

Submission to Health Workforce New Zealand

Investing in New Zealand's Future Health Workforce

This submission is from Platform Trust, Level 3, 181 Thorndon Quay, Wellington.

Contact person: Marion Blake
CEO
Platform Trust
ceo@platform.org.nz
Ph: (04) 385 0385
Mobile: 021 790 587

Background information

Platform Trust is a national network of non-government community organisations (NGOs) that provide a wide range of mental health and addiction support services across New Zealand. Each year around 60,000 New Zealanders access support from NGO services.

Platform members provide a wide range of services that respond to the mental health and addiction needs of individuals, families and communities in New Zealand. Some examples of the work our members undertake are:

- Social housing, housing brokerage
- Employment support
- Healthy lifestyle intervention programmes
- Advice and advocacy
- Vulnerable child, child and youth services
- Peer support
- Education and training
- Family support
- Suicide prevention
- Arts programmes
- Addiction counselling, clinical support and methadone treatment
- Whanau ora services
- Respite and crisis services
- Intellectual disability services
- Specialist services such as eating disorders, refugee and migrant, trauma support
- Residential services
- Strategic sector workforce development
- Social services
- Software solutions for the sector

Platform's membership provides information and intelligence about mental health and addiction service delivery across the country, which in turn drives the strategic vision of the Trust. Access to the perspective and experience of Platform's membership has proved critical in a dispersed health purchasing system, and Platform is one of the few agencies able to provide a national overview across DHB areas.

Platform members (who account for about 90 percent of the total funding for NGO mental health and addiction services) also hold contracts with: the Department of Corrections (primary mental health and addictions); the Ministry of Social Development (child and youth, employment support, family violence, housing); the Ministry of Health; Housing New Zealand; the Ministry of Education; and other entities such as ACC and local governments.

Platform has worked closely alongside the Open Polytechnic in the development of the [Bachelor of Social Health and Wellbeing](#) and facilitate practicum placements in community mental health and addiction services for students as part of their Treatment Issues paper. We frequently work with organisations such as Te Pou o te Whakaaro Nui (Te Pou) to understand the existing workforce and the potential future workforce demands. We are currently in the process of co-authoring a paper about the future of

the mental health and addictions support workforce as a companion piece to On Track¹, a document that describes the future mental health and addictions system.

Summary

Platform is writing this submission as this paper identifies that strategic priorities include mental health and addictions and primary care, and we consider then that the community mental health and addictions workforce is included in the scope of this paper. The kaiāwhina workforce is also a term that is used in this paper to describe a segment of the workforce many of our members employ, however we note that this term is not one that is commonly used by the mental health and addictions workforce to describe itself. We feel this term is too broad to describe the composition of this workforce and that some work should be done to give common definitions to who in the mental health and addictions workforce is within scope of this paper.

We congratulate Health Workforce New Zealand (HWNZ) on its work to date on this paper. We absolutely endorse HWNZ's intention to create a more transparent and robust, future-focused workforce investment model. We also commend HWNZ for acknowledging that future, and in fact current, workforce need extends beyond medicine.

We agree that the current funding allocation mechanism through DHBs, described in the paper as the service funder led process, predictably creates drivers at odds with creating the workforce that is required.

However, we believe that this paper's aim to activate an investment approach to the workforce is in many ways premature. We believe that access to the necessary information and expertise to make evidence informed investment choices is currently lacking and with these omissions in data, such as actual measures of unmet need, we have concerns that the status quo will largely continue. The social investment approach itself in New Zealand is at present a paradox and there is no shared understanding of what that approach entails, but it is clear that social investment includes health investment. It is unclear how this work by HWNZ is joined-up with other government activity and strategy, such as the *Mental Health and Addiction Workforce Action Plan 2017-2021*².

The case for change

As indicated above, Platform strongly agrees that there is a necessity to change the existing processes for workforce investment decisions. We would refer HWNZ to the Productivity Commission's report on *More effective social services*³ that provides significant ideas for how independent commissioning might work.

We find that the paper seems to waiver in its scope throughout the document and if it does in fact include the whole of the health workforce, then it does not acknowledge the complexities of a competitive environment between government agencies, private businesses (for example GPs), community organisations and others.

For instance, in the mental health and addiction workforce, support workers form the largest workforce group – it is larger than the nursing workforce in mental health and addictions. And yet, throughout the country there is huge variance in wage range largely determined by the rates that DHBs pay individual community organisations.

¹ Platform Trust & Te Pou o Te Whakaaro Nui. (2015). On Track: Knowing where we are going. Auckland: Te Pou o Te Whakaaro Nui.

² Ministry of Health. 2017. Mental Health and Addiction Workforce Action Plan 2017–2021. Wellington: Ministry of Health.

³ The New Zealand Productivity Commission. 2015. More effective social services. Wellington: The New Zealand Productivity Commission.

These organisations in many cases have not received contract increases and those that have rarely received the equivalent of the cost of living adjustment. This impacts on community providers' ability to employ and retain their staff, with some staff moving to DHBs, other community sectors (we anticipate more movement to the sectors included in the pay equity decision) and other industries (some members are competing for staff with hospitality businesses). An inability to offer competitive wages sees the required workforce moving away from the need. Beyond simply providing competitive wage rates, capacity for investment in staff development and infrastructure and technology to remain competitive as a service and an employer can be elusive for many employers.

Process to date

While we commend HWNZ on the process that they have undertaken to date to develop this paper, we feel that it is important that the scope of this paper is very clearly defined and consistently considered. If it is the case that the community sector and private workforce are also included within the scope of this paper, we believe these sectors should have been represented in the early co-design and consultation processes. This is because there are numerous additional complexities faced by these employers that might not be represented by service funders, but which will influence the collective ability to develop the future workforce. While many of these factors will of course be outside of HWNZ's remit, knowledge of these factors is critical to adequately understanding the environment. HWNZ workshops also only included medical colleges outside of the government agencies, and other consultation only included members of the DHB's Workforce Strategy Group, yet the aim of this paper is to look beyond the medical workforce. We would strongly encourage HWNZ to involve the community and private sectors in the continuation of this work. It will also be important to consider this expertise in the expert advisory committee composition to ensure that the status quo of weighting certain workforce groups does not continue, which could undermine this whole process.

Proposed investment approach

While we appreciate the intent to create a commissioning approach similar in robustness and transparency to that of PHARMAC, we note that there are fundamental differences in decision making about medicine investment versus dynamic and changing human workforce investment. As you have identified, there are many influences on individuals' choices to enter the health workforce and on organisations' ability to recruit and retain those individuals. We feel that the sliding scale approach with a transition process will allow some baseline workforce components to continue to be invested in, while new or expanded workforces are incentivised.

We agree that an independent agency should make decisions on post-entry training. However, we note that the process described is not an independent one in the same way that PHARMAC's is, as it is subject in its final stages to decisions by the Minister and Director-General of Health. We would consider that the setting of strategic health workforce objectives should be dictated by the Ministry of Health, but that the ultimate investment decisions should be made independently by the expert committee and that all of these decisions be made publicly available. PHARMAC's independence and imperviousness to political influence is what makes confidence in it as a model so high.

We note the intention to improve workforce supply and demand models, however it seems to us that insufficient consideration has been given to how unmet workforce need might be reliably surfaced. With only DHB input into this process as employers, and with the intention to move away from a health-centric workforce to new service models, it seems impossible to determine met need, let alone unmet need in this way.

The community sector has information about the workforce (Te Pou o te Whakaaro Nui, 2015⁴), including vacancies, but these are based on continuation of existing services. In the mental health and addictions sector we know that there is significant unmet need for services and we believe workforce unmet need is inextricably tied with service user need for services.

- New Zealand ranks 14th in the OECD for both [alcohol consumption](#) and [suicide](#).
- New Zealand has the highest rate of [youth suicide](#) in the OECD.
- New Zealanders with mental illness and/or addiction are at [two to three times' greater risk](#) of premature death than the general population. Two-thirds of this premature mortality is as a result of disease/physical illnesses.
- The [World Health Organization](#) has declared that depression is the leading cause of disability worldwide and a major contributor to the overall global burden of disease. Yet recent reports on [global return on investment](#) estimate that the current gap in treatment coverage in high-income countries is 72 percent for depression and 80 percent for anxiety disorders.
- People experiencing mental health issues have accounted for [97 percent of the growth in health related benefits paid by Government](#) in the last ten years. More than 57,000 New Zealanders currently receive a benefit due to the impact their mental health condition has on their ability to work.
- In 2015, of the people under the Mental Health Act, 144 deaths occurred that were suspected suicides, there were 18 serious self-harm events and 23 serious adverse behaviour events reported.
- In 2013, 7,267 hospitalisations occurred for intentional self-harm.

We included these figures to show that there is absolutely unmet need in the mental health and addictions sector, but the appropriate service models to meet this need have to be considered so that the workforce to meet those needs can be determined. With most agencies aiming investment at prevention and early intervention, we would posit that significant investment should be made in the community mental health and addictions workforce.

Prioritisation framework

We appreciate the early work that has gone into this framework and that it is still under development.

We would note that the threshold for evidence considered under this framework will need to be carefully considered. Many of the emerging models for mental health and addictions supports, that provide more integrated or wraparound services, are proving effective. However, as they often involve collaboratively addressing service user needs, it can be difficult to attribute outcomes to any one service or professional.

Platform is working alongside colleagues to determine appropriate outcomes measures to improve service quality and effectiveness in mental health and addictions using PRIMHD data, but with this aspect of health and wellbeing it becomes clear that investment decisions are not as straightforward as they might be in the case of other physical health decisions. The workforce for appropriate models in our sector could be comprised of a multitude of professionals with varying degrees of specialist skills or qualifications.

Process

⁴ Te Pou o te Whakaaro Nui. (2015). Adult mental health workforce: 2014 survey of Vote Health funded services . Auckland, Te Pou o te Whakaaro Nui.

Many of the process issues we have concerns about are described above. Our further comments would be that the 'implementation considerations' included in the paper are commendable, but that they seem included as an afterthought in some respects in the way that they are conveyed. If non-government community organisations are to be included in this process, some serious consideration to the burden that this process may place on them to participate and ways to mitigate that must absolutely be part of HWNZ's work. We would refer HWNZ to some of the work by MBIE in the development of guidelines for government to procure social services. We also understand some work has been previously mooted about cross-accreditation of NGOs contracting with government.

We note that in Appendix two, it appears that almost no consideration has been given to the workforce in our sector, although we note that you have expressed that there will be further work done on these principles in relation to this workforce.

Conclusion

Platform feels that this paper is moving in a positive direction but that more thought needs to take place to determine clearly the scope of the investment strategy and to consult more widely about the challenges and opportunities for developing the whole health workforce, including the non-government workforce. We feel that some clear definitions are required for the workforce groups and workforce investment activities in scope to ensure there is clarity and a shared understanding of these terms and concepts.