

**An evaluation of the
Whanau Ora HIA guide:
informed via its use on the
Ministry of Health's
Criteria for Capital Assistance
for Small Drinking-water Supplies**

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Introduction and context

The purpose of this evaluation is primarily to assist in the further development of the Whanau Ora HIA tool and secondarily to provide an indication of how effective the Whanau Ora HIA (WO HIA) has been at informing the *Drinking water assistance programme: Criteria for Capital Assistance for Small Drinking-water Supplies discussion paper* (Ministry of Health, 2006). This requires consideration of how the HIA was undertaken (a process evaluation), consideration of how the HIA may have informed the policy process (impact evaluation) and general commentary on the guidance provided with, and performance of the tool in a real-life situation.

The draft policy assessed

In May 2005 the Government announced a fund totaling \$154 million to help improve drinking-water systems in New Zealand communities: the Drinking-Water Assistance Programme (DWAP), of which \$13.69 million a year for 10 years is for a Capital Assistance Programme (CAP). The balance, \$17.1 million is available over a period of seven years for a Technical Assistance Programme (TAP).

The DWAP aims to help suppliers to meet the requirements of the drinking-water standards and provide safe drinking-water. It will do this through the TAP, which helps suppliers to write Public Health Risk Management Plans and to use these to improve the operation of their existing facilities. Capital assistance can then be made available for upgrading supplies to meet the standards, where the TAP has identified that this is needed.

The *Criteria for Capital Assistance for Small Drinking-water Supplies* discussion paper was released in June 2006 and submissions closed on 28 July 2006. The discussion paper provides background information on drinking-water supplies and waterborne illness in New Zealand and outlines the current drinking water assessment programme. It also proposes a number of criteria for determining whether a drinking water supplier is eligible to receive capital assistance to improve their supply system.

The discussion paper had four major questions that it was seeking feedback on:

- Who should receive Capital Assistance Programme funding
- What should the Capital Assistance Programme funding be used for?
- How much funding should each eligible supply receive?
- How useful is the deprivation index in assessing a community's ability to pay?

The HIA tool was used to assess how each of the proposed criteria might impact on Maori wellbeing and on inequalities in the determinants of health.

Unfortunately, many small rural communities around New Zealand do not have access to drinking-water of an appropriate standard. The smaller suppliers often have difficulty complying with the drinking water standards, and many suppliers serving fewer than 500 people do not meet minimum standards for safe water. These supplies tend to be in remote and often disadvantaged communities. Sometimes these communities include a high percentage of Maori, and the communities have a number of health and wellbeing issues beyond drinking water access and quality.

The assessment tool - Whanau Ora HIA tool

He Korowai Oranga, the Māori Health Strategy sets the strategic direction for Māori health in the health and disability sector. It requires that a policy tool be developed to identify the impact of government and sector activities on whānau ora (Minister of Health and Associate Minister of Health 2002a), and the Whanau Ora HIA tool is the response to this.

The tool is designed to be robust and able to provide guidance to policy makers on assessing the likely impact of their proposed policies on the health of Māori and their whānau. The Whānau Ora HIA tool is strongly based on the Public Health Advisory Committee's HIA guidance, and is designed to build on its strengths. The Whānau Ora HIA also articulates the role of health determinants in predicating health outcomes for Maori, focuses on equity of health outcomes for Māori and takes into account the aim of He Korowai Oranga.

The WO HIA tool has two major components:

- Supporting and background information in the form of an introduction: an explanation of He Korowai Oranga; an explanation of the HIA process; a glossary; and useful documents and websites
- The tool itself, divided into four distinct stages: screening; scoping; appraisal and reporting; and evaluation.

Process evaluation

The effectiveness of an approach depends on two factors: (1) the type of approach/intervention; and (2) the way in which the intervention is undertaken. Interventions may succeed or fail because of the way they are undertaken. The purpose of a process evaluation is to determine if the process used was appropriate, and whether it can explain why an intervention worked, or did not work.

The following describes the process that was taken to conduct this HIA, including critical reflection on the strengths and limitations of the process.

The steering group and screening

Three people set the general direction of the HIA:

- Gabrielle Baker (representing Maori Health Policy, the team that developed WO HIA; HIA lead)
- Jim Graham (discussion paper author)
- Robert Quigley (HIA contractor to guide the process and mentor the HIA lead).

It is critical that each HIA is steered by a group of key people who collectively know the policy, know about public health and know about the population affected. This was achieved with this small group. At this early stage the steering group was able to confirm that the timeframes for feeding into the policy development process were achievable despite the severe limitations in personnel available to carry out the work.

The steering group held an initial one hour meeting on 28 April 2006 to decide whether the discussion paper was appropriate for undertaking an HIA on. This screening step is the first stage of an HIA. The group used the WO HIA screening matrix to carry out this process. The screening itself was successful in that the tool contained the right type of questions to help the steering group decide that the discussion paper was suitable for an HIA. However the wording of the questions was not clear enough in most cases and some of the questions did not have an appropriate focus. Out of all of the sections of the tool, this was the one that had the most recommended changes to the actual tool itself. A new column for recording responses was also added. The need for these changes was acknowledged at the time, and the changes were fed-back quickly to the WO HIA team for immediate incorporation into the draft WO HIA tool. The suggested changes are presented in Appendix 1.

Setting the boundaries for the HIA - Scoping

To ensure that the scope of a HIA is set broadly enough to capture the concerns of key stakeholders it is important to actually get those stakeholders to help in setting the direction and boundaries of the HIA. This can be difficult as timeframes require quick action. Setting boundaries typically requires a half-day involving people who have often had no exposure to HIA . Identifying the right people to invite and getting these people to turn up are the key challenges at this stage, and can be time consuming. The scoping meeting occurred on the 8th June 2006 from 9.30am – 1pm.

Due to the timeframes the steering group agreed on a small set of key people (six in total) to invite, representing Maori health, drinking water assessors, and a cross-sectoral health approach. Gabrielle Baker followed up by phone with each person, and this approach paid off as all people invited were able to attend. They were:

- Jim Graham, Drinking Water Assistance Programme, Project Leader (MOH)

- Te Miria James Hohia, Strategic Advisor, Māori Public Health (MOH)
- Mike Bedford, National Drinking Water Coordinator, Regional Public Health
- Douglas Lush, Senior Advisor, Public Health (MOH)
- Gabrielle Baker, Senior Analyst, Māori Health Policy (MOH)
- Rob Quigley (Quigley and Watts)

The group had a number of tasks to complete as described in the 'Scoping – getting started' questions in the WO HIA tool. They were:

- What are the aims and objectives of the WO HIA
- What are the boundaries in terms of timing and location?
- When will the assessment be done?
- How much time will it take?
- Who will conduct the WO HIA and what skills are needed?
- Who are the key people to consult with as part of the assessment?
- What is the geographic scope of the WO HIA?
- What is the temporal scope of the WO HIA?
- What parts of the policy are being assessed?
- What comparison policy will be used for the WO HIA?
- What data are available or will be needed to be collected?
- If the outcomes of the policy are not known, what assumptions need to be made to predict the potential outcomes?
- What existing related policy work can you draw on?
- What public or community concerns have been raised around the policy area?

These questions provided a good basis for planning the HIA. There were quite a number of questions and, to attempt to cover these within the ½ day available, draft answers were prepared in the hope that in some cases decisions to accept the draft answer might speed the process along. This was generally considered to be useful, but where a different answer was put forward, it was necessary to immediately dismiss the draft answer and go to a blank-sheet approach to allow free and frank discussion. Even with this process, the number of questions to work through was too many for a ½ day session. It was also noted that some key questions that are typically included in the scoping stage in other HIA approaches were missing. A suggested set of changes to the questions has been included in Appendix 2, and the questions have been prioritised to ensure the most important are always answered first.

A scoping report was produced that set out the answers to these questions and set the basis for carrying out the HIA. It is important to note that some of the issues raised in the scoping report were not further considered in the subsequent HIA because of a lack of human resources to undertake the work. This reflects how the HIA approach must be flexible to the changing demands placed on HIA resources. The final HIA should describe where the HIA veered away from the boundaries set in the scope and outline the rationale for these decisions to ensure the integrity of the process is maintained.

It is usual for the HIA lead to develop a detailed timeframe and project plan for the HIA based on the scoping report. This did not occur in this HIA due to competing work pressures.

The scoping questions provided a strong focus on inequalities, Maori communities and the timeliness of the WO HIA. These are key qualities of HIA in general and also issues that He Korowai Oranga focuses on. To this end, the questions set the HIA up very well to assist in delivering on these broader objectives.

Undertaking the appraisal

Based on the names of people identified in the scoping report, stakeholders were invited to a half day appraisal workshop to assist with the assessment process. This occurred on the 19th July 2006 from 10.00am – 3.00pm. Those who attended were:

- Gabrielle Baker (Ministry of Health)
- Mike Bedford (Hutt Valley DHB)
- Maraea Craft (Ministry of Health)
- Jim Graham (Ministry of Health)
- Maraea Johns (Ministry of Health)
- Braydon Leonard (Canterbury DHB)
- Rob Quigley (Quigley and Watts Ltd)
- Michael Taylor (Ministry of Health)
- Chris Wong (Ministry of Health)

The participants were provided with several pieces of information that were prepared before the workshop:

- An agenda for the day (Appendix 3)
- A presentation about the purpose of the day, and introducing the HIA concept
- Presentations about the population of interest, the evidence about water supplies and wider determinants of health, and the discussion paper being assessed.

The participants were then split into two groups, and they were set the task of assessing one area of the plan per group, spending 40 minutes on impacts and enhancement/mitigation for each area of the discussion paper. The areas under focus were:

- Improving existing community supplies vs. providing supplies to communities that have no current supply.
- Using the drinking water capital funding for operational funding vs. not being able to use for operational funding.
- CAP funding consultants to help communities with applications vs. no CAP funding for this purpose.

For each of these areas the participants had to answer the following questions:

How might the proposed policy be likely to affect the determinants of health?

- i. Describe the impact on each determinant of health
- ii. Identify any measurable indicators or qualitative impacts (eg changes in income levels, key informant interviews)
- iii. How measurable is the impact (qualitative, estimable, measurable)?
- iv. Are there differential impacts on particular groups with respect to each determinant?
- v. Are there external influences that may interact with the policy being assessed?
- vi. Summarise the impact on the determinants of health (positive, negative or neutral).

Because the appraisal process was also questioning the quality of the WO HIA tool, we also asked participants to consider these questions:

- What did you find easy about the questions, what did you find hard about the questions?
- What would you change with the questions?

Finally, the workshop finished with some plenary group work time to discuss how the proposals in the discussion paper might have a potential effect on health inequalities. Participants were asked to:

- Describe the effects on health inequalities
- Identify any quantitative measures
- Say how measurable the impact is – qualitative, estimable or calculable
- Summarise the impact on health inequalities – positive, negative or neutral

One issue that arose early in the workshop was that the section on the determinants of health and prioritizing the determinants of health would have been better placed in the scoping stage rather than the appraisal stage. Given the scoping stage typically involves gathering stakeholder views on the direction of the assessment; it seems a waste not to ask them what determinants of health the HIA should focus on.

Otherwise a separate meeting would be needed, or different process used to choose the determinants to focus on. That was the case with this WO HIA where a separate discussion between the steering group members was required to decide what key determinants to focus on.

The workshop was well attended given the timeframes available. Splitting into two groups allowed a direct focus on additional parts of the discussion paper, while a second part of the workshop that was run in a plenary style allowed a direct focus on those inequalities issues not raised earlier.

The appraisal matrix (Table 4) provided a good framework to guide the assessment process. Given that there are six questions to be answered for each determinant of health identified as being potentially affected, there are quite a lot of questions for participants to consider/answer. This is a difficult process in any HIA, as participants often fly off on tangents, and identify other impacts before finishing answering the six questions for other impacts identified. While people appreciate the matrix style to get an appreciation of what they are meant to be doing, few people appreciate having to answer each of the six questions in a systematic fashion before being able to start on a new potential impact. People also have the potential to get bogged down in detail, rather than spending the time trying to focus on bigger and more important issues.

There are no easy answers for this dilemma. However, the shorter the time available, the fewer questions should be used, and in this case too many questions were asked as feedback on the tool was being sought as well. There needs to be clear guidance in the tool that the number of questions can be reduced where time is an issue, and that the questions can be reworded into layman's language as appropriate. How one person might ask a question is not necessarily how another person might ask it in a different setting. As long as the general thrust of the question is maintained, sticking to the exact wording of the WO HIA guide is not necessary.

Given the above discussion it would be useful to have a very short set of questions developed at a later date to support rapid workshops. Rapid workshops are likely to be the most common use of the tool, whereas it is currently designed around a long-format approach (the health appraisal tool). The health lens tool, while shorter is also too long for a rapid workshop setting.

The inequalities matrix (table 5) produced a worthwhile discussion and allowed the participants to explore issues of inequalities in depth. Suggested changes to the questions heading up the matrix are presented in Appendix 4.

The impact assessment matrix (table 6) was successfully used in a separate workshop situation with a reduced number of participants, attended by:

- Gabrielle Baker (Ministry of Health)
- Maraea Craft (Ministry of Health)
- Maraea Johns (Ministry of Health)
- Rob Quigley (Quigley and Watts Ltd)

Prior to the impact assessment workshop, Gabrielle Baker had picked out what she believed to be were the ten most significant potential impacts of the appraisal workshop, that could be further investigated for their scope and significance. The additional questions asked of these ten potential impacts were:

- Likelihood of impact occurring (low, medium, high)
- Severity or significance of potential impact (small/ low, medium, high)
- Scope of potential impact (affects small or large number of people)
- Expected time to take effect (short, medium or long term)
- Measurability of potential impact (qualitative, estimable, calculable)
- Possible actions to enhance positive or diminish negative impacts

These questions were useful in stimulating new ideas that might be used to mitigate the potential negative impacts identified in the appraisal of the discussion paper. A number of small changes to the questions that head up each column of the matrix (table 6) have been suggested and are presented in Appendix 5.

Impact Evaluation

The impact evaluation draws largely on information from an interview with Jim Graham, the author of the discussion paper, with a particular focus on how the WO HIA was used to inform the policy development process.

The findings of the HIA were fed back to Jim Graham in a letter format, sent on 10 August 2006 (attached as Appendix 6). The letter clearly set out the potential health impacts, both positive and negative, and suggested ways in which to enhance the positive impacts and reduce the negative. The feed back was framed positively, which is useful when attempting to inform and influence decision makers.

“These potential negative impacts do not undermine the importance or viability of the Drinking-water Assistance Programme. The DWAP will deliver significant benefits to a vital area of public health, and we look forward to the programme’s launch.”

The letter presented less information on the positive impacts, despite more information being available, and this has the potential for making this information less usable for the author of the discussion paper. One of the major potential strengths of WO HIA is the ability to promote the good components of programmes and this lack of information provided may reduce the ability of the WO HIA to support the programme. This was described by JG as particularly important when trying to make an argument to someone else, as elaboration on a point is important, rather than just a bald statement.

A significant success for the WO HIA was that JG believed that the WO HIA had largely met the objectives to which it was set and allowed JG to pursue ideas and directions of analysis that complemented the future consultation process about to be undertaken with local populations.

When considering advantages and disadvantages to the WO HIA process, JG was only able to relate advantages and could see no obvious disadvantages to using the approach. The main advantages described were the ability to focus on a Maori viewpoints and population, which would normally be diluted by time spent discussing other population groups; and that the discussion allowed solid arguments to be put around previously less clear issues. For example, how implementation of the different options in the discussion document might affect advantaged versus disadvantaged communities.

Another important success for the WO HIA was that many of the recommendations were seen to be practical and feasible. JG noted that the focus on recommendations to protect Maori communities was particularly useful in providing a balance to other submissions received in the process. This point is particularly important as without this Maori voice, the decision is much more likely to tend towards protecting other communities, potentially widening inequalities in health. Because the recommendations have such a focus on Maori, JG described how he now had the information to assist in taking a more balanced decision, that while not always taking the WO HIA viewpoint exactly, is more aligned with the WO HIA view than would otherwise likely be the case without that viewpoint being provided.

Unintended impacts are typical from HIA, such as placing public health on the agenda of other agencies and/or promoting joined up working, etc. JG noted that the WO HIA did not achieve other impacts as might otherwise be expected, and he put

this down to the lack of agencies/ communities represented. The WO HIA pilot was heavily restricted by the human-resources available for the approach, and because of this, the breadth of agencies represented in the HIA were narrower than other HIAs undertaken in New Zealand. This is both a positive and negative: positive in that the approach fits to the resources available and still produces useful outcomes; and a negative in that the full benefits of the approach are less likely to be realised. JG described that Te Puni Kokiri had been particularly difficult to engage in the standard consultation process, and that in hindsight (it's a wonderful thing), had wished the WO HIA had been used as the bridge to engage that agency. Another group that JG wished had been more involved in hindsight were rural Maori communities.

As the main policy contact, JG described that the WO HIA met all of his expectations from the process. He believed this was because the approach involved experienced and passionate people who were committed to the process. He was concerned that if the approach was 'parachuted into an agency' where the people were not committed to using the approach, that the process could go astray and not be useful. He believed the detail in the guide might put-off some policy makers, and distract them from the underlying concepts and values of the approach. He believed that attempting to work to those values was more important than following the tool 'step by step'.

"The concepts and process are the key thing, and the process will lead you to an outcome. I think people tend to lose sight of the importance of the concepts. If you have a clear understanding of the concepts of things, then you can develop the process a little bit as you go, as long as you retain those concepts."

Finally, when asked about whether JG would use the WO HIA tool again his response was:

"Absolutely, yes. Without any doubt. And I'd encourage others to use it as well. In spite of imperfections perceived or real, you only improve these things by using them more. In the final analysis what it did, was that it gave me a very clear Maori voice around some quite specific issues."

Conclusion

As a pilot process, this was the first occasion in which the Whanau Ora HIA tool had been applied in a practical setting. A small team of committed individuals led the process and followed the proposed steps within the Guide, assessing the Ministry of Health's discussion paper on the criteria for capital assistance for small water supplies.

This evaluation report describes how the WO HIA was undertaken (a process evaluation), considers how the HIA has informed the policy process (impact evaluation) and provides a general commentary on the guidance provided with, and performance of the tool in a real-life situation.

The process evaluation describes each stage of the approach, noting the type of intervention applied and the way in which the intervention was applied. Stages covered included screening, scoping, and appraisal and reporting. Throughout the evaluation information was fed back to the Maori Public Health Group so that the WO HIA guide could be amended where required. Significant changes have been suggested for the screening and scoping sections. The appraisal stage used a workshop approach that engaged a number of key stakeholders, but not as many as might normally be expected due to human resource constraints within the team undertaking the WO HIA. At the appraisal stage, more emphasis is required on the need to follow the values and concepts of the approach, rather than to doggedly stick to the questions one by one. It is recommended that a set of shorter appraisal questions that capture the key points in simple English are developed to supplement the current questions in the guide.

The impact evaluation demonstrated the value of the WO HIA process within a typical policy process, in particular by providing a Maori voice to the process that can be used to balance out competing arguments. THE WO HIA did not deliver any of the possible 'unintended positive impacts' often seen by other HIA due to the lack of human resources to allow wider representation in the various stages of the WO HIA. The WO HIA met the objectives set for itself, had a number of advantages (and no disadvantages identified by the policy maker), made practical and feasible recommendations that have informed the policy development, and the policy maker involved wholeheartedly supported future use of the WO HIA tool by himself and would recommend it to others.

References

Minister of Health and Associate Minister of Health. 2002a. He Korowai Oranga: Māori Health Strategy. Wellington: Ministry of Health.

Minister of Health and Associate Minister of Health. 2002b. Whakatātaka: Māori Health Action Plan 2002–2005. Wellington: Ministry of Health.

Ministry of Health (2006) Drinking-water assistance programme: Criteria for capital assistance for small drinking-water supplies, a discussion document. Wellington: Ministry of Health.

Appendix 1 – Specific changes recommended for the Screening Checklist.

Pose these questions:			
To your knowledge:	Response to the question – provide a small amount of detail to provide a historical note to your decision	Estimated level of certainty for your response to the questions (high, medium, low)	Encourage the use of a Whanau Ora HIA?
Is there potential for positive or negative health impacts for Māori and their whānau? (Think about whether it will affect determinants of health such as socioeconomic or environmental factors or lifestyle.)			Yes / don't know / No
Is there potential for the proposed policy to socially, economically or culturally impact on the health and independence of Māori and their whānau, both negatively or positively?			Yes / don't know / No

Is there potential for the proposed policy to impact on emotional, spiritual, mental or physical health/wellbeing, both negatively or positively?			Yes / don't know / No
Are the potential effects likely to positively or negatively affect Māori death, disability or hospital admissions?			Yes / don't know / No
Has the policy development process reflected protection, partnership and participation principles?			Yes / don't know / No
Does the proposed policy reflect protection, partnership and participation principles?			Yes / don't know / No

<p>Is there potential for the proposed policy to impact on Māori involvement in the planning and delivery of services (of any sector)? (Includes governance, management and operational levels.)</p>			<p>Yes / don't know / No</p>
<p>Does the proposed policy impact on access to services (of any sector) for Māori, both negatively or positively?</p>			<p>Yes / don't know / No</p>
<p>Is there potential for the proposed policy to increase existing health inequalities between Māori and non-Māori?</p>			<p>Yes / don't know / No</p>
<p>Which sectors of Government (eg, Health, Housing, Education, Social welfare, Treasury) might the proposed policy have potential impacts on?</p>			<p>Yes / don't know / No</p>

Appendix 2 – Suggested changes and prioritisation for scoping questions

- What is the budget and sources of funding for the Whanau Ora HIA and any associated work?
- What are the boundaries in terms of timing (when will it be completed by) and geographic location (where will it focus on)?¹
- What are the aims and objectives of the HIA?
- What parts of the policy are being assessed, all of it or just a component?
- What population groups will be the focus of the Whanau Ora HIA?
- What determinants of health will be the focus of the Whanau Ora HIA?
- Who are the key people to consult with as part of the assessment and how might this occur?²
- Who will lead, participate in, and/or conduct the WOHIA and what other skills are needed?
- What comparison policy will be used for the Whānau Ora HIA?³
- What information, policy work or data are available or will be needed to be collected?
- What public or community concerns have been raised around the policy area?
- What methods could be used in the Whanau Ora HIA?⁴
- What are the parameters for evaluating the Whanau Ora HIA?
- If the outcomes of the policy are not known, what assumptions need to be made to predict the potential outcomes?
- Are there any relevant relationships to statutory requirements?⁵

¹ The next three years, or longer? How heavily will you discount future years? What is the Maori community under consideration – a particular region or local authority area, tribal boundaries, the whole of New Zealand, rural or urban?

² Think systematically about whom it is important to involve, for example iwi and Maori providers, Maori-led PHOs, kaumatua, other Maori community groups, other agencies.

³ For example, will an alternative option be the comparison, or comparison with the status quo?

⁴ See appraisal stage for assistance with this question

⁵ For example, resource consent processes (section 32 of the Resource Management Act), gender analysis, requirements for consultation, legislative impact statements, etc?

Appendix 3 – Agenda for the HIA Workshop

Drinking water rapid appraisal workshop.
Featherston Room, Copthorne Plimmer Towers, Wellington
10 – 3pm

10.00 – 10.10	'What does health mean to you' exercise as you walk in, welcome.
10.10 – 10.30	Purpose of this meeting and introduction about HIA, and this HIA so far.
10.30 – 11.20	Salient points about the projects; the community and population; and evidence
11. 20 – 11.30	Working groups instructions
11.30 – 12.20	Work groups. One area of the plan per group. 40 minutes on impacts and enhancement/mitigation for each area of the plan.
12.20 -1.00	Lunch
1.00 – 1.50	Work groups. One area of the plan per group. 40 minutes on impacts and enhancement/mitigation for each area of the plan.
1.50 – 2.00	Feedback from work groups on questions.
2.00 – 2.45	Whole group. Inequalities matrix.
2.45 - 3.00	Summary and evaluation. close

Appendix 4 – revised health inequalities matrix questions (Table 5)

Describe the effects on health inequalities

Identify any *qualitative* or quantitative measures.

How measurable is the impact – qualitative, estimable or *measurable (quantitative)*? (to match the same question format as Table 4).

Summarise the impact on health inequalities – positive, negative or neutral

Appendix 5 – revised impact assessment matrix questions (Table 6)

Likelihood of impact occurring (low, medium, high)

Severity or significance of potential impact (small/ low, medium, high)

Scope of potential impact (affects small or large number of people)

Expected time to take effect (short, medium or long term)

Measurability of potential impact (qualitative, estimable, calculable). *Delete this question as it is a repeat of table 4 and 5.*

Possible actions to enhance positive or diminish negative impacts

Appendix 6 – letter providing feedback to discussion paper author.

August 10, 2006

Jim Graham
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Ministry of Health
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Tēnā Koe Jim

Drinking-water Assistance Programme: Criteria for Capital Assistance for Small Drinking-water Supplies

Thank you for opportunity to comment on this Drinking-water Assistance Programme discussion paper. The Whānau Ora Health Impact Assessment tool has been used to identify how the proposal will impact on the overall aims of He Korowai Oranga: the Māori Health Strategy.

It is important to note that the Whānau Ora Health Impact Assessment tool highlighted the value of the Drinking-water Assistance Programme. Those involved in the assessment phase of the Whānau Ora Health Impact Assessment were all supportive of the programme and the philosophy behind it. There were, however, some concerns about whether the intentions behind the programme would be fully realized.

This letter outlines the eight impacts found in the assessment phase.

Positive Impacts

(1) Reduction in illness

Improved drinking-water supplies will reduce the incidence of illness due to water-borne disease.

(2) Development of community pride and community identity

Communities that work together to make applications and operate improved water supplies will develop a stronger sense of shared identity and a greater community pride.

(3) Development of skills in the community

Communities that work together to make applications and operate improved water supplies will develop new skills.

(4) Strengthening of traditional systems

Development of the water infrastructure will support and strengthen traditional systems such as papakainga.

(5) Spiritual Benefits

Water has a spiritual dimension as well as an ecological dimension. An improvement in water quality carries positive spiritual significance.

Negative Impacts

(6) Some needy communities may miss out

The New Zealand Deprivation Index is central to both proposed funding options. In both options, the deprivation index is used to determine eligibility for funding and the proportion of funding received. In both options it is also a contributing factor in determining the priority of different applications for funding.

It is possible that some very needy communities may have their ability to pay misrepresented by the deprivation index value, and as a result they may miss out on funding assistance. This possibility is acknowledged in the discussion paper (paragraph 105).

This kind of masking is inevitable in any set of descriptive statistics. Some possible ways to reduce the impact of this problem are considered below.

- *Look at deprivation index scores on a more granular scale.*
Deprivation index values for communities are presented by Census Area Unit, but the data is also available for small meshblocks of around 90 people each. A community around a drinking-water supply will usually encompass a number of meshblocks. The index values for these meshblocks will provide a more accurate picture of the community's funding needs.
- *Use ethnicity as a further variable.*
A community's ethnic mix is strongly correlated with deprivation, and ethnicity can be used as an indicator for need (*Decades of Disparity: Ethnic mortality trends in New Zealand 1980–1999*, Ministry of Health, 2003; *Decades of Disparity III: Ethnic and socioeconomic inequalities in mortality, New Zealand 1981–1999*, Ministry of Health, 2006). Ethnicity is not considered as a variable in the deprivation index and so provides an independent source of data. An ethnicity variable could therefore provide a second indicator of likely deprivation.
- *Use life expectancy as a further variable*
A community's life expectancy is strongly correlated with deprivation (*Decades of Disparity II: Socio-economic Mortality Trends in New Zealand 1981–1999*,

Ministry of Health, 2004; *Decades of Disparity III: Ethnic and socioeconomic inequalities in mortality, New Zealand 1981–1999*, Ministry of Health, 2006). Life expectancy is not considered as a variable in the deprivation index and so provides an independent source of data. Neighbourhood-level data on life expectancy could also provide a second indicator of likely deprivation. (See *Monitoring Health Inequality Through Neighbourhood Life Expectancy: Public Health Intelligence occasional bulletin*, Ministry of Health, 2005.)

- *Use variation within a community to identify heterogeneous communities*
A high standard deviation in deprivation index value suggests that a community is very diverse, and in diverse communities a deprived segment of the community could be masked by the presence of a wealthy segment. A high standard deviation therefore signifies that the community's deprivation index value should not be accepted on its face as a good indicator of the community's ability to pay.

There is another potential difficulty associated with the use of the deprivation index. The deprivation index is a relative measure, not an absolute one, and is based on data that cannot be reviewed. These factors make it extremely difficult for a community to know if its deprivation index score is appropriate. The obligation to ensure that a community's deprivation index score represents it accurately cannot, therefore, be placed on the community.

(7) Operational costs are too great for some small communities

The ongoing costs associated with an improved drinking-water supply will be a significant economic drain for some small communities, and if these costs are not funded by CAP, a variety of problems may result.

These problems include the following:

- The burden of operational costs may be too great when compared to the wealth of the community, deterring communities from undertaking the programme.
- The uncertainty of funding in some communities (e.g. Marae, which rely on gifted money) may deter any commitment to ongoing costs
- Health benefits from the programme may erode if unforeseen financial difficulty affects maintenance of the water supply

For these reasons, it is recommended that operational costs are considered for funding where necessary

(8) Deprived communities may have their disadvantage compounded

The most deprived communities will have the most difficulty completing the application process. The more elaborate the application process, the more it functions as a barrier. Requiring a consultant (as in funding option 2) is an additional barrier to such communities.

This effect could cause an increase in inequality. If less deprived communities access the programme while more deprived communities do not, then the gap between these communities will grow.

Some possible ways to reduce the impact of this problem are:

- Use funding option 1, which is a very straightforward application process. This process is easier for all communities to complete and makes it more likely that the most deprived communities will be represented in each funding round.
- Allow more time to the TAP facilitator so assistance can be provided in the preparation of applications.
- Limit applications to communities with deprivation index values of 9 or 10 for the first funding round(s), and focus effort around supporting applications from such communities.

These potential negative impacts do not undermine the importance or viability of the Drinking-water Assistance Programme. The DWAP will deliver significant benefits to a vital area of public health, and we look forward to the programme's launch.

Nāku noa, nā,

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