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Women of New Zealand
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Wahine O Aotearoa

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Submission to the Ministry of Health on: Ageing New Zealand and Health and Disability Services Demand Projections and Workforce Implications 2001-2021

The National Council of Women of New Zealand (NCWNZ) is an umbrella organisation representing 41 nationally organised societies. It has 33 branches throughout the country attended by representatives of those societies and some 150 other societies. The Council's function is to serve women, the family and the community at local, national and international levels through research, study, discussion and action. NCWNZ has a longstanding history of encouraging the promotion of social and health issues, particularly as they affect women.

Because there was a reasonable time frame allowed for discussion to take place, regarding this document, NCWNZ was able to contact branches for their input. The members of the Health Standing Committee and other interested parties were also asked for their input. The following is a summary of their comments.

General Comment
Since 1897 the function of NCWNZ has been to 'serve women, the family and community at local, national and international level through study, discussion and action.' A concern as early as 1897 were the working conditions of nurses and care of the elderly.

NCWNZ has over the last 10 years made submissions to various organisations about the plight of the aging population and their ongoing health needs.

In 1995 a submission to the National Advisory Committee on Core Health and Disability Support Services stated,

"Older people are staying in the community longer and we welcome this trend. However this puts an increasing burden on the carer and family members. Many carers, spouse or family members, are older people themselves and their own health could be jeopardised by the burden of care. The stress of caring for an older person in a family situation can be high. Increasing demands on finances can sometimes result in physical or emotional abuse and neglect and we would hope that planning ensures support for carers and that their needs are met and respite care available."

Some respite care is available to those caring for elderly within a family situation. This is often not taken up, in terms of taking a break, as in many families both adults are working to maintain a quality of life for all.

In 1997, the submission to the "**Prime Ministerial Task Force on Positive Ageing**" contained a very telling line, regarding attitudes to ageing. It was that, *"People should be referred to as growing, rather than ageing, just as our young people are."* The attitude should still be up for consideration.

In 1999, in a submission to the National Health Committee on the Draft Consultation Document: "**Health and Disability Services for Older People**", concern was expressed about the inadequate funding of rest homes for the elderly. Recent proceedings to close residential care facilities run by

the Salvation Army, as one example, highlights to us that this is still a problem that needs serious consideration and action.

NCWNZ welcomes this research document as part of the implementation of our policy resolution that states:
"That NCWNZ recommend, because of the increasing number of persons over 75, that the health policy for New Zealand give greater emphasis to the planning and provisions of healthcare services for older people, both at home and in residential care, with more publicity for the services available in the community." 1999

Our policies state further:
"That NCWNZ advocate the development of a National Strategy on Ageing." 2000

We note with concern however that the consultation process involved, in round 1, fifteen persons representing nine organisations, with consumer representation being perhaps through Presbyterian Support Services (Northern). In round 2 there were eighteen persons representing sixteen organisations with perhaps the New Zealand Council of Trade Unions representing the consumer. The South Island, with its wide rural population and specific issues covering costs of heating and travel were specifically represented by the Canterbury DHB on both occasions. This was seen as not equitable.

Members question why organisations like Age Concern or Greypower were not involved at the beginning of the process, as surely they would have a valid perspective on the issues under discussion.

It was interesting to note the lack of unity amongst your consultees as to the effect of the ageing population on health resources. While acknowledging that there will be an increase in the older population, we believe that does not necessarily mean that there will be a rise in the demand for health services. A recent submission by NCWNZ (3 February 2005) to the Finance & Expenditure Select Committee on the **2005 Budget Policy Statement** noted,

"While it is accepted that people overall are living longer, questions have been raised, particularly by inter alia, economists Len Bayliss and Paul Moeseke, as to whether the social costs of 'an ageing population' should cause particular concern …"

The present generation who will be in the older aged category in 2021 have had the advantage of improved life styles and greater awareness of the benefits of preventive measures and maintaining a healthy fit lifestyle therefore NCWNZ is concerned that the timescale under discussion, 2001 – 2021, is already 4 years into that period. It is assumed that 2001 was chosen because that year offered the most data, but the statement on page 44 of the document that assumed '*the provision of services met demands in that year and that consequently, demand for labour was matched by supply of labour*,' does not reflect the anecdotal reports of the membership.

While understanding that statistical research in such a field as this is an imprecise science, members were concerned about the large numbers of qualifying statements throughout the document. It is agreed that figures do not tell the whole story, that there are social implications for real people within any resultant applications.

Specific Comment
These responses are to most of the specific questions raised under each heading.

7.2 Changes in primary care

- Although most members believe that primary health care is equated with general practice, many also recognise much more should be involved in care delivery. Holistically, primary care should include areas of health, nutrition, housing and safety. Therefore this needs a whole of government approach. Ageing and disability is not only disease related. Environmental factors such as exposure to chemicals, and sunlight affect the way we will age, just as events and life crises can cause the early onset of frailty.
  Most members agreed that much more needs to be done in taking a proactive stance by promoting healthy lifestyles, with the emphasis on diet, exercise, and smoking reduction.

  Other suggestions included :
  - the use of mobile clinics at supermarkets, TV ad campaigns and contact through groups to which the elderly belong, to be used to inform them of choices available;
  - better access for rural communities with more linking of services and more information sharing;
  - the promotion of Healthline as an important communication tool especially where GPs, physiotherapists etc are not readily available.

  It was observed that primary health care has been through numerous changes, often to the detriment of patient care. There is a perception that it has become less focussed on the person and more on the achieving of market model targets. Members believe that long term and continued planning for the care of the elderly, with particular emphasis on keeping people in their own homes where possible, needs to be set in place urgently. Systems, personnel and funding issues and support agencies need action now. We support the Government's stated goal of greater cultural awareness in all processes and protocols, particularly within the health sector.

  While it is acknowledged that there will always be the appropriate health professionals, the capping of numbers training in the medical school is seen as having a detrimental effect now. Student loan debt has created a retention problem as many go overseas to higher paying jobs to enable them to reduce their debt more quickly. The net effect of this being the loss of some of those who are already in the workforce, through stress and fatigue.

- General practice can be made more attractive by the use of financial incentives, by support through the use of technology, e.g. telediagnosis, by outreach clinics visited by specialists, etc. The isolation of rural practitioners could be eased with relief services. A rural liaison doctor could also be appointed to a base hospital to coordinate and mentor rural practitioners. Again, the same funding, relief, support and liaison would be essential.

- It is hoped that the new PHO process will give some certainty of practice and delivery to both the medical staff and the patients. Only time will tell but attracting doctors to the rural heartland has always been fraught with difficulties. Otago University has successfully instituted a rural work experience component into the medical students' curriculum. While the lifestyle attracts, the sense of isolation generally precludes long term stays. Increased availability of technology could assist but having the back-up of other professionals so that reasonable hours only need be worked, are crucial to the retention of the rural doctor.

  A role is seen for the employment of nurse practitioners particularly in the rural sector, but only if their training and experience is appropriate.

- Some changes will need to be made to the current model to particularly suit the ageing population. This may mean that specifically trained health professionals will need to be aligned to a general practice setting. NCWNZ believes that mental health and disability assessments,

and support services should be provided at an early stage for people being cared for in their home.

This could mean more occupational therapists, physiotherapists, 'district' nurses and doctors making home visits. While seeming more expensive this should cost less than residential care.

7.3 What needs to be done to promote new ways of working?

- Many members believe that an evolutionary approach to redefining jobs is likely to be more acceptable to the workforce; that pilot programmes could be tried where this is providing no definitive advantages. These should be properly evaluated before being implemented nationally. The evolutionary approach is seen as possibly being more flexible and able to reflect local issues better. It was agreed that not every new idea will work in all areas.

- NCWNZ felt that if paramedical practitioners were to be trained to undertake skilled but routine jobs, as suggested in the discussion document, then tasks must be well defined.

- Accountability could be maintained by very precise job descriptions with lists of specified tasks. The job description which is a living document requires to be reviewed with the worker on a regular basis as the job evolves. Good supervision would also be required

- Members believe that the HPCA should not be a hindrance as individual health professions have their own sets of guidelines and expectations formulated to ensure that they meet the requirements of the Act.

- It was agreed that rather than more legislation or regulation being needed, a good dose of applied common sense would be simpler.

7.4 How must education and training change?

- NCWNZ feels that accreditation of prior learning and experience should be more extensively used as a basis for the needs addressed in this paper. There will need to be a workforce with inter-occupational mobility. Training needs, therefore, to be more holistic. For people with multi-diagnoses a broad outlook is needed.

- NCWNZ is encouraged that there already exists in many health curricula common areas of learning, so that all primary health care workers have a core curriculum, with add-ons for their particular area. This encourages some standardisation of practice.

  The enrolled nursing (E/N) qualification should be promoted more widely and accepted, as there is still a need for a hands-on bedside nurse who is there for the patient, to attend to their daily needs. NCWNZ understands that the latest E/N's are required to qualify in specific areas which are now written on their practising certificates e.g. in elderly care.

  Support workers in appropriate areas, should be required to do basic module courses and be supervised on the job by professional staff.

  Extra training should be available in geriatric and psychogeriatric nursing care, so that there is an equitable level of care available in all situations. Retraining of workers should be on-going and readily accessed.

  Different training, more understanding of the abilities and strengths of the elderly, more available home help, also need to be considered. Therefore, systems need to be revised and updated to cover a range of situations.

One member has pointed out that, in many courses, what is taught tends to be idealist and as funding is always limited, it might be better used for the purchase and training in the use of equipment, that would assist independence in the home, as well as in care institutions.

- NCWNZ believes that before any changes are made to training there needs to be consultation with all affected parties, i.e. Royal Colleges and other professional bodies, universities, polytechnics, Tertiary Education Commission, etc.

  Current programme providers should cooperate to address the question of what is needed for this group of health service consumers. All groups dealing with health training in the field of care of the elderly and disabled should have input into what is required.

  As stated in 7.2 above, consideration must be given to enabling people to be cared for in their own homes for as long as possible and there needs to be a greater emphasis on the training of caregivers/support workers. Training should take account of the diverse cultural groups living in New Zealand - there needs to be a greater cultural awareness in community health services.

  Training for semi-skilled workers is very important within both the older persons sector and mental health sector. It was suggested that workers are willing to undertake training but the costs to the employer need to be factored into the contracts with the MOH and DHB.

- Regulation should be done within a practice or agency and this would cover the need for more education training and accreditation, especially of support workers, and those working in counselling roles.

7.5 Recruitment and retention

- NCWNZ members consider pay and conditions are generally regarded as being equally important, while for others conditions and recognition are the more important. Recognition of experience must not be overlooked. For support staff, better money and on the job working conditions which include training and supervision, being given credit for excellent service, ensuring that they are not always treated as though at the bottom of the pecking order are important. It is recognised that pay rates for support workers will not improve without incremental increases in skills and a career path.

  Nevertheless, while hospital nurses have finally got a much-needed increase in salary, other health workers also deserve an increase. Workers who give personal care to the elderly whether at home or in residential care are generally very poorly paid. When the government is pushing to get more women back into the workforce these are jobs that would suit part-time workers if they were better paid. The taxation regime for those having one or more part-time jobs is also regarded as discouraging.

- There will always be difficulties in recruitment and retention in rural areas, with most people wanting to live in the main centres, where there is collegial support, professional support and facilities for further referral. To encourage people to work and live in rural areas and smaller communities needs a financial incentive and to recognise that the position is valued and appreciated. Other issues have been dealt with in section one.

  To improve recruitment in the support worker section there should be less casualisation of staff.

  Payment for these workers, at least in the not for profit sector, is limited by the contracts that the MOH and DHBs provide. Additional funding has not, to date, been available to increase wages for the semi skilled support workers.

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- Student debt is a large factor in the recruitment of medical personnel and discourages people from entering a profession that is seen to be not well rewarded. Many young health professionals can earn a lot more overseas where they are in demand. Increasing the numbers being retained in New Zealand would help reduce the stress levels in colleagues, as mentioned earlier. Bringing foreign staff in to replace them, while useful in the short term, is not a solution, as they often do not have the same training or culture.

- With reference to geographical and specialty-recruitment problems members were divided, some believing that they should be dealt with in conjunction with the area concerned but through centralised action.

  Others believe that centralised action is not appropriate. Their argument is that people need to be motivated by factors viewed by them to be important, rather than be directed. A portion of the student debt could possibly be waived to encourage those who have the qualifications needed, to enter some of the service areas that are short of personnel.

  For care-givers who travel to rural clients there needs to be recognition of the true costs involved. To this end NCWNZ at its 2004 conference passed the following policy:

  "That NCWNZ request the Government to include the costs of travel in the remuneration for government contracted providers of home-based care."

- Members agreed that the major issues are the low value given to this work by society, the general low rate of pay, conditions of work, a career path not easily seen or made attractive to young people, the difficulties associated with rural practices, dealing with student loans and taxation regimes.

  Labour shortages can be addressed by encouraging more people into medical, nursing and allied health fields by way of financial incentives, or for some who will work in rural areas, by way of bonds. It worked in the past.

  One member said her support network advises that 80% of care workers work only 2 hours per week. Less than 10% work more than 8 hours per week. Many of these workers who are on a benefit wish only to work restricted hours so as not to affect that benefit. Recent changes in benefit protocols will allow these workers to take up more hours of work without such a restrictive clawback previously experienced. This group is mobile and moves to where the pay and conditions are better.

  Skilled workers, primarily Registered Nurses (RN's) are very scarce for both the DHBs and the not for profit organisations. The fact that MOH has now allowed a much higher rate of pay for RNs, who work in the hospital setting, for example, further disadvantages the not for profit sectors who do not get adequate funding in their contracts to cover these new increases so cannot compete with DHBs.

  There needs to be support and supervision for all employees in the form of constructive feedback and clarity about priorities and best practice approaches. Those most in need are the support workers. Managers of care for the elderly should be post-graduate health professionals of the first order as well as having the managerial experience needed for such roles.

7.6 Maori and Pacific peoples' health

- Over the years there have been many opportunities for Maori and Pacific people to train in the health professions and it would be expected that these people will be working with their communities, providing their health needs, in an appropriate manner. Maori health is very much affected by housing, water, smoking, and diet. A continuation of Maori health workers to work alongside their people and sufficient funds to improve housing and living conditions is still needed.

  Unfortunately, there is still a resistance by some European workers to recognise the cultural needs of Maori and Pacific Island people. More Maori and Pacific Island people, especially women, need to be encouraged to enter the health and caring professions through gaining appropriate pre entry education, scholarships with a commitment to work for a set period following the completion of training, better wages and lower student fees. Existing Maori and Pacific role models should be used to promote this work. There also needs to be more support for whanau who care for their kaumatua and kuia at home. The emergence of Maori Health Trusts is a positive development but they need support, not constant criticism from the media. Programmes to help people give up smoking are having good results. More needs to be done to look at benefits paid for the provision of proactive treatments.

- Caregivers need an understanding of any culture they are working with. It is thought that, rather than training people to only develop cultural awareness of the needs of Maori and Pacific people, more is now required, because of demographic changes, for these people to be sensitive to the cultural needs of Europeans and Asians.

  Cultural awareness has been well covered in those trained in New Zealand but there needs to be training for those coming in from other countries to work here.

- NCWNZ is very aware of, would like to encourage and totally endorses the advertising programmes, targeting Maori and Pacific peoples regarding smoking, obesity, mammograms, cervical smears and the like.

7.7 Disability support services

- NCWNZ believes that while it is reasonable to think in terms of a single labour force specialising in this field, the work related issues will still be common to those on other care positions. Most of these issues have been dealt with under the other heading in this paper, like:
  - A higher value given to this work by society;
  - encouraging the elderly and disabled to live independently, in their own homes, for as long as reasonably possible;
  - a higher rate of payment made possible by increasing funding by the government to agencies;
  - career paths made more attractive to young people;
  - a need for a specialised training package for support carers, together with appropriate supervision;
  - coordination of services and networking;
  - better rural services with well qualified staff, etc.

  As stated in 7.4 the training should include common areas of learning, so that all primary health care workers have a core curriculum, with add-ons for their particular area. This would enable some standardisation of practice.

  Extra training should be available in geriatric and psychogeriatric nursing care, so that there is an equitable level of care available in all situations. Retraining of workers should be on-going and readily accessed.

Different training, more understanding of the abilities and strengths of the elderly, more available home help, also need to be considered. Therefore, systems need to be revised and updated to cover a range of situations.

- Frail older people may be those who have led a previously healthy and active life but are becoming less safe in their own homes. Onset of hearing and vision problems, loss of balance, etc. come on gradually and need early intervention. Treatment of these conditions as well as dental care needs to be addressed promptly. The frail elderly are also vulnerable to depression as lack of mobility, vision, hearing, increasingly isolates them. Some people will usually cope with a specific disability but not with multiple disabilities. Disability support staff need to recognise these needs, empower the elderly to make decisions about their lifestyle, not make decisions for them. People with long term disabilities may have more control over their lives in that they have had time coming to terms with and gaining insight into their problems.

  For older people, particularly those with a disability it must always be recognised their brain may still be active but that their intellectual and recall powers may not always be as sharp as they were. Therefore, any approach made to them should not be dumbed down. Support needs time.

- The true cost of keeping the elderly and disabled safe, healthily fed, cared for physically, mentally and spiritually, whether in private residential care, institutional care, rest homes, retirement villages or their own homes with support services readily available, needs to be assessed. No longer is the current weekly amount paid adequate, thus making the running of many of these places uneconomic and unsafe. There are a large number of semi-skilled workers being paid very low wages, with or without travel allowances, who provide the support for services, either in institutions or in private homes. Most of these people are providing excellent service but their plight is symptomatic of the poor financial state of these institutions.

  NCWNZ strongly supports the notion that remuneration must adequately reflect the expertise of the caregiver and the service being provided.

  There needs to be some recognition of the expansion of disability services that will be needed and readily available in the future. It has been suggested that ACC assessment services be extended and financed to cope with extra workloads and speedier services.

  Residential care is changing, in that the majority of Homes are owned by large companies where economies of scale are promoted. However, contracts with the Ministry of Health and District Health Board often do not reflect the increasing cost structures, particularly in the not for profit organisations. The result is that they end up withdrawing from the service.

  NCWNZ urges the consideration of long term and adequate funding, both for institutions and community-based services.

7.8 Mental health

- The answers in 7.7 above are also relevant to this section.
  Often there is still a stigma attached to patients who have mental illness, reflected in low numbers of persons seeking a career in this field.
- NCWNZ believes that more acute mental health services should be provided. There should also be long term funding and specialist retraining. The funding will also be needed to address public education issues and the promotion of the services available

- Studies should now be underway with organisations already in existence, e.g. Alzheimer's' Society and geriatric experts, to determine how to make access to diagnostic and treatment services easier. NCWNZ awaits with interest the results of the work of the *Expert Committee on Dementia Home-care and Day-Care.*

7.9 Volunteers

- Research priorities should centre around the issues of :
  - Understanding the volunteer sector
  - Being clear about what constitutes voluntary work and what should be paid work
  - Understanding the cost of volunteering, both time and finance
  - Producing guidelines for managing volunteers, including staff training.

  There are a number of groups with experience in such issues, beginning with NZCOSS, NZFVWO, Meals on Wheels, Rural Fire Service, St John's Ambulance inter alia, that could have valuable input into such research.

- NCWNZ feels that volunteers require managing in a similar way to employees, in terms of supervision, feedback on performance, communicating the value of the work that they do, consulting them when hours or conditions are changing, etc.

  Volunteers need guidelines. They need to understand the Privacy Act, relevant health and safety issues, their own limitations, staff expectations and work within the guidelines of their organisation.

  It is the interests of all, that volunteers undergo some basic training, if only to learn how the organisation with which they will be working, functions. Volunteers should be offered the opportunity to be part of the networks that offer such support and training. All paid staff and clients, will need to be clear that the volunteers are filling supernumerary roles, not taking the place of any staff. Staff also need training in managing volunteers. As mentioned above this is already happening in many organizations who would be able to provide leadership in such areas.

  Whether volunteers should be regulated is seen as a grey area, given that guidelines will achieve that. Current law is seen to cover most contingencies. If by regulation the document means like a union, then the questions arise of how, by whom and to what end.

- It is not appropriate to expect volunteers to take responsibility for support of the health and disability services no matter how skilled or experienced they are. Volunteers can be trained to do routine tasks but the clients should be seen by professionals who will make decisions relating to their care. If volunteers want to extend their role then they need to do the appropriate training and become qualified.

Concluding Comments

NCWNZ believes that there needs to be a commitment by all people and organisations working with the elderly, particularly the frail elderly, to recognise the importance of co-operation, collaboration, communication, while still maintaining the autonomy of each group. This needs to be acknowledged at all levels at which this service is undertaken. The attitude of protecting one's sphere of influence cannot continue because of the complexity of the situations in which the elderly, and those who care for them, are in.

Attitude changes within the community will also need to be made. It is important to recognise that there is a link between economic, social, cultural and physical health policies. As a result changes may include a change from the current work patterns, to one where there is more time and scope

allowed to develop healthy family living patterns and for the recognition and support for those who are working to help.

If the quality of family life, which includes a healthy diet, more leisure time and family time is emphasised then we are likely to find the cost of caring for the elderly will decrease in the long term.

NCWNZ believes there needs to be a unified health service, which causes minimum disruption to the patient.

Rural hospitals are seen to be under continual threat of closure. There must be a commitment from the politicians on adequate funding, to pay a premium for staff and services to enable the people of those communities to access health services. More funding should be put into hospital specialist training.

Some members believe that while there may be a need for some appropriately advanced qualifications at all levels, there also needs to be a good dose of common sense. Accepting that services provided need to be cost effective, it seems that the more specialised the service the more remote from the patient the service becomes. A person centred approach is most important to maintain the confidence of those people who receive these services.

Providers of specialist services, e.g. for the hard of hearing, the partially sighted, podiatrists, etc. could offer home visits as the equipment they use is not too cumbersome. Physiotherapists and Occupational Therapists already do this. The elderly may be able to make some payment towards these services from disability allowances. Services outside the medical sector, e.g. Income Support, may also need to be able to make home visits. It is often transport difficulties that deprive older people of the services to which they are entitled.

The Privacy Act is often cited by health services when asked to provide information to families and other caregivers. This can be to the detriment of the patient and the caregiver. Often families would like to be more supportive, but if the patient will not or cannot give permission to contact their family then contact cannot be made.

Problems accessing medical assistance after hours in some areas, especially in rural areas, still needs to be addressed. It is all very well to have all these services under discussion, working well during the traditional daylight working hours, but health problems often arise after hours and it is essential that these same services are available at that time.

Members have pointed out the need for more provision to be made for elective surgery, to improve the quality of life and prevent the need for long periods on expensive drugs. This can have an unnecessarily debilitating effect, especially on older people who are still trying to live an independent lifestyle.

Overall, it was felt that there needed to be a better co-ordination of services. There is some inefficiency and duplication and clear communication with clients is sometimes lacking. This becomes particularly noticeable when patients transfer across regions.

NCWNZ thanks the Ministry for this opportunity to contribute this discussion. We look forward to seeing the final outcome.

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