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Discussion Questions

1. Our major argument is that the Neo-liberal agenda maintains a false discourse of the need for financial restraint using the GFC as the motivator. Australia and New Zealand do not need to maintain this restraint as both economies are robust. We think the paper hinges on the accuracy or not of this argument and invite comment on this.

2. This argument might have been sustained in Australia up until 2013-4, but the economy is now in recession, the public sector bloated and there is a significant need for welfare state restraint particularly in the public health sector.

3. Health care reforms in both countries are more directed towards restructure, rather than NPM activities; hence the paper has not identified the fundamental changes that are occurring.

4. The difficulty of comparing NZ with Australia is that the NZ economy would appear to be in better shape and the health system is not as privatised as in Australia; hence comparisons between the two countries may not be useful.

5. There is a continuing danger in pushing the missed care line, as it may lead to blaming nurses.

6. Our examination of resistance to the neo-liberal austerity agenda is thin. Other than the unions, there appears to be little resistance.
Title: The impact of neo-liberal austerity on nursing practice

Abstract:
There is significant social commentary on the long term impact of the Global Financial Crisis on public sector workers in Europe, particularly for eastern and central European economies. The analysis shows clearly that while the GFC was caused by a failure to adequately regulate markets, particularly the banks and multinational corporations, the cost continues to be borne by tax payers, and those employed in the public service, particularly women. These events have provided stimulus to neo-liberal reforms, bolstered by calls across developed economies for increased austerity within the welfare state, particularly in the provision of universal health care. The irony of these developments is that while the Global Financial Crisis was the result of market failure, the neo-liberal discourse and its accompanying strategies for curtailing the welfare state are now stronger than prior to 2008. In this paper we challenge two assumptions embedded in these facts; the first is that front line service professionals such as nurses have been spared the impacts of the new austerity; and that Australia and New Zealand have avoided the full impact of further new public management reforms given both countries rode the GFC relatively unscathed.

The paper draws firstly on the European literature to illustrate the impact of the Global Financial Crisis on public sector health professionals, particularly nurses and identifies some of the more recent forms of new public management. We then trace the use of these strategies within the Australian and New Zealand public health sectors moving from the macro context of policy reform to the impact on patient care drawing specifically on our own research on missed nursing care. Our analysis highlights the flaws exposed in neo-liberalism that emerged during the Global Financial Crisis that sees governments captured by corporations exposing the limits of both the political and market systems. In the final section we propose possible solutions drawn from civil society such as unions and professional associations that nurses might draw on to maintain quality care.

Introduction: the GFC and neo-liberalism
{Section outlining organisation of paper}

The impact of the Global Financial Crisis on OECD population health and health care systems: major restructures or NPM?
Following the GFC by 2010 health care spending had reduced to 0.1% of government outlay across the European region, with many countries allocating less in 2010 than they did in 2009. The sharpest decline has been experienced in those countries worst hit by the GFC, such as Greece, Ireland, and to a lesser extent, Iceland, Portugal and Spain. While public health spending has increased in more recent years (2012-2015) it has not returned to pre-2009 levels. This pattern differs from previous responses to recessions, where expenditure returned to pre-recession levels once the crisis was dealt with (Van Gool, & Pearson 2014; p 17) and the rhetoric shifts from one of austerity to one of recovery. Van Gool and Pearson (2014), also make the point that in countries where the impact of the GFC was contained or was minimal, such as in Germany, Switzerland, New Zealand and Australia, significant budget cuts and health system restructures continue.
The impact of the GFC on nursing work and patient quality of care has been significant. The European Federation of Nurses (2012) report for 34 countries noted that over half the countries surveyed legislated cuts to nurse salaries, loss of pensions, increases in the age of retirement, along with rising unemployment amongst nurses as hospitals were closed (13 closures in Bulgaria), bed numbers reduced (Italy), or through mergers and amalgamations resulting in redundancies (Iceland). The Federation report also noted that one third of its members raised concerns about patient quality, with a fifth reporting the replacement of nurses with non-registered care workers. Concern for patient care and safety was linked to lack of supplies and equipment, but there was also wide spread reporting of nurse migration out of Europe, dramatic reductions in pay, and legislative loss of over-time, with private employers often able to argue exemptions from legislative requirements (European Federation of Nurses, 2012; Petmesidou et al., 2015).

Austerity measures beyond Europe: health spending cuts in Australia and New Zealand

Modest cuts to health budgets were reported for Australia and NZ in the period 2009 to 2011. However, health budget cuts across the period 2014-2016 are significant and have led to a major shift in how the Australian health care system is described (Russell, 2014, 2015). Commenting on the 2014-15 and 2015-16 Federal budgets Russell makes the following observations. Firstly, out-of-pocket expenses for Australians are now second only to the United States, challenging the very idea that Australia has a universal health service (2014). For example, in the period 2000 to 2012 patient contributions to hospital based health care rose by 10.3%, while the Federal, state/territory and insurers’ costs rose by 3.9%, 7.2% and 5.3% respectively (Russell 2014). Secondly, Russell notes that cuts to the primary and preventative services are significant enough to suggest that this will result in an increased burden on the hospital sector, which depends on Federal government funding; thirdly, that co-payments for prescription medicines are the fourth highest of 14 OECD countries; and finally, funding cuts to the states and territories to run the public acute hospital sector are unsustainable (2015).

In NZ there was a period of sustained increased health investment, particularly in primary health care up until 2008. Recent analysis shows that the Health Vote in the 2015 Budget is an estimated $245 million behind what is needed to cover announced new services, whilst keeping pace with necessary increases caused by population growth and ageing.

Methods

Data for the paper comes from quantitative and qualitative responses from nurses who participated in a missed care survey between 2012 and 2015 in four Australian states (South Australia, New South Wales (NSW), Victoria and Tasmania) and NZ. All five surveys were based on Kalisch’s MISSCARE survey with minor modifications for each state or country (Kalisch et al., 2009). Surveys were conducted on line through Survey Monkey and advertised through either the state based branch of the Australian Nursing and Midwifery Federation or the NZ Nurse’s Organisation (NZNO). In total 7,302 nurses responded. Sixty-two comments dealt directly with reduced funding and austerity measures impacting on nursing care. These were
organised using the framework taken from the various NPM strategies employed in other OECD countries and include; flexible working arrangements; incentive based payments; role substitution of registered nurses (RNs) for unlicensed staff; rationalisation of staffing levels based on numbers rather than acuity; resource shortages; and privatisation of health costs.

**Flexible working arrangements: Casualisation, part-time and wage reductions**
Casualisation has been on the increase since the early 1990s and is best defined as the absence of entitlements to paid annual and sickness leave (Kyger, 2015). The rate has hovered between 25.7% in 2005 to the current rate of 24.5% in 2013 and tends to be higher for women than men with the ratio of female to male 26.7/21.2%. In NZ casualisation or insecure work is estimated to be 30% (New Zealand Council of Trade Unions, 2013).

*After 25yrs in my role, I was suddenly 'restructured' in order to save money. My classification was reduced significantly and I now have to work anywhere and everywhere at short notice* (Victorian participant).

**Forced productivity increases through incentive-based payments**
One of the most popular methods used by governments to bring about increased productivity and efficiencies is incentive based funding. This is not done by increasing funds, but by quarantining a portion of the existing funds and assigning it to bonus pools for those hospitals or jurisdictions that achieve specific targets. In Australia both Federal and state governments have used this strategy consistently over the last 30 years as the basis for funding under the Medicare Agreements (Willis, 2009). One of the most consistent incentive activities reported across the 7000+ survey respondents within Australia was the impact of the National Emergency Admission Targets (NEAT) on missed care.

*My hospital tends to go into over census two to three times a day and this puts all departments under pressure and this is why I am leaving nursing. I am coming up to my second year this month and already I have found that this profession is so hard and strenuous on both mind and body* (RN SA).

**Role substitution of RNs with unlicensed staff**
The most common role substitution is that of Personal Care Workers (PCWs) and Assistants in Nursing (AiNs) employed in community, residential and hospital care. AiN have been introduced into public sector hospitals in NSW, Victoria, South Australia and Tasmania, while PCWs tend to be concentrated in the aged care sector. Training ranges from Certificate 3 to Diploma, and as noted in the section on casualisation the majority in Australia are part time with around 10% employed on casual contracts. In NZ the situation is similar with health care assistants and caregivers and practice assistants providing increasing levels of care in a range of settings.

*Please regulate Assistants In Nursing. Please register AINs Please regulate Australia wide education elements for Cert III Please regulate Registered Training Organisations to all offer same education standard. Please regulate that you can fail at a Cert III level If you want to help Aged Care to provide a minimum standard of care cross Australia please - regulate that all*
Assistant training must be undertaken as a traineeship over 12 months in an aged care facility - regulate that the Commonwealth provide funding to all aged care facilities to undertake traineeships - regulate staff ratios in aged care

Rationalisation of staffing levels based on patient numbers rather than patient acuity
In NZ the 20 DHBs and the Health Care Unions have agreed to collaborate on the safe staffing and healthy workplaces agenda. This facilitates the use of various legislative mechanisms to create a safe staffing policy and from this safe staffing solutions. The safe staffing solution emerging from this unique partnership is the Care Capacity Demand Management Programme (CCDM). The programme attempts to match staffing against acuity but struggles against a culture of measurement and preoccupation with “the bottom line” in which CCDM can only be addressed if it is affordable (Hendry et al., 2015).

Aged Care - poor funding means 1 RN for 110 residents in our facility equals impossible workload. How can aged care continue? (SA RN)

Cost cutting through resource shortages
One of the major issues identified in the five MISSCARE studies was the precarious relationship between resource shortages and its impact on missed care (Blackman et al., 2014). In the first study in SA we were surprised to read that nurses identified this as a key issue. In telling their story, they noted that care was missed and patient care compromised when there was the slightest change to the routine; when equipment was not available, and they were forced to seek it from another ward, or improvise (Henderson et al., 2013);

Pressure to meet targets. Year after year we are asked to complete a wish list of instrumentation & equipment (quite time consuming getting quotes etc) only to be told that there is no funds available yet we still have to reach our waitlist targets & even when we do this there appears to be no rewards! (RN NSW).

Privatisation of health costs
A major component of NPM and austerity measures has been to shift the cost of services from one sector of government to another, and from the state or private provider to the consumer or patient. As Siwwert et al., (Siwwert, S, Seseija, Bilyk, & et al., 2014) notes this has been significant in Australia with 17.3% of the total health expenditure now falling on consumers through private health insurance, gap payments, co-payments and for items not covered by any scheme. For NZ, 77% of health care is met through taxation, with 17% assigned to consumers and the remainder to the private and not for profit sectors (Statistics New Zealand, 2010). The privatisation of health goes beyond patient co-payments to the creation of internal markets within the public health system, and to outsourcing the provision of services to the private sector. This occurs at a number of levels.

In the community we have had an excellent reputation for many years, but over the last fifteen months we have been told the HACC1 funding will go to private agencies and we don’t know
what is happening to half of our nurses. SINCE then we have been completely unstabilised with a high turnover of casual and inexperienced staff, plus the powers that be have insisted we take first year RN s which has been further diluting our skill mix and causing stress to the few permanents that are left. To top it off all the new policies that are continually being pumped into Community are the same ones for the hospital wards which DO NOT equate in people’s own homes (RN NSW).

Austerity and NPM

In the Australian and NZ context our own data taken from the MISSCARE surveys shows that quality care is at risk as nurses struggle to provide patient care. In providing an analysis of qualitative responses from these nurse respondents we demonstrate Crouch’s argument that the culture of austerity is being used to continue the neo-liberal agenda of increasing the privatisation of the public sector (Crouch, 2011).

Points of resistance are hard to identify given the state is now significantly reduced and increasingly entangled with the market. For Crouch resistance lies outside of the state and the market, in civil society, specifically in unions, professional associations and not-for-profits (Crouch, 2011). He suggests that these organisations have the potential to resist both the state and the market, provided their members act in the interest of the welfare state. This has certainly been the case in Australia and NZ where the nursing and midwifery union/s have gone beyond bargaining for higher wages for their members, to lobbying for improved staffing levels (Willis, 2002b). In NZ the establishment of a safe staffing unit was driven, and is sustained by the activities of the NZNO in partnership with government. In addition the establishment of a strong research unit within the NZNO has seen a steady escalation in the number of press releases advocating for consumer welfare needs rather than the needs of NZNO members.

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