Process and criteria for scoring CCDHB Candidates

Aim

The Wellington Branch of the Public Health Association (PHA) believes that there is a lack of information about DHB candidates for voters. We decided to try and fill that information gap by:

a. Surveying candidates and producing an easy to understand scorecard, showing how candidates measure up against key public health values and priorities (as established by PHA processes and as publicly available on the PHA website); and

b. Holding a 'meet the CCDHB candidates' meeting (6pm, 20 Sept, St Johns Church), to enable voters to hear from candidates in person, put their questions to them, and make up their own minds.

This document explains how we produced the scorecard, based on a survey we sent to candidates. We have also made candidates' full survey responses available to the public via the PHA website for voters to make their own assessment.

What is the Public Health Association?

The PHA is a national association that takes a leading role in promoting public health and influencing public policy. We advocate for healthy public policy (e.g. on housing, poverty, child rights, and transport) that keeps people well and prevents illness. Details of our policy positions and values are available at www.pha.org.nz

The Wellington Branch has about 70 members. Our members are professionals working in public health, e.g. doctors, nurses, health promoters, policy makers, researchers, and professors of public health. Members take part in Branch activities as volunteers, outside their 'day jobs'. The opinions we express as PHA members are our own, and do not necessarily reflect the opinions of our employers.

Branch activities are funded through membership fees and donations.

Survey

The candidates statements in the voters handbook are brief and don't necessarily provide information on where candidates stand on issues that are important to the PHA. So we created a survey with questions on four themes:

1. **Population Health:** Understanding that health is not only about hospital care, and is about prioritising prevention and population health issues such as obesity.
2. **Equity:** Focus on equity, reduction of health inequalities, and Maori representation.
3. **Pro-fluoridation:** Support for community water fluoridation.
4. **Knowledge and experience**: Relevant governance and health sector experience, and understanding of the statutory framework that DHBs operate within.

For transparency, the full survey, including candidates' responses, is available on the PHA website.

Sending the survey

We used Survey Monkey to format the questionnaire, which was emailed to candidates on Sunday 28 August. Reminders were sent on 31 Aug, 2 Sept and 4 Sept. The deadline was 8pm on 4 Sept, but late entries were accepted up to 5pm the next day.

Response

We got a good response from candidates, with sixteen replies. Four candidates did not respond: Ross Church, Rev Tavita Joseph Filemoni, Norbert Hausberg and Judy Siers.

Scoring the candidates

Who scored the candidates?

A team of four PHA members evaluated the candidates: Jude Ball, Maria Cotter, Marilyn Head and Dr Prudence Stone. All are highly qualified, and collectively the team has over 50 years' experience working in the field of public health. Jude is a Research Fellow at the University of Otago Wellington, Maria held senior policy positions in mental health and public health at the Ministry of Health for many years and is now a policy contractor. Marilyn is a senior policy analyst for the New Zealand Nurses Organisation, and Prudence is the national child advocacy manager at UNICEF. Work for the scorecard was undertaken during evenings and weekends, in our capacity as citizens and PHA members.

Scoring process

Each candidate was scored independently by two scorers. Then we met as a group to agree the final scores for each candidate. Generally there was high level of agreement. Where there was lack of agreement between the two scorers, we talked it through as a group until an agreement was reached.

Five point scale

For each dimension (fluoridation, population health, equity) candidates were given a score between one and five, representing their alignment with PHA values and policies: as 'very strong alignment, 'strong alignment' etc. These are represented on the scorecard by emojis:

5 =  very strong

4=  strong

3=  satisfactory

2=  weak

1=  very weak

Alignment with PHA values and policies is not applicable for the knowledge and experience dimension. The knowledge and experience score represents our assessment (based on survey responses and the scoring guide below) of the relative strength of each candidate on this dimension.

Scoring guide

A scoring guide was prepared at the same time as the survey was developed and is outlined below.

Fluoridation

The PHA, in line with the World Health Organization, the Ministry of Health, and many other organisations, regards fluoridation as a benchmark public health and equity issue. Fluoridation is well-researched, and the science is clear: community water fluoridation is safe and effective for improving oral health. Dental health issues were the leading cause of preventable hospitalisation in under 4 year olds in the CCDHB area in 2014, and disadvantaged children are the ones who benefit most from fluoridation. It is an important and cost-effective equity measure.

Candidates were asked: "To what degree do you agree with the following statements: I support water fluoridation."

We scored as follows:

Strongly agree = 5

Agree= 4

Neither agree nor disagree = 2

Disagree or Strongly disagree = 1

The rationale for scoring 'neither agree nor disagree' as 2 (rather than the middle score, 3) is that any DHB candidate who is on the fence about water fluoridation is failing to support a key, evidence-based public health and equity measure, and is out of step with Ministry of Health, CCDHB and PHA policy. Therefore we see this as an unsatisfactory rather than a neutral stance.

Population Health

We drew on both open and closed questions to produce a summary score, indicating each candidate's apparent understanding of and prioritisation of population health issues.

Question 1. We were looking for:

- ‘Strongly agree’ to questions 1 a, b, c about keeping people well, climate change and banning sugary drinks on DHB premises. We want to see alignment with PHA policy.
- Neutral or disagree to 1d about ‘personal responsibility’. We want to see acknowledgement that health behaviour is largely determined by the environment, not just people’s individual choices.
- ‘Disagree’ to 1f “When the budget is tight, maintaining hospital-based services must be the highest priority for the DHB”. We want to see acknowledgement that focusing on hospital services at the expense of primary care and preventive community services will be detrimental in the long term, and is counter to the vision articulated in the NZ Health Strategy.

Questions 3, 4, 5, 6.

We were looking for broad understanding of population health, and a focus on:

- Health promotion
- Early intervention
- Investing in children and priority populations
- Primary healthcare & community-based services
- Determinants of health (e.g. income, housing, poverty) and the need to partner outside the health sector
- Joined up services
- Population health concerns: clean air & water, social cohesion, obesity, smoking, physical activity etc
- Acknowledgement of the Treaty, and Maori models of health
- Acknowledgement of obligation to protect and promote the wellbeing of staff (e.g. safer working hours for junior doctors)
- Evidence-based policy and practice

Candidates were marked down if they:

- Had a very strong or exclusive focus on secondary/tertiary services, and hospitals
- Focused on a narrow set of issues, or a single issue

Equity

We drew on both open and closed questions to produce a summary score, indicating each candidate’s stance on and apparent prioritisation of equity issues. In order to receive a score of 5, candidates needed to explicitly emphasise equity as a priority as well as give the ‘correct’ answers to Question 2.

Question 2. We were looking for:

- Strongly agree to 2a: ‘Current health inequalities are unacceptable and DHBs must take action…’

- Disagree or Strongly disagree to 2b: 'Public spending should not be targeted at particular groups based on ethnicity.' We want to see acknowledgement that ethnic disparities exist (over and above socio-economic disparities) and must be addressed.
- Strongly agree to 2f: 'CCDHB must consistently involve Maori stakeholders as Treaty Partners in advisory and reference groups.'

Questions 3, 4, 5, 6

We were looking for:

- a strong focus on addressing inequalities
- acknowledgement that one size doesn't fit all, and fair outcomes sometimes require tailored services and strategic investment
- acknowledgement of Treaty obligations
- focus on developing a culturally competent and diverse workforce
- Connection to, and track record in working with and for Maori and Pacific communities, or other groups/communities with poor health outcomes and/or access barriers
- as an employer, a focus on equal employment opportunities for women and ethnic minorities, and a commitment to the Living Wage.

Knowledge and Experience

This was the most difficult dimension to score because candidates had such different strengths: some were highly experienced in senior governance roles but had little or no health sector experience, while others had broad health sector experience but little or no governance experience. We drew on both open questions (particularly questions 7, 8 and 9) and one closed question (2e) to create a composite score.

2e. We were looking for understanding of the fact that DHB candidates, both elected and appointed, are accountable, by law, to the Minister of Health. Those who answered 'disagree' or 'strongly disagree' were marked down, since this indicates limited understanding of the statutory framework that DHB operate within. (And also suggests they hadn't read the Candidates Handbook, which clearly explains board members' accountabilities).

We were looking for *breadth* and *seniority* of experience in/with the health sector (not necessarily in clinical roles). Ideally candidates will have experience in the community/ NGO sector, as well as primary/secondary/tertiary care settings. We were looking for demonstrated understanding of the health sector as a whole, in all its complexity, as opposed to clinical expertise in a specific area.

We were looking for breadth of experience in governance roles (preferably in complex organisations with large budgets), financial management, and strategic planning. We wanted candidates to demonstrate their understanding of the statutory framework that DHBs work within.

We decided (after much discussion) that candidates could not achieve the highest score (5) if they did not have BOTH health sector AND governance experience. We weighted governance experience in complex organisations more heavily than front-line health sector experience.

Strengths and limitations

The approach we used to survey, score and rank the candidates was well-planned, systematic and transparent, and based on models used by other NGOs. However we want to be clear about the limitations of our scorecard:

- Many voters may have different priorities and values from the PHA and, although the scorecard will provide useful information, clearly not all voters will agree with our assessments. For this reason we invite voters to come along to the Meet the Candidates meeting (6pm 20 Sept, St Johns Hall, Dixon & Willis corner) so they can put their own questions to the candidates. We also encourage people to read the candidates full survey responses so they can make their own evaluation based on their own values and priorities.

- Scores are based only on candidates' answers to our survey. This has obvious limitations because summing up ones stance on complex issues in just a few words is difficult, and it's impossible to judge how well candidates' survey answers reflect what they really think or what they will prioritise if elected. For example, some candidates may have answered in a hurry; some may have felt their commitment to equity (for example) 'went without saying' and failed to emphasise it, and some may simply be better than others at expressing themselves. The survey gives us a bit more information than we would otherwise have, but there is still a lot we don't know about candidates, and how they will perform if elected.

Conflict of interest

One of the candidates is a long-standing member of the Wellington Branch of the PHA. Any perceived or actual conflict of interest was managed by creating a subcommittee that carried out the Branch's local body election initiatives. The relevant candidate was not involved in any way in the development of the Branch's plan to survey candidates, draft the questions or score the responses.