PSA

Submission on the Draft New Zealand Health Strategy

December 2015

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 (the 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 (the CTU), we work closely with other affiliated health sector unions on matters of common interest. We support the submissions of the CTU, NZNO, ASMS and E tū. 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 (HSRA) and the National Bi-partite Action Group (BAG), which are national health forums.

In developing this submission we have spoken with groups of our members in DHBs and community public services to ascertain their views, as well as sharing these views with other health sector unions and organisations.

General Comments

General comments on the proposed Draft New Zealand Health Strategy

The document acknowledges that it is intended to be high-level, to set principles, and to indicate preferred directions and approaches. It also emphasises the need to move to a view of the health system as a whole, including primary care and community-based services, as well as a citizen / user-centred focus. All of which is

The strategy lacks detail …

useful, and we can in principle agree, but there is a worrying lack of detail and concreteness about the roadmap actions, the links between the strategy and the roadmap, and how the desired state will be achieved.

… in particular, on funding issues

Additionally, there is little or no reference to funding, and considerable vagueness – presumably deliberately – about the 'investment approach' and what this will actually mean in practice and what the likely impacts on current funding arrangements will be. The supporting reviews commissioned by the Director-General of Health on Capability and Capacity and Funding have plenty to say about funding issues, and recommendations, but very little has been carried through to the draft strategy document. For example, both reviews find that the current provider contracting model works against innovation and workforce development and they recommend multi-year contracts with providers to provide certainty and support forward planning – but the strategy is silent on this. This does not give us confidence, especially when the challenges section notes that Treasury considers that New Zealand cannot afford to keep providing services as we do now.

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

Funding is not the only 'elephant in the room' not addressed by the strategy: 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 is a good goal, but the strategy and roadmap do not provide any concrete information about how this desired state will come about, other than vague references to 'improved coordination'; 'clarify roles and responsibilities'; 'improve governance and decision-making processes across the system'.

Responses to the questions

Are there any additional or different challenges or opportunities that should be part of the background for the strategy?

In general we agree with the challenges and opportunities, but there are some gaps. The paragraph on p7 on workforce 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, clerical and administrative support people who are integral to the 'one team' approach that is part of the vision of the strategy.

The opportunities should include the opportunity to reorient our health system away from a traditional western model to one that is centred on the needs of individuals, families and communities – a whole of New Zealand approach that can fully reflect and support the range of ethnicities in the country, particularly Māori.

We have already noted the fragmentation of the current health system – but the challenge of integration should be included.

The future we want

Does the statement capture what you want from New Zealand's health system? What would you change or suggest instead?

In general, we can agree with the vision statement which is at a very high level. The Health Sector Directions Forum proposed amending 'live well, stay well, get well' to 'start well, live well and end well', which we support. Other parts of the statement are more problematic – 'people-centred'; 'one team', 'smart system' are imprecise, and capable of different interpretations depending on the context. They essentially mean all things to all people – and in effect therefore mean nothing very much. Clarity is needed, and we have more to say below on this in the section on the five themes.

Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the strategy?

Two further principles are proposed

The refreshed principles are generally satisfactory, and we are glad to see that seven are retained from the 2000 document. We propose two additions to the principles:

- A principle on the determinants of health is needed (e.g. housing, income, employment, social services). Alongside this the need for integration with other services and agencies (WINZ, Housing NZ etc) should be explicit. Principle 8 does include 'collaborating with others' but this needs more precision.
- A principle on utilising all the skills and attributes of the entire health workforce would underpin the system-wide approach envisaged in the strategy and ensure that all parts of the workforce, including allied health, clerical and administrative workers, and care and support workers see their contribution as part of the whole. It would also reinforce the elements of the strategy that deal with workforce development.

Five strategic themes

*Do these five themes provide the right focus for action? Do the sections '*What great might look like in 10 years' *provide enough clarity and stretch to guide us?*

People-powered

We support the focus on people as individuals and as co-producers and co-designers of their health and well-being. However, yet again, this section is long on vision and short on detail of what will actually happen, and how it will happen.

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

Health workers must be trained and supported to use technology

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 Pakeha). Others will be disadvantaged by age, lack of literacy or disability, so supports must be in place for them. The other side of 'people-powered' 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 mental health have commented that it is important that people who are in acute crisis are seen face-to-face by qualified practitioners and not directed to telehealth approaches. Getting the right balance – for service users – between telehealth and primary and secondary care will be important.

Our members who work in home support 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

Individualised funding (IF) is seen as one way forward for 'people power'. It can enable people with disabilities to gain a greater measure of personal independence, and direct their own services. Research[1] supports the proposal that it provides better outcomes for people with disability. For the PSA the problem 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.

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

[1] 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

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

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 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 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.

Closer to Home

People in rural and remote areas must not be disadvantaged

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 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.

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

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 note Māori and Pacific health as a priority, which we agree with. However by not addressing the social and economic determinants of health (unemployment, low wages, child poverty, bad and costly housing etc) the strategy misses the point. The emphasis on 'collaboration across government' is once again vague and imprecise.

Contracted services must maintain skills, specialisms and service quality

We have concerns about moves to further contracting out of services to community and primary health 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.

There are particular concerns in mental health

Members who work in mental health have raised concerns that the provision of secondary mental health care has been restricted over recent years, often in response to DHB financial constraints, and people with significant mental health issues, as well as those with less severe problems, being directed into the primary sector. They see people who cannot afford to pay for primary care being deprived of early intervention when symptoms are less severe, so that personal suffering builds up until they meet the threshold for secondary mental health care. While 'closer to home' is a good goal, it is important that mental health care is accessible when and where it is needed and that affordability barriers for primary

care are removed.

The vision for 'great in 10 years' refers to workforce capability and capacity in primary and community services that provide high-quality care as close to home as possible. We fully support this, but the strategy needs to recognise the community services workforce requires training to raise qualification levels, fair 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'.

Value and high performance

The strategy is light on innovations to deliver better value and high performance.

Underfunding of $1.7 billion since 2009 is ignored

This section is where the direction for funding is more transparent than elsewhere (though still very opaque); but the strategy is light on any real innovations to deliver better value and high performance, nor does it deal with the issue that, in real terms, the health budget has been underfunded by around $1.7 billion since 2009/10 according to research[2] undertaken by the CTU and ASMS. 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. The removal of the ring-fence for mental health funding has meant that they are now under-resourced, so that should be remedied.

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

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. Given the emphasis in the 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 early childhood education and residential aged care sectors, 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 focussed 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.

Our community services members give examples of what this means.

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

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2 http://union.org.nz/sites/union.org.nz/files/Did%20the%20Budget%20provide%20enough%20for%20Health%202015.pdf

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

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.

What the investment approach means in practice is unclear.

Much is made in the strategy of the need for the investment approach; what this looks like in practice is not clear. It seems to be about closer collaboration between departments, DHBs and agencies which all makes sense. But it is a narrow focus on cost reduction, with the hope that better health, economic and social outcome will eventuate. It is very much about managing risk, partly by shifting it to contracted providers and the voluntary sector. The funding review commissioned to support the draft strategy is clear about the proposed direction, and it envisages a greatly increased role for the private sector in competition with DHBs for contestable funding; much of the detail has not been carried through to strategy or the road map of actions. 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.

PSA has experience of high performance work practices

The PSA is also committed to high performing workplaces in both the community sector and the public 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[3]. 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. The submission from AHANZ has useful points about allied health professionals, which we support. 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 goal 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 be a key component of the 'closer to home' objectives. This should be more explicit in the strategy, as well as the role of unions in supporting workforce development.

Ministry of Health staff must be supported to develop the capability to position the Ministry as the system leader

We agree that the Ministry of Health, where we have members, needs additional capability to realise its proper role in system leadership. If there is to be any reorganisation of the Ministry, staff must be assured that their jobs are safe and that they will be supported to transition to new roles through best practice change management and the PSA will expect to be fully engaged from the outset.

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

Smart System

Data systems must be designed around people

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.

The challenge of integrating systems must not be under-estimated

Health Benefits Ltd (HBL) was set up to deliver national programmes for 'back office' shared services between DHBs, including IT procurement and integration. It failed to deliver, and was disestablished. The Auditor-General's report into HBL makes for salutary reading; she notes[4] 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 draft strategy needs to be realistic about the challenges that must be overcome to deal with the fragmentation and achieve the goal of integrated and smart systems. 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

This section is 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 the 'smart system' 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.

Roadmap of actions

Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

The roadmap is a curious mix of detail and small-scale actions; of large and sweeping statements and high-level ambitions; of what is currently happening and what a desired future looks like. It is therefore difficult to comment on it. Getting the strategy right is the first step.

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

For further information about this submission contact:

Christine Ross, Policy Advisor

E: christine.ross@psa.org.nz

T: 04 816 5048

www.psa.org.nz