

Whanganui District Health Board Pro Equity Check-Up Report

Whanganui District Health Board (WDHB) is committed to improving the health and wellbeing of the community residing in our health district. It is clear from our data and the experiences of Māori whānau /families using our health system that improving Māori health and achieving equity for Māori is the primary and most urgent equity challenge for us.

We conducted a pro- equity check-up (audit) in August – December 2018. The purpose of the pro-equity check- up was to assess how well we are embedding a pro-equity approach into our work. The primary focus of the check-up is to identify opportunities and create a strong foundation for our DHB as we work towards equity. To provide a clear-eyed view on where we are at, and provide practical advice on where to focus our efforts for the most sustained impact.

The check-up conducted by Baker Jones (Gabrielle Baker and Dr Bryn Jones) encompassed a review of our documentation including interviews, surveys and workshops with DHB and community governance, management and staff. The executive sponsors are Rowena Kui director Māori health and Brian Walden general manager corporate services.

The report identified that as a DHB we have a number of factors in our favour; however we need to back this up with pro-equity action. In total the recommendations include eleven findings grouped in four themes: *organisational leadership and accountability for equity; Māori workforce and Māori health and equity capability; transparency in data and decision making and authentic partnership with Māori.*

Hauora A Iwi (Māori Relationship Board) supported the findings and recommendations in the report, endorsed by the WDHB Board February 2019.

Our pro-equity implementation work plan spans 24 months and includes professional development, mentorship, equity tools and methodologies, workshops and improvements in systems and processes. Community partners will be invited to participate.

We acknowledge our community partners and their insights that have contributed to the development of the final report.

***Ko au ko toku whānau, ko toku whānau ko au
Nothing about me without me, without me and my whānau***



Whanganui DHB

Pro-equity checkup

Prepared by Gabrielle Baker and Bryn Jones
Baker Jones
December 2018

Introduction

In August 2018, Whanganui DHB and TAS contracted Baker Jones to complete a pro-equity check-up to assess how well Whanganui DHB is embedding a pro-equity approach into its work. The main audience for this check-up is the DHB's Risk and Audit subcommittee, and its findings and recommendations relate to the organisation overall.

This report provides our key findings and a set of preliminary recommendations, which will form the basis of a workshop with the Executive Management team in November, 2018.

The primary focus for the check-up was to identify opportunities and create a strong foundation for Whanganui DHB as it works towards equity. There is no single checklist to assess the equity approach taken by an organisation. Our approach has drawn on health equity literature, health sector guidance documents and our own expertise to provide a clear-eyed view on where the DHB is at, and provide practical advice on where to focus efforts for the most sustained impact.

Throughout our assessment **we looked primarily at Māori health equity issues**. We took this approach because of DHB obligations to involve Māori in decision making and service delivery and to reduce - with a view to eliminating - disparities (under the New Zealand Public Health and Disability Act 2000) and because it is the right thing to focus on for Whanganui DHB (eg the health needs data¹ we had access to showed clearly that improving Māori health was the primary equity challenge for the DHB).

¹ Midcentral DHB and Whanganui DHB Health Needs Assessment 2015

What we did

In conducting the pro-equity check-up we had three main questions:

- What does Whanganui DHB say it does about equity?
- What actually happens?
- How does the DHB meet equity expectations and align with pro-equity best practice?

A summary of our frame for the check-up is included as an attachment to this report.

Document review

We first collected information through a document review, that included documents ranging from the DHB planning documents, reporting, terms of reference, Board papers, organisational leadership and management, data, analysis and needs assessment, DHB policies (eg Whānau Ora policies, recruitment policies, business rules for procurement) and staff development and organisational culture.

Surveys

Following the document review we conducted a series of online surveys that we sent to:

- Whanganui DHB Board members
- Hauora-a-lwi members
- Māori Health Outcomes Advisory Group members
- community providers
- Consumer Council members
- Whanganui DHB Executive Management Team (EMT)
- a wider group of DHB managers
- Māori staff
- Service and Business Planning staff.

The purpose of the surveys was to better understand the norms², culture and values of Whanganui DHB. The surveys were also a chance to test how well what the DHB actually did (eg in engagement with Māori) matched with what it said it did (as identified in the document review). Some of the questions in the survey aimed to get views on potential actions to strengthen the DHB's approach to equity.

Interviews

Lastly we held a series of interviews, mostly face to face. The purpose of the interviews was to triangulate the overall findings through testing and confirming our understanding of what we saw in

² Norms are the unwritten rules that shape “the way that we do things around here”.

the document review and ascertain whether the DHB's actions were aligned with its intentions (as articulated in the documents) from a range of perspectives and identify other areas we should look into or consider in our pro-equity check-up. As with other elements of the check-up we asked specific questions about Māori health and the Whanganui DHB's engagement with Māori.

More detailed reports on the interviews and surveys are attached as appendices to this report. The document review report is provided as an attachment.

What we found

Whanganui DHB has a number of factors in its favour including a visible commitment to equity and *whānau ora*, newly agreed memorandum of understanding with the Māori partnership board (Hauora a Iwi), and a new Chief Executive who is focused on stronger links with the community. However, the DHB needs to back this up with pro-equity action if it wants to address the significant health outcome inequities in the Whanganui district, particularly for Māori.

In total we have eleven findings, grouped into four key themes: *leadership and accountability*, *capability*, *transparency*, and *partnership*. These findings need to be considered in the context of an organisation committed overall to becoming pro-equity (as evidenced by Whanganui DHB and TAS jointly contracting for this check-up and the willingness of interviewees and survey participants from Board to staff level).

Theme: Organisational leadership and accountability for equity

Finding 1	<p>What Whanganui DHB means by equity is not well defined.</p> <p><i>“I think equity is understood by some people, but others confuse equality with equity.”³</i></p> <p>Equity aims are given prominence in planning documents and named as a priority in many cases, but it is not clear what this means as its priority status did not lead to a matching focus on action. In surveys and interviews people either struggled to define equity or highlighted concerns about the way the term and concept are used. The use of diagrams or pictures describing the difference between equity and equality look good on paper but there is no evidence that the concepts themselves are well understood and applied in work every day.</p> <p>Concerning discourses around the term ‘equity’ we noted included:</p> <ul style="list-style-type: none">• the way that ‘improvement in equity’ is often given as an outcome for Whanganui DHB in documents. This gives the impression that any change however small, is good enough or that equity itself is too hard to achieve• the discourse that equity is about “everyone” or that a focus on the greatest good for the greatest number supports equity. (It doesn’t.)• that the term equity is used as a ‘catch all’ term for addressing anything other than ‘business as usual’, which means that the term loses its utility.
Finding 2	<p>The drivers of inequity are not well understood across the organisation.</p> <p>Linked strongly to our finding that equity was not well defined, there was limited and variable understanding of the drivers of health inequities, and in particular the impacts of racism and privilege.</p> <p>We found that DHB staff and leaders mostly understood racism at a behavioural or individual level, not as a systemic issue. And because people did not see individuals acting in racist ways they did not want to talk about it in interviews. Although there were some survey respondents who talked about institutional racism, overall it appeared racism was a taboo topic - which means it is unlikely to be addressed⁴.</p>

³ Survey respondent

⁴ https://sph.umd.edu/sites/default/files/files/Griffith_Dismantling%20Institutional%20Racism.pdf

<p>Finding 3</p>	<p>Demonstrable action to achieve equity is rare.</p> <p><i>"I see lip service but very little evidence of truly listening and redesigning services to ensure real change in many areas."</i>⁵</p> <p>While we saw evidence that an equity lens (the HEAT tool) was used in annual planning, the analysis was patchy and was not matched by an assessment of equity achievements or challenges in the DHB's annual report. In quality reporting, equity activities were rarely discussed, representing lost opportunities to take a pro-equity approach.</p>
<p>Finding 4</p>	<p>There is no clear accountability for equity.</p> <p><i>"KPIs / work plans need to be established so that there is ongoing challenge towards positive social change in this area."</i>⁶</p> <p>In surveys and interviews, many people noted the need for pro-equity key performance indicators (KPIs) for senior DHB staff. Importantly, many survey respondents and interviewees felt optimistic that the Chief Executive has a strong commitment to the organisation being pro-equity.</p>
<p>Finding 5</p>	<p>The whole organisation needs to take responsibility for Māori health.</p> <p><i>"Leaders across the DHB [should be] taking responsibility for their teams work related to equity - not just left to Maori team."</i>⁷</p> <p>There is limited focus on Māori health or health equity beyond the General Manager Māori or Māori-specific teams and roles (like the haumoana service). The strongest evidence of this comes from the survey and interviews where the two most common examples of DHB success are the haumoana service and Hapai Te Hoe.</p> <p>Accountability for Māori health needs to be much stronger across the whole organisation, starting with the EMT.</p>

⁵ Survey respondent

⁶ Survey respondent

⁷ Survey respondent

Theme: Māori workforce and Māori health and equity capability

<p>Finding 6</p>	<p>There is an equity skill gap amongst DHB staff</p> <p>Survey respondents saw the equity capability of the DHB as low — no group rated the DHB higher than an average of 5 out of 10.</p> <p>Our review found the DHB is not consistently recruiting for equity skills. Equity is neither a core competency in its own right, nor an element of the existing core competencies. Some staff members indicated that they did not see equity as their role, even in situations where it was apparent to us it should or could be.</p> <p>The variable equity expertise of Board members was also raised, noting that they are often elected or appointed based on other health or community expertise. This puts more onus on the DHB management to make sure that they are able convey equity issues to the Board. The current equity capability of the Board is not adequate to effectively govern for equity and this threatens progress.</p> <p>There are things that could be done to improve the skills and capability of the staff currently employed but it is also about making deliberate recruitment decisions.</p>
<p>Finding 7</p>	<p>There are not enough Māori staff employed by the DHB</p> <p><i>“We need more Maori staff to match population. Need more Maori Docs/nurses.”⁸</i></p> <p>Māori staff numbers do not reflect the ethnic makeup of the DHB population. The ethnic makeup of the workforce was rated as inappropriate by survey respondents. The influence Māori and Pacific leaders have was also considered inadequate.</p> <p>A perception exists (real or otherwise) that community-based Māori staff are often ‘head-hunted’ to work for the DHB. This might increase DHB Māori staff numbers but is not helpful for the district’s Māori workforce overall and places further strain on community providers. Any attempts to build the Māori workforce of the DHB must take this wider context into account.</p>

⁸ Survey respondent

Theme: Transparency in data and decision making

Finding 8	<p>Decision making needs to be more transparent to be pro-equity.</p> <p><i>“Better information and clear strategies are needed to influence decisions to drive outcomes.”⁹</i></p> <p>Decision-making processes are largely invisible (for example in Board decisions, recruitment) and where there are clear processes (for example in contracting) there is insufficient focus on equity. From what we saw, there is not enough data and analysis provided to support decision making. This lack of transparency and evidence reinforces the status quo and biases towards inequity.</p> <p>There was a sense from interviews that many challenging issues are discussed informally, further reducing the transparency of decision making in terms of equity.</p>
Finding 9	<p>Funding decisions still favour hospital activity despite equity arguments made for community activity.</p> <p>There is a disconnect between the decisions made by Whanganui DHB about where to spend money and the rhetoric about better connections with the community and community providers to achieve equity. While a clear narrative from Whanganui DHB is that the Ministry of Health sets direction for most of its spending, particularly around electives, there are funding decisions within the DHB's control that suggest a preference for hospital spending.</p>

Theme: Authentic partnership with Māori

Finding 10	<p>Stronger focus on Māori participation in service delivery and design.</p> <p><i>“I believe we need to move through the tokenism to genuine engagement and representation and respect to change attitudes and address inequity and racism.”¹⁰</i></p> <p>Whanganui DHB has done a lot to make health services more culturally welcoming for Māori. However, it is difficult to see meaningful participation in service delivery or design including Māori whānau, communities, and community providers.</p>
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⁹ Survey respondent

¹⁰ Survey respondent

	<p>Further, the creation of culturally appropriate services has been considered an 'equity' activity by many in the DHB. The dominance of 'cultural' aspects of care limits the opportunity for a more holistic focus - addressing differential access to the determinants of health, and the broader impacts of racism and privilege in health services.</p>
<p>Finding 11</p>	<p>The partnership with Hauora a Iwi is one-sided.</p> <p><i>“Organisation leaders need to share power and create partnership relationships of value.”¹¹</i></p> <p>DHB staff and Board see the influence of Hauora a Iwi as both strong and appropriate, whilst Hauora a Iwi members expressed concerns that they were seen as a 'tick box' activity.</p> <p>Further, whilst the Memorandum of Understanding (MoU) could certainly be strengthened with the goal of 'authentic partnership', what actually happens doesn't really live up to the aspirations of the MoU. The reality appears to be that Hauora a Iwi are treated more like an advisory group than a joint decision maker. Whether a result of the MoU or the way in which they are implemented, there seems to be a lack of authentic partnership.</p>

¹¹ Survey respondent

Preliminary recommendations

We have identified four main recommendations for Whanganui DHB and plan to discuss these further in a workshop with the executive management team (EMT) in November 2018. In the workshop the recommendations will be confirmed or amended, and more detail discussed around what the first steps would look like.

The preliminary recommendations respond to the four themes identified in our findings:

Rec 1	<p>Strengthen leadership and accountability for equity</p> <p>For sustained success, Whanganui DHB's EMT must be the champions of a pro-equity approach and take on an organisational leadership role to this effect. We provide suggestions for how to start this process.</p>
Rec 2	<p>Build Māori workforce and Māori health and equity capability</p> <p>Whanganui DHB needs the right skills to drive Māori health equity, and a workforce that is fit for purpose to meet the needs of the population that they serve. This includes more Māori staff (particularly in senior roles), and contemporary Māori health and equity expertise across the Whanganui health workforce (not limited to DHB staff).</p>
Rec 3	<p>Improve transparency in data and decision making</p> <p>Improving transparency in decision making will support the DHB to demonstrate a pro-equity approach and be held accountable (by the Board, Hauora a Iwi and the wider community) in its pursuit of equitable health outcomes.</p>
Rec 4	<p>Support more authentic partnership with Māori</p> <p>There is strong potential to work with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services. This needs to be turned into action to avoid appearing to be rhetoric, which could undermine the promise provided by the new Hauora a Iwi memorandum of understanding.</p>

Rec 1: Strengthen leadership and accountability for equity

For sustained success, Whanganui DHB's EMT must be the champions of a pro-equity approach and take on an organisational leadership role to this effect. EMT will have to shape what the role means, but here are some ideas to start off the process:

- 1.1. Publicly commit to Māori health equity and develop a performance framework to monitor (and publicly report) progress by. Whanganui DHB should be clear about its explicit focus on *Māori* health equity, and produce a pro-equity performance framework that is inclusive of health outcome measures, and organisational process and capability measures (through a Māori health equity lens). This is a critical first step to generating greater accountability for the DHB doing all it can for health equity. Relevant measures from the framework could be selected as KPIs for the CE and EMT to drive performance utilising existing accountability mechanisms.
- 1.2. Create a learning environment for EMT and engage external health equity expertise to provide executive team coaching for EMT, focused on a pro-equity approach. Like more conventional team coaching, this could be a mix of one-on-one and group sessions (eg attending EMT meetings quarterly) and could be trialled and evaluated after 12 months.
- 1.3. External equity expertise could similarly support the Board's learning, and growing Board capability to hold the organisation to account for equity performance.
- 1.4. Ensure resources are available to support health equity work, for example committing to a training budget to provide pro-equity, anti-racism/ decolonisation training (starting with the Board¹², EMT and senior managers), strengthening the existing Hapai te Hoe training which describes local examples of the effects of colonisation and racism.

This recommendation is based on the need for accountability mechanisms to ensure that good intentions Whanganui DHB have shown towards health equity are matched with the right kind of actions. Our assessment is that Whanganui DHB will require external equity expertise to support work such as:

- selecting KPIs that are relevant to the role of each EMT member, to enhance individual and collective accountability across the executive team
- the selection of measures for a performance framework.

Careful attention must be given to the selection of measures, to avoid unintended consequences like wasting effort on the wrong tasks ("*...hit the target but miss the point.*"¹³), staff disengaging

¹²Although this recommendation focuses on staff leaders within the organisation team, we found that the Board also needs also to build its equity capability in order to hold the organisation to account for achieving equity.

¹³ Survey respondent

due to lack of progress, or inadvertently increase inequity.

Rec 2: Build Māori workforce and Māori health and equity capability

Whanganui DHB needs the right skills to drive Māori health equity, and a workforce that is fit for purpose to meet the needs of the population that it serves. This includes more Māori staff (particularly in senior roles), and contemporary Māori health and equity expertise across the Whanganui health workforce (not limited to DHB staff). These principles also apply to advisory groups and committees that influence DHB decisions such as the consumer and clinical advisory groups. We recommend Whanganui DHB start with the following:

- 2.1. Develop and implement a recruitment and retention strategy focused on Māori staff and Māori health and equity expertise. An investment approach (where Whanganui DHB sees return over a number of years) is most likely needed. This will involve working with community providers to build their Māori health workforce as well as that of the DHB. We understand elements of this approach exist already. We recommend that this is done in partnership with Māori health providers to address the further perception risk that Māori staff are 'head-hunted' by Whanganui DHB.
- 2.2. Strengthen the role and size of the Māori Health Services Group and support around the Māori Health General Manager as a reflection of the current expectations to put Māori-specific teams in the DHB. It also provides an opportunity to resource the team to help build organisational capability in Māori health and equity.
- 2.3. Develop a 'health equity' competency that would apply to everyone employed by the DHB. Although a 'Responsiveness to Māori' competency already exists, this is not explicitly focused on equity and nor should it be. The development of a 'health equity' competency could be led by staff who have already shown enthusiasm, and could become a core competency for the organisation within the first year. This would assist in recruiting for Māori staff as well as those with health equity expertise.
- 2.4. Strengthen Hapai te Hoe, which is proving wildly popular, with additional content on Whanganui DHB's approach to Māori health equity, cultural safety, and anti-racism. There is evidence of a significant gap in organisational Māori health and equity expertise, and including this in the Hapai te Hoe training, would help lift the baseline expertise for the organisation. The additional content would focus on addressing barriers to care at organisational, structural, or clinical levels.

Rec 3: Improve transparency in data and decision making

Improving transparency in decision making will support the DHB to demonstrate a pro-equity approach and be held accountable (by the Board, Hauora a Iwi and the wider community) in its pursuit of equitable health outcomes. To do this we recommend these actions:

- 3.1. Build capability in equity data analysis¹⁴. This might mean partnering with other health sector agencies (eg the two PHOs) to improve the quality of analysis. Stronger equity analysis will also mean that Whanganui DHB is better equipped to work with, and if necessary challenge, Ministry of Health directions that are likely to increase inequity in the district (eg a focus elective surgery volumes). This could also be used in service change schedules, which currently lack a strong equity assessment.
- 3.2. Share equity analysis widely and include it in all decision making. Analysis should be shared in a way easily understood, and explicitly included papers to the Board and Hauora a Iwi. Equity should also be a feature of public-included sessions of Board meetings, and included on the agenda.
- 3.3. Include equity analysis in all publicly reported data. This includes reporting on improvement efforts (eg safety initiatives) and performance measures such as national health targets (regardless of whether it is mandated by the Ministry of Health).
- 3.4. There needs to be transparency about resource allocation – at the moment it is largely invisible but appears to favour non-Māori. For example, the electives target diverts resources from Māori to Pākehā by focusing on the health needs of the elderly, in contrast to pro-equity approaches that invest in the health of mothers and young families. It is important that there is visibility as to which ethnic groups are privileged and which are disadvantaged by resourcing decisions.

Rec 4: Support more authentic partnership with Māori

There is strong potential to work with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services. This needs to be turned into action to avoid appearing to be rhetoric, which could undermine the promise provided by the new Hauora a Iwi MoU.

- 4.1. Hauora a Iwi MoU should reflect true partnership and be regularly reviewed to ensure that the relationship is one of genuine power sharing. We recommend finding more opportunities for shared decision making between Hauora a Iwi and the Board and

¹⁴ Equity analysis requires not only disaggregating data by ethnicity etc, but also a narrative to help understand the inequities and what might reduce with a view to eliminating these.

suggest a facilitated¹⁵ workshop with Hauora a Iwi and the Board to find mechanisms to make this happen.

- 4.2. Increase use of Māori community and health expertise by the DHB, eg through increasing Māori membership on the consumer council (eg to 50% of membership).
- 4.3. Meaningful participation in the design of services and interventions (eg with Māori whānau, communities, and health and social service providers) to support Māori self-determination and Whānau Ora.

¹⁵ Facilitator should have subject matter expertise on Te Tiriti, Māori health equity, and colonisation.

Appendices:

Interview analysis	Appendix 1
Survey analysis	Appendix 2
References	Appendix 3

Attachments:

Pro-equity check-up frame	
Document review	

Appendix 1: Interview analysis

On 25 and 26 September 2018, Baker Jones conducted ten face to face interviews in Whanganui. Two other face to face interviews were conducted on 14 September, one video interview was held on 19 September and a further interview was conducted on 3 October.

The purposes of the interviews were to:

- test and confirm our understanding of what we saw in the document reviews
- get an understanding of whether the DHB's actions were aligned with its intentions (as articulated in the documents) from a range of perspectives
- identify other areas we should look into or consider in our pro-equity check-up.

Who did we interview?

We aimed for a mix of internal DHB staff and leaders and people outside the organisation who were well informed on how it operated. Broadly speaking our interviewees included:

- DHB staff (including clinical)
- DHB senior managers
- DHB Board members
- Hauora a Iwi members
- health provider staff (PHO and Māori health providers, including management and clinical staff).

What did we ask?

The interviews were semi-structured - meaning we had a core set of questions, but we often ended up asking other questions based on what the interviewee said. The core set of questions covered:

- what the DHB was doing about equity and where else it might focus
- how Māori were involved in decision making and service delivery
- where the DHB is doing well (including an assessment of how well the DHB is doing compared to others in the country)
- data and analytics (this question was asked in different ways depending on the person we interviewed)
- drivers of inequity including the role of racism.

What did we find?

There was a consistent theme in the interviews that **equity is not well understood or defined** in Whanganui DHB's work (7 interviews). This was matched by a similar theme of clear and good intention to improve outcomes for Māori and achieve equity **without corresponding equity focused actions** (5 interviews).

When it came to definitions of equity there was an observation from one interviewee that in Whanganui the *"equity conversation is usually about everyone"* rather than being focused on addressing the gap between the groups fully benefiting from the DHBs activities and those that are not. There was split between those who understood this and wanted the DHB to be more focused on Māori and Pacific populations and those who sought more information to understand where to focus.

Two people we interviewed talked explicitly about the equity lens analysis in the DHB's annual plan and others referred to it more generally. The equity lens in planning is acknowledged as a good start but insufficient. The quality of this assessment is variable and it is seen as an add-on to the core business (eg is completed centrally with limited quality assurance) rather than a normalised part of what everyone in the DHB does.

The **quality of data and analytics** was seen as an issue (8 interviewees) and one called it *"...hit and miss"*. We asked one external interviewee if the analysis the DHB provides is helpful and their answer was straightforward: *"Hell no"*. Other external interviewees too recognised the variability of the data and analytics provided on equity. One Board member noted that **there is not necessarily the equity skills on the Board** in the same way that there are financial governance skills — so members need not just good analysis from the DHB but good explanations on what the data shows. Another external interviewee pointed out that the DHB can produce a lot of papers (eg 200 pages of information for the Board or Hauora a Iwi) but it is hard to digest and interpret so it is easy to miss the point around equity. It should be noted here that the explanations provided by senior staff (in particular the Director of Māori health) in the meetings were often clear and concise and were more helpful than the papers.

There was a discussion amongst a number of interviewees about what we think of as **intersectional analysis**. For example, it was noted that the DHB isn't great at thinking about rural health by one interviewee, but the understanding of the compounding disadvantage of rurality, poverty and racism meant that the impact was felt most keenly by Māori in rural areas.

There was also a sense that equity is being used as a code word — particularly as a more acceptable and less confrontational term to cover racism. **Racism as a driver of inequity was not well understood** and where racism was discussed it was limited to the actions, behaviours or unconscious bias of individuals (6 interviewees).

One of the more subtle themes of the interviews was that hard conversations are often informal, particularly amongst governors. This includes discussions on Māori health, equity and racism. Related to this was a concern that although tough issues around equity might make the agenda for the Hauora a Iwi and Board combined meeting, the meetings were poorly attended by Board members and so the conversations were held with a subset of members only.

There was recognition that **Hauora a Iwi is important but a split in views on its level of influence**. While the Board itself along with a number of senior DHB staff see it as very important, when we asked about the times that the views of Hauora a Iwi have changed a decision there weren't any examples provided. One interviewee said: "*Hauora a Iwi have opportunities to give opinion but this is not always taken on board*".

Despite this sentiment, the role of Hauora a Iwi in annual planning was regularly referenced potentially suggesting in the formal planning process Hauora a Iwi have the ability to directly influence DHB priorities. But there were no specific examples given in interviews.

We also asked about engagement with Māori health providers. The use of the Māori Health Outcomes Advisory Group (MHOAG) was minimal, with separate provider networks set up by some DHB staff. It is also unclear if Hauora a Iwi and the advisory group are well informed enough (by the DHB and by each other) to have the kind of mutually supportive relationship envisaged in the terms of reference for MHOAG.

There was a **general sense of optimism** from many (but not all) of the interviewees about the opportunities in Whanganui to achieve equity. This optimism comes from a mix of positive messages from the Minister about equity (as per the Minister's current letter of expectation to DHBs) and the appointment of a CE specifically to address equity issues. One external interviewee referred to the CE as "*the best thing since sliced bread*". However often when people talked about the factors in Whanganui DHB's favour it often came down to **a reliance on the commitments and skills of individuals** rather than a system wide, embedded approach to equity. There was also concern that there was a 'low trust' environment in the way the DHB operated, often making it hard for the DHB to genuinely partner with community providers to improve health and achieve equity.

We asked the interviewees questions to better understand what they saw the successes were for the DHB. Examples that were raised multiple times include the Hapai Te Hoe induction programme, Haumoana staff and changes to the hospital visiting hours policy.

When we asked about the challenges or things getting in the way of the DHB really focusing on equity challenges the **workforce** (recruiting suitably skilled Māori candidates) was seen as a top concern. Similarly, **prescription from the centre** (eg around child health and elective surgery) meant that the discretionary budget for the DHB was inadequate to invest in the kind of **community services** that interviewees saw as the solution.

Appendix 2: Survey analysis

Baker Jones conducted a series of surveys from 20 September to 28 September, 2018.

The purpose of the surveys was to better understand the norms, culture and values of Whanganui DHB. The surveys were also a chance to test how well what the DHB actually did (eg in engagement with Māori) matched with what it said it did (as identified in the document review). Some of the questions in the survey aimed to get views on potential actions to strengthen the DHB's approach to equity.

A later survey was sent out on 3 October 2018 to capture consumer views.

The surveys were different for each group. For example, for those in management roles we asked about competencies of staff. We asked Māori staff about cultural support, and for staff responsible for contracting we asked about the information they used in the procurement process. However there were core questions we asked of all groups, and this summary focuses on those elements of the surveys.

Around 80 people were sent a survey and 65 surveys were completed. Note there were only two survey responses from the 'consumer council'.

Groups surveyed		Number of responses
Staff group	Executive Management Team (EMT)	6
	Wider DHB management (WM)	13
	Māori staff (MS)	10
	Service and Business Planning staff (SBP)	5
Non-staff group	DHB Board members (Board)	6
	Hauora a Iwi and Māori Health Outcomes Advisory Group (Hal+)	8
	DHB Community Providers (CP)	15
	DHB Consumer Council (CC)	2

How we looked at the surveys

To help our analysis we divided into two groups, one for the staff surveys, and one for the others.

The staff group included: the executive management team (EMT), wider DHB management (WM), Māori staff (MS) and staff from service and business planning (SBP).

The non-staff group included: DHB board members, Hauora a Iwi and the Māori health outcomes advisory group, DHB community providers and members of the DHB consumer council.

Across all surveys we had a mix of ethnicity (we actively sought to get Māori respondents through two targeted surveys), gender (on balance, more women) and (relevant for the internal group) length of service at the DHB.

What the surveys told us: staff group

Overall staff saw equity as important in their work, and the information they had access to on equity was considered at least moderately good. The group that was most concerned about the utility of the information was EMT.

The following two tables present answers to two questions asked of everyone in the internal group. The scale ranking is 0 for 'low' and 10 for 'high':

- How important is equity as a driver of your work? (Scale of 0-10)
- How useful do you find the information available to you on equity? (Scale of 0-10).

Figure 1: How important is equity as a driver of your work?

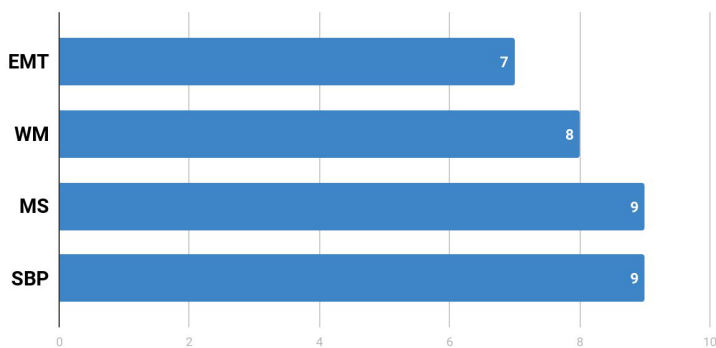
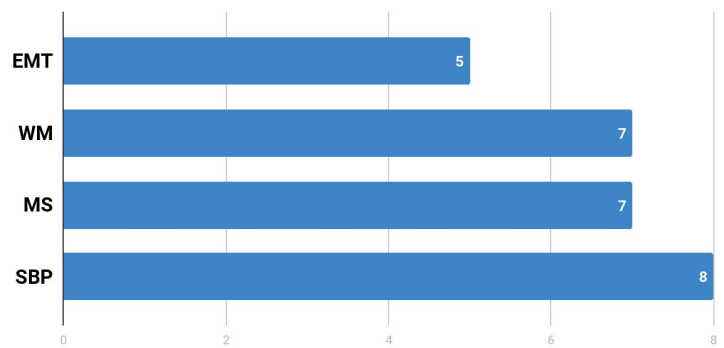


Figure 2: How useful do you find the information on equity available to you?



When asked about their understanding of equity some respondents saw equity as being about equal treatment of all people, or equal access to services:

“Basically I would like to see all community's Maori and Non-Maori be treated the same.” [MS]

Other respondents saw it as being about equal outcomes and different ways of working to achieve those outcomes:

“Providing equal opportunities for improved health status and access to health services through reducing barriers and working with disadvantaged groups to meet their needs in ways that work for them.” [SBP]

Survey respondents saw the equity capability of the DHB as low — **no group rated the DHB higher than a 5 out of 10** (and Service and Business Planning staff rated it as a 3/10).

We asked what the DHB could do to demonstrate its commitment to equity and provided a range of options. The most frequently rated options were:

- **Better connections with Māori communities** (22 responses, equally top rated amongst Māori staff, equally top rated amongst EMT)
- **Employ more Māori staff** (21 responses)
- **Education for Māori communities** (21 responses, equally top rated amongst Māori staff)
- **Improve monitoring of health outcomes** (20 responses, equally top rated amongst EMT)
- **Upskilling staff with formal equity training** (20 responses, equally top rated amongst WM, top rated amongst SBP)
- **Appoint more Māori to decision-making groups** (19 responses)
- **Better connections across the health system** (19 responses, equally top rated amongst WM).

We asked what was most important for the DHB to measure to track equity:

- All groups identified **Whanganui DHB's performance in Māori health compared to other DHBs**
- EMT, Māori staff and staff from service and business planning identified changes in avoidable hospitalisation
- EMT and Māori staff identified DHB spending on Māori health.

We asked what would strengthen each respondent's role to support better outcomes for Māori. A strong theme was **better data and analytics** (7), training (including cultural support, 7), KPIs for Māori health (3) and more Māori staff (3).

We asked EMT, the wider DHB management group and the service and business planning groups about racism. Most respondents said they had conversations with colleagues about the way that

racism impacts health and what we can do to counter that impact at least every now and then (14). Five respondents said they had only superficial conversations or never discussed racism in this way.

"I do not think it is a significant factor." [EMT]

The understanding of racism and its connection with health seemed limited overall. The EMT and wider DHB management groups were given a chance to comment on the racism in health and overwhelmingly described it in terms of personal behaviours (12) and rarely in terms of institutional or structural racism (2).

"I believe we need to move through the tokenism to genuine engagement and representation and respect to change attitudes and address inequity and racism." [WM]

We wanted to know what people thought of the ethnic mix of staff at Whanganui DHB.

Overall respondents did not rate the DHB highly. The highest rating when asked about ethnic makeup of staff came from the service and business planning team (5/10) and the lowest (2/10) came from the Māori staff group. We asked if the current ethnic makeup of senior leaders and clinicians was appropriate and answers were similar. When we asked if Māori and Pacific staff have appropriate influence in the organisation most groups rated the DHB around 6/10 except Māori staff who on average rated it 4/10.

We asked about engagement with Māori and got a mix of responses. When it came to the formal relationship with iwi (Hauora a Iwi) one respondent said *"no decisions are made without the Hauora a Iwi lens and endorsement across the work programme"* [EMT] which was seemingly a view held by a number of respondents. In contrast there was also a view that the group wasn't relevant: *"I am not sure that we do [engage] or need to"* [EMT]. There was also a bit of confusion about the question with some respondents not being clear what Hauora a Iwi is or does.

Similarly there was a split when it came to the Māori health outcomes advisory group (MHOAG). We asked EMT, the wider DHB management group and the SBP group about how often they engaged with MHOAG and 9 said they engaged regularly, 11 said they did not. Half of the EMT respondents said they engaged regularly with Māori health providers, half said they did not.

We asked Māori staff what the DHB did best in engaging with Māori - they highlighted Hapai te Hoe and the Haumoana service. They also noted iwi relationships and use of kaumatua and kuia.

We asked about the DHB's successes in terms of equity over the past 12 months. There were no prompts given, and Hapai te Hoe came through as the most common answer (11) followed by the Haumoana service (6). Two respondents from EMT noted achievements in immunisation rates and in iwi relationships.

We asked EMT and the wider DHB management group about where they would disinvest for equity and elective services was the most frequent answer (4). There were no other themes, although some people were reluctant to give an answer, saying they wouldn't disinvest in anything. We also asked this group about the barriers to equity: inequities in the determinants of health and prescription from central government were the two main themes.

What the surveys told us: non-staff group

We asked the non-staff groups whether Whanganui DHB had appropriate equity capability - and generally the respondents did not give high scores. The Hauora a Iwi group scored the DHB on average 3/10, the community providers 5/10 and the Board respondents 6.5/10. One of the consumer responses rated the DHB equity capability as 9/10, the other 6/10.

The Board respondents were split on whether they had appropriate equity expertise amongst themselves (3 said yes, the rest either didn't know or said no).

Respondents said that Whanganui DHB provided information, eg on the website, through papers and in meetings, on health equity (although some also noted that they received nothing). Two Hauora a Iwi respondents noted that they did sometimes receive statistics - but had not received anything in a while. Generally respondents thought the monitoring information they received was at least moderately good (on average between 5.5/10 and 8/10).

We asked what the DHB could do to demonstrate its commitment to equity and provided a range of options. The most frequently rated options were:

- **Build better connections across the health sector** (18 responses, top rated for community providers)
- **Build better connections with Māori communities** (17 responses, equally top rated for the Hauora a Iwi grouping)
- **Cultural competency** (14) and **formal equity training** (12)
- **Appoint more Māori to decision-making groups** (12).

We asked what was most important for the DHB to measure to track equity:

- Avoidable hospitalisations were identified by all groups as important (top rated amongst the Board respondents)
- Changes in service utilisation by ethnicity and deprivation was also identified by all groups (top rated amongst community provider respondents)
- The top rated response for the Hauora a Iwi group was comparing Whanganui DHB's performance to other DHBs.

As with the internal group, the external group did not rate the ethnic makeup of staff at Whanganui DHB appropriate (Hauora a Iwi group rated it a 3/10, community providers 4/10 and the Board 4.5/10). The influence of Māori and Pacific leaders had roughly the same responses. The makeup of senior leaders and clinicians was similar too, except for the Hauora a Iwi group which rated it 1/10. There was only one response from a consumer (rated 7/10).

We asked a series of questions about DHB engagement with Māori in decision making and service delivery.

The Hauora a Iwi group had a view that they were seen more as advisors than partners to the Board. There were also comments suggesting that the role of HAI wasn't sufficiently understood or supported, particularly given the expectations put on them to represent Iwi:

"I feel HAI are only involved as part of a decision-making process, such as this survey as a tick box exercise to get Iwi approval. To be fully engaged HAI reps should be given info with enough time for consultation with the iwi they represent. The DHB should acknowledge that we don't speak or approve on behalf of iwi HAI extends beyond the table we sit around and getting buy-in takes time. This is an important survey" (Hauora a Iwi and Māori health outcomes advisory group survey).

We asked the Hauora a Iwi group and the Board whether Hauora a Iwi was involved in all relevant decisions (as per the recently signed Memorandum of Understanding). Only one respondent from each group said yes.

We asked about engagement with Māori health providers. The Hauora a Iwi group did not consider this engagement very successful, although the community provider group and the Board tended to rate it as somewhat successful.

One community provider respondent said they did not know about Hauora a Iwi, and five respondents skipped this question.

When it came to conversations about racism and its connection to health, almost all respondents who answered this question said they had conversations, even if only superficially. However the Board was more likely to have had only 'superficial conversations' compared with the other surveyed groups. Despite this, one Board respondent commented *"racism exists and senior leaders need more integrative practices."*

Unlike the internal respondents, there were not any strong themes when it came to DHB success in equity over the past 12 months. It was noted that equity was now on the agenda (Hauora a Iwi group) and that things like this survey were positive. A number of respondents said they struggled to think of answers to this question - or that there was nothing. The appointment of a new CE was noted as an example of success as was progress in 'DNAs' and oral health. The promise offered by a well-run bowel cancer screening programme was also identified.

When it came to disinvestment, the Board respondents in particular wanted more advice from DHB staff before answering. There were a few responses that highlighted the spend in the hospital (both for electives and for community services - the latter wasn't further explained). There were concerns shared by one Board respondent about the costs of "middle management".

Barriers to DHB success in equity were seen as a mix between institutional issues (eg racism) and attitudes or behaviours in the health sector (including a lack of trust by Māori in the DHB). One Board member stated "*[DHB] leaders need to share power and create partnership relationships of value. I see lip service but very little evidence of truly listening and redesigning services to ensure real change in many areas*".

The need for more Māori staff was further emphasised as a barrier to the DHB making progress to achieve equity.

One consumer commented about the desire to see Māori representation on the group, and the two consumer responses were quite divided about the adequacy of influence that consumers have on DHB activity - one rating it as 3/10, the other 7/10.

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