I was invited to give my inaugural professorial address. This is a formal occasion taken very seriously by the University. As the audience was quite different to that attending the Hunter alumni series some of the introductory material is similar to the invisibility paper but I have included it here as the second half of the paper shows the development of my thinking in the year inclusive of and following the action research component of this study.
MANAGING TO CARE

Tena Kotou, Tena Kotou, Tena Kotou Katoa

It feels somewhat strange to stand before you giving my inaugural lecture having spoken frequently here and around the country for the past two years. It reminds me of my mother's scoldings as I knowingly attended country balls before making my debut. However, Annie Jean White notwithstanding I guess in definitional terms in speaking tonight I become "available for public use" - I'm not sure how much I like that thought.

(Acknowledgement to Tanata Whenua.)

In choosing the title "Managing to Care" tonight I want to talk with you about the context of health care today, the position of nursing within this and the possibilities, promises and pitfalls of the future in what is clearly being signalled by government as a "managed care environment".

I will be speaking about nursing as I feel that within my twin portfolios of Nursing and Midwifery, it is the least audible and visible, and most vulnerable in the current reformed health sector.

Let us first recapture the essence of the changes in health care and then explore this with reference to nursing and its practice.

When one looks back over the past decade in New Zealand it is clear the governments of this country, irrespective of political party, have been on a mission of Public Sector Reform. There has been a trajectory of deregulation, first state-owned enterprises and then progressively welfare. There has been rapid-fire legislation that has been at the least dizzying.

OHP  LEGISLATION TIME LINE ( 9 new Acts affecting health 1986-1993)

This reform agenda was a response to an economic crisis from which overseas observers were sceptical Aotearoa/New Zealand would recover. Whilst possibly excessively aggressive in their execution there would be few who would argue that utilities such as banking, telecommunications, forestry and power could be more efficiently managed.

The pattern that was being set was of "New Public Management" based in a philosophy of "agency theory" (Boston, 1991). The hallmarks of NPM were introduced in the State Sector Act (1988) and the Public Finance Act (1989), these included:

OH3  8 POINTS(See below)
1) emphasis on management rather than policy
2) emphasis on generic management rather than professional direction
3) quantifiable output and performance targets
4) separation of policy advice from policy implementation
5) competitive contracting and contestable provision of public services.
6) deregulation with decreased professional and union power
7) emphasis on the individual, self-interest (as a positive attribute) and autonomy.
8) stress on cost-cutting and efficiency.

(Boston, 1991)

The supposed outcome of this emphasis was increased "public accountability".

Public Sector reform using the principles of new public management theory was by no means an Aotearoa/New Zealand phenomenon. It had been an overseas pattern particularly in OECD countries for quite some time but Aotearoa/New Zealand adopted it, as you know and all felt, with a fervour.

Health and welfare had long been targeted for major change. These public services were extraordinarily expensive and the government had little control over price or volume particularly of primary health care services. There was a belief that the sector had been "captured" by the medical profession and that there was little accountability for spending and service developments (Scott, 1994). As with other OECD countries there was a prospect of escalating health costs. Ageing population, increased technological advances, and vastly increased public expectations of health care produced a trilogy resulting in an unaffordable healthcare future. (Blank, 1994)

The introduction of the Social Security Act (1938) had provided Aotearoa/New Zealand with free hospital care and cheap and accessible health care. Private healthcare acted to complement rather than compete with the public sector. There was a firm public expectation of health care as a social right of citizenship. This expectation remained mostly unchallenged until the economic crisis of the 70's despite increasing costs of the sector through the 50's and 60's. By the early 80's there was tight restraint on health resources and all health professionals and most patients became aware that there was a financial crisis. The Labour Government of the time had recognised something had to be done in the 1970's and they had suggested health care reform in their 1974 "A Health Service for Aotearoa/New Zealand." However, the white paper was vocally rejected by health professionals and was never implemented.

In 1983 the Area Health Board Act rationalised the system somewhat by moving 18 health boards (public health) and 29 hospital boards into 14 Area Health Boards which combined hospital and public health services. This was enabling legislation only and these were slow to get organised and were only fully in place in 1989.

The State Sector Act (1988) making government departments 'businesses' and with the Public Finance Act (1989) - government accounting systems cut across the plans of the Area Health Boards and generic management structures were introduced to replace the old triumvirate system of Principal Nurse, Medical Director and Administrator.
As a reflection of the government thinking of the time a report on health was commissioned - the Gibbs Report, 1988, "Unshackling the Hospitals". This report had all the hallmarks of NPM, however, it was not implemented at the time.

With the election of the National Government in 1990 the introduction of NPM into health and welfare was inevitable. In 1991 Simon Upton, The Minister of Health released the document which has become known as the "Green and White Paper" (Upton, 1991). In it is the blueprint for the total reshaping of healthcare, but when one looks closely one sees the major features of the Gibbs report.- What it held, you know and have experienced:

1) integration of primary and secondary care funding (integration also with ACC and continuing care)
2) separation of purchaser and provider with introduction of four Regional Health Authorities (RHA's) and twenty-three Crown Health Enterprises (CHE's) and community trusts.
3) dissolution of the AHB'S and again separation of personal and public health
4) Public Health Commission to purchase and co-ordinate public health services.(disestablished in July '95 and some responsibilities taken by the Ministry of Health)
5) Health Plans (not as yet implemented)
6) National Advisory Committee on Core Health Services (Core Services Committee) to advise on the core services that should be accessible and affordable to all as a minimum entitlement.
7) Community Services Card targeted to low income groups.

The introduction of these wide ranging "reforms" was to take place in an incredibly tight time frame because of the three year parliamentary term. There was just two years from announcement to implementation (1991-1993).

The RHA's, CHE's, and the CHE boards were made up of senior managers who had often been involved in the earlier restructuring of State-Owned Enterprises . Rarely had they previous experience in the health sector. There were very few general managers involved who had health backgrounds, for those who had their health backgrounds were serendipitous rather than deliberate.

"The theory says that the same skills are needed to run a hospital as to manage a brewery, and that ultimately the production of health services is not fundamentally different from the production of beer" (Easton, 1995: 39).

Health professional opinion was rarely sought and channels for taking part in decision making were few.

If the re-formation was an attempt to control the cost of health care by controlling primary health care medical expenditure, nursing got heavily injured in the cross-fire, as did anyone else referred to as "health professionals".
Practice

The practice arena for nursing has, predominantly in recent decades, been the hospital. We speak of health care and community care but largely practice sickness care in institutional settings. These settings have been restructured, disassembled and re-engineered to such an extent in the last decade that the picture might be seen to resemble children playing with lego. Since the advent of the Area Health board Act in 1983, nurses have experienced an erosion of their well entrenched and well understood hierarchical system. Principal nurses positions in hospital boards were centralised to Area positions which in turn were case aside for area generic management positions following the State Sector Act and then rearranged again with the introduction of the CHE and RHA system and the dissolution of Area Health Boards in 1993. But this did not end the change for nursing - it simply became more turbulent and the winds of change reached tornado.

OHP - HURRICANE

Several CHE's are now on their third post '93 management and service delivery restructurings. Some nurses ventured into this management windstorm, some have even survived within it, many have been cast out and some have just held on. Nurses at charge nurse and staff nurse level have predominantly sought to protect their patients in the central still space of a tornado. They have taken the buffeting in an effort to have the patient remain as untouched as possible by the turbulences, chaos and debris of management changes.

They are communally and individually exhausted "I've never felt so lacking in elastic" was the comment of a committed experienced nurse.

The eye of the tornado is no place for trying to build a new house. These nurses have been predominantly in survival mode - head down, doing what they know is the constant of health care - the provision of the best care they can give to the people with whom they come in contact. they are doing this with fewer staff, sicker patients, shorter lengths of stay and large increase of casual staff. The care they still manage to give was wonderfully and expressively captured by Monique in her Inside NZ film which showed on TV3 last year - I use this with her permission.

VIDEO (with commentary as it is shown)

And abridged version of HOW CAN YOU BEAR TO BE A NURSE (Mallison in Benner & Wrubel, 1989, 370-371)

I honour and acknowledge the three nurses in this film, Paddy Dunford, Deana Martin and Leonie Johnson and all the unnamed and unidentified nurses currently sustaining patients in environments that are anything but providing sustenance to these nurses.

Education

The move of nursing education into the polytechnic system is distant history in NZ. It was a system with a strongly vocational focus but little research infrastructure or concern.
The Education Amendment Act, 1990 and the success of the "experimental" nursing degree programme has changed the polytech environment forever and we currently have the prospect of several amalgamating into a single umbrella university. Research interest has intensified particularly in response to the NZQA push in this direction.

The design and accreditation processes for these new degrees around the country has been time consuming, expensive and energy draining, superimposed on this rapid curricular development was a major restructuring of clinical arrangements. The "clinical unbundling" exercise, so called, further cleaved education and practice by placing them in purchaser/provider relationships and made patient access for teaching purposes a commodity to be haggled over and subject to financial transactions.

Interestingly, consistent with international trends in nursing literature the curricula began to increasingly focus on HEALTH rather than ILLNESS care and in doing so inevitably became aware of the socio-political influences on health - its intrinsic links to language, culture, land, education, employment (Chopoorian, 1986: White, 1995).

**OHP - CHPOORIAN QUOTE**

Students are educated to understand the possibilities of nursing as an autonomous profession with a health focus. These graduates have been educated for our health care future - community based and health focused - that they don't fit snuggly into our sickness system at present is simultaneously both our problem and our hope.

The present practice environment is hardly conducive to the "protected status" health care professions hope to offer their beginning practitioners. It is an environment stripped of mentors, experienced registered nurses who might act as role models. One large metropolitan hospital acknowledged last year that it was functioning (malfunctioning) on a workforce in which over 80% of its RN's had been registered for a maximum of 2 years. The casualisation of the workforce and the reliance on agency staff is far from conducive to good learning, good practice or good care.

We know from research in the States (Kramer 1990) that Magnet hospitals, so called for their reputation for good quality, cost effective patient care exhibited the following nursing staffing characteristics:

**OHP: MAGNET HOSPITALS**

Staff are recruited and retained when:

1. working with other clinically competent nurses
2. no floating or floating only within a designated cluster
3. no or limited use of agency nurses or casuals
4. limited employment of new graduates
5. self managed unit work groups
6. all or high registered nurse complement
7. highly selective employment based on valuing of:
   (a) people
Well some of our CHE's are trying for "self managed work groups!!" – same name, nothing in common with the Magnet ideal.

In post graduate education we have been slow to develop. Not having a degreed workforce left little impetus for graduate awards, and little nursing research emphasis led to only a trickle of Masters prepared and not even a trickle of doctorally prepared nurses. We are now experiencing the consequences of this whilst Massey, Vic and latterly AIT are providing Masters programmes but we can’t magic a cadre of experienced researchers out of the ether to attend to our pressing research need. As nursing research reached the cutting edge of qualitative methodology development the tide turned and whilst it helped us speak to each other more articulately about our practice no one outside in policy and decision-making positions was listening to what they regarded as "anecdotes" - just give us the facts - the numbers.

Treasury driven New Public Management managers were not interested in anything that could not be "counted" and "accounted" for. The influence of this philosophy was ably told to us in the cartoons - wonderful parameters of society.

**OHP- CARTOONS x 2 by Tom Scott**

Our challenge is now to provide programmes of research embracing all methodological perspectives in order to be able to use number to engage in conversation and words to illuminate through thick and rich description of that which we know of health care.

So what do we do? Doing nothing is no longer an option. The legislation is either in place or soon revised which could see the disappearance of nurses as a registered publicly accountable disciplined (or able to be disciplined) profession. We have the threat of Health Independent Training Organisations, NZQA unit standards on frameworks possible reopening of the Nurse's Act a plethora of care workers seen at a quick glance at a short term "bottom line" as cost effective.

So what can we do to do? Something? Plenty! and we need to do it by combining our practice, education and research endeavours to work in partnership with the community and the public.

Firstly we have to come to terms with the environment in which we are now working.

Boston's analysis provides us with several points of action:

"The new health system is notable for:

(a) The absence of any locally elected participation in its governance: boards elected at the 1989 local authority elections were replaced overnight by
appointed commissioners in July 1991, themselves now replaced by appointed boards.

(b) The creation of two ministerial portfolios: Health and Crown Health Enterprises. These represent, respectively, the Crown's purchase and ownership interests.

(c) Reliance on a network of contracts from ministers, through RHAs, to an array of public, private, and voluntary providers to integrate and co-ordinate services.

The lack of public or health professional input to CHE boards is something that is timely for review. It is vital for public interest that we work together and with Bill English (present Minister for Health) to redress this.

The contracting process is now an embedded philosophy in this country - individual in interest, emphasis and consequence.

We may not like the contracting process but we must understand contracting processes and cycles, the meaning of prospective payment systems, DRG’s, critical pathways and managed care with all its variations on the themes. In doing this we must site our understanding within the service requirements of the Minister of Health and position ourselves with respect to these.

"The next ten years will be a dynamic time for the sector. The purpose of this document, Advancing Health in New Zealand, is to set our the context for the changes we can expect over this period. It outlines the directions in which national policies and regional and local developments are taking the sector, and identifies some of the opportunities being created by these developments. It also identifies the issues that are still being worked through." (Shipley, 1995: 1).

Jenny Shipley, (immediate past Minister for Health) then goes on to name the key themes for the next three years:

**OHP - KEY GOALS**

- Shifting resources to reduce health status disparity
- Decisions on service delivery closer to communities incl managed care
- Development of more fair and open decision making mechanisms for service rationing
- strengthened focus on equity
- Maori health focus
- evidence-based guidelines and other quality-assurance tools
- increased role for primary, community and ambulatory services
- better value for money

(Shipley, 1995)

Nursing is extraordinarily well positioned to help make these things happen. The goals we would hold would not be different. We may well have set up different
structures to facilitate these and very difficult processes to implement them. However at least we all headed in the same direction. That's a start.

Let us look at what we might do in practice:

**Practice:**

Now that CHE's are, hopefully, becoming less tornado like and are settling down to an appreciation that health care management is very different to that of breweries there is an increase in some CHE's in willingness to listen to nursing experience and expertise.

The Ministers of Health and CHE talk of the need for "managed care" but managed care need only mean cost effective, quality, accessible, co-ordinated and integrated care (Cohen, 1993). We have an extensive and strongly research based literature on nurse case management and managed care. So why hasn't our input been visible? We have not been listened to, in several notables CHE's nursing critique of structural reorganisation towards managed care has not only been dismissed but the nurses have been dismissed or subject to restructurings in which they no longer have a place on the "organisational plan". The loss of experience has already been highlighted as a problem and is being exacerbated at the moment particularly throughout the South Island in a way that should be seen as scary to anyone concerned with the health and sickness care in NZ. In several community based managed care proposals put to RHA's the proposers have been told that the RHA is only contracting with large and established groups and to try joining one of them - taking plans to established providers the answer comes back - "it's not in our current business plan".

Not that this will deter us. Nurses are well prepared to not only take part in but to lead the way in integrated care management in a way that allows a family to have a guide through the complexity of the health care system. We are the ones the public trust and we have the skills - what we don't have collectively and individually is the desire to set up our own "business". What nursing can do is to provide this cost effective, integrated, quality health care within a publicly owned and funded system. What we need to show this is a series of funded research projects designed to explore the most effective and efficient care delivery systems as happened in both Britain and the USA. The nurses are there willing and ready to step out into such projects. What they are unable to do is to mortgage after already mortgaged properties and to risk the family welfare to create a "business" with a "profit" motive. They largely do not want to set out themselves to be "private sector health providers".

Leunig cartoon from Human Cost of Mangementalism (Rees & Rodley1995).

**Education**

An integrated system of care requires appropriately funded and targeted education. Risk management and service development education funded by the employer; clinical specialist practice and prescribing education funded by the Clinical Training Agency, and Masters level education - professional, clinical and research funded by CTA and the Ministry of Education, with Doctoral work funded by the Ministry of Education). This cascades of education would provide leading edge internationally research based knowledge and skills for practice.
Such exploration would enable development of nursings knowledge base within all patterns of knowing - Empirical, Personal, Ethical, Aesthetic and Socio-political.

Public opinion polls in the United States suggest that the more 'business-like' hospitals have become in the public's mind, the lower the public's level of trust and confidence in them. The Journal of the American medical Association reported that in 1990 in the U.S. the quality of the nations hospital care was ranked somewhat higher than that of automobile repair shops but, lower than that of supermarkets and airlines (Blendon, 1988 in Aiken, 1990). Despite this public confidence in in nurses remained high( Hart, 1990 in Aiken, 1990)

Research

And it is research that will be the key to the system of nursing practice development fitting together - and fitting consistently with the Ministers' calls for evidence-based practice and our International Council of Nurses theme for 1996 International Nurses Day this year - better care through research.

We will have practitioners engaging in research based practice and academics engaged in practice based research. Practitioners focusing on and developing skills in reflective and consumer inquiry where they improve their practice constantly from both their own critical reflection on practice and from the cumulative international professional wisdom and research. Academics with skills of formal inquiry working with clinicians to design the appropriate practice based and focused research (Crisp, Moss & White, 1995).

This, I crystal ball gaze, as taking place at the place of practice by researchers with academic positions but sited clinically in Practice Research and Development Units.

These things we are ready, willing and able to do. We have 30,000 registered nurses in NZ with annual practising certificates - that is a valuable resource, lots of public dollars in this investment. Nurses walk with patients and families through times of vulnerability - we meet people intimately at times of compromised health. We believe a fundamental requirement of our practice is to uphold your dignity and "provide wise comfort and promote health" as Jocelyn Keith quotes from Florence Nightingale and we do this under sometimes the most difficult of circumstances. This humaneness meeting humaneness is wonderfully expressed by Kryl in her poem "Sunshine Gives Living Centre" (Chinn & Watson, 1994).

Read Poem and show OHP Policema with spinal injuries and his newborn baby

If we do this with you in partnership what can you do for Nursing in this troubled time?
- our friends in educational institutions
- our friends in clinical healthcare practice
- our friends in the community
Friends in the Educational Institutions

Our friends in the university you can understand our need to be externally focused and vocationally oriented and that this can be done without compromise to academic integrity - our need at times to push the speed along on some of the academic processes.

Our friends in the polytechnics you can understand and push for research infrastructure and conditions of work that allow time for creative scholarship.

Friends in the Health Sector

Our friends in the main sector at national and local levels - talk with us, you'll be surprised what we know.

Don't see us as handmaidens but as equal collaborators in the effort to improve health outcomes in NZ.

Help us develop clinical career paths that will keep the available clinical experience and expertise and facilitate the development of innovation practice. Please don't straight jacket this by excessive casualisation on burn us out by unacceptable patient loads, don't cast us aside in your restructuring because we don't "fit" some organisation blueprint.

Our Friends in the Community

- Help us develop a national nursing research and development trust to provide independent infrastructure for our research into best practice.
- Please make it known that you object to having money exchanged for nurses learning to practice to have access to helping to care for you - it's charged as "slow down cost".
- Resist the stereotypes and move away to seeing broader notions of what nursing is and can be in relation to health particularly public health and primary health care, not just sickness care.
- Remember when you are well and in policy influencing positions, that which know of us when you are sick or vulnerable. Don't suppress your knowledge of us in suppressing your memory of unpleasantness.
- Join us in attempting to counteract the human cost of managerialism in a health care system that should quite rightly and appropriately be quality, cost effective and efficient but also a compassionate, comforting and health focused.

So in standing here in my role with associated responsibilities what I need to say to you is that without including us and without listening to us you may have managed treatment, you may have managed sickness, you may have managed outputs - but you won't have managed care.

Thank you.

This paper was partially developed when I moved to New Zealand but the case for their being a separate pattern of socio-political knowing was a direct result of my search for the answers to the question “what’s going on here?” which became the thesis.

NOTE: This publication is included in the print copy of the thesis held in the University of Adelaide Library.

It is also available online to authorised users at:

http://dx.doi.org/10.1097/00012272-199506000-00007

Whilst about Midwifery, this article displays the development of my thinking about "knowing" within a practice discipline. It builds on the thinking behind the "patterns of knowing" writing.
MIDWIFERY

The Balance of Intuition and Research

New Zealand College of Midwives 1996 Conference, Christchurch

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Convinced of the need for doctoral level study that enabled senior nurses in practice to hold practice as the focus of their study I led the development of professional doctorates in Nursing and Midwifery at the University of Technology, Sydney. Included in the compulsory course work were subjects on health policy, leadership and a subject named International Frame of Professional Practice in which the intellectual and cultural pedigree of ideas about health and health service delivery were critically explored. The design of this programme was heavily influenced by my doctoral research. The second half of this article shows the development of the thought coming from this work.

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This paper was an invited paper presented to a broad audience of health services researchers. Although in Wellington it was attended by a senior group of international researchers and policy makers. This was an opportunity to speak about issues of concern to nursing to an audience outside nursing.
Health Services Reform
Health Services Research &
Nursing:
What counts and what is valued.

NOTE: This publication is included in the print copy of the thesis held in the University of Adelaide Library.
White, J. (2002). Displaying our Wares: What do we show, to whom do we show it, and where should our wares be displayed. Invited Keynote, The We are Able and Artful Nurses – College of Nurses, Aotearoa NZ Conference, Nelson, New Zealand, September.

This paper was presented in New Zealand at the end of 2002 when I was deep in the writing of the doctorate and struggling to understand nursings’ invisibility. The paper develops the idea more completely than was appropriate within the thesis itself.

This paper was the foundation for an abridged version presented in Geneva at ICN and several papers to nursing audiences in Australia since that time. Each paper was of course refashioned to context and the ideas further refined.
Displaying Our Wares:
What do we show,
to whom do we show it, and
where should our wares be displayed?

"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has"
(Margaret Mead cited in Mason, Leavitt & Chaffee, 2002, preface)

We are Able and Artful Nurses Conference
The College of Nurses, Aoteoroa
Nelson, New Zealand
September, 2002

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White, Jill. (2002). Displaying our wares: what do we show, to whom do we show it, and where should our wares be displayed. In That we are Able and Artful Nurses – College of Nurses, Aotearoa, N.Z. Conference, Nelson, New Zealand, September 2002. (Invited keynote).

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