PSA Submission

New Zealand Health and Disability System Review

May 2019

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

PSA Submission on the Health and Disability System Review

About the PSA

The New Zealand Public Service Association Te Pūkenga Here Tikanga Mahi (the PSA) is the largest trade union in New Zealand with over 73,000 members. We are a democratic organisation representing 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.

The PSA has been advocating for strong, innovative and effective public and community services since our establishment in 1913. People join the PSA to negotiate their terms of employment collectively, to have a voice within their workplace and to have an independent public voice on the quality of public and community services and how they are delivered.

For this submission the PSA has canvassed members who work in community public services (CPS) and district health boards (DHBs). We also invited our Deaf and Disabled network to respond to our survey. A total of 805 answers were received and analysed.

The PSA is an affiliate of the New Zealand Council of Trade Unions Te Kauae Kaimahi (CTU) and we support their submission on the review.

The PSA's recommendations for a fairer and better health and disability system

Our recommendations are summarised in the table below. Considered as a package they will lead to improved health outcomes and better workforce capability. This would set the health and disability system in NZ on a good path to deal with future health and related work challenges.

Table 1: PSA's recommendations for a fairer and better health and disability system

Theme	Recommendation	Outcome
Public system	To create a fully public system with fair contracting arrangements and limited number of for-profit organisations.	A non-competitive public system would not capitalise on people's health challenges which are often none of their own fault such a non-communicable disease, chronic diseases, disabilities or simply getting older. We believe that the system would better deliver on better and more equitable outcomes.
Pay and Working Conditions	• That work of all levels in the health and disability sector be properly valued and paid accordingly. • That pay and employment equity is ensured across the sector • That DHBs and community service providers recognise adequate and stable compensation systems which go beyond salaries, and should include: Paid training opportunities; Planned and systematic pay and benefit upgrades; Fringe benefits; and In-between-travel and Sleepover compensation • That the size of the income gap between members of the healthcare workforce be reduced. • That good working conditions and participation of workers is mainstreamed across the health and disability system.	The value of improved pay and working conditions in the workforce is immense. Research demonstrates that improved valuation and pay of workers improves overall staff retention. Career paths lead to efficient and meaningful use of workers – the ability to retain experienced workers provides stability to organisations, enhances morale and ensures consistent services. In the context of the New Zealand health system, these recommendations will influence improvements in staff levels and reduction in workloads and time pressure.
Work Environments	• That the Ministry of Health (MoH) and DHBs recognise healthy and safe workplace environments as a prime requirement for health and disability workforce development and the provision of high-quality services.	Negative work environments are detrimental to both service users and the workforce, placing our most vulnerable citizens at increased risk of poor health outcomes as health workers struggle to provide high quality care.

	• That persistent workplace environment issues be addressed at all levels and across the whole system. • That the MoH and DHBs recognise the influence of working environments on patient outcomes. • That the quality of healthcare facilities be improved, and the quality of healthcare facilities be recognised for its influence on staff and patient outcomes.	Poor conditions are also detrimental to staff retention, with overseas work environments increasingly seen as attractive to New Zealand staff, as they are perceived to provide improved education and conditions. Members reported many factors of their working conditions as undesirable, including workloads that are perceived to be unrealistic, decreasing numbers of staff coping with increasing throughput, and increasing expectations to extend work hours to absorb additional responsibilities.
Address Workforce Shortages	• Development of an integrated workforce across the DHB and community sectors so that we have cohesive workforce planning and development across the delivery arms and connected/integrated workforce planning across occupations. • That an overarching workforce strategy be developed across the health and disability and community sectors, with a focus on staff retention and diversity of workforce demographics. • That a commitment be made towards achieving and maintaining safe staffing levels for all services across the sector. • That workforce shortages be addressed so that safe staffing levels are achieved without compromising working conditions or access to professional development. • That workforce capacity and capability be strengthened to meet increased demand, as predicted by long-term forecasting models.	A quality health workforce is a crucial component of the modern health care environment, because it has a direct effect on patient and consumer health outcomes. To meet future demands on the health and disability system and its workforce (including the use of new technologies) an increased focus on recruitment and retention of skilled health practitioners will be vital. Workforce planning would also include countering the trend towards an increasingly atomised workforce and focus on promoting team-based work structures that are made up of multi-disciplinary occupations and valuing the contribution of the different occupational perspectives to counter and challenge the hierarchical and siloed nature of the current structures. Increases will also be required to meet the extra demand for health care workers because of population changes. Ensuring healthy workplace environments will be key to achieving this goal, as retention is influenced by an array of factors including workload management, leadership, and general positive workplace experiences.
Digital Infrastructure	• That the MoH and DHBs recognise the need for integrated digital information sharing platforms, and that a digital information system be developed and implemented *across all* health and disability sector services and providers. • That digital systems be implemented to allow for timely access to critical service user information from all service providers when	Survey respondents regularly and clearly articulated that the lack of a smart system for information access and sharing can be detrimental to the timeliness and accuracy of patient care. Lack of compatibility between different digital systems leads to limitations in information sharing, unnecessary administrative work, and higher risk of error in treatment provision.

	relevant (and given permission by service users).	Health providers will be enabled to share critical information electronically, enabling all providers to give service users timely and consistent care within an environment that has strong and clear accountabilities for safeguarding privacy and confidentiality of patient or service user information. While the development and implementation of a smart system across the health and disability sector will be a significant task, there is immense opportunity for modern technology to assist in the gathering and sharing of health data and information, as well as opportunities for insight into healthcare trends through analysis of data collected. This will support evidence-based decision making at policy and patient care levels.
Functional Infrastructure	• That the infrastructure of the health and disability sector be improved to reduce complexity for service users and providers. • That a consistent, standard approach to healthcare be set up across the sector to promote consistency in workplace practices. • That a commitment be made to improve ongoing relationships within the health and disability sectors' various service providers and agencies, and between health and other sectors. • That DHBs ensure service providers within and between districts work with each other to develop and maintain a coordinated approach to healthcare across the sector (connecting public health, primary care, community-based care, and secondary services).	Fragmentation of services in the NZ health and disability system has often been a target of criticism, and reduction of fragmentation of services will allow for fostering of greater collaboration between service providers and agencies. Reduction of fragmentation will improve timeliness of access to services, reduce duplication of labour and resource use, and reduce the barriers to health created by (often unavoidable) movement between medical practices or geographical regions. Introduction of standard workplace practices will aid in the provision of healthcare by aiding workforce functioning. Introduction of universal job roles across similar providers in the sector will aid workers to provide equivalent care regardless of their location and reduce barriers to providing care that arise from misunderstandings of job roles and responsibilities or other operational procedures. Multiple respondents described variations in workplace practices between different service providers – even those of the same nature – as a cause of high levels of stress and confusion, ultimately hindering their ability to provide timely care to service users as well as being detrimental to

		workplace relations. Many employees in the health and disability sector receive significant levels of on-the-job training for their positions, leading to high variability in training quality and outcomes as it depends on the knowledge of the trainer. This variability could be reduced by introduction of standardisation of positions.
Relationships and Workplace Dynamics	• That workers are enabled to democratically participate in workplace and decision-making processes. • That a commitment be made to improving workplace culture and relationships. • That an emphasis be placed on improving engagement and communication between management and staff, and that support and cooperation in the workplace be promoted as vital to a healthy workforce. • That High Performance/High Engagement (HPHE) be introduced as an opportunity to improve systems and processes and devolve decision making so that it can be more responsive to patient/person centred care.	Effective organisational leadership is vital for a healthy workforce. It is important that organisations have in place structures to support both decision-makers and those affected by the decisions. In addition, obtaining organisation-wide buy-in through engagement between management and staff is at the heart of developing a healthy environment. Relationships between staff and management are critical, with many employees citing management-staff dynamics as implicit in decisions to remain or depart a workplace. Survey respondents also regularly emphasised the benefits of feeling valued and recognised by their employers and management through active and democratic participation in the workplace.
Funding	• That one national health and disability strategy be delivered through a national funding framework that includes capacity for regional responsiveness. There are currently many different pricing models operating within disability, the health of older people and mental health. • That health and disability sector funding be significantly increased to decrease barriers to achieve positive health outcomes and to reduce inequalities. • That future funding models be designed to be more adaptable to change, such as in response to changing service demands.	It has been well established that effective investment approaches require more than re-prioritisation of funding allocations, but an increase in total funding. A large proportion of respondents outlined funding limitations as a large barrier to providing high quality healthcare, urging increased funding to improve the access to and/or quality of equipment, resources, staff levels, and equality of care. Introduction of consistency in pricing models would ensure equity of access and outcomes. Current funding approaches in New Zealand has yielded what is referred to as “postcode healthcare”, in which the point where a service user enters the health system is an influence on the outcome of their care. Funding needs to be adjusted into a model that does not allow the location of your

		treatment to affect the quality of care you receive.
Cultural Sensitivity	• That a commitment be made to increase representation of Maori and Pacific peoples employed in the health and disability sector across all occupational categories. • That principles of the Treaty of Waitangi such as partnership, participation, and protection be promoted to achieve collaborative service delivery. • That a culturally sensitive framework for the health and disability sector be developed and implemented, including improved cultural education for service providers. • That the health and disability sector evolve beyond an exclusively Westernised system, removing barriers to providing patient-centred care for non-Western patients or service users • That a commitment be made toward achieving a workforce that more accurately reflects the changing ethnic composition of the NZ population.	Improved cultural education will allow for improved cultural sensitivity, improving access leading to a reduction in inequalities in health outcomes and improved environments for service users and providers. Many areas of the current health workforce in NZ do not reflect the changing ethnic composition of the New Zealand population. Further strategies are required to increase the proportion of Māori and Pacific students enrolling in and completing health and disability related programmes. The changing demographic profile of New Zealand is also driving changes to the health workforce, with an increasing demand for a workforce that is culturally appropriate and knowledgeable, and able to deliver services to diverse communities.
Education *(Training & Ongoing Development)*	• That a national framework be developed to identify issues and gaps in health and disability workforce education. • That the role of DHBs and health managers as educators be strengthened. • That mechanisms be introduced to allow for ongoing training and professional development, equipping all health practitioners with knowledge and skills to respond to the constantly changing environment.	Respondents regularly indicated a desire to be able to access ongoing training and development, as well as identifying areas for improvement in standard health qualifications. The outcomes of improved education are immense, as employees who have received job-specific training are typically more productive and confident. The need for ongoing education is also significant for a variety of health practitioners to stay current regarding constantly changing aspects of health practices. It is crucial that training not be limited to new employees, and that all practitioners be provided with access to ongoing training opportunities.

Disabilities	• That a commitment be made to adequately meet the needs of those with disabilities and the workers providing their services. • That the health and disability sector develops solutions in tripartite for a health and disability system that respects the rights of disabled people and the workers who provide their services. • That current contractual funding arrangements are transformed to ensure strategic and sustainable workforce planning in the disability sector	Utilising the voice of those with diverse needs will offer the opportunity to develop models for providing support and care for disabled people based on what the service user needs, rather than what an alternative body perceives as a requirement. In line with this, specialised training to work with disabled people should be incorporated into the mainstream with the trainers themselves being disabled or experienced with disability services.

Introduction

The PSA welcomes the New Zealand Health and Disability System Review (hereafter: Review) designed to future-proof our health and disability services. We understand that the focus of this Review is to ensure recommendations will improve the equity of outcomes. Recommendations will also have to address technological, demographic, workforce and other challenges that will confront the system over the coming years.

The New Zealand Health System Review undertaken by the World Health Organisation (WHO) in 2014, as well as several other recent OECD reports and overviews, agree on the **challenges** posed by an ageing population, health inequities and the growing burden of non-communicable and chronic diseases including mental health. Like many other developed countries NZ needs to consider how to ensure

- high quality care and support for an ageing population with different expectations to services than the previous generation
- equal outcomes for all regardless of their socio-economic status, ethnicity or disability
- reduction of inequalities to consolidate access to health care services
- managing non-communicable diseases and chronic conditions such as obesity, cancer and mental health conditions
- affordable and timely access to services
- administrative efficiency shown via the availability of doctors, medical records and test results
- a preventive, safe, coordinated, engaged and human-centred care process
- greater integration and coordination of services within and between primary and secondary care and inter-sectorality with other social services, i.e. provision of a continuum of care
- workforce planning and training
- consistency of pricing models
- valuation of health, care and support workers reflected in their pay and overall working conditions

Opportunities to improve the performance, structure, and sustainability of the system with a goal of achieving equity of outcomes must respond to the above challenges. In our submission we will address a selection of those challenges. Please note that the system delivering services for mental health is excluded from this submission. The PSA actively participated in the **Mental Health and Addiction Inquiry**. We made a substantial submission outlining ten areas for action and 26 recommendations. A summary of our recommendations is attached in Annex 2.

Having said this it is crucial to consider all health-related reviews and inquiries and interlink actions to achieve a transformative system which yields more equal outcomes for all. **Policy coherence** is key. As one of our members puts it 'better housing, better family support, resilience training as a young person, (…) less access to drugs and alcohol and gang contacts' are just some of the concrete policy areas which need to be integral to a strategy for a better health and disability system. **Gender** plays a crucial role in health, care and support services. Especially in care and support services where work is often undervalued. The vast amount of paid and unpaid care and support work is still undertaken by women

and therefore unequally distributed. Women in unpaid care and support work cannot equally participate in the labour market and are therefore disadvantaged in terms of pay and career paths opportunities. If we want to achieve a system that delivers a high road to healthcare and support services, the creation of decent work and long-term workforce planning are essential. To achieve this the Review panel needs to consider, promote and invest in active labour market policies, health policies, social policies, education policies, migration policies, and macroeconomic policies. The International Labour Organisation (ILO) recommends the 5R Framework (especially regarding care and support work):

1. **Recognise** unpaid care work
2. **Reduce** unpaid care work
3. **Redistribute** unpaid care work
4. **Reward** care workers through more and decent work
5. **Representation** and collective bargaining for care workers

As a concrete policy measure the ILO recommends the implementation of gender-responsive and publicly funded leave policies for all women and men. Above all the ILO highlights the importance of universal access to quality care services.

A brief assessment of our current system

The following will outline an assessment based on the PSA's experience working in and with the health and disability system over many years.

The strengths of our health and disability system

Our system in NZ is characterised by being a **universal system** which is largely public. People living in NZ have universal access to healthcare. The public system doesn't take one's income into consideration when designing, allocating or prioritising services. Our public system is carried by a **highly skilled workforce** providing **high-quality services**. These workers care! They are highly committed and motivated to deliver human-centred and needs-oriented services to those who are in need. Our system allows for innovative thinking. For examples, we have created mobile services for rural areas to ensure services are delivered to where people live and require support. We also established integrated community health hubs which are closer to people's homes and less medicalised environments.

The weaknesses of our health and disability system

Underneath the overall framework of a universally accessible system with a workforce that is skilled and dedicated, there are weaknesses that challenge the very fundaments of the systems.
Inconsistent funding of DHBs based on population rather than on the *needs* of that population are a problem to deliver responsive and effective services. Inadequate funding arrangements such as the funder-provider split and contracting out services to for-profit organisations undermine universal access, the well-trained and motivated workforce and the delivery of high-quality services. The result of **rivalry**

and competition is often a winner-loser scenario. The winner is awarded a new contract or increases the organisation's profit; the loser is the health workforce and the health of the overall population.

Workers are burdened with increased work demands (diminishing their health), inappropriate pay, insufficient training, limited representation or participation in decision-making. Work arrangements become increasingly diversified and unable to protect workers adequately who work as contractors, labour hire workers or casual pool workers. Especially in home support, the workforce is increasingly atomised or individualised leading to a decrease of information sharing, cooperation, safety and effective participation in decision making. This leads to ineffective solutions without hearing those who experience and have to deal with challenges on a daily basis.

Patients or service users experience long waiting times and once they are in, stretched staff are looking after them impacting their ability to deliver the highest quality services possible. The problem of allowing competition and profit making in health gambles with people's universal access to high quality services. The problem of a competitive health market is often turned on its head by naming the workforce as a problem (and not as an asset as highlighted above). Because short-term profit making is the focus of many organisations, long-term planning on how to attract, maintain and sustain a skilled and dedicated workforce is de-prioritised. Our system is also not sufficiently Treaty based and fails people with higher needs.

The principle and attitude of competition rather than cooperation results in a non-collaborative culture and climate at work which needs urgent attention. This core weakness needs to be addressed as a **systemic issue** and not as a specific issue of some DHBs or providers.

Opportunities the review presents to change our health and disability system for the better

Following on from the weaknesses outlined above, this review creates an opportunity to design a **fully public system** without for profit services (including primary care). A **fully public system** needs to be based on cooperation and must value a highly skilled and protected workforce to deliver optimal services to every New Zealander when they need them. In line with considering making our system fully public there is also an opportunity to re-assess the **funding processes and arrangements**.

In relation to the **workforce** there is an opportunity to think about how the system can enable workers to truly and meaningfully participate. Workers know which solutions are best suited to fix issues at the frontline. They know how to be more patient-centred and needs-oriented. They know how to provide culturally sensitive services. They know how to improve the culture and climate at work. They know how to maintain and sustain a well-trained workforce. They know how to flexibly adapt to new developmebnThey know how to better cooperate. They know how to achieve better outcomes for patients or service users. And so the list of reasons could continue for higher engagement with the workforce. It has also been shown in numerous studies that high engagement leads to increased productivity and efficiency, as well as better health and well-being of the workforce. There is a real opportunity to replace hierarchical and siloed decision making through high performance high engagement principles and approaches.
The Review also offers an opportunity to improve **health literacy** among the public and with it the chance to increase awareness and access to preventative services. Health literacy enables the public to

find, interpret and use information and health services to make effective decisions in relation to the person's health and wellbeing. It includes effective communication between the healthcare worker and the patient. This is strongly related to communicating in a **culturally sensitive way,** on which our members shared a lot of insight (see below).

Risks that might arise in the review process and with the design of a new system

The world of work and especially the **world of health, care and support work** is continuing to change as we speak. Technological change - including automation of some services and digitalisation of others – and its impact still needs to be fully understood, as it will most likely mean substantial changes for the workforce and the services it delivers. Some of those changes will be welcomed, while others pose a significant risk if not well managed. The **atomisation of sections of the health and disability workforce** seriously undermines our future ability as a country to undertake workforce planning and development. The development of non-standard work (e.g. labour hire and contracted work) produces distortions across the workforce. The workforce is split and polarised through the development of low paid, minimally trained, atomised workers versus specialised, highly influential workers. This is contrary to developing a stable well-trained workforce. A well-known example can be seen in platforms that match a customer (or patient) with a service (or health care worker). We observe this especially in disability and support services. It is seen as a valuable mechanism to increase choice and control for disabled people because they have access to flexible services. Yet, it poses challenges to ensuring a well-trained, protected workforce that delivers high-quality and safe services. As mentioned earlier, this is tightly related to the diversification of forms of work and demands reflection and action on how to ensure that workers are trained, protected and have access to collective representation regardless of their work status (i.e. being an employee, a contractor or a labour hire worker).

In addition to these changes, **community services** will remain critical to the delivery of services in NZ. A lot of those services are undertaken by private providers, and to avoid increased privatisation (due to the reasons provided above) we need to find solutions to ensure high-quality community services within a public system. High-quality service delivery to people in need should be the motivator and driver and not the possibility to make profit from people's illness. Community delivery of services should be based on responsiveness to community needs and not the amount of cost.

You asked, we answered

To answer the questions posed by the Review panel we surveyed our members and summarised the answers below.

Methodology

A set of recommendations was prepared based on data collected through a survey of PSA members working in health and disability services. We also surveyed our members in the Deaf and Disabled Network. The survey offered members the chance to provide their input as a frontline worker in the

health and disability sector. The survey was composed of six qualitative questions. We received a total of 805 responses.

Responses were categorised based on common themes in the content of the answer and assigned codes based on these themes. Coded responses were then grouped and further analysed.

Values for our future public health and disability system

As the union for workers in public and community services we strongly uphold the value of solidarity, realising social justice, acting with integrity and respect, developing concrete solutions to improving working conditions and to encourage democratic participation. Our members carry these values into the workplace every day and treat people accordingly. Unfortunately, there are barriers in the current system that impact negatively on our members to act with full integrity. A system which is built -among others- on the values above will deliver fairer and better access, services and outcomes for the public.

The PSA strongly supports the intended outcomes of equal access, equity of outcomes through quality services delivered by a well-trained, stable, highly valued, culturally sensitive workforce.

How would the best health and disability system for New Zealand look in 2030 and how would it differ from today?

To answer how the best health and disability system for NZ could look like in ten years, we asked our members what conditions in their day to day work within the current system would best enable them to provide high quality services. We also asked our members what changes in their work would contribute to better access and fair outcomes for service users. Some themes came through very strongly which are outlined below.

Our members made a strong call for **adequate staffing levels,** which goes hand in hand with reduced workload and time pressure. Members regularly mentioned that they cannot take their meal and rest breaks which is a worry not only for their health and safety but also for the health and safety of the patients or service users. Our members highlighted the following:

- *'We need more staff in Allied Health, we are chronically understaffed.'*
- *'We continue to do statistics which indicate our workload is unsafe yet nothing is done about it.'*
- *"If there were better staffing levels, us as clinicians would not be so restricted by time when meeting with clients face to face, and this would mean we could develop a better more personal rapport with people, rather than feeling you need to get down to business quickly as your time is so limited."*
- *'Adequate staffing levels and a higher value being placed on administration work would help a lot! Currently we are looked at as an easy target for saving money because we are viewed as providing a 'non-essential' service, but nothing could be further from the truth - try performing an urgent surgery if no one has booked it for you.'*

A further need was identified for improved **workplace conditions** in relation to the **environment** people work in (e.g. cleanliness, noise, air conditioning etc.) and their work spaces (e.g. sitting at desk). Related to improved workplace conditions was the need for adequate resourcing in terms of having access to **equipment** and technology (such as computer programmes) where it is required. Further to having

access to the right equipment was the often expressed need to have improved access to **information** through better sharing and organisation of patient records and notes. Our members said the following:

- *'We need management that communicates with all staff regularly and to have other staff communicate with each other regularly.'*
- *'We need better communication with other external agencies working with the same clients.'*
- *'Currently we are made to use several computer programs which are not suitable for our needs. There is much time wasted and frustration on the part of the user. Even the letters we print out to send to GP's and other clinicians print out with irregular characters and at times part of the text of the letter will appear in the letter head randomly. This is totally unacceptable. '*
- *'We need faster IT systems development and less paperwork'*
- *'I need a software where I can access all information instead of having to look through multiple softwares to find the information I require.'*

The need for improved relationships at work, be it between managers and frontline staff or between occupations, was mentioned as an essential requirement to increase the functioning of the system. This points towards the need for a **culture change** towards true support, valuation and cooperation of everyone's work. Consequently, staff are engaged and eager to participate.

To ensure the right and appropriate number of staff are employed now and in the future, our members highlighted the importance of **staff retention**. For example, members highlighted managing the difficulty between time pressure and patient care due to a lack of staff and high turnover:

- *'It would be good if clinical staff didn't view patients or service users/service users as an actual burden which needs to be shook off - patients or service users being forced out of the hospital when they could use a day or two more is frankly counterproductive and potentially dangerous.'*
- *'It is really hard to give best quality care when you have high pressure to see patients or service users in a short space of time.'*
- *'Stable staffing with sufficient casual cover when staff on leave and easily accessible funding for professional development and training will hugely contribute to work satisfaction and retention (avoiding wasting time & resources recruiting, orientation, & training & then repeating again i.e. negative cycle)'*

Low pay, low recognition and poor working conditions are strongly attributed to low staff retention and high turnover, which in turn create unnecessary inefficiencies. In fact, **poor pay and working conditions** arguably influence all the above-mentioned points. High turnover makes it difficult to ensure adequate staffing, and it increases workload and time pressures due to training needs of new staff. If not trained fully, new staff will find it difficult to share and organise information in a standardised way creating not just inefficiencies. Potentially services are provided that are not useful or may even be harmful to the patient or service user. Support and cooperation are challenged through high turnover as relationships need to be re-build. Stress and uncertainties make it more challenging to build such relationships due to a lack of time and work demands and not knowing if the person is staying for long. This creates issues for management trying to manage an unsustainable situation. Insufficient communication on their behalf can contribute to a low morale which increases the already severe and wide-reaching impacts of high turnover due to poor pay and working conditions.

In summary, a better health and disability system would be built on good pay and working conditions. In ten years, our health and disability system would be characterised by maintaining, attracting and retaining a highly qualified staff in adequate numbers, who are valued and recognised by the public *and*

their pay. Good working conditions for our staff in our future health and disability system would contribute to the desired culture change in our public and community services. Mutual support, valuation, cooperation and high engagement would become the norm in our workplaces.

Necessary changes which make our health and disability system fairer and more equal for everyone (including Māori and Pacific people)

To answer which necessary changes can make our health and disability system fairer and more equal for everyone especially for Māori and Pacific people we asked our members what it meant to them to provide culturally responsive and inclusive services. Again, some themes came through very strongly which are outlined below.

Our members underlined that **cultural support** for staff is key to providing the best possible services and therefore treating Māori and Pacific people -once they are in the system- fairly and equally. One member highlighted aptly that '*having access to cultural support services (meant) to ensure cultural needs are taken into consideration and met - listening to patients or service users values and meaningful goals to ensure that care is patient focused and relevant to individualised care - ensuring family members and social support networks are included in decision making and rehab sessions.'*

To provide good cultural support, **cultural education** is a pre-condition. Many members expressed a need for more cultural education (both during training and as part of ongoing development). Those already equipped with wider cultural knowledge linked it with improved cultural responsiveness. The idea of cultural support and education triggered a lot of comment among our members:

- *'To me it means doing the best to understand and use cultural processes that makes service users feel that the service provided is culturally inclusive. To collaborate with service users in getting a better understanding what cultural inclusive would mean to them.'*
- *'What we need is more learning about diversity and specific cultural experience of clients, and increased access to cultural supports.'*
- *'Be aware of client needs under the obligations to the Treaty of Waitangi for Maori and any other requirements for any other ethnic group.'*
- *'We need services that address people's needs in a holistic way and respond to the person within their cultural and social setting, recognising that people's cultural needs vary and accepting that people choose to live in different ways.'*
- *'Personally, my intermediate knowledge of Te Reo Maori and good grasp of geographical iwi localities allows me to use correct pronunciation with names and to identify places of origin.'*
- *'To be adequately educated and skilled in being culturally aware. To know what the barriers are and put things in place to bridge the gap.'*
- *'Better education and the ability to create spaces that can incorporate inclusive services.'*
- *'To have a good understanding of what cultural world-views might be relevant for different patient groups, so that we can be more prepared and specific in identifying barriers and supportive actions for individuals in that group. Being proactive in appreciating and welcoming people (staff and service users) who are different from us as individual in that workforce.'*

Our members felt it was required to integrate a truly **multi-cultural perspective** into the health and disability system. They suggested that our health and disability system should not be designed exclusively (and rigidly) around Western ideals, values and practices for health. This led members to

elaborate on being enabled to deliver patient centred and needs- oriented services that include the family and respect the diversity in needs. Our members underlined that an exclusively Westernised system poses a barrier to providing patient-centred care for non-Western patients or service users. For them the lack of perspectives and options demonstrate ignorance towards diverse needs, which can in turn act as a barrier to accessing health care. Exclusively Western systems can also stigmatise non-Western approaches, so that even when alternative options are available, they are considered of less value and effectiveness compared to Western approaches (e.g. the inclusion of the family in the healthcare journey).

- *'End of life cares need correct procedure for the ethnic group.'*
- *'Actually, accepting and incorporating appropriate and inclusive services. We all get some training and there is some support but when it comes to practice many find requests for blessing of a bed space 'funny' requests. If you don't follow the majority on the floor you are looked at as the 'weird' one. I want my workspace to have no 'normal' label. A transgender person has the right to be addressed the way they wish without staff having discussion about it at nursing station.'*
- *'That people of varying cultures are respected and supported in a timely manner. That the treatment is tangata whai ora and whanau inclusive. That people are asked what they need and how this can be met in a cultural friendly and appropriate manner. Cultural practices and rituals are encouraged and supported, and health services listen to tangata whai ora and their whanau.'*
- *'To have knowledge of all cultures of people we come across, building on the bi-cultural foundation of TOW. When coming across a new/novel cultural group I may not have worked with before having available some organisation or group appropriate to the culture who can provide some base level training to improve'*

In summary, it is evident that our health and disability system like other systems does not reflect the composition of our population in NZ. It would be highly desirable to have a system in place which encourages and employs people of different cultures and backgrounds. This relates to education and training as well as workforce planning. As staff diversity still needs to be improved, our members focussed on what is needed to be more culturally sensitive as the system currently is not sufficiently addressing cultural diversity. The lack of diversity visible through staff, ideals, values, practices or approaches is a barrier for too many patients or service users to access the system. If we want a fairer and more equal health and disability system, we need to improve staff diversity and cultural sensitivity.

Necessary changes to enable disabled people to have equal opportunities to achieve their goals and the life they want

Any changes in our health and disability system to enable disabled people to have equal opportunities to achieve their goals and the life they want need to be based on the **UN Convention on the Rights of Persons with Disabilities (CRPD),** which was ratified by New Zealand in 2008. In fact, the CRPD serves as a guidepost for a coherent policy approach to a life a disabled person wants.

The CRPD underlines that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms- including the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability (Article 25). The CRPD also assures the right to work and employment (Article 27) which is an integral part for the person's inclusion into society and the resulting health and well-being effects.

The PSA supports the **Enabling Good Lives (EGL)** vision and principles. The goals of creating a person-centred system that enhances the self-determination of disabled people are in line with long-standing union values like social justice, solidarity, equality and non-discrimination.
However, decades-long **underfunding** of the disability sector has put a variety of pressures on the sector (see Deloitte report for more information). It has fostered a sense of competition between the interests of disabled people, workers and providers. This sense of **competition** hindered and hinders cooperation, collaboration and genuine co-design processes. The PSA supports change that stops this vicious circle to make genuine transformation a reality. This means concretely that changes to the disability system must:

- produce greater choice and control for disabled people and their whanau;
- respect the rights of all people and maintain and enhance the working conditions and security of support workers;
- support providers in working differently

Realising one without the other wouldn't be desirable nor sustainable. We recommend engaging all three parties to **design solutions that respect disabled people's rights, workers' rights and providers**. Decent lives and decent work for disabled people is rooted in enhancing flexibility which requires elemental structural changes to make the system work for people. Having access to flexible choices means and results in:

- being able to make decisions on a daily basis like a non-disabled person
- being able to access the same opportunities as everyone else (e.g. education, work, housing, social and cultural inclusion etc.)
- stopping deprivation, isolation and exclusion in all spheres of life

Enhanced flexibility is not limited to choosing support workers. In fact, concentrating only on flexibility of support work does not realise the EGL objectives. The PSA believes that a decent life and decent work for people working with disabled people is rooted in sustaining and enhancing their working conditions. **Good working conditions** are the fundamental basis for delivering the high-quality and respectful services disabled people deserve. Good working conditions mean:

- The full realisation of Care and Support Workers Equal Pay Settlement, the Sleep-over Settlement and the In-Between Travel Settlement (decent pay)
- Job security and security of hours
- Health and safety at work
- Ongoing learning and training opportunities
- The opportunity to join a union, bargain collectively and participate in decision making which impacts on to worker's ability to perform work
- The opportunity to experience new things as disabled people live their good lives

Due to increasing complexities with service users (dual disability related to e.g. a person's mental health and an intellectual disability) and aging service users and related medical issues need to be recognised. These developments put increasing pressure on support workers. Therefore, additional targeted **training** is vital and needs to become an integral component of any health system that is supposed to deliver good outcomes. We also need a **culture change** that truly values workers and their services. And we need to stop or substantially change current **contractual funding arrangements** which are the biggest barrier to any workforce strategy including the realisation of good working conditions.

The realisation of these working conditions is challenged by a **diversification of work arrangements,** such as engaging people on a contract instead of employing them (as mentioned above). Contracting and platform work challenge the employment relationship and undermine the above outlined settlements and workers' rights**.** Working in people's homes also challenges the idea of collective worker participation and engagement. Consequently, workable solutions by frontline staff are not discussed and aren't considered to improve services for disabled people. **Platforms** which match workers with disabled people are becoming more common. Keeping an overview of an increasingly individualised system will be extremely difficult. This in turn impacts on overseeing funding arrangements, workforce planning and ensuring high-quality services delivered under safe conditions by trained professionals.

In summary, changes designed jointly by disabled people, unions and providers to enhance access to flexible choices, enhanced working conditions and greater participation for workers in public and community services are key to improving our health and disability system to enable disabled people to have equal opportunities to achieve their goals and the life they want. This needs to be supported by a transformed culture in the sector and changes in (contracted) funding arrangements.

Thank you very much for the opportunity to be heard.
We would like to be actively involved in the ongoing process of the Review.

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Resources

ILO (2018), Care work and care jobs for the future of decent work, available at: https://www.ilo.org/global/publications/books/WCMS_633135/lang--en/index.htm

Eurofound (2019), Working conditions and workers' health, available at: https://www.ilo.org/global/publications/books/WCMS_633135/lang--en/index.htm

OECD (2018), Mental Health and Work: New Zealand, available at: http://www.oecd.org/els/mental-health-and-work-new-zealand-9789264307315-en.htm

WHO (2014), NZ health system review, available at http://www.searo.who.int/entity/asia_pacific_observatory/publications/hits/hit_new_zealand/en/

Deloitte (2018), NZ Disability Support Network- Funding and Financial Analysis: NZ Disability Support Providers, available at: https://www.nzdsn.org.nz/funding-and-financial-analysis-new-zealand-disability-support-providers-deloitte-report-23-november-2018/

Annex 1

We asked our members to '**Please complete the following sentence:**
''If I could make one suggestion to enable the health system to function better, it would be…''. We are including a selection of the answers we received below.

Table 2: Quotes from PSA members on the most important thing that would make our health system function better.

Less bureaucracy, more ability to treat people - I have a health limiting issue which the DHB won't assist with because I don't fit the criteria and yet it's making me very ill. I have to pay for an operation myself because they won't think outside the square.
We need to review the last 40 years examine the policies that have allowed the Heath Services to be overwhelmed by the demand. I know this may seem difficult to write but .... we need to exclude all recent migrants (unless refugees) for the first 10 years from free Public Health care. Exclude all those with 2-year work Visa's getting free health Care. All Students Visa's require the person to have Private Medical Insurance, so why not extend it to include the afore mentioned groups. Health Funding is not keeping up with demands for health services. The pressure on resources grows with and aging population. Look at Australia for a better funding model for Health Services - Medicare.
Respect administrators in their field and understand that it is a speciality too. We are proud of ourselves and what we do to glue it all together to achieve patient outcomes and good results as part of the team. Management have a lot of meetings but is anything getting solved? Does you manager know what you actually do?
Hire management that are not weak in character and that lead their peers and staff into a united workforce. This would give our staff more confidence when working with patients or service users. This also applies when adhering to policies and procedures. Too many are in place that are not followed.
If all DHB's and health providers worked within the same systems. More time/funding/space for acute services so electives aren't always pushed back resulting in them turning into urgent. Early intervention. Patients or service users need to become too unwell before they are even considered for sufficient treatment. More GP services available and for reduced costs so more people would use them which then could relieve some of the pressure on already pushed hospitals.
I strongly feel that it should be the employers/ manager's responsibility to educate other team members/ organisation about the employee's disabilities after the induction in a respectful, caring and inclusive way so that one does not have to keep repeating time and again. it can be exhausting
Funding that is appropriate for the level of need - DIRECTED to the places that require it and not to manages who do not understand the roles they are managing. It is great that the bowel screening has been put in place but without extra funding to treat the cancer that is found there was not a lot of point in rolling it out. It has caused frustrations for extra-long delays for cancer and non-cancer patients or service users alike.

To concentrate the health money allocated to the care of patients or service users and cut the many layers of management - they are a waste of health dollars. We currently have a Business Manager who is creating clinics - she has no idea how we use the clinics and we have to go behind her and correct what she has done. She is probably earning double what I earn! The clinics have in the past been organised by the poorly paid Reception staff
From where I stand - we need to have much better computer programs for patient data, typing (Soprano) and theatre programs. I don't know whether we have a very cheap version of everything but none of the above programs works well - consequently we have IPM theatres which does not work with our old version of IMP patient data. Things just do not work and no-one is taking responsibility to make things work. Very frustrating!
Support the development of community health services, they are not 'add-ons" they are integral to keeping people out of hospital and allowing them to flourish.
To resource it better with the right people for the right job who can make the right and informed decisions - who actually know about the health system; and resource it better with funding.
Sort out the funding issues for people's discharge destinations or support needs. At the moment, we have several different funding pools (ACC, Access Ability, Long Term Chronic Health Conditions, Older Person's Health, Mental Health) If someone falls under more than one category it becomes incredibly difficult to plan for discharge as there are arguments between funders about who is responsible. Inevitably delays discharge.
Have more checking systems. i.e. I personally have been referred within the hospital system (not by my GP) a few times and on two occasions the referral was never done. I followed this up and had a halter monitor done but it was never reported on. I was told that I was going to be referred as a Priority One for another service and that was in July last year - still waiting, obviously the referral hasn't been done. If they had someone checking the clinic letters to ensure these things were underway they would have been caught early.
Change the system so we're all working as part of one system, rather than many different organisations working in the own system and not being able to treat patients or service users in a smooth and coordinated way. Improve communication between organisations and with patients or service users. Share data and information better to better inform the development of services, and more direction from the ministry about what could be done.
Having a 'one stop shop' for consumers to use, then directed where their needs might be best met. Too much confusion, multiple Agencies & people give up trying to access as all too hard. - Govt needs to be honest about what it can fund & what it can't. If minor surgeries not able to be done, tell people don't leave them on a waiting list 'in hope' Making medical insurance tax deductible would be a good. Start for those who can take this up.
1. Disestablishing residential care services and creating Emergency respite services helping to reduce deinstitutionalization. - - 2. Ensuring that services that use kaupapa Maori Values can evidence this and are accountable to these values and their correct use, including expertise at the ground level. - - 3. Regulating the work force and introducing an expectation that all Support Workers register to a professional body ensuring that all people that work with those with a experience of Mental illness and or disability including dual diagnosis meet the criteria of a code of ethics that the as individuals are accountable too.

Create regional health models to engage with the whanau, hapu, Iwi and various other diversities of the area. - Research tells us that Maori and Pacifika rate high in all the bad statistics, so programmes designed by Maori and Pcsifika, for Maori and Pacifika WITH Maori and Pacifika need to be considered in this space. There also needs to be more of a push to enable a sustainable Maori and Pasifika workforce.
Look after your staff in all department; Drs, Allied, Cleaners - all others are looked so well; why not admin; why can't each and every ADHB staff have free meal, coffee; good car park; good incentives, good wages; good hours;
Two things - firstly, each person working within the health system should acknowledge accountability of their own actions, reflect, learn and move on. Secondly there is no place for ego in healthcare.
Clear pathways of ACCOUNTABILITY - currently the service reports to Senior Leadership team who then reports to the Executive leadership team ... which the seems to use the SLT as deniability scapegoat. For example, when Funder/Ministry asks 'why didn't you see this problem coming?' the ELT blames the SLT for not keeping them informed, then SLT demands more metrics from the service which is a diversion of attention away from actually fixing the problem. You can't make people listen if they don't want to unless they are made to be accountable. - This problem was foreseen 2 years ago by the service but the SLT didn't want to listen. - The Real Question is 'why didn't the executive leadership review regularly their own 10-year old Strategic plan which also identified the problem happening at this time?'
More money. With more money you can hire more medical professionals and reduce waitlists, you can get better equipment and have better trained staff which reduces incidents of misdiagnosis, you can provide better support systems to vulnerable clients...it all comes back to the funding, You can probably make minor improvements without throwing more money at the issue but big improvements will require more funding.
We have to make the healthcare professions appealing to today's high school students, because we need them to become the GPs, nurses, physiotherapists, speech language therapists, social workers, etc. who will keep the healthcare system functioning in the coming decades.
Increase the system capability to improve health care quality and achieve equity by adopting strong system approaches, increase integration and reduce the number of DHBs so that they can be released from artificial boundaries that inhibit collaboration and integration, which modern health care systems need to do to improve quality of care.
To employ enough people to keep up with the caseloads, more office space and more Case managers and support workers. Sorry two suggestions: More room at the Hospital Mental Health Wards (Wgtn and Hutt), as people are getting shuffled around or sent home to make room for recent admissions.
We have a diverse community - with a diverse range of careers is it not feasible that in my cases, where ever possible that same cultures are with their same people. - Where a better understanding of what is sensitive and what is not. - I do understand that this may not be the case in some areas.
Remove the business for profit model in Health and Disability Services. Fair remuneration for employees is one thing, maximising returns for shareholders should not be part of the system. Public health systems should be just that, public. Remove duplicated management functions by combining DHB's and force a standardisation of medical IT systems. Duplication at this level uses resources that could be better used elsewhere.

Getting Patients or service users seen more quickly through the Out patients or service users department. Where someone needs MRI, or other scans that these are done before the patient gets an appointment with a Specialist. That all departments communicate with one another so that Patients or service users are not getting 2 appointments on the same day and time.
Focus on preventative health and early intervention. - Otherwise it is the vase social structures that contribute to health members of society - housing, stability, income, purpose, self-determination, whanau, social connectedness. Then education and health systems to respond to all
That all the DHBs in NZ, and GP services have access to all patient files. Perhaps, seeing all service use the same programs could help, or maybe all services use Clinical Portal which holds all information about each and every patient up n down NZ
To have better morale in this place. It is obviously 'us' and 'them' mentality. We feel very undervalued in our roles. The work seems thankless and we do such a good job but only have communication by those above us when we have made a mistake!
To improve communication between the various services so everyone is moving in the same direction and working towards the same objectives and goals. To remain client centred and focused and to work to that 'high standard'.
Have independent investigators come and take an inside look at every department asking the ground working staff, not management how to make the service more efficient. Gather the feedback without identifying the employee to management or other colleagues as we all know workplace bullying is rampant in Health. Take a serious look at statistics of employees who produce the best results within each service that are measurable / monitored through QM (nationwide) and ask those individuals how to make the service more efficient.
For the DHB and the GP's to use one database for patients or service users therefore enabling services to know what is being provided and where the gaps are. Also linking in the Justice and Work & Income Departments, for just 2 of the many other Depts.
Allow health professionals to do the job in hand and not have so much bureaucracy. There are so many positions above the staff that are on the floor looking after the clients. These people above are only putting paper work/policies in the way of actual care to maintain health. - Example: Manager, Team Leader, PA's., CNS, CL Psychologist, OT, RN'S, EN's, Support Workers, CLIENTS. Then above that we have MANAGEMENT - which has many tiers - Is there any funding for the needs of clients left??? -
Assisting families that care for their family members by financial assisting either by encouraging them or to get employed by a provider in the industry to do the cares for their family members without being prejudiced against. Of course, they have to go through all the normal employment procedures and training. A lot of families are already doing this but struggle financially. Admittedly there are some families that would take advantage of this however there are a lot of care givers that do this also.
Funding at the ministry/NASC level that actually meets needs - because organisations are already adapting and learning well at the grassroots but aren't funded properly so can only affect so much positive change.

Community health is not an institution like a hospital. Support workers are on their own in peoples' homes they have to make all the calls e.g. if they need to call an ambulance. They need level 4 dementia training to counter abuse and palliative care training to be more sensitive to people's need when they are dying. People are not born with empathy they have to learn it. Over and above manual handling, medication oversight and infections control training all NZQA NMIT training, in-house training is not up to standard. Support workers are not treated with dignity and respect. The healthcare companies' admin needs to be surveyed and get client feedback on the admin. Currently admin rides along on the support workers good name.
The population is both growing in number and increasing in size. More and more bariatric people are being admitted to hospital. These people NEED specialist equipment to shorten their length of stay in hospital. The Waikato DHB is not interested in being pro-active in obtaining this essential equipment despite formal representation by degreed health professionals. - The one thing that really matters is the government investing a lot more money in procuring both support services and equipment via the health service and Ministry of Health for patients or service users of all sizes in both acute hospitals and community settings.
Although our new Labour Government is now taking up the mess left by National Government and its failures to recognise the health of the Community by their cutbacks and running down of the Health system it will take time to fix. - But the recognition is Health is the forefront of keeping people and our Tamariki well which leads to better productivity and wellness for all.
If we had one database that includes a messaging tool between all primary and hospital services for patient care, it would be easier to keep track of patient history and an easier way to track referral paths thus making it easier to work more collaboratively. Also, to include councils, ministry of education, local organisations more so in community health projects getting a better understanding, input and not double handling of projects being designed.
Stop treating Carers as only deserving a low wage, not-very-intelligent people who are only there to make money for the higher management. If it was not for the carers there would not be a company. - Listen to the Carers; pay them a respectable wage; treat them as intelligent, caring individuals instead of exploiting them. - (I would strongly suggest that all Management personnel spend at least a week (more for senior management) helping with the daily cares of two or three of the company's clients. If nothing else, it would give them greater respect for the carers who do this every day and can still smile!
Standardized documentation across the country, this is a small country in terms of population so can be done. policies and Procedures should also be standardized. This ensures the continuation of care across the country and this should also set the bench mark for quality of care offered. Currently nurses are phoning the 'last' care providers in order to get basic information, like med. regimens, contact information etc. when clients move and are transferred to another care provider. All time wasted.
For complex situations, give staff time to work out the best possible opportunities. Take the pressure off and stop the blame game
To have a specific service for people who are homeless. A base in each district perhaps like a day room for ?? O.T. and the like. Provide a meal prepared by the client. Education i.e. budgeting
Listen to what the clients want and need most. Assessors often have little or no background info when they go out to meet clients. Also, for the coordinators to have some sort of medical background. They all work hard but so much of our care needs to be specific to health issues and they often struggle to understand these issues.

More than one thing as this is so important: Fund it appropriately- listen to what the staff on the front line are saying around this- ensure University training is adequate. Pay staff the same rates as private. Make the DHB a place that experienced clinicians want to work- take funding from areas that do not have quality of life impact eg arts, events etc and put money where there is genuine need particularly in child health. Child disability services are severely underfunded with dangerously high wait lists and extremely burnt out workforce.
Invest more in preventative health services to shift the balance from illness to wellness.
LISTEN and design systems within the health sector for the purposes that you state they are for. All too often it seems many of our systems and policies are designed to stifle reports of bad performance or stifle anyone from reporting bad practices i.e. They seem to love shooting the messenger. One last thing...The Unions representing people, like the PSA have to also play their part and their reps need to front up and do what they say they will and try to support their members. Sometimes like us all they do well with the resources at their disposal and other times they don't do so well.
Get the hospital processes working in a logical and efficient way instead of being disjointed, illogical and impractical. Even with correctly trained and efficient staff, we are hampered by the processes we have to follow that simply do not work.
To make more time for those we care for instead of time schedules that don't allow us to have the care we need to give or the time. As a Carer in a Dementia unit we are rushed and don't have the time to spend with our residents and this needs to be changed.
Allow 'locating' for Allied Health and nursing staff, so that staffing levels improve, and cover can be provided for leave etc.
Make the system fairer for all - the funding gap between ACC and Ministry of Health continues to grow yet if MOH clients could access the services/funding that ACC clients can, there would be better outcomes in every sphere for people including being able to access services to increase mobility.
Adopting public health principles will re-orientate the health system to deliver better health more cost effectively by focusing resources on prevention and addressing highest priority health needs first.
More funding is urgently needed as the disability sector cannot keep up with the demand. We are constantly making cuts that essential mean the disabled person cannot access services they are needing to function while still maintaining quality of life. So many have been declined as due to services needed for social reason, i.e. meeting mum for coffee, needing to be closer to family for no other reason just to be closer to family or current equipment is suitable but needing different equipment as to heavy for carer to lift
If people could utilise support services directly, in that these organisations do not have to seek outside approval, wait for NASC, WINZ, or other 'red tape' procedures, (with Services that seem to be overloaded with too few staff and not enough time). - There are also procedures in place, like a person must have a Case Manager/Clinical team and Clinical Plan, to engage with some services. If someone needs help they should be able to get it from the organisation in their area, funding could be available for self-referrals, and more peer support.

To have more responsibility with the client, one on one basis, built up on trust with Healthcare, reporting back, when asked to do jobs and you decline them, then you should get your marching order given, makes the job harder cos the girls have to squeeze the client in, that has been declined by other support workers. Also to many support workers over 65 who only do 3 jobs a day and could do more work.
To have a lot more qualified, care workers and extra administrative staff, some to just be the voice to listen at the end of the phone.
More information, more education and the chance to keep training.
Hiring more people with lived experience in each service. Pay parity for all the workforce. Training and recruiting younger people. Having inspirational leaders! Team work, team work and team work.
That the Service Managers/ Health Advisors shadow shifts with the Community Support Worker so they see what they do day to day. Meet the staff at their level. Remember a complement goes a long way. Praise your staff and follow through with what you said you would do. Remember we all human not robots.

Annex 2

Summary of recommendations of the PSA submission to the 'Government Inquiry into Mental Health and Addiction'

This submission addresses 10 key areas for action and encompasses 26 recommendations, listed here. We have used the term Tangata whai ora to refer to people experiencing mental illness. A translation of this is a person on the journey to wellness.

WORKFORCE PRIORITIES

Address workforce shortages

- Introduce an overarching workforce strategy across the Mental Health and addiction sector, including the issue of staff retention.
- Properly value work and pay accordingly.
- Develop an integrated workforce who could have career paths seamlessly across the DHB and community sector.
- Integrate education and training across and between sectors, which enables the flow of mental health and addiction workers between services.
- Ensure pay and employment equity across the sector.

Ensure safe staffing

- Agree to safe staffing levels for all services across the sector and implemented.
- Address workforce shortages so that safe staffing levels are achieved without compromising decent working conditions and access to professional development.
- Ensure safe staffing includes staff to client ratios both in the acute inpatient/forensic units and community services – across both DHBs and NGOs.
- Ensure work cell phones and laptops are provided for ease of communication.

Engage with staff

- Investigate barriers to implementing a High Performance/ High Engagement approach throughout the sector in order to create a culture shift that values the insights of people working closely with Tangata whai ora.

MENTAL HEALTH AND ADDICTION SERVICES

Integrate services into one cross sector mental health strategy

- Develop and implement a national mental health strategy that encompasses the DHB and community sector.
- Integrate services across the DHB and community sector.
- Ring fence funding for mental health.

- Fully fund and resource mental health services for tangata whai ora experiencing high, enduring and complex needs. This includes: Community mental health centres, acute inpatient units, longer term residential facilities, respite facilities, community support work services.

Provide a continuum of care

- Standardise contracts with providers in the community sector without restricting flexibility to reflect individual client needs and local service innovation.
- Ensure the transition between different services is smooth, seamless and based on the needs of Tangata whai ora.

Review Compulsory treatment orders

- Review the operation of compulsory treatment orders to ensure they are fit for purpose.
- Resource the Substance Addiction Compulsory Assessment and Treatment Act by making the necessary facilities and staffing available.

Mental health in prisons

- Increase resources for forensic mental health services.

Addiction services

- Frame alcohol and other drug addiction as a health first issue, while also holding people to account for criminal behaviour.
- Resource Alcohol and Other Drug (AOD) services so that waiting times are eliminated.
- Ensure that decisions about appropriate services for Tangata whai ora with co-existing problems/dual diagnosis are driven by the needs of Tangata whai ora rather than cost shifting and/or availability of services.

ASSOCIATED PRIORITIES

Intervene early

- Fully fund and resource mental health in the primary health sector, before Tangata whai ora become acutely unwell.
- Implement prevention strategies.
- Raise awareness in communities and schools.

Meet basic human needs

- Ensure everyone has access to an adequate standard of living including warm dry housing. The basic social determinants of wellbeing should be available to every person.