PSA Submission: Draft Health of Older People Strategy

7 September 2016

PSA
For a better working life
New Zealand Public Service Association
Te Pūkenga Here Tikanga Mahi

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Introduction

Who we are

The New Zealand Public Service Association: Te Pūkenga Here Tikanga Mahi (PSA) is the largest trade union in New Zealand, representing 62,000 members who are taxpayers and users of the health system. We are a democratic organisation with members in the public service, the wider state sector (the district health boards, crown research institutes and other crown entities, state owned enterprises, local government, tertiary education institutions and non-governmental organisations working in the health, social services and community sectors.

Our membership

Of these members, around 17,000 work for DHBs as allied health, mental health and public health professionals and support workers, and as administration and clerical support. We also have around 6,000 members who work in community-based public services, providing home support to elderly and disabled people, providing mental health and drug and alcohol services, and residential disability support services. They are employed by not-for-profit and private providers who are funded through contracts to DHBs and, in some cases, directly by the Ministry of Health.

Through the New Zealand Council of Trade Unions: Te Kauae Kaimahi, we work closely with other affiliated health sector unions on matters of common interest. We are an associate member of AHANZ, the peak body for allied health professional associations, and maintain close links with organisations and consumer groups in disability, home support and mental health. We participate in the Health Sector Relationship Agreement and the National Bi-partite Action Group, which are national health forums.

Submission structure

We note that the draft strategy's structure reflects its five proposed objectives, and that the five themes[1] of the New Zealand Health Strategy are woven throughout the section on each objective. This submission is structured around the themes of the New Zealand Health Strategy to avoid the repetition that would arise from commenting on each theme for each objective.

The submission starts with general comments, then discusses each theme,

[1] The five themes of the New Zealand Health Strategy: People Powered, Closer to Home, Value and High Performance, One Team, Smart System.

and finally provides specific comments on some of the proposed actions.

General comments

The document acknowledges that it is intended to provide overarching direction for the system for 2016-2026, and proposes actions to support the achievement of the strategy.

The strategy takes a life course approach, which is reflected in the proposed the vision and objectives.

The proposed vision is, "Older people live well, age well and have a respectful end of life in age-friendly communities.

The proposed five objectives are:

- Healthy ageing
- Acute and restorative care
- Living well with long-term conditions
- Support for people with and complex needs
- Respectful end of life.

The strategy lacks detail …

The themes from the New Zealand Health Strategy are woven into these five objectives.

All of which is useful and we can in principle agree, but there is a worrying lack of detail and specificity about many of the actions, and how the desired objectives will be achieved. Many of the actions are at a high-level.

… in particular, on funding issues

The proposed strategy does not deal with the issue that, in real terms, the health budget has been underfunded by around $1.2 billion since 2009/10 according to research undertaken by the CTU and ASMS, and this is a conservative estimate[2]. There is no acknowledgement of this shortfall, just an assumption that the funds must be stretched even further. We do, of course, support getting value for money and better performance but continued underfunding is not the answer.

This does not give us confidence, especially when the challenges section notes the growing health needs arising from our ageing population and the growing complexity of need.

There is considerable vagueness about the "investment approach"' and what this will actually mean in practice and what the likely impacts on current

[2] http://union.org.nz/sites/union.org.nz/files/Did-the-Budget-provide-enough-for-Health-2016.pdf

… what the investment approach means in practice is unclear

funding arrangements will be. We would be concerned if it is a narrow focus on cost reduction, with the hope that better health, economic and social outcome will eventuate; or if it is about managing risk by shifting it to contracted providers and the voluntary sector.

The reviews commissioned by the Director-General of Health on Capability and Capacity and Funding had plenty to say about funding issues, and recommendations, but very little has been carried through to the draft strategy. The funding review commissioned to support the New Zealand Health Strategy was clear about the proposed direction, and envisaged a greatly increased role for the private sector in competition with DHBs for contestable funding. The private sector will not be interested in the difficult and intractable issues; they will cherry pick the easier and more profitable services, reinforcing health inequities.

… and fails to state how a fragmented sector will be brought together in an effective system

We have a highly fragmented health system with 20 DHBs and hundreds of NGO and private providers, including PHOs. Having all these elements functioning as a coordinated and aligned health system will be necessary to support the achievement of the strategy's objectives, but the strategy and actions do not provide any concrete or specific information about how this will come about.

Workforce

In general we agree with the challenges and opportunities, but there are some gaps. The paragraph on page10 on Workforce Development needs to identify the challenge of ensuring we recognise the contribution, and fully utilise, the skills of the entire workforce, not just doctors and nurses but also allied health, technicians, home and community support workers, clerical and administrative support people who are integral to the 'one team' approach that is part of the strategy. This would reinforce the elements of the strategy that deal with workforce development. We comment in more detail on workforce issues throughout the submission

Themes

People Powered

We support the focus on people as individuals, as co-producers and co-designers of their health and well-being, supported by informed choice. However, there are two assumptions that concern us in particular:

There is a place for telehealth, but those unable to access it must not be left behind

There is a heavy emphasis on telehealth and technologies, assuming that people will in future engage with health services through technology. There is no doubt that technology developments offer significant opportunities, and for some people this will provide benefits. But others will struggle; they will not be able to afford to buy and run the devices so will be disadvantaged vis-à-vis the tech savvy, assertive and affluent sections of the population (who will

be predominantly Pākehā). Others will be disadvantaged by their age and/or disability, so supports must be in place for them.

Health workers must be trained and supported to use technology

The other aspect of telehealth is the need to ensure that health practitioners are supported with up to date technology for their jobs, and are fully trained and supported in its use to maximise its benefits. Protocols to maintain the security of personal health information will be important.

Our members who work in home support have expressed concerns about technology being used for surveillance purposes. For example, GPS on cars or phones to track location and the time spent with a client.

Individualised Funding must be backed up with good employment practice, preferably through providers

Is it envisaged that individualised funding (IF) will be used to maximise people's choice and flexibility? IF is seen as one way forward for a people power centered system, and is currently used in the disability sector. It can enable people to gain a greater measure of personal independence, and direct their own services. Research[3] supports the proposal that it provides better outcomes for people with disability. For the PSA the concern with individualised funding is not with the concept or the ambition, but with the lack of consideration of the workforce required to provide independence for the person with disabilities. These concerns centre around employment relationships, wages and conditions, training and qualifications, and health and safety.

Under the New Zealand model of IF, many disabled people will directly employ their support staff. There is no doubt that many will be good employers, but generally small employers struggle with the capacity and capability to deal with employment matters well. From a worker perspective it is best that support workers under IF are employed by providers. This would provide them with greater employment security, access to training and health and safety support, and probably make it easier to ensure regular hours. We note the Australian Disability Insurance Scheme introduced in 2013 that serves as a useful model for offering choice to those needing support whilst supporting good employment practive - while there are some situations where workers are directly employed by the person with a disability, most are employed by a provider.

The in between travel case shows the way forward for regularising the care and support workforce

Care and support work is often seen as 'women's work', done by family members, neighbours or friends and is not valued for the skills, knowledge and responsibilities that are required. Having a provider employ the worker means that there is more scope to negotiate fair wages and conditions that are consistent across the sector. There is a growing realisation that better

[3] Karen R. Fisher, Ryan Gleeson, Robyn Edwards, Christiane Purcal, Tomasz Sitek, Brooke Dinning, Carmel Laragy, Lele D'Aegher and Denise Thompson, *Effectiveness of individual funding approaches for disability support,* Department of Families, Housing, Community Services and Indigenous Affairs, 2010 p. viii

training and higher level qualifications are required for the care and support workforce and this was part of the in-between travel case settlement reached by the PSA and the Ministry of Health, where work is now underway to regularise the workforce. The changes are significant and when achieved will ensure guaranteed hours for the majority of the workforce, paid training to enable support workers to gain level 3 qualifications, wages based on the required levels of training, and fair and safe workload allocations. This needs to be explicit in the strategy and actions, and needs to be funded.

Negotiations also underway as a result of the Kristine Bartlett equal pay case and all parties hope that a settlement can be reached soon. The PSA seeks recognition of the skills and equal for aged care residential and home support workers. This needs to be factored into the strategy and funded.

Workers must not bear the cost of greater flexibility in service delivery for older people. Our experience in the home and community care sector is that those workers, bear the cost of client flexibility. A client can cancel a scheduled visit by a support worker at very short notice, the provider is not funded for non-utilisation, and so the worker is not paid for the work they did not perform through no reason of their own. This can place significant financial pressure on that worker (and their families), who are already low paid with uncertain hours of work. The high degree of client choice has been a significant challenge in the regularisation of the workforce resulting from the in-between travel settlement. The lack of guaranteed hours of paid work also risks non-compliance with the new statutory provisions on employment standards.

Closer to Home

People in rural and remote areas must not be disadvantaged

More clarity is needed about how the Maori and Pacific peoples' health needs will be met

Contracted services must maintain skills, specialisms and service quality

Again, we support this theme in general, and we know that it is what people and their families want. Members however have questions about equitable access for older people in rural and provincial areas, and it would be good to see more detail on how the strategy will ensure that they do not miss out. In effect this theme is a challenge to the DHBs about where services are best delivered and how they are configured.

Māori and Pacific peoples have a greater degree of health inequalities; and accessible and affordable community, primary and whanau services are important in supporting better outcomes. The strategy does acknowledge Māori and Pacific health as a priority, which we agree with. But again, the strategy is short on detail.

We have concerns about moves to further contracting out of services to community organisations. If this happens it must be balanced with measures to ensure that skills, specialisms and service quality are maintained. For example, one member from a remote area reported that emergency services are being run by aged care nurses, which may be adequate for low-level

emergencies but may well also carry risks for the public and for the health workers. The other issue in more contracted services is more fragmentation of services.

The PSA supports the aim of workforce capability and capacity in primary and community services to provide high-quality care as close to home as possible. However, the strategy needs to recognise the community services workforce requires training to raise qualification levels, equal pay and conditions, job security, and adequate health and safety. It must also be respected and valued for its important contribution to peoples' well-being and health, and not just seen as low-value 'women's work'.

Health and safety is a real issue for our members

In terms of health and safety, issues for our members include working alone, dealing with challenging (and sometimes violent) behaviours, dealing and lifting heavy clients. The drive towards community based care means that this will increase and will heighten the need for safe staffing levels. The strategy will need to ensure that workers have adequate and safe working conditions in the community/

Our comments above about telehealth are also pertinent to this theme.

Value and high performance

Underfunding of $1.2 billion since 2009 is ignored

As noted above, the strategy does not deal with the issue that, in real terms, the health budget has been underfunded by around $1.2 billion since 2009/10. There is no acknowledgement of this shortfall, just an assumption that the funds must be stretched even further. We do, of course, support getting value for money and better performance but continued underfunding is not the answer.

As they struggle with their own deficits, DHBs have consistently underfunded contracted providers through mechanisms such as increasing service levels within the same (or decreased) funding, or dropping services.

Large scale private provider are becoming ever-bigger players, putting downward pressure on wage and service levels

Given the emphasis in the draft strategy on the shift to primary and community services, it is crucial that any shift is properly funded. We note that, over time, community and NGO providers are often taken over by large, for-profit organisations with puts even more pressure on the wages and service levels. The experience of the residential aged care sector, where large scale foreign owned companies attracted by the guaranteed government funding have entered the New Zealand market, are germane here. The private sector is focused on maximising the return to its owners and shareholders; the risk to public value is that the government has to step in in case of service failure, as we have seen in the private prisons debacle with Serco.

To illustrate this point, our community public service members have many

Do they leave the client's dishes in the sink?

examples of provider management solutions to dealing with funding shortages: for example, a client who previously had an hour for home management being cut back to 45 minutes – ostensibly as part of the restoration model encouraging independence, but not taking into account the importance of the relationship with the client and the fact that the client may not be capable of some tasks. Should the worker leave the client with a tub full of dishes because the 45 minutes is up?

Members also point out times where one home support worker is expected to use a hoist on their own, where in a rest home or hospital situation, two workers would be assigned. Qualified workers are trained not to use hoists on their own. Not sending a second worker is a cost saving to the provider.

Our comments above about what the investment approach means in practice being unclear are also relevant here.

PSA has experience of high performance work practices

The PSA is also committed to high performing workplaces in both the community sector and the health sector with a view to creating a climate and culture where frontline workers, including those who might qualify as public entrepreneurs, can flourish. We have two principal objectives:

- Enabling PSA members to have good jobs, within a workplace culture of meaningful and substantive engagement of workers and their union with the employer on how the work is organised and carried out
- Supporting the delivery of high quality public services that provide value for money and good outcomes for New Zealanders.

A high performing workplace is one where our members can mobilise their knowledge to improve the efficiency and quality of services and embed positive and productive workplace relationships and practices with a view to creating sustainable services, sustainable jobs, and productive workplaces.

Involving the workers who do the jobs, and harnessing their ideas is the way to deliver high performing services

The PSA believes that high performance workplaces can be achieved through a culture of engagement and collaboration by direct, meaningful and regular engagement with the workforce on all matters over which the workforce directly influences performance. This is essential for sustained high performance and for achieving the productivity gains that employers (and members) seek in a time of scarce resources. In the highly unionised public sector the union is central to improving productivity and innovation and the PSA wants to be involved.

Sustainable Work Systems is the PSA's high performance programme

For example, we have developed Sustainable Work Systems (SWS) as a programme for putting the high performance workplace agenda into practice. SWS sits within our wider agenda, and is an important and effective tool for realising high performance in workplaces where the conditions are right for it. We have a number of projects underway with employers to implement this

programme. It has been running with bookers and schedulers at Bay of Plenty DHB since 2009, where the introduction of SWS reduced (and sustained) the time taken for scheduling acute appointments from 5 hours to 1.5 hours, significantly reduced the need to rebook appointments at short notice and allowed patients to choose their appointment times so that they are much more likely to turn up.

Kaiser Permanente in the USA is a model

We have visited Kaiser Permanente in the US, where the health company and a coalition of unions have a long-standing formal partnership based on a shared commitment to high performance through employee involvement[4]. This has delivered significant benefits and savings to the company, to the workers – and to their clients and patients. If the government is serious about high performance, it needs to work with unions to promote and participate in such approaches.

One team

The one team approach must value and use the skills of all health workers

Our members support the principle of working together in local teams and across the system. However, there is a real problem about how the clinical professions view the contribution of the full range of health workers. Allied health and technical workers need to be seen as integral and equal participants in multi-disciplinary care teams; and clerical and administrative workers and home support workers need to have their roles and ideas respected and valued.

This theme has a focus on workforce development, including the skills necessary for integrated care. We support this, and expect that unions will be fully involved in implementation. Adequate support for training and qualifications must be part of this. There must be a clear understanding – from all parties – that the health workforce is wider than the clinical workforce, and includes the non-regulated workforce which is a key component of 'closer to home'. This should be more explicit in the strategy, as well as the role of unions in supporting workforce development.

Smart System

Data systems must be designed around people

The challenge of integrating systems must not be under-estimated

Much is made throughout the document about the need to improve data analytics and collection, as well as the transformative potential of technology. However, the systems need to be designed around people – both clients and service users and the staff who use and operate them. We have made points above about the currently fragmented DHB / provider system and this is starkly shown up in the proliferation of incompatible IT systems.

For example, Health Benefits Ltd (HBL) was set up to deliver national programmes for 'back office' shared services between DHBs, including IT

[4] http://www.lmpartnership.org/sites/default/files/2012_national_agreement.pdf

procurement and integration. It failed to deliver, and was disestablished. The Auditor-General's report into HBL makes for salutary reading; she notes[5] that:

> *'The change required had been underestimated … The (IT) programme's goals were ambitious, requiring creating a single system that could replace 20 systems and different ways of operating. It appears that HBL underestimated the health sector's fragmentation. This made achieving the programme's objectives in the time allotted particularly challenging.'*

NGOs, and their workers, must be supported to develop IT capability

The strategy needs to be realistic about the challenges that must be overcome to deal with the fragmentation if it is to realise its objectives and supporting actions. The strategy also glosses over IT and capacity and capability deficits in NGOs and providers – if they are to be part of an integrated national information and data system, they will need considerable capacity and capability building, as well as training for staff.

Unions must be involved in the impact of technology on jobs

The draft strategy silent on the potential impact of technology on jobs and changed work practices. Good planning and communication with workers and their unions must be part of implementation, as well as ensuring that any changes to jobs are done with – and not to – the workers, so that they are supported into new areas of work and new roles as needed.

Proposed Actions

Overall, the proposed actions are a curious mix of detailed, small-scale actions on one hand, and of large, high-level ambitions on the other; of what is currently happening and of what a desired future looks like; thereby making it difficult to comment. Specific comments on some of the actions are provided below:

Healthy ageing

The actions and body of the strategy need to be clearer that healthy ageing begins from birth, rather than from a particular age later in life. Healthy lifestyles and choices can maximise the chance of a person staying well for longer as they age.

Living well with long-term conditions

Please see our comments about the regularisation of the workforce and funding throughout the submission, especially pp. 5-7.

We support **Action 9: Ensure that those working with older people with long-term conditions have the training and support they require to deliver high-quality, person centred care** in principle, but believe that the sub-actions are

[5] Para4.12, p17. http://oag.govt.nz/2015/inquiry-hbl/docs/health-benefits-ltd.pdf

at high level and lack specificity.

Action 9a refers to the regularisation of the kaiāwhina workforce in the home and community support services. Is this referring to the regularisation process occurring as a result of the in between travel case? If so please see our comments above (pp.5-7). Regularisation is significant and when achieved will ensure guaranteed hours for the majority of the workforce, paid training to enable support workers to gain level 3 qualifications, wages based on the required levels of training, and fair and safe workload allocations. This needs to be explicit in the strategy and actions, and needs to be funded.

If achieved, regularisation will go a long way to addressing some of the actions listed in this section concerning the capacity and capability of kaiāwhina workforce, recruitment and retention, and better skill utilisation. The home and community care sector has a high turnover, which is a cost to both worker and employers, and impacts on the quality of care to clients. The strategy must have retention measures, including equal pay (p.6), in place.

Other measures to support the achievement of these actions are the implementation of high performance work practices and employee engagement described at pp. 8-9 of the submission.

Many of the actions have either the Ministry of Health or DHBs listed as the leads. Unions and providers/employers must also be closely involved if these actions are to be successfully implemented.

Action 11c: Develop commissioning and funding approaches for home and community support services that describe core aspects for national consistency, but allow for flexibility at the local level –

Is this referring to individualised funding? If so, please see our comments on p.5. Or is this about a broad commissioning process or simply contracting out?

The PSA views commissioning as a broader strategic process to:

- Identify the broader social outcomes that need to be achieved
- Assess the needs of people in an area, with those people
- Design a service that will meet these needs and outcomes, and
- Deliver a service in a way that best meets these needs and outcomes

Commissioning is distinct from privatisation or contracting out, which is only one option when deciding on the best way to provide a service. There is much to be gained from a more strategic, integrated and long-term service design and implementation discipline that draws heavily on programme evaluation, ongoing service planning and cross-sector data, and emphasises the public

sector capabilities needed to make this a reality.

When services are contracted to not-for-profit providers, they need to be fully funded so they can invest in the training, systems and tools needed to deliver social services. The capability of not-for-profit providers also needs to be built so they can effectively participate in the commissioning process.

Data and evidence must be used to assess the effectiveness of those services, including the impact on the public sector to deliver services.

Support for people with high and complex needs

Action 15c: Promote contracting models that enable people to move freely to different care settings most suited to their need.

Please see our comments directly above regarding Action 11c under Living well with long-term conditions

Action 16a; In specific locations, trial commissioning one organisation to coordinate health and support services for frail elderly people etc

Please see our comments directly above regarding Action 11c under Living well with long-term conditions.

Action 18d: Explore options for aged residential care facilities to become providers of a wider range of services to older people, including non-residents.

We have some concerns about this, please see our comments at the end of p.6.