**Quality improvement scientific symposium virtual session three: keynote presentation – Pat Snedden**

**Accessible transcript**

**Visual**

**On a black screen, text in white reads: ‘Pat Snedden. Should we still be arguing about equity?’ Pat is a grey–haired man wearing glasses and a blue checked shirt. He appears in a small video feed in the top right corner of the presentation slide.**

**Audio**

(Pat): Kia ora. Kia ora tātou katoa. Look, it's a pleasure to be here, actually, and to have the opportunity to, kind of, talk in this way, and I'm just going to share some slides with you now about what we... are talking about today.

**Visual**

**Large black text in the middle of a slide with a white background reads: Should we still be arguing about equity?**

**Audio**

(Pat): And I want to start by thinking about... this question – should we still be arguing about equity?

**Visual**

**A new slide has a date in the top left corner: 1952. Beside this is a brown coloured banner with a depiction of two carved figures performing a hongi beside text in white: Waitangi Tribunal. Te Rōpū Whakamana i te Tiriti o Waitangi. Under this is a black and white photo of three children standing in a field watching the burning remains of a house engulfed in flames. A title above the photo reads ‘Māori Shacks Go Up in Smoke’.**

**Audio**

(Pat): If I think about the time that I've been in the health system – going right back to, um, uh, the middle 1980s, when I helped set up Health Care Aotearoa and the bicultural primary care process, through to today I think one of the things that has, uh, really challenged the system is this question of equity and, indeed, the question of institutional racism in our system. And I think that, you know, it's hard, often, for health professionals to get to grips with what really is, initially, a data story without some form of connection or emotional resonance. In this first illustration here in front of you, really, is the burning of the papakāinga down at Ōrākei on the Auckland waterfront in 1952.

This is Ngāti Whātua being burnt out of their houses. Now, what's kind of significant about this is that's two years before I was born – I'm now 66 – and, um,... it was – this was the outcome of a decision that the powers that be – Auckland Council and the Crown – made to 'clean up' that area in anticipation of the royal visit from the Queen.

**Visual**

 **A slide shows two framed black and white photos side by side. The one on the left is under the date 1978 and shows a bird’s eye view of a fenced–off compound of corrugated–iron roofed buildings and dirt roads. The photo on the left under the date 1982 shows protestors forming a human wall with linked arms.**

**Audio**

(Pat): Now, when you think about the experience of Māori in New Zealand and you think about the... the reasons why the... issues around institutional racism and about the way in which we deal with our Treaty partners has been such a matter of controversy, it's hard to escape the 1978 occupation of Bastion Point, which was ended by the largest single use of the state force against the civilian population in New Zealand next to the 1951 waterfront strike. And it was in 1982 – on that right–hand side – that for me was the, if you like, um, opening of understanding about what just might have been going on in our history that would have been different to what I had been brought up with, taught with and actually had experienced. And so in 1982, I joined Ngāti Whātua on the land when, after the second occupation, they were moved off the land, and, uh, I was arrested along with Joe Hawke and his whānau, and, um, we were... convicted of trespass. Uh, well, some of us were, anyway, convicted of trespass on that land. And in that, uh – in that moment... and in the subsequent experience with Ōrākei, when Joe invited me to look at running the economic development of the tribe, which at that stage had been reduced to a quarter-acre urupā down on, uh,... (CLEARS THROAT) the front of the waterfront on Tamaki Drive – you know, I started to understand at a domestic level what the, uh, diminution of the Te Tiriti had been, where Māori voices and, um,... challenge to the system and process was coming from; the impact that it had on the lives of whānau right down in the street level and the, uh, need for a much more, um, educated Pākehā population in New Zealand about the issues that had brought Bastion Point on.

**Visual**

**A slide of black text on a white background: The Crown has invested some $220 billion into the health system since 2000, with little measurable improvement to Māori health outcomes – Wai 2575 summary.

Audio**

(Pat): And... (CLEARS THROAT) to give you an idea of the scale of the difficulty – if you think that was 1982, um, when we did that second occupation of Bastion Point, then some 20 years on, I got myself involved in the health system at the governance level, so moving from consulting with Health Care Aotearoa into... Helen Clark asked me to sit on the Auckland Board – uh, DHB – and then I shared Counties, and I came back to Auckland. And, you know, this moment of coming back into the health system in 2018 was, uh, along with the summary position laid out by the, um, Wai 2575 summary of the Waitangi Tribunal, that the Crown's investment in health since 2000 had been so significant and the Māori improvement had been infinitesimal. And I asked myself the question as a kind of New Zealander who is... wants to see our nation as a nation where people are honoured for who they are; that our treaty partnership is actually seen to be dynamic, seen to be capable of great things in a 21st century context. And to be caught again, um, after so much, kind of, intention to do the right thing, that in fact, the outcomes in Māori health have been so poorly advanced was, for me, a major shock, again.

**Visual**

 **A dotted line surrounds a blue text box containing words in white which reads: Health inequities are differences in health that are avoidable, unfair, and unjust. Smaller black text under the blue box reads: Source: Whitehead 1992, adopted by WHO.**

**Audio**

(Pat): And so I determined at this time, coming back into leadership of the DHB, that maybe what we ought to do here is actually have a look at health inequities, that we might as well do at a very systematic level – understand what's going on, which is avoidable, unfair and unjust, and deal with it. So this culminated in a series of conversations with DHBs up and down the Northern region, um, from Waikato north, where the questions were asked – I went to each of these DHBs, into their Māori caucuses and their Māori groupings and Māori providers, and asked a series of questions about if we were to do something differently, what would it be? And back came, um, really resonant feedback, which was really, uh, DHBs had to be in the process of full partnership with Māori, that Māori had to have the capability of independently looking after their own affairs, that there needed to be real comprehensive reform in the system, and that the kind of levels of pūtea that had been made available by the Crown for Māori historically were so poor that there needed to be a major and seismic shift in what occurred in those matters.

**Visual**

**A new slide has the triangle shaped blue and grey logo for the Auckland District Health Board. A dotted line forms a border around the slide which has a title inside a text box: Drivers of Inequity. Reid & Robson (2006) Based on Camara Jones (2001). Under this title is a picture of an iceberg and beside this, a series of bullet points:**

* **Differences in the quality of care.**
* **Differences in access of care.**
* **Differences in determinants of health, exposures, and opportunities (individual, whānau, neighbourhood, collective, intergenerational)**

**Along the bottom of the slide is a diagram of four green circles each with a word inside. Each circle is separated by a mathematical symbol. SDH plus access plus quality equals inequity.**

 **Audio**

(Pat): And, you know, it was pretty easy to understand just why all the position as it sits today has got – we've got ourselves into this position. You know, when you look at the kind of academic constructs of what impacts when equity doesn't go right, you can see that the simple things about the quality in care, the access to care and the fundamental, um, blindness, if you like, to our health analysis, to the social determinants, that, you know, this is not just what's happening in the rooms of the GP or in the rooms of the hospital; this is about – how does a community resuscitate itself in such a large way from a situation where the Crown has been, effectively, um,... complicit, um, to their diminution in health status? There is no other population in New Zealand that has gone backwards in health terms since the 2000– uh, yeah, 2000 to 2020 than Māori. This can't be right. And so we have to actually understand just what is the things that drive this process.

 **Visual**

**A title in a blue font heads a new slide: ‘Innovate: Kaiārahi Nāhi and Pacific Planned Care navigators.’ A series of bullet points follow. The dot of the bullet point is yellow and the text is black.**

* **Kaiārahi Nāhi – 10 Māori Senior Clinical Nurse Specialists with their own model of operating and culturally specific approach**
* **Pacific Planned Care equity team – 10 Pacific Senior Clinical Nurse Specialists with culturally and language specific approaches.**
* **Dual functions: patient and whānau navigation AND equity quality improvement**
* **Engaged with over 2200 patients and whānau.**

**Audio**

(Pat): And an example of... wanting to get to the bottom of, um, the ability of Māori and Pacific to exercise– uh, to be... to be enfranchised, to actually be able to experience a healthcare equivalent to their non–Māori, non–Pacific neighbours – we did an exercise in Auckland District Health Board as a result of a series of deep dives which went into each of our clinical practices, and we asked the question – if we put Māori in front, in control of this process, what would be the outcome, and how would it change? And so astonishing were the challenges to the current methodology that we invested in – uh, as a part of a move to shift the thinking in the hospital and to shift the praxis in the hospital, we invested in an idea of having Kaiārahi Nāhi and Pacific Planned Care navigators – to have nurse practitioners, both Māori and Pacific, who took a particular interest in the referrals from the general practice, who were able to navigate the process whereby the people in the system were getting access to the care in a way which was, um, if you like, streamlined. That enabled us to... really, um, think differently about – how do we unblock the pathway of care for Māori or Pacific coming into our system? And of course, when we put the... the attention of our, um,... clinicians on this matter, and when we raised their... raised their understanding of just where the gaps and where the blocks in the system were, we found, even with a small cohort of 2500 patients, 2200 patients, within two or three months, that we were able to actually significantly and beneficially shift and change the experience of those patients coming into our system. Now, these were patients referred from general practice coming in whose history had been disastrous. We are… disastrous in the sense that the long wait times; the fact that they had very little understanding of how the system worked; the fact that our system, in fact, was, um, to many respects, um, loaded against them – in terms of the multiple call-backs that they had to do in order to get through the system; the fact that when there was a degree of difficulty in what was being presented, that that slowed them up. And all this, when compared to non–Māori, non–Pacific, showed that the intervention of the navigators was wholly positive and radically shifted and changed the outcomes. Now, the question you had to ask yourself, as running the DHBs – if the intervention of the navigators could do such positive... impact on our system delivery, why have we not been doing that for years before? Why have we not done the self-analysis that would have enabled us to actually identify where the blockages were? Why were we not putting ourselves in the shoes of the patient, who was coming into a system they often didn't have much knowledge of – were, uh, not trained in the, um, navigating of that system – and had been reduced through the process of waiting times to being very poorly served in what we were doing?

**Visual**

**A title in a blue font heads a new slide: ‘Equity Quality Improvement Approach.’
Achieves Patient Outcomes:**

* **Achieved care important to the patient and whānau; reduced physical and emotional suffering; enabled people to live their lives while receiving treatment**
* **Significantly reduced average long waiting times to meet non–Māori/non–Pacific average long wait times**

**Monitors system changes:**

* **Coach and inspire teams where changes are implemented**
* **Data led**
* **Communicates with patient journey stories to highlight the variation from the “expected pathway” (patient insight led)**
* **Track structural and operating policy changes.**

 **Audio**

(Pat): How might we change the whole system and process to, um, challenge this? How might we actually get people on board, not from a point of view of 'you must' but from the point of view inspired to do what was the right thing to do in our system? How could we use the data and the intelligence that we gather on a regular basis to call out practices which were negative and were obstructional in what we did? How would we actually use the story, the patient's story, as being the method and the lever to actually prod open processes that had been, um, uh, harmful in respect of their delays to the patient groupings that we were most looking to enfranchise? So how did we have to track and, uh, address both the structural and the policy issues that would come out of this? We took that on as a process – and we're in the middle of it right now, and we're about to invest further in this whole issue of navigation. But the question we're asking ourselves is – at what level and at what point do we actually have the clinical community itself change its reflexes around this? And this is the thing that we're most concentrating on at the moment. The navigators have been a huge assistance to prove the point, that with, um, effective support structures, the people who, um, we most wish to lift in terms of their care access can get it and will get it and will get better care as a result of it. But how do we do this? How do we ensure that occurs in our system without needing to employ a whole range of these navigators to make this possible? How do we make the system we have itself much more flexible and intuitive to the needs of Pacific and Māori? And what we're – and this is what we're trying to achieve.

**Visual**

**A new slide has a title in a text box: People Are Willing To Have Conversations About Equity And Racism. Under this is a series of bullet points in black text with some words highlighted in red text.**

* **We need to hear and understand these issues through the lens of those most affected**
* **We need to (in red) deeply understand data, pathways, context (in black) experience.**
* **Change is required, need to see action, flip the script**
* **Recognise our own privilege and (in red) that we have a system that continues to privilege some groups and disadvantages others**
* **Understand that (in red) proximal explanations are insufficient**
* **(in red) Eliminate victim blaming/deficit language**
* **Don’t underestimate how powerful (in red) clinical leadership (in black) is.**

 **Audio**

(Pat): What we've found in this process is that, um, effectively, clinicians are prepared to have conversations about equity and racism. Now, when we first got it to this, in 2018, both the government and the clinical community were pretty apprehensive about going down the route of actually identifying what constitutes institutional racism in the system, what, uh, constitutes unfairness or inequity, how this sees itself and how it's gonna be played out on a national scene. So what we did was, effectively, take it to the board of ADHB and put up a paper, uh, to that board, which was to say, 'This is how we see ourselves not addressing the issues that we should be in relation to Māori and Pacific.' This caused a very significant and quite, um, influential debate to occur – not simply at the board level, but at the level of the clinical community. And what we decided to do is be unafraid of taking these issues on – be respectful, be clear, find a language that includes people, but don't fall away from the requirement to actually address face–on stuff which becomes clear it is not simply that people are missing out, but that the structure and the process that we're using is effectively excluding them. Now, this was, um, a big and important conversation, which then we shared with other DHBs around the country. Now, one of the things that occurred which made this really, um, easier to do was that in the most recent, uh, changing of board chairs, which was in November 2020, we now have five Māori chairs within the 20 DHBs. So the – and we have a Pacific, uh – we have Vui Mark Gosche at Counties. So we've got much more now a context and a... environment where these conversations not only have to be had, but that we have to start to change our praxis to recognise the fact that we've done so poorly for so long. It's, for some, quite difficult to do, but for the most part, we are finding that there is high levels of commitment to this change. And in the sense, as more and more people come with it, then it becomes more and more capable of us to actually go into all sorts of areas of the business where we think there are blockages and misunderstandings or where there, in fact, have been system processes which, effectively, on a race basis, deny people access. And we have addressed those things, and we are doing them, um, as quick as we can, and the organisation is coming with us. Ailsa Claire, who's the DHB CEO at Auckland, began at the beginning of last year a whole series of, uh, seminars about institutional racism in the DHB, and these seminars have been hugely well attended. And so when we came to the praxis change, people were aligned and available to do it – or enough were, anyway, to make it positive and useful.

**Visual**

**A new slide has a dotted line making a border around a pyramid–shaped diagram of blue rectangular text boxes. A title at the top of the slide in blue text reads: Organisational readiness for equity work. The smallest text box at the top of the pyramid reads: Innovation and Breakthrough Performance. The next box down reads: Building Strategic Capability. The next box down reads: Integrating Culture and Systems. The next box down reads: Foundation and Strategy Building. The last box forming the base of the pyramid reads: Awareness and Start Up. An orange arrow points to this box. Along the bottom of the slide in small black text: Source: Dr A Breeze Harper, Torch Anti–Racism; Levels of implementing anti–racism for Organisational Diversity, Equity and Inclusion.**

 **Audio**

(Pat): And this is the way I think we need to shift and change what happens in the organisation, because you can't just start at the top, in the terms of – you can't be at the innovation breakthrough performance if you haven't done the legwork around the awareness of, uh, inequity, awareness of institutional racism; if you haven't done some of the building blocks here, which actually help to make your business more and more acutely capable of making the pivot to change and to actually understand the reason they're doing it. So you need system and process, and the thing – it's not simply somebody carrying a torch; it's actually getting right down into the base of your organisation and examining the things that ought to be done differently, bringing Māori and Pacific into that conversation in the front end, asking them to be part of your critical faculty about the assessment of the things that work and the things that don't work. Consider, for example, bringing everybody into this process as an organisation so that they understand that nobody's being picked on, but everybody's being examined for the thing that needs to happen, and then get on with it, and that it will be lumpy from time to time. But the really important part about this is that you will be making progress, and when you hit a rock, when you get really strong pushback about this stuff, take the time to pause and to actually give respect to people who don't agree with you. The important thing about this stuff is that it doesn't work with just the people who agree with you. It's because people who start to disagree with you, and then come across to it makes it much more powerful as a methodology for moving forward. That's why, kind of, understanding where you are in the organisational readiness for this equity work is really important for you.

 **Visual**

**In the top right corner of the next slide is a logo showing the silhouette of a figure throwing a red fishing hook across New Zealand on a blue globe. Next to this is text reading Manaiakalani, the hook from heaven. Below this is three images side by side. The first image shows three figures, all of different heights, trying to watch a baseball game over a tall fence. They all stand on the same sized boxes. The tallest figures can easily watch the match, the middle sized figure can just see over the fence and the shortest figure can’t see a thing. This image is labelled Equality. The second image shows the same three figures at the fence watching baseball. This time, the tallest figure isn’t standing on a box, the middle figure stands on one box and the shortest figure stands on two boxes. All three can see over the fence and watch the game. This image is labelled Equity. In the third image, the fence and the boxes are gone. All three figures stand on the ground with an unobstructed view of the game. This image is labelled Liberation. Under these three images is black text reading: Beyond Business as Usual.**

**Audio**

(Pat): And, I mean, that's in the end what we're trying to do. What we're trying to do here is, um, get to the end of the deliberation process here. We're changing all the dynamics in order to make that happen. This will be, uh, several years' work for this to occur, but in every part and in every, uh, space that we actually make a, um, an advance, then people get more and more confident about a) having the conversation and b) changing the praxis. And that's what we're trying to do – we're trying to change the praxis that addresses at its heart the institutional racism and the inequity in the system. We're being brave and honest about it, and we're asking people if they wanna come with us, and we're prepared to be of assistance and share anything that we're doing. Nō reira, kia ora mai tātou katoa. Thank you very much.