Measuring and Improving State Sector Productivity

Submission to the Productivity Commission

Date: 11 September 2017

Contact

MARILYN HEAD, BA, MSC, PGCERT PH, SENIOR POLICY ANALYST

DDI 04 494 6372 OR 0800 283 848 | E-MAIL **MARILYNH**@NZNO.ORG.NZ **|** www.nzno.org.nz

NEW ZEALAND NURSES ORGANISATION | PO BOX 2128 | WELLINGTON 6140

About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation, Tōpūtanga Tapuhi Kaitiaki o Aotearoa, (NZNO) welcomes the opportunity to comment on your issue paper: *Measuring and Improving State Sector Productivity.*

2. NZNO has consulted its members and staff in the preparation of this submission.

3. As an affiliate of the New Zealand Council of Trade Unions (NZCTU), NZNO also met with the Productivity Commission ("the Commission") and other unions to discuss the objectives of the inquiry.

4. As noted at that meeting, we are not sanguine that the time NZNO puts into responding to the myriad of duplicative consultative processes purporting to improve state sector services is an efficient use of our limited, member-financed resources.

5. Respectfully, the ideological framework the Commission operates within appears to be focused on moving away from universal state services and community and individual empowerment, towards targeted, privatised services and individual self-responsibility. This is contrary to the direction recommended by NZNO in its recent publication "Priorities for health" which identifies actions needed to

ensure state services deliver measureable cost-effective improvement in population health and health equity, which underpin productivity[1].

6. However, in line with our understanding of what you are looking for, this submission is limited to *briefly* identifying issues and programmes that measurably affect:

    - the ability of nurses to efficiently deliver health care they are trained to deliver; and
    - the sustainability of the nursing workforce.

7. In general, we feel that there is a lack of coherence and leadership on core government policies, which translates to a lack of shared tools, indicators and measurement. The lack of consistent and shared approaches across multiple agencies with respect to our aging population, climate change, and child poverty, for example, too often leads to misaligned, even contradictory strategies, that may "hit the target, but miss the point"[2].

8. Meaningful results in the state provision of health services are those demonstrated over time at population level showing: improved equity; improved health and safety; and long-term sustainability.

9. NZNO would be happy to discuss any matters arising for this submission.

DISCUSSION

Integrated Policy:

10. It is widely acknowledged that "health makes an important contribution to economic progress, as healthy populations live longer, are more productive, and save more"[3]. Population health is shaped by the social determinants of health, with the most productive nations being those with the most equitable social structures and economic systems[4].

---

[1] NZNO 2017. *Nursing Matters: priorities for health*. Wellington: NZNO. http://www.nzno.org.nz/Portals/0/publications/2017%20NZNO%20Manifesto%20-%20Nursing%20Matters.pdf

[2] Eg Armagh, M. 2015. What have five years of the shorter stays in the emergency department health target done to us? *NZMJ*: Wellington. Retrieved https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1421-4-september-2015/6640

[3] WHO website: health and development retrieved September 2017 http://www.who.int/hdp/en/

[4] Commission on the Social Determinants of Health. 2008. *Closing the Gap in a Generation: health equity through action on the social determinants of health*. Final Report of the

11. Despite multiple health 'reforms' over the past decades[5], there are still significant disparities in access to all levels of care, including access to basic primary health care (PHC), the most cost-effective means of reducing future health and social service demands and improving equity[6]. See, for instance, the Ministry of Health's *Ngā mana hauora tūtohu: Health status indicators for Māori*[7].

12. High productivity in the health sector is largely dependent upon an efficient interface between all aspects of community and hospital care. That interface is provided by the nursing team, which comprises regulated nurse practitioners (NPs), registered and enrolled nurses (RNs, ENs) and midwives, supported by unregulated health care assistants (HCAs) or kaiāwhina).

13. Nurses constitute the largest group of health workers, providing frontline health care in almost every health setting 24/7 throughout Aotearoa New Zealand. The extent to which nursing workforce is utilised, developed and sustained has a very real impact on the health of New Zealanders.

14. Unfortunately little has changed since NZNO's analysis of the challenges for health detailed in a comprehensive document prepared for the 2011 election[8], which we strongly recommend it to your attention.

15. Significant barriers still include, for example, the continued failure to update obsolete medicines legislation (the long-awaited new regulatory regime for therapeutics products foreshadowed in 2015 appears stalled) or to address the unsustainable reliance on migration (the highest in the OECD) to meet on health workforce demands, resulting in a poorly utilised health workforce, with a high turnover.

16. More fundamentally, there are systemic issues, eg with the delivery mechanism for PHC (the main entry point to the health system) through capitation-based private GP services, which present cost,

---

Commission on the Social Determinants of Health. Geneva: WHO: National Health Committee.

[5] Parliamentary website. Retrieved September 2017. https://www.parliament.nz/en/pb/research-papers/document/00PLSocRP09031/new-zealand-health-system-reforms

[6] World Health Organization. 2008. Primary health care: Now more than ever. Geneva: WHO.

[7] Ministry of Health website. Retrieved September 2017. http://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators

[8] NZNO. 2011. http://www.nzno.org.nz/Portals/0/publications/New%20Zealand%20Nurses%20Organisation%20Manifesto%20Elections%202011.pdf

cultural and location barriers, often to the most vulnerable and those with higher health needs where there is the greatest potential for productivity gains (ie better health outcomes over a lifetime, from timely, low level health interventions).

17. Currently, neither policy nor funding models allow for the potential of integrated PHC services to *contribute* to health as well as to prevent and manage disease to be realised - eg through services centred on employment, community empowerment or environmental integrity as well as professional health education, counselling and screening, immunisation etc.

18. ACC is another area where increasing co-payments preclude equitable access to care and opportunities for prevention and early intervention. A $50 co-payment (roughly equivalent to the usual doctor's fee) is a significant deterrent to registering an injury, which undermines the inclusiveness and accuracy of collected injury data and prevents timely assessment and treatment.

19. There is simply a lack of vision with regard to coordinating core government policy and aligning investment in state services that fundamentally affect the conditions in which "we grow, live and work"[9] that consequently affects measurement and productivity.

20. Disparate and poorly aligned policy and regulatory frameworks for housing, child poverty, employment, social support (benefits, minimum wage) climate change, and investment, are manifestly wasteful of human and other resources. For example, the tens of millions of dollars poured into concentrated throat swabbing programmes to stem the shameful rise in child rheumatic fever amongst poor Māori and Pacific peoples are consistently undermined by cold, damp housing and poverty[10], yet 'new' regulations for insulating rental properties introduced in 2016 reinforced the status quo of outdated, inadequate standards[11].

21. Similarly, multiple papers by the Law Commission and others, including *Controlling and Regulating Drugs* (2010); the *Misuse of Drugs Act*

---

[9] Commission on the Social Determinants of Health. 2008. *Closing the Gap in a Generation: health equity through action on the social determinants of health*. Final Report of the Commission on the Social Determinants of Health. Geneva: WHO: National Health Committee.

[10] Massey University Environmental Health Indicators website: http://www.ehinz.ac.nz/indicators/indoor-environment/health-conditions-related-to-cold-and-damp-houses/ and http://www.ehinz.ac.nz/indicators/indoor-environment/health-conditions-related-to-household-crowding/

[11] "*These are minimum standards and are consistent with the national requirements for new buildings and alterations introduced in 1978*" Beehive Website Q & A Tenancy law Changes : https://www.beehive.govt.nz/sites/all/files/Q&As.pdf

Review (2011), and the earlier Issues paper *Alcohol in our lives* (2009) highlighted the huge human, financial and social costs of the inconsistent approach by Justice and Health Ministries to drugs (legal, prescription and illegal), yet subsequent policy, regulation, and legislation have failed to act upon the recommendations.

22. Moreover, even where there are common, evidence-based tools available for policy planning, development of major infrastructure at local, regional and international level eg the excellent Health Impact Assessment and Whānau Ora Impact Assessment tool, developed by the Ministry of Health, they are not used.

23. Without a shared vision or tools, measurement of the efficiency and productivity of state services is often fragmented, too narrowly focused and taken over too short a timeframe. Eg Key parts of the Children's Action Plan (part of the suite of fragmented development of regulation and action around 'vulnerable children') completely failed to recognise, let alone measure, the significant impact of the lead coordinator role for children's Teams (CTs) being delegated to nurses. Waikato and Christchurch DHBs found that workloads nearly doubled, immunisation programmes were disrupted, and the health of both at risk and acutely at risk children compromised. Both Ministries – Social Development (now Ministry of Vulnerable Children Oranga Tamariki) and Health – reported very positive outcomes from the CTs and were unaware of the adverse consequences for nurses.

24. This 'positive spin' is not unusual in Health innovation, the most egregious example being the now defunct Health Benefits Limited (HBL) using $500 million DHB funding with dubious results[12].

25. Meaningful results in the state provision of health services also require measuring so-called 'externalities' like the health impacts of work on workers and stressors, happiness, ability to engage with their communities and families outside work, etc. Work is not productive if it costs the public health system and drains quality of life (time for exercise, free time not on call, emails or multitasking, parenting etc.)

Care Capacity Demand Management (CCDM)

26. CCDM is a management system focused on improving the quality of care for patients, the work environment for staff and organisational efficiency. The programme is an organisational approach to ensuring the demand for patient care is matched accurately and effectively with the resources required, in 'real-time'. It was developed as part of a 'safe staffing/healthy workforces initiative, and is being implemented and resourced via an agreement between the 20 DHBs (shared

[12] Auditor-General, *2015 Inquiry into Health Benefits Limited*. Retrieved September 2017http://www.oag.govt.nz/2015/inquiry-hbl/docs/health-benefits-ltd.pdf

services), the New Zealand Nurses Organisation (NZNO), the Public Service Association (PSA), and the Service and Food Workers Union (SFWU)[13].

27. CCDM has been introduced in all DHBs (but not community provided services), and two DHBs have decided against using the only credentialed tool to data management, TrendCare. Although there have been some good results, DHBs have generally used it to address immediate staffing shortages, and have been slow use to act on the long term implications.

Nurses contributing to positive health outcomes

28. the following fact sheets detail some of the measured ways in which nursing workforce contributes to positive health outcomes:

    - College of Primary Health Care Nurses, NZNO. 2012.*Maximising the Nursing Contribution to Positive Health Outcomes for the New Zealand Population* retrieved September 2017 http://www.nzno.org.nz/Portals/0/publications/Maximising%20the%20Nursing%20Contribution%20to%20Positive%20Health%20Outcomes%20for%20the%20New%20Zealand%20Population,%202012.pdf

    - NZNO. 2011. *How nurses in aged/residential care improve health outcomes* retrieved September 2017 http://www.nzno.org.nz/Portals/0/publications/How%20nurses%20working%20in%20aged%20and%20residential%20care%20improve%20health%20outcomes.pdf

    - NZNO *How nurses in nurse-led clinics improve health outcomes* retrieved September 2017 http://www.nzno.org.nz/Portals/0/publications/How%20nurses%20in%20nurse-led%20clinics%20improve%20health%20outcomes%20-%20fact%20sheet.pdf

    - NZNO. 2011. *How nurses in primary health care improve health outcomes* Retrieved September 2017

      http://www.nzno.org.nz/Portals/0/publications/How%20nurses%20working%20in%20primary%20health%20care%20improve%20health%20outcomes.pdf

[13]TAS website: Care Capacity Demand Management https://tas.health.nz/strategic-workforce-services/safe-staffing-health-workplace/care-capacity-demand-management/

29. Other examples of collaborative PHC models, best practices and tools for supporting non communicable disease (NCD) efforts include

- **Whānau ora Model at Te Manu**: Te Manu Toroa is a community led whānau ora model that utilises a range of clinicians (including an NP, community nurse specialists, tamariki ora (Well Child) nurses, practice nurses), GPs, dentist, dietitian) and other social service and juvenile justice workers to deliver kaupapa Māori health and social services to a poor, high needs, mainly Māori, population[14].

- **National Child Health Information Platform** (NCHIP): NCHIP is a software solution for a system that collects health milestone information for children aged 0-6 years old, mainly provided by nurses across six service providers: Lead Maternity Carers, General Practice, Well Child Providers, New Born Hearing, Oral Health Metabolic Screening and the National Immunisation Register. The database is monitored by a co-ordination service which works to ensure all children receive the milestones scheduled for them and ensure good health or appropriate follow through.

  The system has been live in the Waikato since November 2014 and Gisborne since November 2015, and is due to roll out in Taranaki and the Lakes district in the first half of this year.

- Family Planning New Zealand's nurse-led telehealth services to ensure access to advice and treatment eg prescriptions for contraception, emergency contraception pill for rural clients and those in areas where there are no FP services.

- **Victory Community Centre** – Award winning school-based community centre. As part of an extensive range of services, many provided voluntarily, nurses provide easy access to a wide range of free health and social services Ie Plunket Nurse, Parent's as First Teachers and Pathways to Health Solutions, midwives, cervical screening, hearing tests, B4school checks, Work and Income and NZ Police Victory base and our own After Hours Nurse Clinic[15].

- The Primary Health Care Organisation, **Compass Health**, covers a large number of GP practices, and monitors and supports them to attain targets relating to a variety of preventative diseases. It monitors each medical centre's population and advises the practices how they compare to other practices in the area. The practices are paid an incentive to deliver on these targets and also receive a

[14] Walker, L; Clendon J; Nelson, K. Nursing roles and responsibilities in general practice: three case studies *J PRIM HEALTH CARE* 2015;7(3):236–243.
[15] See Website http://www.victorycommunitycentre.co.nz

payment as each target is reached. Nurses are responsible for all the screening recalls etc.

The PHO also employs a team of Health Promoters who run regular free sessions covering all aspects of Healthy Lifestyle Living and Self-Management courses. One of the remote practices, The **Eketahuna Community Health Centre** was set up by and is run by nurses working in isolation. These nurses are supported by phone by the Medical Centre in the next town, and have five hours doctor service once a week.

Lack of robust measurement in Health Workforce Planning - unproductive initiatives

- We have already referred to the **overreliance on immigration** to meet health workforce needs – see our recent discussion document on *Internationally Qualified Nurses: Immigration and other issues*. (2016) which details the risks and adverse consequences. http://www.nzno.org.nz/Portals/0/Files/Documents/Resources/Policy%20Analyses/2017-02%20FINAL%20Immigration%20discussion%20paper.pdf.

  See also Hawthorne's analysis of extremely poor outcomes from immigration for Aotearoa New Zealand[16] and Zurn and Dumont's 2008 analysis for the OECD *Health Workforce and International Immigration: can New Zealand' compete*[17]*.* From NZNO's perspective, policy planning, monitoring and measurement of immigration outcomes is highly reactive and short-term.

- **National bowel screening programme**: Despite funding to roll out the national bowel screening programme after a lengthy demonstration in Waikato, and despite recognition of, planning and funding for urgently needed workforce development including training and education for nurse endoscopists, the latter has not happened. In 2016 four nurses completed the education programme at the University of Auckland; this year the course was withdrawn because there were only two applicants. This did not deter the budget announcement of the roll out in 2017 and, as far as we are aware, nothing has been done to address the situation. The endoscopy Governance Group (EGGNZ) is focused on developing consistent standards of training and qualifications because the

[16] Hawthorne, L. (2012). *Health Workforce Migration to Australia: Policy Trends and Outcomes 2004-2010*. Melbourne. Hawthorne, L. (2014). *A Comparison of Skilled Migration Policy: Australia, Canada and New Zealand*. Melbourne. Retrieved from http://sites.nationalacademies.org/cs/groups/pgasite/documents/webpage/pga_152512.pdf

[17] Zurn, P., & Dumont, J. (2008). Health Workforce and International Migration: Can New Zealand Compete? (DELSA/HEA/WD/HWP No. 33). Paris.

quality standards for bowel screening programme have been prioritised even though there is no-one to deliver it.

- **Nursing workforce** – there are longstanding issues with the effective use of all three nursing scopes of practice and underrepresented groups including Māori, Pacific, and male nurses. Nurse practitioners and enrolled nurses face employment barriers, while supported entry into practice through the Nurse Entry to Practice programme is available to just 60% of new graduates. The extraordinarily rapid and largely unmonitored introduction of unregulated HCAs led to a lengthy period of uncertain roles and substitution which was unsafe for both workers and patients, and has led to the rapid decline of the enrolled nursing workforce. While steps have since been taken – largely because of safety issues and the advocacy of nurses – the impact productivity of this significant workforce change has yet to be measured in terms other than staffing costs.

CONCLUSION

30. NZNO's main concern is to ensure that state services' productivity is measured against indicators developed through coordinated, long term policy and planning, not only specific programmes. Meaningful results in the state provision of health services are those demonstrated over time at population level showing: improved equity; improved health and safety; and long-term sustainability.

31. We suggest there need to be shared tools, such as Health Impact Assessments, which are consistently used across agencies.

32. We have made a number of suggestions and offered examples of areas where nursing could be used to improve health sector productivity and health outcomes.

33. We trust the above is useful and look forward

Marilyn Head

Senior Policy Analyst