Behind closed doors

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February 2019

A report in partial fulfilment of receipt of a nib Senior Health Journalism Scholarship in May 2018

This research was initiated by receipt of a nib Senior Health Journalism Scholarship I May 2018. The initial proposal was to look at how district health boards (DHBs) make decisions about what is discussed in board meetings with the public excluded; essentially what drives secrecy in board meetings.

It did not take long to determine there are rules and guidelines around what is discussed with the public excluded; the extent to which these rules are adhered to would require lengthy investigation. Instead my research shifted from the question of secrecy at the DHB governance level to the place of elected boards and the democratic process that underpins DHBs.

Whether DHBs are secretive with regards to their boards meetings is of little relevance if there is no public interest in their machinations

Some of the information contained in this report, along with interviews with researchers and DHB board members, went towards creation of the feature "Secrets, fears and empty chairs" which was published in *New Zealand Doctor* (13 February 2019) and made available outside of the *New Zealand Doctor* website paywall. A copy of the feature is included with this report.

The report will be sent to the Health and Disability System Review panel as a submission.

Thanks to nib for sponsoring this scholarship and encouraging journalistic endeavor.

Thanks to my daughter Madeleine Fountain for her research assistance in data collection.

Thanks to all those who shared their experiences on and off the record

Thanks to my colleagues at New Zealand Doctor

Where it all started

DHBs were created in 2001 by the Labour Government as part of a reaction to the market-based policies brought into health in the 1990s by the National Government. The earlier National reforms had replaced the area health boards, espoused by National in the 1970s and brought into existence under Labour in 1989.

Fourteen area health boards replaced 25 hospital boards and, as their name suggests, the area health boards were to be responsible for health issues beyond the running and maintenance of the country's many and varied hospitals.

The new area health boards continued the legacy started in 1909 of hospital boards having elected board members, with some additional appointed members. Board members were elected for a three-year term at the local body elections. The health minister could appoint up to an additional four board members to supplement perceived shortfalls in representation on the board.

As local bodies, area health boards were subject to the Local Government Official Information and Meetings Act, rather than the Official Information Act used mostly for centralised government organisations.

But area health boards were not long for this world. When National took power in 1990, then health minister Simon Upton unleashed reforms on both the science and health sectors; introducing first to science market-driven ideology which saw government science agencies replaced with "crown research institutes" required to run at a profit and a new central purchaser. Similar reforms were visited upong the health sector, a sector far more complex than the science sector.

As a result, on on Budget Day 1990, the boards of each of the area health boards gathered in advance of an announcement from Wellington, that being, they were all out of a job. The elected boards were replaced by temporary commissioners charged with heralding in the new system over a two-year period.

Hospitals were reframed as crown health enterprises, governed by government-appointed boards and charged with providing hospital services; regional health authorities, also governed by government-appointed boards, were charged with purchasing the services.

A raft of other changes were introduced to appease different sectors of society and the health service – the Public Health Commission and public health agencies appealed to those conscious that population issues such as vaccination, clean water and healthy food traditionally came second place to hospital based services; proposed community trusts appealed to those fearful of losing local hospital services in rural and hard to reach areas of the country; the independent health plans appealed to Māori who felt the mainstream health services had failed to serve Māori effectively; the Core Services Committee appealed to hose in management who had long tried to straddle government demands and public expectations – here was a committee charged with deciding what services should and should not be funded and provided by the state.

A hard-hitting advertising campaign sought to sell the public on the benefits of the changes.

The previous democratic underpinning of public health services – the inclusion of elected boards at some level – disappeared with little fanfare aside from some campaigning by groups like the Coalition for Public Health.

As it turned out, within a few years, almost everyone was disappointed. Some of the agencies never eventuated, others were subsequently tweaked as the public revolted over paying overnight charges in hospital as regional variation in access to drugs and treatments irked the public, and hospitals competing for contracts did little to improve overall quality and coverage of services.

By the time Labour took power in 1999, the National Government had already begun reforming its reforms. Labour swept them aside altogether. District health boards became the new go-to agencies for health services funding, and for provision of hospital services.

The new DHBs were in many ways a throwback to the former area health boards – the key differences being that where once there were 14 area health boards, now there were 21 DHBs, later reduced to 20 following the merger of Southland and Otago DHBs to become Southern DHB.

The new boards also saw a return to elected boards, but instead of being subject to the Local Government and Official Information and Meetings Act as the area health boards had been, they were subject to the Official Information Act.

By statute, each DHB has three advisory committees, hospital, community and public health, and disability support, all reporting back to the main board. Committee meetings are held every six to eight weeks and board meetings once a month.

Finance and Audit Committees, responsible for some of the sensitive financial discussions and oversight did not hold meeting open to the public.

Public and not so public meetings

Hand in hand with elected members, the democratic process at board level sees board and board committee meetings open to the public. There are four meetings to be held monthly and these are usually held two each fortnight

Often extensive agendas must be publicly available ahead of the meetings.

While board and committee meetings are open to the public when the begin, how long the meeting remains open to the public once proceedings get underway can vary.

To gauge the level of secrecy involved in DHB meetings I engaged help to look at the minutes of all DHB full board meetings (not the committee meetings) held over the year May 2017 to May 2018, to seek a measure of openness.

The first challenge was tracking down the minutes. Every DHB in the country has a different website design, so finding the meeting times, agendas and minutes can be a bit of a hit-and-miss click fest, typically starting with the “About Us” button. (Note: For a couple of years New Zealand Doctor used to routinely tweet the date and times of all the country’s DHB meetings as a public service but the time required to track down all the dates eventually made this activity too costly timewise.)

Once the minutes are uncovered, there is no consistency as to what information is provided.

Nevertheless, taking what was available, I looked for an average length of meeting for each DHB and the average time spent with the public excluded.

The result; only one out of the 20 DHBs provided clear details of the time a meeting starts, the time at which moves to excludes the public and the time at which the meeting finishes. That board was the West Coast DHB.

Specifically, over the year, the average length of a West Coast DHB board meeting was just over 3 hours, broken down into 1 hour and 22 mins open to the public and 1 hour and 42 mins with the public excluded, during which time board members also took a 30-40 min lunch break.

As to the rest of the DHBs, information available is patchy. Counties Manukau gives no indication of the length of its meetings. Waikato, Lakes, Mid Central, Tairāwhiti and Taranaki mention only the time when meetings start.

Auckland and Northland sit for a total of around 4 and half hours but don't indicate the time at which the public are excluded.

The remaining DHBs give meeting times ranging from 1 hour to 2 hours and 45 mins leaving the reader of the minutes to assume this is just the public part of the meeting. The results are summarised in Table 1.

Table 1 – Summary of average length in time of DHB board meetings from May 2017 to May 2018

DHB	Note	Time meeting open to public	Length of time public excluded	Total meeting
Auckland				4 h 24 mins
Bay of Plenty*				
Canterbury		2 h 14 min		
Capital and Coast		2 h 35 min#		
Counties Manukau	No details on meeting times			
Hawkes Bay		2 h 29 min#		
Hutt Valley		1 h 45 min#		
Lakes	Start time only			
Mid Central	Start time only			
Nelson Marlborough		1 h#		
Northland				4 h 35 min
South Canterbury		2 h 48 min#		
Southern	No meetings			
Tairāwhiti	Start time only			
Taranaki	Start time only			
Waikato	Start time only			

Wairarapa		2 h 19 min#		
Waitemata		1 h 35 min#		
West Coast		1 h22 min	1 h 42 min (including lunch break of 30-40 min)	
Whanganui		1 h 28 min#		
*data missing #assuming this is public part of meeting only				

As a rough measure, this data shows potentially half to two thirds of a meeting is held with the public excluded.

Boards are legally required to give a reason for excluding the public and usually refer to the New Zealand Public Health and Disability Act which, in clause 32 of schedule 3, allows for excluding the public from part or all of the meeting if having them present would be likely to result in disclosure of information that, among other reasons, could be withheld under the Official Information Act. Appendix 1 contains the relevant clauses, 32 and 35, of the NZPHDA

If the limited information available suggests that over half of the board meetings are being held with the public excluded, how boards decide what to discuss when is important.

I contacted all the boards and asked about their policy around drawing up agendas and deciding what will be discussed with the public excluded. The responses show boards to be pretty consistent in following the guidance provided by the State Services Commission.

The State Services Commission's guidance on DHB chairs states the role includes: "chairing board meetings including: setting the annual board agenda; setting meeting agendas; ensuring there is sufficient time to cover issues; ensuring the board receives the information it needs – before the meeting in board papers and in presentations at the meeting; considering which matters should be dealt with in the 'public included' and 'public excluded' portions of DHB board meetings, encouraging contributions from all board members; assisting discussions towards the emergence of a consensus view; and summing up so that everyone understands what has been agreed…"[1]

Asked about policy around drawing up agendas and deciding what will be discussed with the public excluded, the boards are relatively consistent with the guidelines recommended by the commission.

The response of Bay of Plenty DHB legal executive Cherie Martin is typical of most DHBs.

When a member of the executive team submits a paper, they identify if it is to go under the public part of the agenda or with the public excluded, Ms Martin explains by email. The chief executive and chair discuss and agree on those items to be excluded. It is the board chair who is ultimately responsible for making the decision on the agenda. The board secretariat and in-house advisor identify the relevant clause in legislation that applies for the exclusion of the public.

[1] Resource for preparation of governance manuals – guidance for district health boards. Chapter 5 Role of the board chair http://www.ssc.govt.nz/governance-manuals-guidance-dhbs

Despite suspicions throughout the sector to the contrary that board members might discuss issues outside of mandated board meetings, few boards held any gatherings aside from the scheduled meetings.

Table 2 summarises the responses from the DHBs to questions regarding the process undertaken to decide which items are discussed with the public excluded, who is ultimately responsible for making decisions on the agenda content, any written policies on the process for deciding whether the public should be excluded, the extent to which board members meet to discuss issues outside normal board/committee meetings and if so for how long and whether the board holds regular meetings aside from the mandated meetings. Details of the letter sent are provided in Appendix 2.

Table 2 – Meetings aside from mandated public board and committee meetings	
Auckland	The board does not hold any other regular meetings outside of the mandatory board and committee meetings scheduled for the year The Auckland DHB board does meet in a 'board only' session for 1 hour during each full board meeting. The purpose of this meeting is for the board chair and board members to have informal discussion. On occasion the board holds workshops for planning, training and to be briefed on various matters relating to its role and responsibilities.
Bay of Plenty	The board has board-only time scheduled and meet for half an hour every quarter prior to the board meeting. The board does not hold regular meetings other than the mandated board and committee meetings. Once or twice a year they may have a workshop for planning or training purposes.
Canterbury*	
Capital and Coast	To my knowledge (interim chief executive Julie Patterson) the board does not meet in advance of board/committee meetings and does not hold regular meetings aside from the mandated board and board committee meetings.

Counties Manukau	Informal dialogue between CMDHB board members can occur between meetings on an ad-hoc and as-required basis. This might include communication via e-mail and phone conversations. The CMDHB board members meet 1 hour ahead of each full Board meeting. There are no DHB employees present for that session. The meeting is informal in nature and no decisions or formal resolutions are made during this session. Outside the mandated Board sub-committee meetings (Hospital Advisory Committee, Disability Advisory Committee, and Community and Primary Health Advisory Committee), nominated board members also attend Audit Risk and Finance Committee and Māori Health Advisory Committee meetings. Neither of these committees is authorised to make decisions or resolutions on behalf of the Board. Special meetings of the Board may be called where there are specific matters that require the Board's attention between routine meetings. Once or twice a year, the Board may also hold informal workshops for planning, strategic development and training purposes.
Hawkes Bay	The board does not routinely meet in advance of board/committee meetings. The board does not hold regular meetings aside from the mandated board and committee meetings. Once or twice a year the board does hold workshops for training and/or planning purposes
Hutt Valley	"To my knowledge" (acting chief executive Dale Oliff) the board does not meet in advance of board/committee meetings and does not hold regular meetings aside from the mandated board and board committee committee meetings
Lakes	The board on occasion meets outside the board meetings. For instance, in respect to CE performance appraisal. All committee and board meetings include community representation and iwi representatives
Mid Central	No pre-board/committee meetings of the board are held and the board does not meet regularly outside of mandated board and committee meetings.
Nelson Marlborough	There are no formal meetings of board members outside of the normal monthly board/committee meetings. The board does not routinely meet in advance of the board/committee meetings. There are two annual meetings involving NMDHB board members and members of the Iwi Health Board, starting at 10am and finishing at 2pm
Northland	Northland DHB's board does not routinely meet in advance of the board/committee meetings. The board does not hold regular meetings outside mandated board and committee meetings

South Canterbury	The board does not meet in advance of the board/committee meetings and does not hold meetings aside from the mandated board and board committee meetings
Southern	As the Southern DHB board was replaced by a commissioner in June 2015 it is not subject to the NZ Public Health and Disability Act requirement to open meetings to the public. However, it does hold pulbic forums and Hospital Advisory Committee, Disability Support and Community & Public Health Advisory Committee meetings open to the public as set out in the act
Tairāwhiti	The Board does not routinely meet outside the publicised meetings, not for any period of time prior or after the official meeting time. The only time there would be a meeting outside the normal meeting cycle would be for a matter that is urgent, with minutes confirmed at the next meeting. This is an extremely rare occurrence, the last being five years ago.
Taranaki	Taranaki DHB board does from time to time meet in advance of board/committee meetings. This is never for in excess of 30 minutes. The board does schedule workshop dtes throughout the year for planning or education. These are utilised as and when required.
Waikato	Our Board does have “Board and Chief Executive Only” time, prior to the monthly Board meeting. This is an opportunity to share perspectives on matters that are developing, but more usually to discuss general approaches to things that might be taken into more formal reporting at a later date. An hour is allocated for this discussion. Waikato DHB does not use such sessions to bypass legislative provisions around transparency. The Board is expected to keep a record of its decisions and the formal meeting process is an essential part of that. The Board does convene from time to time (perhaps once a quarter) by way of informal workshop. No decisions are taken at workshops, no resolutions are moved and no minutes are taken. Although there are no policies around how these are conducted, they are generally low-key and involve the Board and staff interacting much more informally than would be the case at a Board meeting. Generally they occur at the “storming” stage of an issue (for example, compiling the budget, or preparing a plan) where different perspectives are sought and challenged. The Waikato DHB does not generally hold ad hoc meetings outside of the regular monthly meeting cycle. The legislation allows this to occur and we have done so in the past - notably last year when the Board was confronting some difficult issues – but at present we have a much more settled meeting cycle
Wairarapa	“To my knowledge” (acting chief executive Catherine Sheridan) the board does not meet in advance of board/committee meetings and does not hold regular meetings aside from the mandated board and board committee meetings

Waitemata*	
West Coast*	
Whanganui*	

Public spirited

Public meetings as a device to engage people in health sector decision-making have largely relied on local media being present to report on the meetings for the benefit of the public.

For years, local newspapers and regional radio stations saw the various health board meetings as a source of regular and often front page news. For health reporters in all centres, attendance at health board meetings not only kept the reporter informed about decisions being made, it also led to useful relationships with board members.

As newsrooms around the country have diminished in size due to budget cuts arising from failing business models, attendance at meetings of a wide range of public agencies has fallen dramatically.

I suggest the model of elected board members on health boards included the expectation that for democracy to be seen to be done, the meetings of these boards would be covered by the media.

Yet, even though routine attendance by the news media at DHB meetings can no longer be taken forgranted, it is hard to see what DHBs have done to counter the lack of media attendance, other than maybe breathe a sigh of relief.

All DHBs have communications teams who are tasked with engaging with the media. In light of the media's inability to attend every meeting as they have in the past, the DHB might think to provide information about the meeting, maybe a summary of key decisions made at DHB meetings in the form of a media release, a straightforward way for the DHB to communicate with the media and public

For media-shy organisations, a media release has the advantage of keeping the DHB in control of the message, at least in the first instance. How well resourced the local news room is will determine the extent to which media releases are followed up or queried. In some cases the releases will be run as news stories with little modification.

Producing media releases following meetings would not only be of use to the media but also to the public at large.

Sounds like a good idea. Does it happen? Well, not really. In fact DHBs vary considerably in how they make use of their communications teams to communicate with the public and the media.

It is relatively straightforward to measure DHBs use of media releases because this information is included in reports by DHBs to the Health Select Committee

However, as with the data on public exclusion in meetings, making comparisons between DHBs is difficult because while the committee asked for some quite specific details on salaries of communication staff and the number of media releases sent, the DHBs collated the data in different ways.

For example, in some cases the figures for public health communications, such as vaccination campaigns, may or may not be included in the figures. Where it is highlighted this data has been left off in an attempt to make the data as uniform as possible, across the DHBs

Table 3 shows the number of media releases distributed in the 2016-2017 year by each DHBs and the annual cost of the communications team for that year.

More detailed figures are provided in Appendix 3.

Table 3 – DHB communications team costs

	Number of media release 2016/17 (2015/16)	**Total expenditure in 2016/17 on communication team**
Auckland	29 (24)	$1,301,939
Bay of Plenty	103 (78)	$277,143
Canterbury/West Coast	60 (78)	$680,973
Capital & Coast	38 (26)	$386,122
Counties Manukau	5 (13)	$1,093,111
Hawkes Bay	82	$380,503
Hutt Valley	6 (5)	$182,847
Lakes	104 (69)	$3529.83†
MidCentral	103 (112)	$270,000^
Nelson Marlborough	Does not keep track of media releases issued	$200,846
Northland	65 (85)	$329,000
South Canterbury	5* (13)	$80,000
Southern	117 (89)	$360,012
Tairāwhiti	83 (55)	$136,000
Taranaki	130 (142)	$267,084
Waikato	129 (87)	$335,000^
Wairarapa	35	$116,122
Waitemata	491# (397)	$585,870
Whanganui	55 (66)	$298,360

*Board says low number is indicative of a good relationship built up with media
#Incorporates "unique situations where the communications team has provided a formal response to the news media or proactively issued materials with a view to promoting DHB activities."
†Seems low ^Estimate based on salary bands provided
Where DHBs have provided figures for regional public health communications, I have not included them in the total

A crude measure of how well a DHB is delivering on the communication front would be the cost per media release based on the costs attributed for salaries for each communications team, the cost per media release ranges from $235,804 in Counties Manukau to $57,316 per release in Auckland down to $2054 in Taranaki and $1626 in Tairāwhiti.

But it is a crude measure, like so much of DHB reporting it is impossible to make direct comparisons because there is no guarantee over how data has been collected. In addition, some DHBs do publish internal and external news on their websites but this often requires the reader to find the news.

Almost all DHBs have social media accounts with the exception of Lakes DHB

Table x – DHB presence on social media

	Facebook	Twitter	YouTube
Auckland	x	x	
Bay of Plenty	x	x	x
Canterbury	x	x	x
Capital & Coast	x	x	
Counties Manukau	x	x	x
Hawkes Bay	x	x	x
Hutt Valley	x	x	x
Lakes			
MidCentral	x	x	x
Nelson Marlborough	x		x
Northland	x		x
South Canterbury		x	
Southern	x	x	x
Tairāwhiti	x		
Taranaki	x	x	
Waikato	x	x	x
Wairarapa	x	x	
Waitemata	x	x	x
West Coast	x	x	x
Whanganui	x	x	

Elected boards

The reinstatement of elected boards fulfilled an election promise. The National reforms of the nineties had left the public feeling disenfranchised.

Communities that had hoped to take over the running of their local rural hospital found it was not as straightforward as taking simply taking over operation of a facility they had invested in with regular fundraising; in many cases they had to purchase the facilities.

The promise of a core set of services that the public health services would be expected to provide to everyone disappeared when the committee charged with the task admitted defeat; alternative health plans were placed in the too-hard basket; public health agencies never eventuated, the Public Health Commission was short-lived; and the hoped for market-driven innovation through competition failed.

Nevertheless, ten years had passed since the demise of area health boards and the dumping of elected boards. According to Otago University health services researcher Robin Gauld, the romance with elected boards might well have been over by the time Labour reinstituted them with the creation of the DHBs.

A professor of health policy, Professor Gauld, has written extensively on structures in the New Zealand health system, and in 2014, with co-author Miriam Laugesen, published *Democratic Governance & Health: Hospitals and Politics of Health Policy in New Zealand*. He says New Zealand is unique in sticking with a model incorporating elected board members.

Professor Gauld has looked closer at the number of and type of candidates standing for DHB seats.[2]

The first set of elections for the new DHBs took place in 2001. These elections saw 1084 candidates contest 146 out of 147 seats (one seat had only one candidate). Enthusiasm was variable arund the country. In Waitakere ward, one of three that made up the Waitemata DHB area, 50 people stood for three seats. Likewise, in Christchurch, long a hotbed of public interest in the goings on of health managers, 75 candidates contested five seats. Elsewhere numbers were more subdued.

The mix of the 1084 candidates was: 55 per cent male, 5 per cent were DHB employees, 7 per cent were incumbent board appointees and 12 per cent Maori. Only around half of those appointed to boards under the National reforms, stood for election in the new regime.

So, 2001 saw 1084 candidates; by 2004 that number had almost halved to 518 and in 2007 the number was 428 standing for 147 places. By 2016, the last time DHB elections took place, 363 candidates stood for 133 positions.

Looking for board members

Why the decline in numbers standing for DHB boards?

In the first instance, there is no doubt some elected board members have found the restrictions that arise from the dual accountabilities – first and always first to the minister and a distant second to the people who elected them – very frustrating.

The boards are implementing policy mostly created at the national level – the New Zealand Health Strategy – and with funding streams largely tied up either in operational matters – payroll and facilities maintenance – or otherwise to political initiatives.

The country's annual Budget is a breeding ground for health sector initiatives which often come without the benefit of DHB once-over.

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[2] Are elected health boards an effective mechanism for public participation in health service governance? *Health Expect*. 2010 Dec; 13(4): 369–378. Published online 2010 Nov 4. doi:10.1111/j.1369-7625.2010.00605.x

Professor Gauld suggests that, as the awareness of the limits of what DHBs can achieve beyond implementing central government policy hit home, people felt they could not make a difference.

And while potential board members may have felt a little deflated over their inabililty to achieve significant change; expectations of them are high,

The State Services Commission sets a high bar when describing the skills typically expected of a board appointee, presumably skills that would also ideally be found in elected members. Here's the list found in the State Services Commission's *Resource for preparation of governance manuals - Guidance for district health boards*[3]:

Generic skills for a board member will usually include:

- a wide perspective on, and awareness of, social, health and strategic issues;
- integrity and a strong sense of ethics;
- financial literacy and critical appraisal skills;
- strong reasoning skills and an ability to actively engage with others in making decisions;
- knowledge of a board member's responsibilities, including an ability to distinguish governance from management, understanding of collective responsibility and an appreciation of the Crown as owner;
- good written and oral communication skills;
- an ability to contribute constructively and knowledgeably to board discussions and debates.
- These qualities will usually be demonstrated through some or all of the following:
- governance experience in significant organisations with either a commercial, public service or community focus;
- experience at chief executive or senior management level in organisations that have commercial or public service attributes;
- holding senior positions in relevant professional areas including, but not limited to, health, social services, finance, law, and social policy;
- relevant governance or management experience in community or professional organisations.

In addition to these qualities, members might bring particular expertise to the board room table.

And there is no let up once you are on a board. [finished ere]

Here is the State Services Commission's guidance on general behavior of board members[4], stating "The list below is not exhaustive nor in order of importance, but it should assist boards to specify appropriate behaviours"

- *Responsibility to the entity*. Members need to recognise and always act consistently with their responsibilities to the DHB and to Ministers. Members owe a duty to the organisation as a whole and are not to act purely in the interest of a specific group. They should attend induction training and board members' professional education to familiarise and update themselves with their governance responsibilities.

[3] *Resource for preparation of governance manuals – guidance for district health boards*. Chapter 17 Board appointments and reappointments http://www.ssc.govt.nz/governance-manuals-guidance-dhbs

[4] Resource for preparation of governance manuals – guidance for district health boards. Chapter 6 General behaviours of board members. http://www.ssc.govt.nz/governance-manuals-guidance-dhbs

- *Strategic perspective.* Members need to be able to think conceptually and see the 'big picture'. They should focus as much as possible on the strategic goals and overall progress in achieving those rather than on operational detail.
- *Integrity.* Members must demonstrate the highest ethical standards and integrity in their personal and professional dealings. They should also challenge and report unethical behaviour by other board members.
- *Intellectual capacity*. Members require the intellectual capacity to understand the issues put before them and make sound decisions on the entity's plans, priorities and performance.
- *Independent judgement.* Members need to bring to the board objectivity and independent judgement based on sound thought and knowledge. They need to make up their own mind rather than follow the consensus.
- *Courage.* Members must be prepared to ask the tough questions and be willing to risk rapport with fellow board members in order to take a reasoned, independent position.
- *Respect.* Members should engage constructively with fellow board members, entity management and others, in a way that respects and gives a fair hearing to their opinions. In order to foster teamwork and engender trust, members should be willing to reconsider or change their positions after hearing the reasoned viewpoints of others.
- *Collective responsibility.* Members must be willing to act on, and remain collectively accountable for, all decisions even if individual members disagree with them. Board members must be committed to speaking with one voice once decisions are taken on a DHB's strategy and direction.
- *Participation.* Members are expected to be fully prepared, punctual and regularly attend for the full extent of board meetings. Members are expected to enhance the quality of deliberations by actively asking questions and offering comments that add value to the discussion.
- *Informed views*. Members are expected to be informed and knowledgeable about the DHB's business and the matters before the board. They should have read the board papers before meetings and keep themselves informed about the environment in which the DHB operates.
- *Understanding.* Members are expected to recognise the need for service delivery to positively reduce disparities between various population groups. Members are expected to understand Māori health and Treaty of Waitangi issues (Schedule 3, clause 5 to the New Zealand Public Health and Disability Act 2000). This includes establishing and maintaining processes to enable Māori to participate in and contribute to strategies for Māori health improvement and to foster Māori capability.
- *Financial literacy.* Boards monitor financial performance and thus all members must be financially literate. They should not rely on other members who have financial qualifications, but should undertake training to improve their own financial skills where necessary.
- *Sector knowledge.* Members need to make themselves familiar with the activities of the entity and sector. This is likely to include attending induction sessions and ongoing background study.

Difficulties facing Māori representatives

For Māori candidates, research has found the pressures are great should they be successful in gaining place on a board or being elected to a board.

In research for her doctoral thesis, Joy Ponoho interviewed 18 people about their experiences as Māori directors on DHBs.[5]

[5] A Maori-centred inquiry into health governance: Maori directors on District Health Boards, doctoral thesis of Joy Panoho, Massey University, May 2013. Available on Massey University website, www.massey.ac.nz

In a Massey University media release at the time she received her doctorate in 2013, Dr Ponoho says the directors felt they were burdened by the responsibility of being the sole advocate for Māori health on their boards.[6]

"They described fulfilling the role of 'a walking Treaty workshop' – that was in their own words. Regardless of the best intentions of their non-Māori counterparts, enormous gaps in understanding about Māori politics, Māori expertise, and Māori networks exist."

"Well over half the directors I spoke to recounted incidents of confrontation where they had to educate their non-Māori counterparts about the underlying issues affecting Māori health. While this then led to improved levels of understanding, it can be quite an exhausting burden."

Dr Panoho says some problems stemmed from the legislation, New Zealand Health and Disability Act 2000, which leads people to believe that it is required that DHB boards have at least two Māori directors.

In fact, when then health minister Annette King announced the creation of DHBs she was quite specific about the requirements for Māori representation.[7]

In a memorandum to the Cabinet Social Policy and Health Committee (provided in Appendix 4), Mrs King, now Dame Annette, explained that a large part of the rationale for establishing the DHB structure was the desire to involve local communities to a greater extent in the health decision-making process.

Dame Annette intended that Māori be represented on boards "in a number and manner that will give Maori an effective and informed voice in the conduct of the Boards' business, and in a way that reflects the priority given to disparities in Māori health compared to other New Zealanders."

To that end, it was proposed there should be a minimum of two Māori members on each board, with additional members in areas with high Māori populations. The number of Maori seats should be proportional to the proportion of Maori in the population, plus one additional Maori member to reflect the greater health disparities in the Maori population.

The memo notes the extra burden of expectation carried by Māori board members and that having a minimum of two or more Māori members will enable that load to be shared and increases the likelihood of the voice being heard.

The memo states: A baseline of at least two seats reinforces the Government's commitment to reducing disparities in Maori health, and it gives greater credibility to the Crown/Maori partnership precept (although it should be noted that many Maori consider that only a 50:50 Maori to non-Maori membership ratio gives true meaning to the Treaty commitment).

However, the ultimately wording in the legislation requires the minister to "endeavour" to ensure that Maori membership of the board is proportional to the number of Maori in the DHB's resident population and, "in any event" there are at least 2 Maori members of the board.

The word "endeavour" means there are boards that have only one Māori director, and some that have had none at all.

Another difficulty identified by Dr Panoho in her thesis was the selection of Māori representatives.

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[6] Māori DHB directors challenge status quo, Media release from Massey University Study finds Maori DHB directors overburdened, 20 May 2013 https://bit.ly/2MV8N4i

[7] Memorandum to Cabinet Social Policy and Health Committee from hon Annette King, Minister of Health, 1 August 2000, Equitable Representation of Māori On DHB Boards

Because the Government's consultation over who should be appointed to directors' roles is done through a tribal process, some potential candidates can be excluded because they are no longer living in their tribal area.

But the most difficult challenge faced by Māori directors, according to Dr Panoho, comes from the attitudes of other directors.

"Many felt there was little cultural or historical understanding of the damage to Māori health brought about by the process of colonisation. Māori directors have valuable grassroots experience that is an important strategic tool for DHBs. This experiential capital is as valuable a resource contribution as, for example, a law degree or an accountancy degree."

Despite the difficulties experienced, Dr Panoho's interviewees recognised that without the legislation there would be little or no Māori representation.

"All participants recognised the importance of having a seat at the table even though progress was at times hard to measure. Most felt, overall, they were having a positive impact and there was an opportunity to change attitudes and help turn Māori health statistics around."

In 2018, research by AUT senior lecturer in Maori health Heather Came pointed to examples of the Ministry of Health at the time reducing checks and balances to ensure Māori representation.[8] Decisions to close the ministry's internal Māori health directorate Te Kete Hauora, to revoke the need for DHBs to produce a Māori health plan and to reduce DHB requirement for consultation over their annual plans were all seen to have the potential to undermine the place of the Māori DHB directors.

Why don't people vote?

Irrespective, it seems, of the quality of candidates, voter turnouts in local body elections, where DHB board members are elected, is trending down.

Professor Gauld found that voter turnout in 2001 was 50 per cent, in 2004, 42 per cent and 2007, 43 per cent.[9] Figures from Local Government NZ show a jump in 2010 (49 per cent) but then 41.3 per cent in 2013 and 42 per cent in 2016.[10,11] The voter turnout trends for local government mirror those in national elections.

Professor Gauld suggests the turnouts raise questions over the extent to which the broader public are interested in health-care governance and even whether they should be expected to vote.

Though if you drill down into the voter stats, turnout is consistently highest in rural areas, followed by provincial areas and lowest in urban areas. In health, rural voters have ongoing concerns about the sustainability of their local services and their access to services and likewise other services. So the figures suggest will be mobilised if their services are threatened.

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[8] Unravelling the whāriki of Crown Māori health infrastructure *NZ Med J* 2017;130[1458] 7 July

[9] See reference 1

[10] The 2013 Elections – what are the lessons? http://www.lgnz.co.nz/nzs-local-government/vote2016/final-voter-turnout-2016/

[11] Internal affairs website

Professor Gauld cites Canadian research relating to appointed Canadian boards "most citizens wish only to be consulted and they expect and prefer that 'the experts' take responsibility for actually making the decisions."

If this is the case, Professor Gauld suggests participatory mechanisms other than elected representatives may be more appropriate for garnering community input.

The Government-appointed Health Quality and Safety Commission's consumer-engagement programme, Partners in Care, works from the premise that consumers should be "actively involved in decision making about health and disability services at every level."

The commission's guide cites the Treaty of Waitangi and the Code of Health and Disability Services Consumers' Rights as two legislative documents underpinning the need for consumer engagement in health services.

Several DHBs have embarked on creation of consumer councils. It seems hardly rocket science these days to suggest that working effectively with consumers and engaging them in the creation of services is critical to producing health services that make a difference. The commission cites other benefits as safer care, less waste, lower costs and better consumer and health provider satisfaction and staff retention.

In the chief executive's foreword, Janice Wilson writes: "By including consumer perspectives, health providers will spend more wisely and policies will be fit for purpose because consumers have been actively involved."

The vision is that the consumer voice should be heard at all levels. *Engaging with consumers: A guide for district health boards* recognises the challenges in finding consumer representatives, and draws up a potential skillset with some similarity to that proffered by the State Services Commission for DHB board members. [12]

The Hawke's Bay DHB Consumer Council was established in 2015. In what could be seen as a twist or irony, it holds regular meetings which include sections with the public excluded.

The push for greater consumer representation and input into health services and policy at all levels, potentially reinforces the argument for continued democratic representation at the board level. People with the ideal criteria prepared to stand for election maybe in short supply but that does not mean the system doesn't benefit from elected representation.

More problems with the model

In 2010, Len Cook and Robert Hughes of Victoria University's Institute of Policy Studies looked at changes to governance arrangements in public health arising from a report by the Ministerial Review Group which proposed changes to structures at the top of public health.[13]

They find that public sector management systems have continually failed the health service in all four previous health sector management models that had been in place since 1980.

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[12] Engaging with consumers: a guide for district health boards. https://www.hqsc.govt.nz/our-programmes/partners-in-care/publications-and-resources/publication/2162/

[13] The new governance arrangements for the public health sector and the need for wider public sector reform, Len Cook and Robert Hughes, Institute of Policy Studies Working Paper 10/04, February 2010

They say it is not “unreasonable to conclude that the current achievements of the public health service result more from the strengths and culture of individual institutions, and the commitment of health professionals, managers and support staff in their treatment and care of patients, that from the public sector system that is operates in, or any of the four health sector management models put in place by respective governments since the mid 1980s.

“The resilience that gets things done despite not having a supportive public sector management system probably reduces confidence in collective activity of any sort. It may have contributed to the great difficulty in achieving a timely consensus among DHBs on matters of real consequence to the long-term effectiveness and efficiency of the health systems.”

“This resilience is likely to have reinforced the fragmentation of services.”

In 2015, the New Zealand Health System Independent Capability and Capacity Review, commissioned by the Ministry of Health, noted the DHB board structure “presumes competence in governance and leadership, including from elected members”. But this appears to be lacking in practical day-to-day execution, the review team said.

It suggested reducing the number of board members to nine. The current mix did not respect the leadership requirements to competently operate large, complex organisations.

It warned that where boards lack competence, executive managers can have too much influence on decisions.

Further engagement

There is a certain circular problem with democracy at DHB board level.

The complexity of the role makes it hard for your average community representative to take part but when they do their hands are pretty much tied by decisions made by central government.

The lack of ability to influence significant change at the local level means communities remain disconnected from their boards and do not attend meetings, which are, in any event, held at times that make it hard for many people to attend.

Coincidental changes in the media industry mean many outlets do not have the resources to send reporters to meetings so if something of public interest is discussed it is possible this will go unnoticed.

But the very element that is causing strife for the news media business model could also help DHBs attract public interest. As we see above most DHBs have some social media presence but, to date, none appear to be live streaming their meetings.

This is despite the fact many local bodies, including the largest, Auckland City, are already doing so.

At central government level, select committees are making use of live streaming. Last year the deputy clerk of the house Rafael Gonzalez-Montero announced that select committee rooms one and two in Bowen House have been set up for live-streaming of public proceedings on Facebook.[14]

And people making submissions to select committees will be asked if they want to do so via video conference.

[14] Live-streaming and video-conferencing make select committee meetings more accessible, Office of the Clerk, New Zealand Parliament website, 13 June 2018 https://bit.ly/2tf45ph

The Justice Select Committee made use of the technology to stream its hearings into new medicinal cannabis legislation.

The Waitangi Tribunal last year live streamed submissions to its Health Services and Outcomes Inquiry (Wai 2575) on YouTube.

Back in 2017, Horowhenua mayor Michael Freyen who is also a MidCentral DHB board member called on the board to consider live-streaming its meetings.

Mr Freyen had successfully introduced live-streaming of the council meetings when he was elected mayor in 2016 . The DHB board discussed the issue of live-streaming board and committee meetings at its 23 May 2017 board meeting and "it was agreed that this not be progressed at this time."

A shame they don't have live-streaming as would provide useful details as to why the board made that decision. I guess you had to be there.

Cost appears to be one of the issues but Taupo and Horowehenua councils appear to manage perfectly fine with a single camera set up and microphones on every desk. The livestreamed sessions are then stored on YouTube.

Provided it has been made easy for the public to obtain copies of the reports for discussion, this would seem to be a good option.

Additional sources

New Zealand Health System Reforms, New Zealand Parliament websitehttps://www.parliament.nz/en/pb/research-papers/document/00PLSocRP09031/new-zealand-health-system-reforms

New Zealand Health Service Review, Health Systems in Transition 2014;4[2] Asia Pacific Observatory on Health Systems and Policies

The New Zealand Health System: Independent Capability and Capacity Review, Suckling, Connolly, Mueller, Russell, June 2015, https://www.health.govt.nz/about-ministry/what-we-do/new-zealand-health-strategy-update/capability-and-capacity-review

Governance in district health boards, Health Reforms 2001 Research Project, Report No. 2. Pauline Barnett, Clare Clayden, On Behalf of the Health Reforms 2001 Research Team, August 2007

The new governance arrangements for the public health sector and the need for wider public sector reform, Len Cook and Robert Hughes, Institute of Policy Studies Working Paper 10/04, February 2010

Democratic Governance & Health:Hospitals, Politics and Health Policy in New Zealand, Miriam J. Laugensen & Robin Gauld, Otago University Press, 2012

Interviews and personal communication

Gregor Coster

Jackie Cumming,

Robin Gauld

Mary Anne Gill, board member, Waikato DHB

Tim Tenbensel

Richard Thompson

Appendices

1 Memorandum to Cabinet Social Policy and Health Committee from HON ANNETTE KING, MINISTER OF HEALTH, 1 AUGUST 2000, Equitable Representation of Maori On DHB Boards

2 Clauses from New Zealand Public Health and Disability Act relating to exclusion of public

3 Letter to DHBs requesting details on policies and procedures around excluding the public

4 Responses from each DHB to request for details on policies and procedures around excluding the public

5 Data on spending and cost of communications teams

Appendix 1 – Excluding the public

The following are the clauses in the New Zealand Public Health and Disability Act used by DHBs to exclude the public

32 Right of board to exclude public

A board may by resolution exclude the public from the whole or any part of any meeting of the board only on 1 or more of the following grounds:

(a)

that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information for which good reason for withholding would exist under any of sections 6, 7, or 9 (except section 9(2)(g)(i)) of the Official Information Act 1982:

(b)

that the public conduct of the whole or the relevant part of the meeting would be likely to result in the disclosure of information the public disclosure of which would—

(i)

be contrary to the provisions of a specified enactment; or

(ii)

constitute contempt of court or of the House of Representatives:

(c)

that the purpose of the whole or the relevant part of the meeting is to consider a recommendation of an Ombudsman made under section 30(1) or section 35(2) of the Official Information Act 1982 to the board:

(d)

that the purpose of the whole or the relevant part of the meeting is to consider a communication from the Privacy Commissioner arising out of an investigation under Part 8 of the Privacy Act 1993:

(e)

that the exclusion of the public from the whole or the relevant part of the meeting is necessary to enable the board to deliberate in private on a decision or recommendation as to whether any of the grounds in paragraphs (a) to (d) are established in relation to all or any part of any meeting of the board.

35 Maintenance of order

(1)

At any meeting of any board the presiding member of the board may require a member of the public attending the meeting to leave it if the presiding member believes on reasonable grounds that, if the member of the public is permitted to remain, the behaviour of the member of the public is likely to prejudice, or to continue to prejudice, the orderly conduct of the meeting.

(2)

At the request of the presiding member, a constable, or officer or employee of the DHB concerned may remove or, as the case requires, exclude a member of the public from a meeting of a board if the member of the public has been required under this clause to leave the meeting but—

(a)

refuses or fails to leave it; or

(b)

having left it, attempts to re-enter it without the permission of the presiding member.

Appendix 2 – Letter to DHBs

The letter sent to DHBs requested the following information:

Details of the process which is undertaken at your DHB to decide which items on an agenda are discussed with the public excluded

Who is ultimately responsible for making the decision on the agenda

Who makes the decision as to which clause of the OIA applies to a decision to exclude the public

Copies of any written policies on the process for deciding which issues should be discussed with the public excluded

I am also interested in the extent to which board members meet to discuss issues outside of the normal board/committee meeting structure.

Does your board routinely meet in advance of the board/committee meeting and, if so, for how long?

Does your board hold regular meetings aside from the mandated board and board committee meetings – if so, how often and for how long?

Responses were received from:

Appendix 3 – Data on spending and cost of communications teams sourced from written answers supplied by individual DHBs to the Health Select Committee in early 2018.

	FTE 2016/17	FTE 2015/16	Total cost 2016/17	Total cost FTE 2015/16	Number of staff in specific earning range	No of media release (previous year)
Auckland	7.77 plus 1.47 project support (regional public health – 2.58 plus 1.29 contractors, Organ Donation NZ – 1)	4.82 (2.52, plus 2.1 project support plus 108 contractors,1)	$1,301,939* ($360,229, $45,094)	$692,030 ($333,509, $50,904)	Not provided The higher cost is 2016/2017 was due to the employment of a direction of communications on contract as part of a "stabilisation and turnaround" programme for the comms team	29 (24)
Bay of Plenty	2.5 plus 2 (Toi Te Ora) An additional 0.3 FTE on casual contract basis form October 2016	2.5 + 2 (Toi te Ora)	$$277,143 (+$141,479)	$263,469 (+$138,705)	Not provided	103 (78)
Canterbury/ West Coast (joint comms team)	7.3(2 contractors	8 (2 contractors)	($680,973 + contractors $260,163	$697,776 + contractors $209,055)		60(78)
Capital and Coast	4.5	4.4	$386,122	$367,638	$120,000 to $129,000 – 1 $80,000k-$90,000 – 2 $60,000-$79,000 –1.5	38 (26)
Counties Manukau	1 media relations 8 permanent communications	1 media relations, 5 permanent communications	$212,000 + $881,111	$163,517 + $341,340		5 (13)

(excludes Ko Awatea)			(plus $375,199 outsourcing	(plus $84,913 outsourcing		
Hawkes Bay	4.6	4.3	$380,502.75	$352,900.05	Not provided	82
Hutt Valley	1.91	2.20	$182,847	$162,110	$100,000+ 1	6 (5)
Lakes DHB						
Mid Central	2.5 Also 1.5 web staff and 2 graphic designers)	2.5	No total given Est. $270,000	Same	$50,000-$100,000 – 2 <$50,000 – 4	103 (112)
Nelson Marlborough	2.7	2.4	$200,846	$178,986	Not provided	Does not keep track of media releases issued
Northland	3 plus (FTE not specified – communications manager, communications coordinator, internet/intranet manager and outsourced staff	3 (FTE not specified	$329,000	$308,000		65 (85)
South Canterbury	1	1	$85,000	$80,000	Not provided	5[1] (13)
Southern	3.4	2.6	$323,021	$360,012	Not provided	117 (89)
Tairāwhiti	1.75	1.75	$136,000	$136,000	$80-$85,000 – 1 $50-$55,000 – 1	83 (55)

[1.]Indicative of the relationships developed with the media and not reflective of the amount of coverage received. The purpose of a press release is to ensure specific key messages can be delivered to a variety of media and stakeholders. In South Canterbury we have two newspapers and are able to work closely with the health journalists on a daily basis to ensure our community are informed regarding health provision in their area. As such we rely less on press releases and more on relationships (Note from report)

Taranaki	3.30	2.34	$267,084	$185,586	Not provided	130 (142)
Waikato	3 (plus one graphic/web designer, webmaster	Not provided	$ 335,000 Estimate based on salary bands PR contracted consultants for SmartHealth 2016/17 $48,537	Not provided	$80,000+ 1 $70,000-$80,000 – 2 $60,000-$70,000 – 1 Below $60,000 – 1	129 (87)
Wairarapa	1.5	1.5	$116,122	$67,317	Not provided	35
Waitemata	6.08 FTE	$564,813FTE	$585,870	$564,813	$160,000-$169,000 – 1 $100,000–$109,000 – 1 $70,000–$79,000 – 1 $60,000–$69,000 – 2 $50,000–$59,000 – 1	491 (397)
Whanganui	4	4	$298,360	$279,352	$90,000-110,000 – 1 $80,000-90,000 – 1 $60,000-70,000 –1 $38,000-40,000 – 1	55 (66)

Appendix 4 – Requirement for Māori representation

1 AUGUST 2000

HON ANNETTE KING, MINISTER OF HEALTH

Memorandum to Cabinet Social Policy and Health Committee

Equitable Representation of Maori On DHB Boards

PURPOSE

1. This paper makes recommendations on how to achieve equitable representation of Maori on the District Health Boards (DHBs).

EXECUTIVE SUMMARY

1. The Maori representation paper links with a paper on DHB elections which is scheduled for the following Social Policy and Health Committee meeting. That paper will include advice on how to implement an STV system with constituencies for DHB elections.
2. The DHB Board will be collectively accountable for achieving the government's objectives for Maori health and reducing health disparities between Maori and other New Zealanders. Maori representation on Boards will assist Boards to achieve those objectives. It will operate alongside the Treaty-based partnerships that DHB Boards will be required to establish with mana whenua in their area.
3. It is proposed that the proportion of Maori members on a DHB reflects the proportion of Maori in that DHB's population, plus an additional member to ensure Boards can effectively address Maori health disparities. This will ensure a minimum of two seats on each board, with more in areas with high Maori populations.
4. Boards will have seven elected members and up to four appointed members. The desired levels of Maori representation should ideally be achieved through a combination of elections and appointments.
5. A proportional voting system such as STV is more likely to ensure representation of Maori (and other minority groups) than first-past-the-post systems such as that currently used in local body elections). This aligns with Cabinet's preference [CAB(00) M 19/14]. The Ministry of Health is working with the Department of Internal Affairs to provide advice on how STV could be implemented for DHB elections in 2001.
6. No election system will *guarantee* Maori representation, however, so regardless of the electoral system, the election results will need to be supplemented with appointments to achieve the desired Maori representation levels. Maori involvement in the appointments process would be desirable and the Ministry of Health will advise the Minister of Health on how to achieve this, before the 2001 appointments process.

BACKGROUND

1. The Government has agreed there will be equitable representation of Maori on DHB Boards. [CAB (00) M 2/4 refers]. Some options for achieving this were canvassed in an earlier paper [ref. Ad Hoc Ministerial Committee meeting 17 April 2000].
2. Ministers have asked for a further paper that clarifies the appointment and election options, and compares the merits of each.

3. This paper links to the paper on election options for DHBs, as well as two accompanying papers on the Treaty of Waitangi in Health Legislation, and the proposed partnership between Maori and the Crown at national and DHB levels.

WHAT ARE WE TRYING TO ACHIEVE?

An effective Maori voice at governance level

1. An effective Maori voice at DHB Board level will be important as Boards move to give effect to the Government's commitment to improve Maori health and to the principle of participation at all levels of the health sector under the Treaty of Waitangi. While achieving Maori health development will be a collective board responsibility, there will, nonetheless, be considerable pressure on individual Maori members to 'perform'. As well as being familiar with the issues and developments in Maori health, Maori members will need to be well versed in both boardroom and health politics - as will non-Maori board members.

A local perspective on Maori issues

1. Equally, candidates will need to be able to reflect local concerns. A large part of the rationale for establishing a DHB structure is the desire to involve local communities to a greater extent in the health decision-making process. Accordingly, Board members will need to be able to demonstrate that they have the confidence of, and can speak for, a considerable proportion of the DHB constituency.

EQUITABLE MAORI REPRESENTATION

1. "Equitable representation" in the context of DHB Boards is taken to mean that Maori will be represented on Boards in a number and manner that will give Maori an effective and informed voice in the conduct of the Boards' business, and in a way that reflects the priority given to disparities in Maori health compared to other New Zealanders.
2. To this end, officials propose that there should be a minimum of two Maori members on each Board, with additional members in areas with high Maori populations. The number of Maori seats should be proportional to the proportion of Maori in the population, plus one additional Maori member to reflect the greater health disparities in the Maori population.
3. Experience has shown that Maori members on Boards carry a burden of expectations beyond that of other members. That is particularly the case where there is a sole Maori member. Two or more members would enable that load to be shared, and also make it more likely that the Maori voice will be heard on those Boards where there would otherwise be only one Maori representative on a Board of eleven. A baseline of at least two seats reinforces the Government's commitment to reducing disparities in Maori health, and it gives greater credibility to the Crown/Maori partnership precept (although it should be noted that many Maori consider that only a 50:50 Maori to non-Maori membership ratio gives true meaning to the Treaty commitment).
4. Cabinet has decided there will be seven elected DHB members and up to four appointed members [CAB (00) M 19/14(b)]. Annex 1 sets out the estimated numbers of Maori seats on an eleven-member Board under a population proportion model, with an additional Maori member to reflect Maori health disparities. All Boards would have a minimum of two Maori seats. Two Boards would have four seats, one Board would have five, and one would have six seats.
5. If insufficient Maori are elected through the electoral process, the Ministerial appointments process will need to supplement those results. With only four appointed positions available, there may be some practical problems

achieving the desired Maori representation levels where higher numbers are required, so some flexibility will be needed.
6. Reserving seats specifically for Maori raises issues of compliance with human rights legislation. The justification for this measure is set out in Annex 2.

THE ELECTION OPTION

The Mode of Election

1. The existing local body voting method has not been effective at delivering equitable representation for Maori or other minority groups. Only about 5% of local body members are Maori (although it is believed around 10% of candidates are Maori)[1].
2. There is significant overseas evidence that proportional voting systems such as STV and Limited Voting (where voters have fewer votes than the total number of members to be elected) are more likely to be effective in promoting representation for minority groups and better reflecting the make-up of the electorates. Voting rights actions have been taken by ethnic minority groups in the United States with at-large simple majority elections. STV and related systems also appear to have the benefit of encouraging positive campaigning and coalition building among candidates and positive voting by the constituency.
3. The Ministry of Health is working with the Department of Internal Affairs (Local Government) and the Ministry of Agriculture and Fisheries (Rural Affairs) to provide advice as soon as possible to the SPH Committee on how to implement an electoral system with single and multiple member constituencies, and STV where there are multiple members [CAB (00) M 19/14 (cc)].
4. It is important to note that adding a constituency system to STV will weaken its ability to achieve equitable representation.

Alternative Electoral Option

1. If STV is not adopted, an alternative electoral option is a process that resembles the General Election, with a Maori roll and dedicated Maori seats. This has the twin benefits of being familiar to voters and of being comparatively easy to implement. A Maori roll is also the only way to guarantee the election of Maori board members.
2. For the national elections, people self-identifying as Maori have the choice of going onto the Maori roll or the general roll. In the case of DHB elections, it is proposed that all people self-identifying as Maori when enrolling for the national elections would be sent the voting papers for Maori DHB seats as well as for the general DHB. They would exercise their right to vote as Maori by returning the Maori voting papers. This would avoid the problems of either having to construct a separate Maori DHB roll, or of having to confine the Maori DHB vote to only those on the national Maori roll.

Footnote(s):

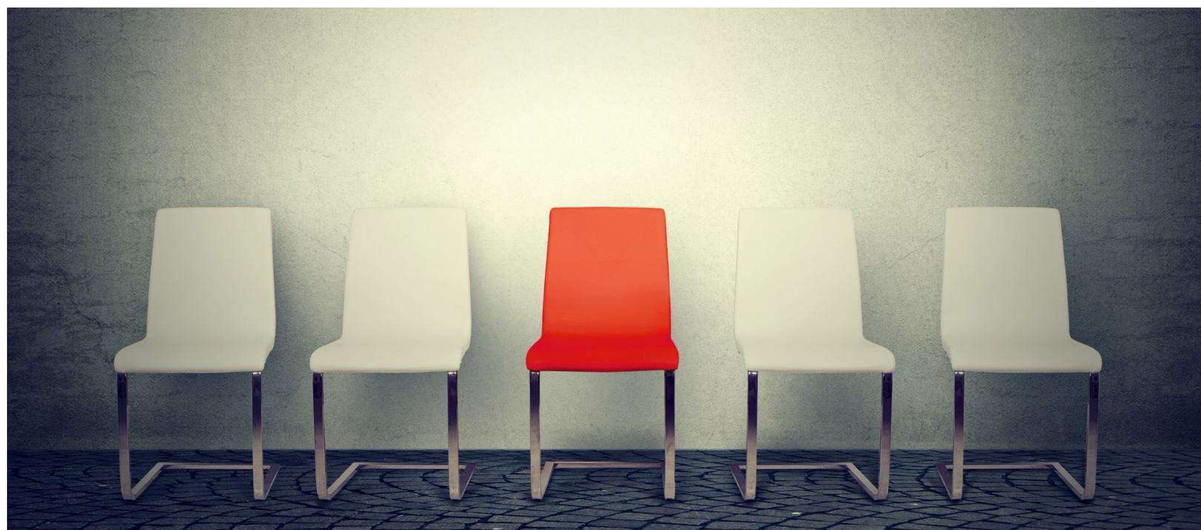
1

Department of Internal Affairs (1994) *Local Government Candidates 1992*, Local Authority Information Series No. 8, Department of Internal Affairs, Wellington

Appendix 5 – Text version of feature article published in New Zealand Doctor (13 March 2019) and www.nzdoctor.co.nz 15 March 2019

Secrets, fears and empty chairs

By Barbara Fountain



Many of the decisions our DHBs make – and the problems they face – are revealed months after the event. Is secrecy the problem, does the public care, or is something wrong with how we organise health governance?

We have no way of knowing if something is impacting on service delivery; we have to take DHBs at their word – Jackie Cumming

ROTTING hospital buildings, outrageous spending by health bosses, patients languishing on waiting lists: the headlines come thick and fast, and the public is left feeling uneasy.

Every three years, voters put representatives onto the country's 20 DHBs, in hope they will look after the public interest. Scandals emerge, raising doubts about board members' competence, and fears that crucial information is being withheld. New Zealanders' love affair with health boards has had a rocky path.

The affair's heyday was back in 1925, when hospital boards numbered 46. The heart was ripped out of the relationship in the 1990s, when the then National Government ditched elected boards as part of its market-based health reforms.

Had the Government of the day moved more carefully with its ideological drive, that might have been the end of the romance. But some reforms went too far – most famously, an ill-fated plan to charge for overnight stays in public hospitals.

And so the embers of the romance were stoked to a burning passion not seen in countries with similar health systems. In the early 2000s, the Labour Government fulfilled an election promise and reinstituted elected boards. The public breathed a sigh of relief – their locally based system had been saved.

It wasn't quite the same, though. The decade without publicly elected boards had seen the commercial model dominate, and public hospitals compete with one another.

Transparency of decision-making had been so limited, no one had been required to draw up an agenda for a public board meeting for nearly 10 years.

Media outlets, feeling the early impact of online competition, had started to shrink their reporting staff. The era when reporters attended several board and committee meetings each month slowly slipped by, and hasn't returned. Meetings also have become less frequent.

The reforms had brought communications managers into the health boards, just as it had in corporate life where public relations' control of the messaging had long been standard practice. (See "$1million for five media releases" below)

The relationships built through reporters fronting up regularly at board meetings were well gone. Instead, a battleground was forged, in which DHBs claimed journalists were only after bad news and journalists claimed DHBs weren't telling them anything. In the meantime, the seats reserved for the public at board meetings were mainly empty.

Waikato DHB board member Mary Anne Gill has seen it all. Her 30 years in journalism began with regional reporting for the *Wanganui Chronicle* in Ohakune, and later with the *Taranaki Daily News* in Taumarunui. Journalism runs in the family. Two siblings have made a name for themselves as foreign correspondents: Michael Field in the Pacific and Catherine Field in Europe.

Mrs Gill covered the gamut of community politics – county and borough councils and hospital boards – and loved it.

She recalls Taumarunui County Council meetings that lasted all day. At some point in the 10 hours of sitting, councillors would go "into committee" (excluding the public) to discuss a footpath or a pothole in a country road.

Mrs Gill says she would push back, not out of any sense of right or wrong but because "the public will want to know about this, because that pothole is on the road where Fred takes the kids to school".

Moving on to the *Waikato Times*, she would routinely pick up a council agenda and write five or six articles ahead of the meeting, much to the chagrin of councillors wanting her to wait until they had discussed the matters.

No, was her reply; the information is in the agenda, it's public. She was well known for fighting council attempts to keep stuff out of the public eye.

Her next role, communications manager for Waikato DHB was, she says, a shift to the "dark side" (journalism-speak for public relations). She got a closer look at agendas and became a

stickler for common-sense language, telling managers, if she couldn't understand the agenda, they couldn't expect the board or the public to understand it.

"Sometimes I would win, sometimes I wouldn't," she says. "Sometimes greater minds than mine would prevail."

She would identify the agenda items that might get media interest, and tip off the media. Some reporters might have been suspicious of her intentions, but she says it was her reporter-self passing on what she felt was "quite a good story".

When the board held discussions involving money – for example, the purchase of new machinery – it would automatically go into committee. The reason cited would be the need to discuss contractual issues around a tender going to market. But Mrs Gill questioned that, and says she continued to do so in her next role – as an elected board member.

Right from her first meeting, she says, she pushed back. She noted the board was planning to discuss some agenda items in secret because, it appeared, someone felt uncomfortable discussing them in public.

"I get that you keep the price out of it, but don't put the whole paper into committee simply because at some point you discuss prices," she says. "In fact, let's have the discussion in open [meeting] about the need for [the new service/machine] and what's driving it."

Organisations hold meetings behind closed doors because they think it is less risky.

"So you get your typical bureaucrat, looks at the paper and thinks, Oh, we're mentioning that we are going to have to consult with contractors. So, boom, put that into committee."

Mrs Gill doesn't believe there is anything inherently sinister about matters discussed with the public excluded.

But why is it an initial fallback position? Mrs Gill says confidentiality is drummed into the board from the start. It becomes a mindset. There are people who have been on councils and they come from a different environment and they will push boundaries.

Pushed on what fear gives rise to the risk averse behaviour, Mrs Gill says, "I honestly can't put my finger on it. One of the things I said quite regularly as a communications manager is 'we need to front foot this, this is our story'." Sometimes it comes down to the personality of the chief executive.

Agendas first port of call for public

I just can't see the ability as a board member
to make a huge difference. It is just really limited
– Mary Anne Gill

AGENDAS MATTER. They are the first port of call for a member of the public wanting to engage with DHB governance.

The New Zealand Public Health and Disability Act allows DHBs to exclude the public from all or part of a meeting for various reasons, and refers to the Official Information Act. The

Crown Entities Act provides a framework for the governance of crown entities, like DHBs, and for accountability.

Rules around how meetings should be run are provided by the State Services Commission.

An official information request by *New Zealand Doctor* to all DHBs reveals they know the rules.

Here's a typical scenario, described by Bay of Plenty DHB legal executive Cherie Martin. When an executive team member submits a paper for the agenda, they identify whether it should be discussed in the public or confidential session. The chief executive and chair then confirm which items will be dealt with out of sight of the public.

The board secretariat and in-house adviser then identify the relevant clause in legislation that applies for each item to be discussed behind closed doors. The board chair is ultimately responsible for making the decision.

As a past chair of two DHBs – Counties Manukau and West Coast – Gregor Coster has made many calls on what subjects appear where on a DHB agenda.

Like Mrs Gill, Professor Coster cites commercial activity as an area where the public will often be excluded; issues relating to health and wellbeing of individuals and matters relating to fraud are also mainly discussed in closed sessions.

While chair of Counties Manukau, he created a policy paper on making these decisions; he introduced the policy at West Coast DHB.

He says it might be appropriate to discuss privately whether a certain building contractor should be awarded a contract to build, say, a mental health unit. But the board can go back into public session to resolve that the tender be approved. Any prices will show up in the books eventually, so the board might as well make them public, he says.

It's clear boards differ greatly on how risk averse they are with agendas, Professor Coster says.

He doubts any holding back of information is driven by central government politics. In his experience, health ministers of various hues support DHBs being as open as possible.

"I've seen a strong desire to see as much discussed in public [as possible], consistent with the purpose of the act. They are publicly elected boards, they are there for a reason.

"The principle should be, if this can be in public, then we should do it in public…if you believe that, and don't use the public-excluded option to hold three-quarters of your meeting with the public excluded, then I think you're on the right track." (See "How secretive is your DHB?")

If a decision is passed in a public session and no one is there to hear it, is it secret?

If someone takes the time to read the agenda, the minutes should reveal decisions made and acted on in the public part of the previous meeting. And it's worth remembering, board meetings are a tiny part of the business of running a DHB. There are other avenues for accountability and transparency – the annual plan process, the annual grilling by the health select committee and consultation on specific processes.

As New Zealand approaches local body elections later this year – with DHBs included – a few people may trickle in to board rooms to have a listen. But voter turnout figures suggest the romance with elected boards is dying.

In 2001, 50 per cent of eligible voters placed a vote; in 2016, 42 per cent did. *The New Zealand Herald* surveyed DHBs last year about the cost of the 2016 board elections; 13 responded, the cost totalling $3.59 million.

Mrs Gill last year called on the Government to defer this year's DHB elections while the Health and Disability System Review is under way, given the review is likely to make changes to DHBs.

In response, health minister David Clark told *the Herald* he did not want to prejudge the review outcome, and any changes decided on would take time to implement. Strong governance and leadership would be needed through any transition period, Dr Clark said. Postponing elections would create "unnecessary uncertainty".

In 2017, the 209 DHB board members – 140 of whom were elected – and four commissioners were paid almost $6 million for 30 days of work each year, according to data gathered by *the Herald.*

By comparison, up to $60 million went on the salaries of 231 chief executives and their senior executives.

But the issue isn't so much cost as effectiveness. Once elected, board members are often surprised to find they're highly constrained in how much they can do.

Starting with the minister's letter of expectations, board members receive a lot of direction. The Ministry of Health tells them how many cases most of their board's various services can care for, and what they will get paid to provide.

Mrs Gill says she understands why, in 2001, the Labour Government wanted to go back to the old hospital board days, when community people on boards actually decided the health needs of their communities.

But that's no longer how it works. Board members have a small amount of control on discretionary spending, she says. Waikato DHB would not be free to initiate another scheme like its lifestyle innovation Project Energize, a big success for the region.

The system is wrong, for many reasons, Mrs Gill says. "When people vote, they don't know what the hell they are voting for.

"The people who stand say, 'I'm going to stand on the platform where I'm going to get more health services for Taumarunui'. Well, it's just not going to happen."

She wanted to work inside the system, and point out it's wrong. "I'm not standing again," she says, "not because I think I've been useless. [It] sounds silly, [but] I think I have made a difference in some of the things I have said.

"But I just can't see the ability as a board member to make a huge difference. It is just really limited."

Level of interest in joining board another problem

WHICH RAISES another problem facing DHBs: the level of interest in being a board member.

Of a board's 11 members, seven are elected and four appointed by the minister. Two board members should be Māori.

University of Otago health policy researcher Robin Gauld says the initial rush of interest from people wanting to stand when the DHBs were established has diminished over time.

In 2001, 1084 candidates stood; by 2004, the number had almost halved to 518; and, in 2007, 428 people stood for 147 places. By 2016, the last time DHB elections took place, 363 candidates vied for 133 positions.

The shortage of candidates is perhaps not surprising. State Services Commission guidelines list the desirable traits in a board member; there's a lot to live up to.

The list includes: a wide perspective on, and awareness of, social, health and strategic issues; integrity and a strong sense of ethics; financial literacy and critical appraisal skills; strong reasoning skills and an ability to actively engage with others in making decisions; and good written and oral communication skills. Ideally, these skills will have been honed through governance and management experience at senior levels.

For Māori board members, there are additional challenges. In her 2013 Massey University doctoral thesis on the experience of Māori DHB board members, Joy Panoho points out, despite the intention that DHB boards would all have two Māori members, the legislation requires only that the minister "endeavour" to ensure at least two Māori members. Not all boards meet the requirement.

In a media release, Dr Panoho explains the Māori directors she interviewed felt burdened by the responsibility of being the sole advocate for Māori health on their boards, being "a walking Treaty workshop".

"Many felt there was little cultural or historical understanding of the damage to Māori health brought about by the process of colonisation. Māori directors have valuable grass roots experience that is an important strategic tool for DHBs. This experiential capital is as valuable a resource contribution as, for example, a law degree or an accountancy degree."

Dr Panoho's interviewees recognised that, without the legislation, there would be little or no Māori representation.

"All participants recognised the importance of having a seat at the table, even though progress was, at times, hard to measure," she writes.

"Most felt, overall, they were having a positive impact and there was an opportunity to change attitudes and help turn Māori health statistics around."

Professor Coster, who was appointed to the boards he chaired, says health boards are richer for having the community perspective provided by elected members. But he has concerns about the board structure.

The quality of representation achieved through elections is the problem, he says.

"I've met some wonderful board members whom you are delighted to work with, and others where you go, 'I think they're a waste of space.'"

He cites board members with a penchant for disappearing in the middle of board meetings for an hour to conduct their own business. “I find that disrespectful of the process, having been elected by the public.”

Board composition requirements leave little leeway to ensure sufficient board members have health expertise. Given boards are dealing with multimillion-dollar budgets, that’s a problem.

And it’s a problem likely to get worse if the Health and Disability System Review recommends fewer DHBs.

Unlike local government, where councillors often come up through community boards, gaining more experience and expertise as they move up, health representation is very specialised, Professor Coster says.

He’s happy with 11 members per board but would like to see the balance between appointed and elected at six and five (or vice versa), and the 20 DHBs reduced to six.

“You are dealing with stuff like mental health, and this is something that has to be taken very seriously. It would be nice to have, I think, a few more people with expertise in the right areas on these boards.”

Board competency is a perennial issue.

In 2015, the *New Zealand Health System Independent Capability and Capacity Review*, commissioned by the Ministry of Health, noted the DHB board structure “presumes competence in governance and leadership, including from elected members”. But this appears to be lacking in practical day-to-day execution, the review team said.

It suggested reducing the number of board members to nine. The current mix did not respect the leadership requirements to competently operate large, complex organisations.

It warned that where boards lack competence, executive managers can have too much influence on decisions.

But, in suggesting the number of board members should drop to nine, the review also recommended a convoluted system to ensure a public voice on boards. This would see the minister appoint six of the nine members; the remaining three would be rotated onto the DHB board fora staggered six-monthly term from a community advisory board. Advisory boards would consist of 12 members, elected by the community every three years.

How did it get so complicated?

At Victoria University’s Health Services Research Centre, director Jackie Cumming says boards’ historical community emphasis has been replaced by accountability to the minister. This affects the degree of openness, Professor Cumming says.

She notes that DHB elections can be damaging to groups that fail to gain representation.

Community councils were proposed to improve public input, but have been slow to develop. Some are doing okay, while others are “terrible”, she says.

Some are also picking up bad habits. The Hawke’s Bay DHB Consumer Council meetings include items with the public excluded.

The councils are intended to provide input into service delivery, but Professor Cumming says the way the system works "is a bit of a joke".

"We have no way of knowing if something is impacting on service delivery; we have to take [DHBs] at their word."

The fact new money often comes with the minister dictating where it should go makes a nonsense of the community being able to have a say in it, she says.

While the problem of naivety and lack of skills in elected board members is often cited, Professor Cumming says these characteristics are just as likely in the members appointed by politicians.

Elected, appointed and sacked three times

If I think I was going to end up back in the compliance and financially driven model, I would have little interest in going back – Richard Thomson

DUNEDIN BUSINESSMAN Richard Thomson has been both elected and appointed, and also sacked, three times, from roles on health governance boards.

His first ousting was in 1990, when the then health minister Simon Upton dumped area health boards altogether in advance of the rollout of National's market-driven health reforms.

Then, in 2009, National health minister Tony Ryall sacked Mr Thomson as Otago DHB chair, holding him accountable for fraud by senior staff at the DHB. Mr Thomson could stay on the board in spite of the minister, thanks to having been elected onto it in the first place.

Six years later, as an elected member of the Southern DHB board, he was sacked along with his fellow board members by National health minister Jonathan Coleman over the board's financial struggles. He wasn't out of the picture for long. New commissioner Kathy Grant appointed him a deputy commissioner. (The other deputy, Dunedin accountant Graham Crombie, died last month.)

Mr Thomson is careful choosing his words when asked which system he prefers. He says the elected model enables people to stand up for public opinion. "That may or may not be a good thing," he adds.

But the DHB with its 11 members is an unwieldy body for both management and the public to engage with, he reckons.

The commissioner system has been much more satisfying for him personally, in terms of real engagement. Mr Thomson attributes that to the Southern DHB's team approach. It's a dynamic that has worked well, he says; commissioners have held regular public meetings.

"We take the view that, if we don't engage with our public or staff, we have no hope of making meaningful change."

And, while the DHB does not have board meetings per se, it has continued to run the board committees.

Mr Thomson is animated about the potential for changes that would not have been possible in previous board incarnations.

However, time is running out. The legislation that set up the Southern DHB commissioner expires this year. There will be elections for a new board in November.

Will he stand again?

"I think if I believe we can continue work we are doing around trying to transform the system, I would have some enthusiasm. If I think I was going to end up back in the compliance and financially driven model, I would have little interest in going back."

Putting it more passionately, he says, "It would break my heart to go back to that kind of approach."

University of Auckland health policy researcher Tim Tenbensel is more exasperated. Elected boards are just not having any effect, Dr Tenbensel says.

They have already disappeared from similar jurisdictions such as Australia and Canada.

If boards were making decisions that really mattered to people in their area, people would be at the meetings, Dr Tenbensel says.

"You can tinker with the structures, maybe give elected board members particular areas of interest but, ultimately, what do they have control over?"

Is it worth the time and money worrying about secrecy in boards, and tying ourselves in knots trying to find the right democratic structures, when DHB boards can do little of their own accord, other than deciding on the contractor for a local development?

If elected boards are to remain, a reset will be needed.

Democracy needs openness to breathe. Boards' risk-averse, batten-down-the-hatches lack of transparency has to go.

Relationships may never run smoothly between DHBs and the media, but access to information should be the norm.

"Beam them out," says Professor Cumming – in other words, livestream DHB board meetings. This, she says, would be a great start. "Give people more of a chance to see what is happening, and they might be more inclined to have a say."

The justice select committee last year used Facebook to livestream hearings on cannabis legislation and the Treaty of Waitangi has livestreamed hearings held for the kaupapa inquiry into health services and outcomes.

Many of the country's councils routinely livestream meetings; Taupo District Council got the ball rolling in 2010. Some use internal video systems, others use YouTube to broadcast and archive meetings.

Figures quoted in 2017 for the small Westland District Council show an initial set-up cost of $16,700 and an annual cost of $3700 based on one meeting per month.

At Auckland City Council, meetings are streamed; in February, viewer numbers ranged from 0 to 152. It's not possible to say how many of those watched the meeting "live" or later, or

for how long. But even a handful of viewers compares pretty favourably to the empty chairs seen at most DHB meetings. Broadcasting also has the effect of lifting councillors' game and providing media with the opportunity to cover meetings.

Bigger questions dog the whole matter of board effectiveness. Professor Cumming says these include, "what is the place of the board meeting; does everyone contribute; how much time is spent on strategic versus operational issues?"

Technology will increase the channels for informed citizens to give feedback and input. Nearly all DHBs – with the exception of Lakes – have some form of social media.

And surely the onus lies with the elected representative to ensure views are heard, not with the individual citizen to battle to be heard.

Dr Tenbensel considers elected representatives in smaller towns might have more impact but, with huge boards like Auckland's, he wonders whom the elected representative is actually representing.

Democracy is a precious thing and, even if it is a remnant from a quaint time of local hospital boards, no element of democracy should be dismissed lightly.

Professor Gauld says locals may not show up to vote in the DHB elections, but politicians know they will rally around if their local health services are threatened.

Elected boards, no matter the quality of the governance, are a symbol of communities taking a "last stand against the marketisation of New Zealand health care", he writes in the book Democratic Governance & Health, co-authored with Miriam Laugensen.

He also notes the current model allows governments to claim victory for local successes while it also deflects to the DHBs any blame for failures and controversies.

That would be hard to give up.

The DHB board table is also of value to Māori, as seen in Dr Panoho's research.

Enough time may have elapsed since the market-led reforms that the public will end its affair with elected boards, or be happy with another avenue of transparency and ac-countability such as livestreaming of meetings or regular public forums as the Southern DHB uses.

Professor Cumming sees no sign of people's interest in health services abating. With the growth of long-term illnesses, and as people have fewer episodic interactions with health professionals, interest in what is happening with services, and why, can only grow. Primary care and mental health services are set to have an impact on a much wider group of people and their families.

Accountability will be called for and, as Professor Gauld points out, politicians have been happy to have that at arm's length.

When I catch up with Mrs Gill a few months after our initial chat, I find her more upbeat about boards.

She explains that not long after we first spoke, she attended a presentation to all of the Midland region boards by Heather Simpson, the health economist chairing *the Health and Disability System Review.*

"Her opening salvo was 'there is nothing in the legislation preventing boards making significant decisions about the health of their people', which is amazing," Mrs Gill says.

"I was heartened by that." Heartened to the extent she is now concentrating on some projects she wants to see through before she finishes her term.

Much is riding on the review. Ultimately, Professor Coster says, the public will decide in next year's general election whether they are happy to support any proposed changes arising from its recommendations.

"Where that lands is anybody's guess."

How secretive is your DHB?

DHBs should routinely not be holding three-quarters of their meetings with the public excluded – Gregor Coster

To measure DHBs' preference to stay out of the public gaze, I looked at how much time in DHB board meetings is spent with the public excluded.

The plan was to take 12 months of board-meeting minutes for each DHB and use the recorded meeting start and finish times, and the time at which the meeting excluded the public, to come up with an average length of meeting and an average length of time with the public excluded.

I would then allocate a score to the exclusion time as a percentage of the entire meeting, scoring the most open at 0 and the most secretive, 100.

Tracking down the minutes is the first challenge. If you were an organisation wanting to engage people in your decision-making, a big red button with the words "decisions here" could be a winner. But on many DHB websites, to get to meeting times, agendas and minutes is a "click fest", typically starting with the "About Us" button.

Even with the minutes, the plan to score DHBs falls to pieces because, as with so many DHB data, there is no consistency.

Only one DHB, West Coast, provides the time a meeting starts, the time at which it excludes the public, and the time at which it finishes.

Specifically, over the year, the average length of a West Coast DHB board meeting was just over three hours, broken down into one hour and 22 minutes open to the public and one hour and 42 minutes with the public excluded, during which time board members also took a 30 to 40-minute lunch break.

Being generous, I don't count lunch break, and come up with a score of 43, putting West Coast towards the "open" end of my scoring system.

As to the rest of the DHBs, information is patchy. Counties Manukau gives no indication of the length of its meetings. Waikato, Lakes, MidCentral, Tairāwhiti and Taranaki mention only the time when meetings start.

Auckland and Northland sit for a total of about four and a half hours, but don't indicate the time at which they close the doors to the public.

The remaining DHBs give meeting times ranging from one hour to 165 minutes; I assume this is just the public part of the meeting.

Despite suspicions that key decisions are made away from board meetings, few DHBs reported, when asked, that board members meet regularly outside the scheduled board meetings: a training day here, a planning day there.

Former DHB board chair Gregor Coster suggests, as a yardstick, DHBs should routinely not be holding three-quarters of their meetings with the public excluded.

But long and detailed conversations with the public excluded should not be automatically viewed as suspicious, Professor Coster says.

Complex and thorny issues need long debate, he says.

As a board chair, he always sought consensus, feeling it was important boards acted as a single team and everyone was in agreement with decisions made.

[sidebar story]

$1 million for five media releases

There is little relationship between the size and cost of a communications team and the number of media releases produced

Counties Manukau DHB's communications team cost $1.093 million in staffing in 2016/17. That year it produced five media releases, eight fewer than the year before.

Annual figures supplied to the health select committee last year show huge variation in the use of media releases by DHBs as means of communicating with media and the public. They also show little relationship between the size and cost of a communications team and the number of media releases produced.

As part of its annual review of DHBs, the health select committee seeks answers to more than 160 questions, including the number of PR and/or communications staff, contractors and consultants used and how many media releases were released in the financial year and previous years. Given the size differences, it is difficult to make direct comparisons between DHBs. A lack of consistency in data exacerbates the problem. For example, some DHBs specifically state they include or exclude regional public health communication costs. Others don't.

Counties Manukau DHB was not the only one sitting on five media releases; Hutt Valley produced the same number but at a staffing cost of $182,847.

South Canterbury also produced five media releases (with a staffing cost of $80,000), but explained the low number was due to a good working relationship with local media. Presumably, the DHB communicates by talking to reporters rather than through emailed statements.

Included in the Counties Manukau total is a salary of $212,000 for a "media relations" staff member. Not included in the total, but also supplied by Counties Manukau, is another $351,059 for the then busy communications staff of innovation centre Ko Awatea. The subsequent ditching of the sector quality and innovation conference, the APAC Forum, run by Ko Awatea, and controversy over building costs has seen the centre's communications merged with the DHB's. Also excluded was $375,1999 in outsourcing.

DHB communications team costs sourced from answers provided to the health select committee in early 2018

	Number of media releases 2016/17 (2015/16)	Total expenditure in 2016/17 on communication team
Auckland	29 (24)	$1,301,939
Bay of Plenty	103 (78)	$277,143
Canterbury/West Coast	60 (78)	$680,973
Capital & Coast	38 (26)	$386,122
Counties Manukau	5 (13)	$1,179,024
Hawkes Bay	82	$380,503
Hutt Valley	6 (5)	$182,847
Lakes	104 (69)	$3529.83†
MidCentral	103 (112)	$270,000^
Nelson Marlborough	Does not keep track of media releases issued	$200,846
Northland	65 (85)	$329,000
South Canterbury	5* (13)	$80,000
Southern	117 (89)	$360,012

Tairāwhiti	83 (55)	$136,000
Taranaki	130 (142)	$267,084
Waikato	129 (87)	$335,000^
Wairarapa	35	$116,122
Waitemata	491# (397)	$585,870
Whanganui	55 (66)	$298,360

*Board says low number is indicative of a good relationship built up with media
#Incorporates "unique situations where the communications team has provided a formal response to the news media or proactively issued materials with a view to promoting DHB activities."
†Seems low ^Estimate based on salary bands provided
Where DHBs have provided figures for regional public health communications, I have not included them in the total