



NEW ZEALAND COUNCIL OF TRADE UNIONS
Te Kauae Kaimahi

**Submission of the
New Zealand Council of Trade Unions
Te Kauae Kaimahi**

On the

**Review of the New Zealand
Health and Disability Sector**

**P O Box 6645
Wellington
May 2019**

Summary of Points and Recommendations

1. The CTU welcomes a review of the health and disability system and particularly welcomes the focus on equity.
2. The principles in the 1938 Social Security Act for health care remain as relevant today to working people as they were at that time.
3. Changes in the form of Zero Fees to under 14s and the extension of low cost access recognise the financial pressures on individuals and families from health care costs.
4. The Review should report on the realisation of Universal Health Cover (UHC) as a critical component of poverty reduction and health equity.
5. A new or revised New Zealand Public Health and Disability Act should have equity as its central principle.
6. Cost is an unacceptable barrier to accessing primary health care and general practice services.
7. People who need health operations and procedures should not have different access depending on where they live or their ability to pay.
8. The social determinants of health are central to all health policy and health strategies.
9. A strengthened public health approach, public health leadership and increased public health focus are all required.
10. The Review should examine systems for better recording and reporting patterns and trends of occupational diseases.
11. Workforce supply and conditions of work for the medical, midwifery, nursing, allied health professionals, administrative, and other health workforces are inextricably linked to the performance and quality of our public health services.

12. This Review should note the equity differences between the treatment and services for people with disabilities acquired through illness compared to those who are covered by the ACC scheme.
13. The Review should report on the growing pressure and needs for dental services to be fully publically provided.
14. Climate change is a new and critical health equity issue.
15. There are compelling reasons why New Zealand can and should be spending more on health that require an open appraisal and public debate about health care spending.
16. Health needs and treatments are more efficiently and equitably provided through public health care provision.

1. Introduction

- 1.1. This submission is made on behalf of the 27 unions affiliated to the New Zealand Council of Trade Unions Te Kauae Kaimahi (CTU). With over 310,000 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 welcomes a review of the health and disability system to assess how the health system meets the needs of the people of Aotearoa New Zealand and the experiences and expectations of unions, NGOs, communities, health professionals and the workforce. Particularly it welcomes a focus on the issue of equity.
- 1.4. The health sector is strongly unionised and the CTU health unions represent more than 90,000 health professionals and workers. A number of CTU health sector affiliates are making their own submissions to this Review. While endorsing the submissions of our members, this CTU submission concentrates on equity issues for working people: access, cost, quality and delivery of health services. It leaves the health workforce issues to our affiliated unions to articulate.
- 1.5. A significant interest for the wider union movement over a long term has been the ability of working people to access primary health care services at low-cost. The union movement has had a unique role in the establishment of access to low-cost primary health care services in the form of trade union health clinics. We are proud of that history and it has direct relevance to health needs and delivery now. The establishment of New Zealand's wider health service and the direction of the 1938 Social Security Act was strongly influenced by the union movement.
- 1.6. The provision of health services for working people is not just a social imperative, it is an economic imperative. Health services, funded through taxation, are a type of

wage – a social wage - as free or low-cost provision represents income that would otherwise have to be incurred.

- 1.7. At a macro-level there are both social and economic imperatives to review the performance of our health service from an equity perspective. Poorer health of people and population groups has enormous societal and economic costs.
- 1.8. While we note that on international standards our health system performs relatively well, there are many new pressures and challenges facing the health system to which we need better responses. These challenges are urgent.
- 1.9. The disproportionately poorer health experience and outcomes for Māori, Pacific peoples, people with disabilities, and people living in low socio-economic areas are the most obvious. Other new challenges and pressures are demands for new treatments, new drugs, new technologies, an increasing ageing population, rising incidences of obesity, diabetes and mental illness and the compounding health effects from high levels of poverty.

2. Our Public Health System and its Origins

- 2.1. The concept of a free, universal and comprehensive health service for all New Zealanders was established in the 1930s and driven by the ideals of Dr Gervan McMillan – a doctor providing health care to workers on the Waitaiki hydroelectric dam project.
- 2.2. At the time, many thousands of working people had moved to the small South Island town of Kurow to work on the hydroelectric dam project. With support from the unions on site, Dr McMillan, concerned about unmet health needs and the poverty in the workforce, established a health practice for the workers on the dam project. In an article recording the history of this, Don Matheson refers to this as *“the first internationally recorded expression of what today sits within the United Nations Sustainable Development Goals - and now known as Universal Health Coverage”* (Matheson, D, 2017.)

- 2.3. The Kurow Scheme was the blueprint for the Social Security Act of 1938 with its principles that health care access should be universal and a right; that there should be no barriers for patients to receive needed health care and that all New Zealanders should have equal access to the same standard of treatment. These principles are as relevant today to working people as they were then.
- 2.4. Free primary health care was not part of the 1938 Social Security Act due to resistance at the time from the New Zealand chapter of the British Medical Association (NZBMA). The NZBMA fiercely rejected the introduction of free GP visits on the grounds that a Government should not interfere with the special relationship between a doctor and a patient.
- 2.5. The CTU notes the changes now in the NZMA position which are reflected in their 2011 health equity position statement. But the legacy of the decision to charge fees in primary health care is substantial and remains. Changes occurred in 1996 to reduce primary care fees with free GP visits firstly to under six year olds. Zero fees were extended to children under 13 in 2015 and then in 2018 extended to under-14s. These are significant changes towards recognising the financial pressures on individuals and families from health care costs. And there have been some other shifts and positive changes too.
- 2.6. Movement towards lower fees for an estimated 540,000 additional people also came through with reduced co-payments as of May 2019 through the introduction of lower fees for people with Community Service Cards. This move is effective in protecting people from financial hardship and impoverishment from health care costs and in the direction of Universal Health Coverage (UHC).
- 2.7. We recommend that this Review in its first report examine the progressive realisation of UHC as a critical component of poverty reduction, and a key element to reducing social inequalities and to achieving health equity.
- 2.8. A review of the New Zealand Public Health and Disability Act 2000 should ensure that the principle of equity should be at the centre of a new Act.

3. Health Equity and the Social Determinants of Health

- 3.1. Given this review has a major focus on improving health equity there needs to be a focus not only on the health care system in place in which illness is treated, wellness is managed and illness prevented, but also the wider systems and environments in which people live, work and are housed.
- 3.2. Key gains in health equity will also come from other initiatives and indeed other votes. Reducing poverty, supporting access to affordable healthy homes, reducing violence and improving education outcomes all improve equity and health outcomes. We note the strong evidence and support from the World Health Organisation (WHO) that spending in such areas pays off in terms of improving health and potentially reducing the demands on health care services over time (World Health Organisation, 2013).
- 3.3. The 2008 Commission on Social Determinants of Health (CDSH) marshalled evidence on how to promote health equity including fostering a global movement to achieve it (World Health Organisation, 2008). The Commission called on the WHO and all governments to lead action on the social determinants with three principles of action:
- Improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age;
 - Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally and locally;
 - Measure the problems, evaluate action, expand the knowledge basis, develop a work force that is trained in the social determinants of health and raise public awareness about the social determinants of health.
- 3.4. We commend these principles and actions relating to the social determinants of health to be at the centre of our health policy, strategies and legislative framework.

- 3.5. Collaboration across health and other sectors, and with communities and individuals, to address the non-health determinants of health outcomes is not easy but it is vital. We also need to bring together the two agendas of health equity and climate change to address the urgency of that problem. Climate change is a health equity issue.

4. Population Health

- 4.1. Action to improve health outcomes via strengthened public health approaches, public health leadership and increased public health focus are essential components of improving health equity and health outcomes. As stated in the newly published book, *The Health of The People*, “individuals and families have only a limited capacity to protect their own health” (Skegg, D, 2019).
- 4.2. Section 6 in the New Zealand Public Health and Disability Act 2000 defines public health as, “goods, services and facilities provided for the purpose of improving, promoting or protecting public health or preventing population –wide disease, disability or injury”.
- 4.3. Unfortunately the term “public health” gets confused in the minds of many with publicly funded health services. This has the effect of detracting and diminishing the importance of the role of public health.
- 4.4. In the book, *The Health of the People*, the observation is made that the Ministry of Health “seems to be overwhelmed by the challenge of overseeing personal health services, mainly through District Health Boards, with tightly restricted funding. There is lip service to the importance of health promotion and disease prevention, but these activities are given far too little attention” (Skegg, D, 2019, pg 9).
- 4.5. Many of our most significant health challenges will be improved by taking stronger public health measures. The current stalling in relation to bowel cancer screening and the length of time it is taking to introduce this screening programme nationwide is a case in point of the loss of momentum over the last two- three decades on population health and public health approaches.

- 4.6. Of significant interest to all unions is occupational health. There is a real lack of a concentrated focus on occupational health as a health issue. For example, though asbestos is the biggest workplace killer there has not been anywhere near adequate action to address this cause of workplace disease. This is despite decades of action by New Zealand unions who have been at the forefront of campaigns and legal action to manage the handling of asbestos and to ban it.
- 4.7. A greater focus on occupational health as a public health concern would have significant ability to improve workers' health and health outcomes. We acknowledge that Worksafe as the health and safety regulator has a principal role. But the lack of a public health approach in the health system may have been a factor in the inadequate and indeed poor attention on occupational health diseases and conditions. As a result workers and their families suffer. Alarming evidence is emerging now about the high number of suicides in the construction sector. Occupational factors are common features in some of our main health concerns.
- 4.8. Stronger disease prevention and health promotion approaches are required, along with joined up responses to addressing occupational health issues affecting workers.
- 4.9. A vital aspect of good occupational health treatment and prevention is information on its incidence and context. Because much occupational disease has long latency and could be triggered in multiple environments, the work factors can be overlooked and the disease may go unreported and patterns of occurrence may not be noticed. The health system plays a vital role in identifying, recording and reporting cases to relevant authorities. We suggest that the Review consider ways to encourage such reporting and make it easier to do.
- 4.10. There must be a change to seeing public health as an essential mechanism to improve health equity and health outcomes. Some measures are outlined by David Skegg as to how this could be done (Skegg, D, 2019, pg 99-119) . They must be considered, as well as a review of the Health budget that is allocated to population health.

5. Primary Health Care and Very Low Cost Access

- 5.1. Primary health care is the anchor of health care services and to improving health outcomes. We note the compelling evidence on the critical role of strong primary health care to achieving better and more equitably distributed health outcomes.
- 5.2. Cost is a major barrier to better access to primary health care. Cost is an unacceptable barrier to accessing primary health and general practice services.
- 5.3. A recent article looking at inequality in our health system quoted the results from the large Health Quality and Safety Commission's large national patient experience (Shuker, C & Gauld, R, 2019). This survey showed that cost barriers disproportionately stop Māori and Pacific people from seeing GPs and getting medications. Nearly a third of Māori (28.7%) and Pacific (29.3%) patients responded that cost stopped them visiting a GP or nurse, compared with 18.5% of European patients. Nearly a quarter of Māori and 22% of Pacific patients said cost prevented them picking up a prescription, compared with only 7% of Europeans and 15% of other ethnicities. And it is not just about money. Māori adults were less likely than Europeans to answer yes to the question: "was the purpose of the medication properly explained to you?"
- 5.4. The model of union health clinics established in the 1980s to provide low-cost primary health care to low-income families and workers are an important part of the Union and Aotearoa New Zealand's health system history. They are a model to review in the quest to achieve better health outcomes.
- 5.5. The trade union health clinic model was established on the basis of the definition of Primary Health Care from the 1978 Alma Ata Conference,

The World Health Organisation Conference at Alma Ata defined primary health care as essential health care made universally accessible to individuals and families in the communities by means acceptable to them through their full participation and at a cost the community and the country can afford. It forms an integral part of both the country's health systems of which it is the nucleus and the overall social and economic development of the country.

- 5.6. Trade union health clinics were born out of a determination to provide more accessible health services based on community principles to residents in lower socio-economic areas and to beneficiaries and low-income people. The Federation of Labour (FOL) and the Combined State Unions (CSU) supported the establishment of health services that would provide low-cost medical services and the FOL provided political and financial backing. Those loans have been written off as a gesture of support and solidarity. Unions still provide support to trade unions health practices.
- 5.7. The trade union clinics, and later joined by other low cost health services and iwi health providers, were supported by an umbrella organisation - Health Care Aotearoa (HCA). Formed in 1994, this was a network of NGOs and third sector primary health clinics sharing as an explicit goal a commitment to the unmet primary health care needs of Māori and vulnerable populations. The clinics offered not only lower patient fees, but also population-focused preventive care services. Trade union health clinics were founded on a community based model. It is widely held by those involved in this movement that it is this community model which gives it its great strength.
- 5.8. The model has evolved and there are still a number of union health clinics in the country though the model has morphed somewhat into what is now known as Very Low Cost Access (VLCA). This scheme was introduced in 2006 to provide low cost health for people living in more economically deprived areas with an established funding stream. While the VLCA model is still in place, it has been weakened and was seriously undermined in 2016 by a report on primary health care funding which, while it sought to increase access for people on low-incomes to primary health care, did so by criticising and undermining the VLCA funding model (General Practice NZ, 2015).
- 5.9. A review of VLCA health services in 2013 identified the additional demands and clinical complexity issues faced by VLCA practices. And even though fees are lower for patients, none of the practices reviewed were charging maximum co-payments

because of cost barriers and pressures for their populations. This puts enormous strain on the practices and the staff working in the practices.

- 5.10. If there is a strong push, and there is, to more services being delivered in primary health care settings to reduce hospital admissions, then there needs to be more consideration to supporting more practices based on the trade union health clinic-type model. These community based models with different employment arrangements for medical staff, along with longer opening hours, need more support.
- 5.11. There must be more and different models in primary health care that are an alternative to the GP private business model to meet complex health needs of diverse communities and improve equity. Such models would have salaried medical practitioners and also embrace the wider role for nurses in primary health care.
- 5.12. As all GP and PHC services are required to be under a Primary Health Organisation (PHO) for funding purposes, an important equity-focussed question is how well PHOs are serving community-based, low-cost access practices. The last two decades have been very difficult for smaller PHOs who are serving high needs populations. Many of them have been forced to wind up or integrate with larger PHOs who do not necessarily share the same values or community base.

6. Variation in Hospital and health Services

- 6.1. A frequently made comment by working people and citizens is that having entered the public health hospital and public specialist systems, people get good treatment and services. But there are variations in services and access provisions.
- 6.2. The New Zealand Atlas of Health Care Variation collects data from all over the country and shows variations in different places. The Atlas will be a useful new tool to assess the variation and the quality of health care through its mapping and as stated “will be incredibly useful for seeing patterns and starting to ask questions about why, after you’ve accounted for the different populations living there, different places seem to do things differently (Shuker, C & Gauld, R, 2019). It is

inequitable that people who need health operations and procedures have different access depending on where they live or their ability to pay.

- 6.3. DHBs all collect information on waiting times for specialist appointments and waiting lists and some of these are recorded in the form of health targets. While we had and have criticisms of health targets, the information about waiting times and access is essential data for mapping access and equity.
- 6.4. While our hospital-based services are held in good regard, there are growing concerns about access to services. There are enormously concerning issues regarding access to maternity, dental health, cancer and elective services. Timely access to mental health services has become a national crisis graphically described in the Mental Health and Inquiry Report, He Ara Oranga (NZ Government Inquiry, 2018).
- 6.5. There are multiple reasons behind barriers to access and we cannot and do not address all of these in this submission. But the role of the workforce is critical in this and the pressures on the workforce and this is expanded upon in our affiliates' submissions. Access to services is inextricably linked to medical, nursing, midwifery and allied health professional workforce issues – both to shortages, workforce sustainability and salaries. There are constant big pressures on health professionals working in rural areas. Pressures are across the workforce and the role of other health workers in sustaining our health services is undervalued and under-recognised.
- 6.6. This Review should draw attention to the anomaly that is created when people with disability caused through illness do not receive the same level of services, compensation and rehabilitation as those who are covered by the ACC scheme. This is an issue of equity.
- 6.7. The Review should also draw attention to the growing pressure and needs for dental services to be fully publically provided and the inclusion of dental services in improving health equity and outcomes.

7. Funding and access

- 7.1. Most of the funding for New Zealand's health service comes from taxation, with government spending at \$18.2 billion in 2018/19. Our public health care is tax-funded and it is a small segment who will pay more for service in the private sector. It is a deeply held belief of the people of Aotearoa New Zealand that we should have access to all secondary and tertiary health services through the public health system.
- 7.2. There has been a position argued in recent years that we cannot sustain or afford a comprehensive public health service. We challenge that view and are very concerned that the view is based on a misrepresentation of health care spending. We endorse the call in an article about the funding of New Zealand's health care systems for an honest appraisal and public debate about health care spending. (Keene et al., 2016).
- 7.3. There are compelling reasons why New Zealand can and should be spending more on health because of population growth and ageing, mounting evidence of increasing unmet need and also because if the needs are not met by the public health service they have to be borne by the economy in other ways. Investment in health care mitigates later health costs and improves quality of life.
- 7.4. Capital expenditure is a significant issue and will be an ongoing for most of our DHBs. Treasury reported in 2007 of DHBs "sweating their assets and under-funding repairs and maintenance to help balance their books" (Treasury, NZ, 2017). The neglect of capital expenditure over the last ten years means that the need for additional Crown support will continue. The case of the state of the buildings and general neglect at Middlemore Hospital was a wake-up call for the health system,
- 7.5. Added to this is the growing pressure on the health system caused by the growth in poverty and homelessness and rises in the incidence of obesity, diabetes, alcohol and drug misuse and addiction, and rates of depression and suicide. This has all been exacerbated by significant underfunding of DHB hospital services.

- 7.6. There has been a focus on strengthening primary health care to deliver services closer to home and in community settings and this is supported. But we note the data and concerns suggesting that funding is not moving or increasing into primary health care. We support the call for further investigation to understand why services and funding are not moving into primary health care settings.
- 7.7. People on higher incomes are more likely to buy health insurance (Ministry of Health, 2016). While long waiting lists will lead some people to purchase private health insurance this will be out of the reach for most working people. People with private health insurance have quicker access to non-urgent treatment than those without health insurance. This is a driver of inequity of access in the health service.
- 7.8. There are strong reasons and compelling evidence to conclude that health needs are more efficiently and equitably provided through public health care provision. Treasury itself notes this (Treasury, NZ, 2012). Private provision of health care is not better for people, the country and the economy as is shown so very clearly by the health outcomes from the United States health care system.

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