Submission of the

New Zealand Council of Trade Unions

Te Kauae Kaimahi

To the

Ministry of Health

on the

Update of the New Zealand Health Strategy

P O Box 6645

Wellington

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1. Introduction

1.1. This submission is made on behalf of the 31 unions affiliated to the New Zealand Council of Trade Unions Te Kauae Kaimahi (CTU). With 320,000 members, the CTU is one of the largest democratic organisations in New Zealand.

1.2. The CTU acknowledges Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and formally acknowledges this through Te Rūnanga o Ngā Kaimahi Māori o Aotearoa (Te Rūnanga) the Māori arm of Te Kauae Kaimahi (CTU) which represents approximately 60,000 Māori workers.

1.3. The CTU is involved in various health sector forums including the Health Sector Relationship Agreement (HSRA) and the National Bi-Partite Action Group (NBAG).

1.4. We welcome the opportunity to make a response to the draft update of the New Zealand Health Strategy (Draft Strategy). Accessible quality health services are critical to the hundreds of thousands of workers we represent and to their families and whanau. There are many thousands of health sector professional and workers who are part of unions. We endorse the submissions of our affiliates: E tū, the Association of Salaried Medical Specialists (ASMS), The Public Service Association (PSA) and the New Zealand Nurses Organisation (NZNO) on this Draft Strategy.

1.5. The Consultation Documents asks a number of questions on the Draft Strategy. This submission addresses those questions. However, there are additional issues that we have raised which fall outside the feedback form questions.

Draft Update of the New Zealand Health Strategy – Concerns

1.6. The Health Strategy must deliver a robust, resilient and fair future focused Health Strategy for those who access health services, those who work in and deliver health services and for the wider population. As written, the Draft Strategy does not raise our trust or confidence for an accessible and equitable future-focused health system.

1.7. We are concerned about the lack of detail and evidence base supporting the Draft Strategy, the over-use of jargon with little definition or clarification of what lies beneath the generic language in the Draft Strategy. The terms “shared goals” and “partnership” are repeated throughout the Draft Strategy without an explanation of what these terms actually mean in practice e.g. “Partnership” - what does this mean? What are the benefits? From whose lens? Who are the partners? Do they have equal influence? And what are the “shared goals” so often referred to in the Draft Strategy?

1.8. We are concerned that the Draft Strategy is silent on key issues such as universal access to quality care and health services; achieving a fair and equitable public health system; outcomes that a future focussed Health Strategy should achieve; how these will be measured and how the Health Strategy and its actions are resourced and funded.

1.9. There is a noticeable absence of the role of social determinants and factors leading to good health. While there is reference to health disparities of Māori and Pacific people, there is no reference to the health disparities faced by low-income people. There is a lack of any reference to the role of public health measures in improving population outcomes other than in relation to obesity.

1.10. If service users are able to access health services early (particularly vulnerable groups), health problems are identified, monitored and addressed early then the impact downstream on the health system is more favourable in terms of cost, likelihood of complex problems arising and better health outcomes. However, this is noticeably absent throughout the Draft Strategy. Furthermore, there is no reference to the Primary Health Care Strategy (2001) which raises the question of what is the role and status of the Primary Health Care Strategy in the Draft Strategy?

1.11. The Draft Strategy refers to the “investment approach” many times throughout the document without any explanation of what this would mean for the health sector. Investing in people is an attractive concept but the only example of this approach in

New Zealand is the Forward Welfare Liability model that is currently being implemented in the social welfare sector. The suitability of this model has been criticised for social welfare[1],[2],[3] and is highly questionable for the health sector. There is no evidence provided as to how an investment approach would work in the health sector and how it would improve overall health outcomes. This is discussed further in this submission.

1.12. The Draft Strategy implies through several actions and statements the likelihood of privatisation of public services and infrastructure and increased use of the third sector through contracting out of services. These could have significant impacts on the workforce such as increased insecurity of employment and the problems of lack of workforce development, poor working conditions and cost-cutting that have been all too evident in the residential care sectors. This is of serious concern to the CTU. If this is not the case, the Strategy should provide assurances to this effect. But if this is the case then the Strategy ought to directly communicate this in the interests of openness and transparency with unions and the wider sector.

1.13. The Draft Strategy has a strong technology focus. Although technology is already important and will play a strong role in the future, it raises a number of concerns for unions including the impact on jobs, services, infrastructure and costs. In addition not everyone has access to technology. In particular, people with low incomes, the elderly and people with disabilities may have limited access or difficulties in using technology. Recent examples in the health sector (e.g. Health Benefits Limited) and wider State Sector highlight an increasing trend of poor and rushed planning, excessive costs resulting in little or no benefit and ill-informed decisions regarding technology solutions. The health sector can ill afford to continue making these costly mistakes.

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[1] Rosenberg, R. (2015) The Investment Approach in Not an Investment Approach, *Policy Quarterly*, 11 (4) p 34- 41

[2] Chapple, S (2013) Forward liability and welfare reform in New Zealand, *Policy Quarterly*, 9 (2) pp 56-62.

[3] Productivity Commission (2015) *More Effective Services,* Wellington, New Zealand.

Consultation

1.14. A Health Strategy is a significant piece of work for which there must be adequate time for submitters to analyse the issues and provide recommendations. The short consultation process and ad-hoc coordination of engagement meetings with the sector (on several occasions key groups including unions were not aware of meetings) has made it difficult to make an informed submission on the many far reaching issues which must be considered in a limited timeframe. The limited time-frame has also impacted on submitters' ability to provide alternatives to what is contained in the Draft Strategy.

1.15. We urge caution in finalising and rushing implementation of the Draft Strategy without full and proper public consultation. It is clear that further work is still required before a final Strategy can be agreed upon. Without this information and input there is a high risk of ill-informed decisions and poorly developed actions and roadmap.

1.16. Given the complex nature of the health sector, the CTU strongly recommends continued involvement of forums such as the HSRA Steering Group and the NBAG for engagement in further discussion of the Strategy. A more coordinated approach to consultation and open lines of communication will assist in information sharing, dialogue and building confidence in workers, the wider health sector and public on the credibility of the development of a Health Strategy.

2. Consultation Questions: (Update of the Health Strategy: Submission Form)

Challenges and opportunities:

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

The importance of health inequalities and how they affect health outcomes needs to a much stronger part of the Draft Strategy. There is an almost complete absence of the role of social determinants and factors leading to good health. Given the substantial work and research done on the importance of the social determinants of health, their absence from the Draft Strategy is inexplicable. The social determinants of health drive health inequalities. As the WHO Director General, Margaret Chan states:

> *Health care is an important determinant of health. Lifestyles are important determinants of health. But... it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place.*"

Though there is recognition of the disparities that Māori and Pacific Island people face, the health disparities faced by low-income people in general do not feature as areas of attention or focus of work in the Strategy, the five themes or the action plan.

There needs to be more emphasis on the critical role that primary health care services play in improving health outcomes and the principles that effective primary health care services are based upon: the concept of "Health for All" which is well known and understood at a local, national and international level.

The document talks about "how to meet the needs of New Zealand's most disadvantaged". The document refers to one of our strengths being a publicly funded universal health system and yet there is a move reflected in the document on more targeting rather than sustaining universal services. The move to a more targeted health system will result in a shift away from a universal health system. This is in spite of the increasing evidence that the best health outcomes are from universal services. It will also undermine public support for the publicly funded health system as fewer people benefit from it, and it will create poverty traps.

The health disparity of people with intellectual disabilities is of serious concern and the failure of the Draft Strategy to actively address these disparities is disappointing. The poor health status of people with intellectual disabilities continues to exist even though there is comprehensive empirical evidence of the health inequalities affecting this vulnerable group. Despite this information, there is no comprehensive or systematic response to the health needs of New Zealand children and adults with intellectual disability.

Additional challenges not addressed in the Draft Strategy include the impact of International Trade and Investment Agreements on the health sector. For example, the provisions of international agreements such as the Trans-Pacific Partnership Agreement (TPPA) may affect the ability of the government to change or modify contracts, utilise policy and regulatory levers to combat health issues such as tobacco or sugar control, and maintain access to affordable medicines. The impact of TPPA being ratified by the New Zealand Government needs to be considered in respect of the health sector.

We are concerned at the absence of issues related to Climate Change and future implications for population health, services and infrastructure. Climate change is already affecting, and will continue to have an effect on social and environmental determinants of health including clean air, safe drinking water, sufficient food and secure shelter. It will affect some of our nearest neighbours in the Pacific, in turn impacting New Zealand's population. The effects of Climate Change cannot be ignored and must be considered as part of a future focused Strategy for the health system.

The future we want:

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

> So that **all** New Zealanders **live well, stay well, get well**, we will be **people-powered**, providing services **closer to home**, designed for **value and high performance**, and working as **one team** in a **smart system**.

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

We are concerned at the use of jargon language in the document e.g. "people-powered" or "one team". It is cynical to use a term like "people-powered" when the intention is increasingly to devolve control of the system to private contractors who individuals find difficult to hold to account because the relationship with them is at bottom a commercial one controlled by remote holders of the purse strings, and frequently individuals requiring services are those who are least in a position – often because of their health condition – to hold anyone to account. If the reference is to voucher-like systems where funding is effectively in individual hands, that has other well-known problems including loss of the bigger picture of the public good.

These matters should be explicit and in the open in a Strategy. Using terminology like "people-powered" is sloganeering in order to be able to claim public support on the basis of obfuscation of real intentions. These phrases mean little in themselves, can mean quite different things to different people, and have different interpretations according to context. This statement should clarify direction; instead it will mean quite different things to different readers.

The central statement of "All New Zealanders live well, stay well, get well" does not adequately capture the issues affecting the sustainability and future focus of the health system. We support the suggestion at the Health Sector Direction Forum on 19 November 2015 that the central vision statement be rephrased to "start well, live well, end well". The start of life, living well and ending well all represent pertinent issues and resonate with statements throughout the Draft Strategy such as "…starting and finishing in homes…". This would be more helpful in forming the basis for a future focused Strategy.

Ideally the final Health Strategy and its actions would be linked to each part of the central vision statement "start well, live well, end well". These are broad terms but can possibly link and guide the Strategy more clearly in comparison to the current draft.

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

3 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?

The retention of the 7 principles from the 2000 Health Strategy and the addition of one more are supported. They provide continuity and stability in the health care system beyond political cycles. However, though the principles are retained, they are not embedded and do not translate into the narratives of the five themes or into the road map.

Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 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?

Five Themes

The Five Themes should be connected and provide a clear, evidence based analysis of the issues and appropriate actions to progress a future focused Strategy. The Draft Strategy does not provide us with confidence or assure us of the future of the health system given the lack of clarity and detailed information on several actions identified under each theme. Instead it raises a number of risks and disconnection between what needs to happen - addressing health needs and health inequalities - and actions for addressing these needs. The lack of emphasis on population health priorities will affect the sector if the Draft Strategy is implemented in its current state. It will give rise to a number of unintended consequences and most worryingly lose focus of people and the role public health system.

Given the gaps in detail and lack of clarification on themes and several actions it is difficult to support the Five Themes or the actions under each theme. A summary of the high level issues are identified below under each theme but the CTU and affiliated health sector unions welcome the opportunity to discuss these and other issues in greater detail further with the Ministry of Health.

People-powered

The People-Powered theme promotes a people-centred approach to health services and having service users as partners. Whilst we encourage a health system taking into account the perspective of the service user we also urge caution regarding the actions proposed and seek greater clarity on these actions and details of the theme.

Acknowledging the special relationship between Maori and the Crown (principle)

The Draft Strategy needs to show more awareness of New Zealand's social and cultural context - in particular tangata whenua and tikanga based principles in healthcare. The principle acknowledging the *"special relationship between Māori and Crown"* in the Draft Strategy must be reflected in a meaningful, credible and continuous way to achieve better outcomes. Māori must be given solid recognition in policy and health development planning. There are specific reasons why Māori have some of the poorest health outcomes of any group. There is plenty of research and evidence that highlights health inequalities and social determinants of health for Māori (indigenous health). Whilst access to services can be affected by cost, access can also be affected by the cultural connection to the system, services and practices that do not align with Māori. These issues must be examined and *relevant, culturally appropriate* approaches for addressing health problems affecting Maori identified with solutions led by Māori.

Māori naturally have a people-centred approach and this must align with the Closer to Home theme in that Māori must lead in the design and implementation of actions aimed at addressing Māori health issues. However, Closer to Home actions must be well resourced and supported by the Ministry

of Health and other agencies to enable Māori to achieve better outcomes. Similarly, there are specific cultural settings for other vulnerable groups such as Pasifika, immigrant communities and also refugees who often arrive from displaced backgrounds. There are specific issues and backgrounds that need to be examined urgently and *relevant, appropriate and culturally sensitive* solutions identified for these groups (from a cultural perspective) to help reach better health outcomes.

Cultural Settings

New Zealand's population is culturally diverse with many ethnicities and with this comes a number of challenges including trust, confidence, accessibility to quality services and engagement in the health system. The Draft Strategy lacks evidence on the issues affecting these populations in terms of engagement in the health system, or an examination of why these issues exist. For example, does the Draft Strategy, system and current structures contribute towards people's trust and confidence in the system or does it act as a barrier for positive engagement? If people do not have trust and confidence in the system, the Draft Strategy is unlikely to meet expectations of the people-centred approach.

The Draft Strategy discusses the connection Pasifika communities have to churches and the opportunity this provides in access points for health care. This is encouraging but it should be happening *already* so the question must be asked why this is not happening? What are/will be the barriers and what must be done to overcome these barriers from a structural and cultural perspective? The Draft Strategy lacks meaningful discussion on these issues.

Digital Solutions

The Draft Strategy discusses digital solutions aimed at providing greater access to information and evidence based health advice for service users. This is encouraging, however, it is not clear, how "access" to information and services will best be achieved through digital solutions or if in fact the digital solutions which enable remote access to patient health information is secure. The Roadmap discusses the use of telehealth in delivering timely and responsive services. Whilst, telehealth and the use of technology is useful particularly for the younger population there are also a number of limitations associated with digital solutions. For example, not everyone has access to technology particularly those who live in low-socio economic areas or some people with disabilities. In some instances it may not even be about access but more about technology literacy. Is the Ministry of Health confident that with a rollout of telehealth and other technology services people will have access, knowledge and be able to use these services?

Whilst technology provides a channel for accessing services and information, it is only useful if the person is able to understand the information, navigate patient portals and connect to telehealth services. Health literacy plays an important role in improving the health perspective of the service user

therefore it is important in changing behaviours and understanding information that is relevant to improving health outcomes. Any digi-health solution will require a high standard of health literacy for successful uptake and implementation – has this and associated challenges been considered?

The Draft Strategy does not mention whether there will be trials to assess the effectiveness of the digital solutions, or whether the digital solutions will be available in various languages reflective of communities in New Zealand e.g. Māori, Chinese, Samoan, Indian etc or those with specific disability needs. If these issues have not been explored, we recommend further analysis on the effectiveness of digital solutions for health services, including uptake in low-socio economic areas, by people with English as a second language, or by people with disabilities who are limited in accessing technology, and the level of technology and health literacy required to fully utilise the tools.

Whilst there may be benefits for the service user in accessing health information and improving health literacy through digi-health solutions there is a risk that this could lead to less face-to-face time with health professionals, possibly complicating health problems further (if left untreated). The process and engagement through digi-health solutions needs to be managed carefully and have input from the health workforce some of whom will be required to spend more time entering information online for the patient as opposed to doing other clinical work.

Individualised funding

We are concerned about risks related to Individualised Funding and the lack of balanced discussion on the model in the Draft Strategy. The wish for people to be autonomous and in charge of their own care needs is appreciated but there are major employment and health and safety issues which need more attention.

The issues that are raised by turning dependent citizens into employers of their carers have not been confronted. Such arrangements can move people into the responsibility of an employer without the necessary training or adequate cognisance of the employment responsibilities which may become complicated by the dependency of the relationship and the high degree of trust that is required. This can lead to much more than the usual (and often difficult) problems when an employment relationship breaks down.

We support the concept of the consumer having choice in the employment of their support worker but advocate for it to be managed through an organisation that is accountable for managing the employment and the health and safety requirements (which are significant) to the level of the Home and Community Support Standards and other relevant legislation.

<u>Closer to Home</u>

The theme, "Closer to Home" is focused on the shifting of services and care being delivered close to where people live. The notion behind people being able to access health services close to home is unassailable. And the vision laid

out in, “what great might look like in 10 years“, is also unarguably a good one. But there are components missing in how Closer to Home services will translate into the delivery of accessible, effective, quality health care services for all people.

Primary Health Care Services

A central component of close to home must be the role that primary health care services play in improving health outcomes and the established values of primary health care services: the right to health for all; people centred care; a central role for communities in health action; prevention and health promotion as integral part of the health response; and local action.

The identification of primary health care services as the basis of improving health outcomes is essential because of the strong evidence that primary care is associated with a more equitable distribution of health in populations and can improve overall health and reduce differences in health across major population subgroups.

For some people health services need to be close to where they work. And they also may need to be close to the communities that people associate with e.g. Iwi associating with discrete Māori health services.

Health Inequalities

Effective primary health care improves the health of groups who face health inequalities. The Draft Strategy acknowledges health inequalities for Māori and Pacific peoples. Addressing the health inequalities of Māori and Pacific people is a recognised major health priority. Missing, however, in the Draft Strategy are the health inequalities caused by low socioeconomic status and the health inequalities and challenges caused by lack of access to social determinants which affect good health: adequate income; quality housing, decent employment. While the importance of these factors are recognised by health professionals and workers, and also in some of the current funding arrangements e g. Very Low Cost Access scheme; in refugee health contracts, the omission of the health inequalities faced by people with lower socioeconomic status is a crucial and inexplicable missing component.

The Investment Approach

It is a concern that the theme Closer to Home includes reference to the investment approach given it is unclear what is meant by this approach for the health sector. The investment model that is currently being applied in the Ministry of Social Development (MSD) uses techniques from the insurance industry to calculate long-term costs to the government of welfare services. This approach only focuses on costs to the government and ignores the benefits to individuals and the community from welfare services. It is ill-advised and we suggest potentially dangerous, to suggest an investment

approach in the health sector when there is no agreement about what is meant nor any evidence that it will improve health outcomes.

The Health Workforce

The demand in providing services Closer to Home has impacts for the workforce and is an essential consideration in delivering services Closer to Home. There has been a substantial growth in the non-regulated workforce providing services to people in their home but without the commensurate funding needed, the employment arrangements needed for decent working conditions nor the training required. Workforce requirements are an essential but missing consideration in the Draft Strategy of delivering services Closer to Home.

One team

The theme "One Team" is unclear. Several areas identified under the theme lack detail, future focus and is silent on what is meant by a number of actions which leaves it open for misinterpretation.

Health Workforce

The One Team theme largely refers to the clinical health workforce but there is little reference in the Draft Strategy to the wider health workforce. The health workforce is wider than the clinical workforce and entails both the regulated and non-regulated workforce which are intrinsically linked in the delivery of health services.

The theme Closer to Home is focused on the shifting of services and care to the home. This requires an emphasis on the skills, conditions and sustainability of the home support workforce as well as its growth to meet demand – yet there is little discussion around the challenges of meeting workforce requirements for the delivery of services and care closer to home. This approach to care and service provision has more complex requirements of the workforce, both in the nature of work and the workplace, and in the requirements of health workers who are physically or professionally isolated in people's homes. Over recent years the sector has had to address problem after problem arising from the non-regulated workforce: the sleepover case, in-between travel case and equal pay case are symptoms of numerous problems in the sector. It demonstrates that leaving it to 'the market' to resolve these problems does not work. A strategic approach is required to providing a sustainable workforce that has the training and skills required, addresses workplace health and safety challenges, and provides attractive careers that enable retention of experience in this growing sector.

We recommend the One Team theme is redrafted to encapsulate all parts of the Health workforce so as to "reflect a whole of workforce approach" which recognises the importance of each workforce in the delivery of health services and the challenges and benefits for workers in both a qualitative and quantitative way for the future.

The generic reference to workforce development does not provide assurances that the Draft Strategy has identified the direction and priorities for the health workforce in the future. This is of serious concern. The Health Strategy should clearly identify the challenges, opportunities and priorities for workforce development including workforce shortages and training pressures that need to be addressed to assist implementation of a Health Strategy in future.

The health sector workforce is highly unionised therefore input from health sector unions is critical in understanding workforce issues and developing a response to these issues.

Who is the One Team?

The One Team refers to NGOs but there are a number of other groups that contribute to health outcomes. The health workforce, whanau and community is and should be at the heart of the One Team but the theme requires a broader view that includes the role of Iwi, Unions, DHBs, wider health sector providers, other Government agencies (e.g. housing, corrections, MSD, Local Government), health groups, education providers, representative and advocacy bodies in working together to improve coordination, health services and outcomes for New Zealanders. One Team must be inclusive of all people in New Zealand, and who participate and connect with the health system. This is lacking in the Draft Strategy. If the Draft Strategy refers to collaboration in actions and the Roadmap then One Team must be inclusive of all participants who can enable collaboration, particularly at community level.

Roles and Responsibilities for the Workforce

The actions for One Team refer to clarifying roles and responsibilities for the workforce. It is unclear what is meant by this action. We strongly encourage union consultation on the One Team theme and clarification of the actions regarding roles and responsibilities. Similarly, the term “flexibility” is often used throughout the One Team theme (and Draft Strategy) yet it is unclear what is meant by *“flexibility and full use of skills …. continuing to reduce barriers that currently prevent this, including legislative barriers”.* This statement is of serious concern as it not clear what it means and more specifically what is meant by legislative barriers or *“flexible use of the health and disability workforce.”* The Health Strategy needs to clarify what is specifically meant by this action and statement.

Volunteers

The need to support families, whanau and individuals in communities in their roles as carers of people close to them is highlighted in the Draft Strategy including the need for *“…tailored information and training for volunteers….opportunity to contribute to design choices …..”* The Draft Strategy, however, is silent on how this training would occur, what it would involve, by whom, the incentives and expectations on unpaid

carers/volunteers, and implications for employment and health and safety. The Draft Strategy needs to clarify the statement above and specify details for unpaid carers/volunteers, expectations and implications for the sector.

Reliable Workforce Data

The Draft Strategy refers to the use of workforce data to inform workforce planning, however, this assumes that there is a reliable workforce collection data system in existence. There is a large gap in reliable and robust data collection of both the regulated and non-regulated workforce for the health sector. This is a well-documented issue that has been raised on several occasions previously by unions and sector organisations. In order to provide a true and reliable picture of New Zealand's health care workforce, there must first be a system in place for workforce data collection. We consider that either the Ministry of Health or Health Workforce New Zealand (who have been specifically tasked this role) should play a more active role in collating reliable workforce data to better inform workforce planning.

Value and high performance

The Value and High Performance theme lacks detail and clarity on the intent behind actions, and raises a number of concerns regarding sustainability, accountability and transparency. The actions (without saying specifically) can be interpreted to also mean greater use of the private sector in the delivery of services, Public Private Partnerships and Social Investment Bonds.

We oppose actions which are short-term in focus, will result in privatisation of services and infrastructure, affect quality care and services, lead to insecure employment, deterioration of pay and employment conditions, lack of transparency and impact adversely on smaller communities. Instead, we recommend the Draft Strategy's focus should be on improving the effectiveness of current infrastructures, strengthening contract management and monitoring processes, building existing alliances in the sector and putting effort into greater collaboration. There should be reviews of whether current private provision by contracting out or outsourcing are in fact working in terms of sustainability and outcomes.

The CTU and affiliated health sector unions are keen to participate and play a part in initiatives that improve the overall function of the health sector and promote sustainability.

High Performing Workplaces

We support the action around implementing/dissemination of best practice initiatives. There are opportunities for less disruptive incremental changes to be made in comparison to contracting out services and infrastructure. Such changes can contribute to cost savings, add value, improve efficiencies, build trust and confidence in the sector, and minimise disruption to the sector which would otherwise occur through more significant and risky "transformational" changes.

The CTU supports a high-trust system with better cohesion. The CTU-affiliated health sector unions have played a strong collaborative role in helping to create high performing workplaces. This role has included working in partnership with DHBs to facilitate change, innovation and identify better ways of working *together*.

There are opportunities for Unions, DHBs and other stakeholders in the health sector to work collaboratively on developing a high trust working environment and sharing best practice initiatives. The CTU and its affiliated unions are keen to play a part in fostering constructive relationships and innovative workplace practices.

The Investment Approach

The term, "the Investment Approach" is now strongly associated with the Forward Welfare Liability (FWL) Model and with the form that is being applied in the Ministry of Social Development (MSD) towards welfare beneficiaries. Analysis of the MSD Investment Approach shows that it is fundamentally flawed in that it does not consider benefits, only costs, and then only looks at the costs to government[4]. The Productivity Commission state that the MSD Investment approach is not a cost- benefit analysis and recommend that "it should be further refined to better reflect the wider costs and benefits of interventions". They state that "slavish application of an investment approach based purely on costs and benefits to Government (like the FWL) might lead to perverse outcomes. For example if the health system were to seek only a reduction in future health costs then there might be little done if anything, to discourage obesity as early deaths from obesity would reduce future fiscal liability".[5] Because of the lack of clarity and different interpretations around the Investment Approach it should not be included as a direction or policy in the final Health Strategy without further in-depth clarification, discussion and agreement.

Expanding the Use of Contracted Out Services

Expanding the use of contracting for health and equity of health outcomes is an action identified under the theme. We view increased use of contracting out services and infrastructure as detrimental to New Zealand's economy and public health system. In particular, greater risk of private sector commercially driven behaviour will seriously weaken and undermine the public health sector and affect the ethos of the wider public sector.

We believe that outsourcing and wholesale use of contracting out services will allow the private sector undue influence over services in the public health system. Contracting out services or a national outsourcing approach are said to enable the transfer of risk regarding delivery failure to the private sector. In fact the state can never remove itself from risk because the public expects it to provide these important services. Instead (as with the recent Novopay and

Serco cases) the state finds itself shouldering the risk and with added costs to retrieve the situation.

The Draft Strategy leads to this way of thinking. International (e.g. the United Kingdom's National Health System) and local examples such as the centralisation of food production in the 1990s e.g. Tempo which had negative consequences for service delivery resulting in liquidation of the provider and more recently the problems arising from the privatisation of Wellington region's hospital laboratory services. These examples highlight the risks and failures of outsourcing and privatisation of public services, infrastructure and associated issues including fragmentation of the health service, lack of democratic, accountable and transparent processes, changes to services and increased costs. These examples show that the outsourcing approach has been hugely controversial and fiscally there are more and more questions emerging about the financial viability and quality of contracting out services and infrastructure.

We hold serious concerns regarding the nature of work if contracting and outsourcing approaches were to progress e.g. prevalence of contractors, casualised workforce and deterioration in pay and conditions for workers. The CTU holds serious concerns regarding this development and the continued negative effect contracting out will have on employment and the hollowing out of public services.

Ownership of facilities and equipment by a third party for the delivery of services poses great risks for DHBs particularly their ability make most efficient use of the assets, control the cost of them and to buy back assets in future. The desire to expand the use of contracted-out services introduces competition and profit-driven motives into the delivery of public services, which is in stark contrast to the collaborative and service orientated approach of the public sector. The proposed approach inevitably leads to the health sector being increasingly privatised, posing major risks that threaten patient safety, equity, quality of care, services and capacity of the health sector.

We are also concerned where the expanded use of contracted services an outsourcing may result in the shifting of services and jobs to larger Centres, privatisation and the subsequent pressure on smaller communities who are already struggling in terms of economic development and job growth. It is disappointing to see the Draft Strategy not provide any evidence, information or analysis on the impact of contracting out and outsourcing services, including on smaller/ regional communities.

Maintaining and building the capacity and capability of DHBs to provide services should be the long-term strategy of government and DHBs. Use of the private sector as a short-term solution for "quick wins" is short sighted, irresponsible and not a sustainable approach to addressing problems. We believe the focus should be on improving the effectiveness of current infrastructures, contract management and monitoring processes.
The CTU opposes contracting out of services and infrastructure under an outsourced provider arrangement.

Transparency and Accountability

We support the comments under the theme around transparency of information and accountability. However, the theme contradicts itself in terms of the focus on contracted out services and private sector role in the delivery of services. Accountability is affected where private sector involvement increases in the delivery of public services and infrastructure. The lack of accountability mechanisms and impact on transparency if services are contracted out and outsourcing approaches are undertaken concerns us. Under an outsourcing approach, public spending is more difficult to scrutinise as private sector providers are not covered by official information requests.

There is also a risk of hollowing out the expertise and capability of the health sector, so that monitoring of services cannot be effectively carried out, and the ability to resume provision of services is lost. Any proposal to nationally outsource the provision of services and infrastructure encourages a commercial profit-driven approach. Given the small size of New Zealand's health sector and the specialities required, private provision frequently has few if any competitors.

If prices are driven down by government contracting requirements that aim to reduce Crown costs and achieve accountability through short term contracting, the results are too frequently short term positions taken by contractors with regard to improving systems (including technology and record systems) employment, pay, training of staff and ongoing staff development.

We are also concerned about the recommendation arising from the Capability and Capacity review that the number of Board members on each DHB Board be reduced to nine members (from the current 11) with six of the nine members appointed by the Minister of Health. We have strong concerns regarding democratic representation and decision-making processes on DHB Boards. The proposed increase in Ministerial appointees on DHB Boards is in direct contradiction to the people-powered theme and patient-centred care approach in the Draft Strategy. If the Draft Strategy has an emphasis on transparency of information and accountability of decision-making we do not see this recommendation as promoting either of these but rather it diminishes democratic representation and processes. The Capability and Capacity review recommendation does little to increase trust and confidence in the system by service users, whanau, workforce, community advocates and wider health sector.

Technology costs

The Draft Strategy signals significant technology changes which will have cost and resource implications for the sector. The action regarding technology costs will need to consider many facets of technology improvement and be well connected to implementation of digital health solutions and actions highlighted under the Smart System theme. We are concerned, however, that the Draft Strategy has a high technology focus yet there is no information to clarify viability or how the actions will be funded.

Increasingly the complexity of technology projects means increased risks of failed projects (such as Novopay). It also makes it more difficult for low-capitalised contractors, especially NGOs, to take part in it. This is likely to mean contractors will be large, often overseas-controlled multinationals with even less connection to local communities undermining themes such as "Closer to Home".

There is a strong likelihood that the demand on Information Technology (IT) infrastructure and future ongoing maintenance will require increasing levels of investment by DHBs. This adds further financial pressures to DHBs if this is not known, or costed appropriately and will inevitably have an adverse effect on funding for service delivery and workforce implications. Further information is required and analysis disclosed before a well-informed decision can be made particularly given the likelihood of high technology project costs.

Quality and Safety

We support the action around strengthening relationships to continuously improve system quality and safety particularly around reducing patient harm. However, as mentioned already it is unclear which other organisations are seen as part of the partnership or which quality and safety initiatives are identified in terms of primary and rest home care – how will these initiatives be identified and who will have input into identifying them? The workforce often plays a significant role in promoting the culture of quality and safety and as such must have the opportunity to participate in the continuous improvement system.

Smart Systems

The "Smart System" theme has a strong technology focus aimed at accessibility of information, data and smart systems that improve decision making, reporting and gaining efficiencies from emerging technologies. Whilst it is inevitable that technology will play a greater role in the health system in the future we are concerned at the impact of these changes if they are not carefully planned, the impact on jobs, and duplication with other areas of work. For example, there are other IT programmes being undertaken in the sector such as through Health Partnerships Limited which may potentially overlap with actions outlined in relation to the people-powered theme (digital solutions) and smart systems.

The CTU urges caution in finalising the Draft Strategy too quickly in this regard. Instead we encourage a thorough analysis of other work in relation to technology that may be underway already in the sector and detailed analysis of any proposal to progress the Smart System actions including assurances around funding and resourcing and whether the sector has the foundations to withhold such solutions e.g. a capable, high speed broadband service that is accessible in all areas of New Zealand.

Technology Platforms

To implement a smart system across all DHBs, there must be a robust and reliable IT platform to launch smart information systems and promote timely access to health information. The National Infrastructure Platform (NIP) project conducted by HBL highlighted the fragile state of the current ICT platform and systems used by DHBs. The demise of HBL has seen the NIP project transferred to the new DHB owned entity Health Partnerships Ltd but the status of the project remains unclear.

We are concerned that without a full understanding of the current state, implementation challenges and costs, the sector risks developing infrastructure solutions which are costly, not fit for purpose, affect timely access to information, privacy and security considerations, risks duplication with other programmes, risks business continuity and adversely affects the integrity of the health system.

Greater investment in quality infrastructure to underpin the longevity and sustainability of IT and other support services in the health sector is required. However, the Draft Strategy is silent on the issue of cost and resources required to implement the actions for Smart System or who will fund this initiative. One of the actions under the Value and High Performance theme alludes to IT project funding but does not specifically identify who will address the costs or any evidence of the budget for IT. We seek assurances that funding from DHB funding streams is not relied upon to meet implementation costs.

It is likely there will be many hidden costs (such as implementation, resourcing, upgrades, ongoing maintenance and infrastructure costs) associated with initiatives under Smart System as has been the case with similar large scale IT-related projects in the State Sector.

The technology solutions identified under Smart System need to be carefully considered and all relevant information made transparent to Unions, workers and DHBs. In New Zealand, there have been several examples of State Sector agencies undertaking IT initiatives (e.g. Novopay) which have been poorly planned, managed and implemented resulting in excessive costs which were unnecessary, avoidable and ultimately resulting in project failures or significant re-planning.

Technological solutions can be difficult to understand due to complexity and is an area which is foreign to many people due to its technical nature. This is a risk as it makes it easier to push through a proposal which is poorly developed or not understood by the workforce or the sector and poses implications for service delivery and costs.

Further information is required and analysis disclosed before a well-informed decision can be made on whether to progress any IT related initiatives given the likelihood of high implementation costs as has been proven by the Finance Procurement Supply Chain (FPSC) programme undertaken by Health Benefits Limited (HBL). The Office of the Auditor General in October 2015 released

findings into the performance of HBL and in particular the FPSC programme. The analysis was critical of a number of factors that contributed to the difficulties of the programmes including an ambitious and complex programme, which was risky with poor management and inadequate communication. The FPSC programme was not only expensive with no benefit to the sector but created unnecessary stress and anxiety for staff, and loss of institutional knowledge which the sector cannot afford to lose.

Standardisation of Approaches

There is reference to Standardisation of approaches in several parts of the Draft Strategy including under Smart System. It is unclear what is meant by standardisation in the context of the Draft Strategy, however, recent examples show that the quest for standardisation in various areas of the health sector have frequently not been successful and have resulted in budget blowouts. For example, the FPSC programme conducted by HBL which financially was a disaster and caused unnecessary stress for staff, loss of institutional knowledge and job losses. The CTU seeks further details on the Smart System and clarity of goals such as *"standardisation of approaches".*

Privacy Considerations – Information Sharing

The Draft Strategy must ensure the public have trust and confidence in safe, accessible and relevant health services. We are concerned about potential issues associated with confidentiality and privacy surrounding the accessibility of patient information. Mental-health information is a particularly sensitive instance. For example, there is a risk that people who are engaging in illegal substance abuse may not be so forthcoming with their issues if they know the information will be recorded and available to all health professionals. We strongly urge caution where the rights of patient/service user may become compromised through the wide and easy accessibility of patient records.

Greater emphasis on information sharing and data matching across DHBs and government agencies is of concern if not undertaken properly. The Privacy Act 1993 makes specific considerations for information that is shared and data matching across agencies. Although there are merits to global access to information there are also a number of issues that could arise as to how this information is managed, accessed and distributed if requested between DHBs and by other agencies.

Concerns surrounding centralisation of patient information such as access, confidentiality and privacy of patient information is also heightened given the number of privacy breaches due to IT failures by State Sector agencies over the past few years (e.g. ACC, MSD, MoH, EQC, NZ Post). Patient's private information must be protected first and foremost - protection must not be undermined or devalued in pursuit of efficiencies and cost savings.

Finally, patient data and application support must remain with and managed by DHBs. It is important DHB's maintain ownership of patient and hospital information. There are many details lacking in relation to the Smart System

theme including who will be involved, how this will work and how will it be resourced. In any case we hold concerns about private and confidential information being held by another facility (third party) and the risk of data mining as has been the case previously in New Zealand and internationally with the privatisation of such services in the IT area.

Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 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 not evidence-based and is unclear in several areas. Some actions are too prescriptive (micro-management) such as the "*number of people able to access patient portals*" or too targeted. For example, actions addressing obesity are identified but are targeted towards certain population/age groups. Obesity is problem that is affecting the whole population and likely to have a big impact on the sector therefore it would be more effective to have a national response to obesity that has a future focus for the long-term.

In other areas, actions are either too broad or represent current activities already happening such as "*obesity reduction initiative in place"* and other actions represent what should already be occurring but are not such as *"partnerships between DHBs in the management of long-term conditions."* The Strategy and Roadmap does not identify why this is the case - what are the barriers to these actions not occurring already? How can the barriers be overcome and by whom?

The Roadmap needs to be informed by what the Draft Strategy is aiming to achieve but the actions and connections are unclear on how this will occur as the Draft Strategy itself is unclear on what will be achieved. As mentioned earlier, the Draft Strategy is not well connected, balanced or reflective of the challenges, opportunities, expectations or goals for the sector. If the themes in the Strategy itself do not interconnect then it does not bode well for a Roadmap of actions which is likely to be underwhelming and off the mark for the sector.

Turning strategy into action

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

The Draft Strategy needs to be guided by the principles that are meant to underpin the Strategy. The Strategy needs to include the perspective of the service user – this requires actively engaging with not only the sector but population groups on the challenges, opportunities and most importantly what people want for the public health system and identify the goals collectively. The Draft Strategy takes a selective approach to health issues which avoids a universal approach to goals and outcomes.

In order to develop a future focused Strategy, the past must be understood (from all perspectives) to inform future actions. The final Health Strategy must include the narrative (stories) from the perspective of a service user, their whanau and the wider community – what do health outcomes/strategy look like to a service user? What has been their experience and what do they want for future experiences?

The Health Strategy is a significant document. Therefore an evaluation and monitoring programme examining the implementation, effectiveness of actions and experiences of users must be built into the roadmap and its actions.

The lack of information on outcomes in the Draft Strategy is concerning. For example what are the outcomes the Strategy is seeking to achieve? What will it look like, how will this be determined and how will it be measured? Is this long-term or only in tune with the proposed life of the Strategy (which broadly coincides with the political life cycle)? To have a national Health Strategy there needs to be a national measure. Unfortunately the national measure is absent from the Draft Strategy and related documents. Without this information those implementing the Strategy will not know what it is aiming to achieve or how it should continue into the future.

Any other matters

7 Are there any other comments you want to make as part of your submission?

We strongly recommend a wider strategic response towards the development of a Health Strategy that is based on equity, access, protection, and transparency. The absence or lack of focus on the Draft Strategy on population health priorities is deeply concerning and raises the question – do these priorities even matter and are they a priority for the Ministry going forward? Many of the priorities do not feature in the Draft Strategy such as mental health which is having a profound effect on people and the health system yet markedly absent. We would have expected population health priorities to be the cornerstone of the Draft Strategy and effort given to addressing these issues. Instead the Draft Strategy is unbalanced, and prioritises cost and health expenditure over quality care and services, meeting the health needs of people, improving health outcomes and addressing health inequalities.

Health cannot be seen in isolation from other social issues – there is a domino effect between health and employment, social welfare, education and other services. For these reasons and those raised in this submission, the draft Strategy must take a more strategic analysis of the challenges affecting the sector now and into the future (beyond the political cycle and beyond the sector itself). A Health Strategy that does not address drivers of health from outside the "health system" is doomed to fail.

3. Summary of CTU Recommendations: Draft Update of the New Zealand Health Strategy

3.1. The CTU and affiliated health sector unions welcome the opportunity to discuss the issues raised in this submission in greater detail further with the Ministry of Health. This could extend to discussion at forums such as the HSRA Steering Group and the NBAG for engagement and discussing the Draft Strategy in future.

3.2. That the guiding principles are supported and provide continuity and stability beyond political cycles.

3.3. That the final Strategy shows more awareness of New Zealand's social and cultural context - in particular Tangata Whenua. Māori must be given greater recognition in policy and health development planning including design and implementation.

3.4. That because the unions are the means by which the workforce is represented there should be input from health sector unions in understanding workforce issues including workforce development and developing a response to them.

3.5. That the CTU and affiliated unions continue to play a part in fostering constructive relationships in the health sector and innovative workplace practices that improve the overall function of the health sector and promote sustainability and high performing workplaces.

3.6. That further work is required before a final Strategy is agreed upon and caution is urged in finalising and rushing implementation of the final Health Strategy.

3.7. The central statement of "live well, stay well, get well" should be rephrased to "start well, live well, end well". However, this statement requires further work and clarification so it is well understood.

3.8. That there is a greater emphasis on addressing health inequalities, how they affect health outcomes, the social determinants of health and the actions needed to eliminate health disparities.

3.9. That the value of universal services in promoting optimal health outcomes is promoted and the critical role that primary health care services play in improving health outcomes.

3.10. That the Health Strategy avoids language and jargon which is unclear and open to different interpretations. The Health Strategy must reflect in accessible and understandable language the goals of the health systems.

3.11. That the Investment Approach is not included as a direction or policy in the Final Strategy because of the significant faults in its current implementation in the MSD and the ambiguity surrounding its meaning.

3.12. That the perspective of the service user be taken into account and caution be applied regarding the actions proposed under each of the five themes with greater clarity on these actions.

3.13. That there is better clarification and connection between the five themes, actions and Roadmap: currently this is unclear.

3.14. That there is further analysis on the effectiveness of digital solutions for health services including uptake by people with low incomes, with English as a second language, or with disabilities who are limited in accessing technology, and the level of technology and health literacy required to fully utilise the tools.

3.15. That the process and engagement through digital health solutions is managed carefully with participation from the health workforce.

3.16. That the concept of consumer choice in the employment of their support worker is generally supported but it is managed through an organisation that is accountable for managing the employment and the health and safety requirements (which are significant) to the level of the Home and Community Support Standards and other relevant legislation.

3.17. That there is a reliable system in place for workforce data collection in order to provide a true and reliable picture of New Zealand's health care workforce.

3.18. That the “One Team” theme is redrafted to encapsulate all parts of the Health workforce so as to “reflect a whole of workforce approach” (regulated and non-regulated workforce).

3.19. That “One Team” is inclusive of all people and groups in New Zealand who participate and connect with the health system.

3.20. That there is clarification of statements and actions proposed under “One Team”: for example, what is meant by reducing legislative barriers or *“flexible use of the health and disability workforce”* and similarly - the incentives, expectations and implications for employment and health and safety for volunteers as carers.

3.21. That the technology solutions under “Smart System” are carefully considered and all relevant information made transparent to Unions, workers and DHBs and that further information analysis required and disclosed before a well-informed decision can be made on whether to progress any IT related initiatives given the likelihood of high implementation costs and risks of failure.

3.22. That there is more explanation and detail on the “Smart System” and clarity of goals such as *“standardisation of approaches”.*

3.23. That the implementation costs and resourcing of actions are not dependent on constrained DHB funding streams.

3.24. That as a national Health Strategy it should contain national measures of success. The evaluation and monitoring programme examining the implementation, outcomes, effectiveness of actions and experiences of users must be built into the roadmap and its actions.