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Case Study

Development and implementation of a shared governance model in a mainstream health unit: a case study of embedding Aboriginal voices in organisational decision making

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Abstract. This case study focuses on the development and implementation of a governance structure and processes by a mainstream health unit that valued the principles of Aboriginal self-determination, empowerment and leadership by Aboriginal staff in organisational and service delivery decisions and elevated Aboriginal voices by embedding cultural inclusion in such decision making. Various models of embedding Aboriginal voices in the governance of the unit were developed and implemented over time. Ongoing review and reflection identified limitations and opportunities for improving the embedding of Aboriginal voices in organisational decision making. In 2017, Aboriginal staff and senior management implemented a joint governance model for providing strategic leadership of the unit with the objective of enhancing the delivery of culturally appropriate population health services for the benefit of Aboriginal communities. In its 3 years of operation to date, the model has provided strategic oversight of the organisation, implemented several strategic initiatives, including a cultural assessment process, maintaining and strengthening Aboriginal recruitment, monitoring employment vacancies, establishing a wellbeing leadership group, monitoring budget allocation and developing an Aboriginal data management protocol, and has provided additional professional development opportunities for Aboriginal staff. This case study demonstrates the feasibility, importance and benefits of engaging and embedding Aboriginal voices in the governance of a mainstream health service delivery unit, as well as the need for ongoing reflection and improvement. Further translation of the model to the operational levels of the unit is required. The governance model has the potential to be replicated in a tailored manner in other mainstream health units and organisations delivering services to Aboriginal peoples and communities.

What is known about the topic? Aboriginal people continue to experience the poorest health outcomes of any population group in Australia. Closing the gap in Aboriginal health requires Aboriginal people to be active and equal participants in all levels of decision making. Governance of mainstream health organisations is predominantly positioned in the Western medical positivist paradigm, which fails to embed Aboriginal voices in organisational and service delivery decision making.
What does this paper add? This case study describes the processes taken and the outcomes achieved thus far by a mainstream health service delivery unit developing and implementing a governance model that embedded Aboriginal perspectives in its decision making. It highlights that through commitment and persistence, as well as acknowledging the challenges of working between two worlds, it is possible to reconstruct existing governance models, allowing respectful

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and meaningful space for Aboriginal people to co-design and co-share the governance of health service delivery. This case study demonstrates the potential of the cultural governance model to be replicated and applied to other mainstream health service delivery units.

What are the implications for practitioners? This case study highlights the need for health services to invest in employing and empowering Aboriginal people to co-develop and co-lead a shared approach to organisational governance through processes that are culturally safe, inclusive and appropriate.

Keywords: Aboriginal, cultural governance, empowerment, equity, First Nations peoples and communities, health service delivery, leadership, organisational change, organisational governance, public health.

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Introduction

Racism is an organised system based on the ideology of racial inferiority[1] and is a fundamental social determinant of health that causes unequal distribution of social and economic resources.[2–4] Racism can be expressed through attitudes, behaviours and practices and occurs at three levels, namely internalised, interpersonal and institutional.[1,5] Institutional racism is expressed by differential access to employment, quality health care, power, information and resources, as well as participation in governance at various levels.[5]

Providing culturally unsafe or inappropriate services for Aboriginal peoples can have detrimental effects on health outcomes, lead to a distrust of mainstream health services and influence decisions about engaging or avoiding health care.[6] The employment and engagement of Aboriginal people within health services is crucial to the design and delivery of culturally appropriate and safe health care for Aboriginal people and communities.[7] Aboriginal health professionals can thereby play a significant role in addressing institutionalised racism and influencing health policy and practices[8] to ensure a culturally safe workplace.

Australian mainstream health services are often identified as providing culturally inappropriate and unsafe services for Aboriginal people,[9] having a devastating impact on health outcomes as a result.[3,10] The delivery of Australian mainstream health services is predominantly positioned in the biomedical paradigm, characterised by biological processes, and measured and interpreted quantitatively and objectively.[11] Such methodologies have been challenged for their failure to not value or incorporate Aboriginal perspectives or practices.[4]

Challenging organisations and government to include Aboriginal voices in decision making

Aboriginal people have long advocated for policy reform and a voice in parliament to be included as active participants in legislative and policy decision making processes.[12] In 2017, Aboriginal and Torres Strait Islander leaders engaged in discussions about constitutional reform. A model that facilitates input into federal policy and legislation was agreed upon, but this model is yet to be designed and implemented. State and regional plans have, however, been developed and implemented to build strong partnerships and promote social, economic and cultural wellbeing through opportunity and empowerment.[13] Such initiatives are underpinned by the principles of self-determination, engagement and local decision making to drive input into service design and delivery.[13]

The concept of engagement varies across settings and ranges from the community having full control to involvement in joint planning and joint governance to engagement being tokenistic to the community having no voice in decision making.[14] There is no single definition of effective engagement in health services from an Aboriginal perspective, but building effective relationships and empowering Aboriginal people to be active participants in the design of policy, programs and services, as well as in governance, are suggested to be beneficial.[14,15]

Mainstream health services often operate using a top-down management approach where health service priorities and processes are decided upon with limited engagement with communities and/or consumers.[16,17] Such approaches reinforce colonial decision making and power structures,[18] and have the potential for healthcare services to have little benefit or to cause harm to Aboriginal peoples.[19] In contrast, partnership approaches can encourage active participation through principles of shared decision making and shared power, responsibility and commitment.[14,15]

Models of culturally appropriate organisational governance

'Governance' refers to the way a group of people organise themselves to achieve goals, and includes the processes, responsibilities and structures to make decisions and implement policies.[20] The World Health Organization describes health governance as a way of guiding and regulating functions to achieve objectives and promote and maintain population health.[21] Health organisation governance is inclusive of boards, directors and operational management being responsible and accountable for delivering and monitoring health care quality and outcomes.[17] Aboriginal governance prioritises culture,[22] enables Aboriginal people to have the power and authority to inform policy[20] and focuses on the principles of self-determination and autonomy over the political, social and economic environment of Aboriginal communities.[23] Embedding cultural values, principles and practices in organisational governance requires respectful relationships, leadership, shared decision making and mutual accountability.[23]

Although there are models of good governance within Aboriginal Community Controlled Organisations and

Box 1. Implications for public health research, programs and service delivery

- Aboriginal staff collectively identified key issues and gaps in the organisation's business and led the way in guiding and developing a structure that promotes Aboriginal self-determination, autonomy, empowerment and leadership
- Success in the implementation of the governance model lay in management's commitment to address Aboriginal health by being open to other ways of working and adopting a decolonising approach to research, moving from a deficit to a strength base model in health promotion and research
- The success of the joint governance model has resulted in Aboriginal leadership opportunities
- This model evidences that, when non-Aboriginal staff give up space and share power, Aboriginal people thrive
- This case study demonstrates this cultural governance model can be replicated and applied to whole-of-population health programs and research
- Public health researchers and practitioners must understand the need to address Aboriginal health outcomes within a holistic view of health

Aboriginal health settings,[24–26] there is limited information about the operationalisation of models that embed Aboriginal perspectives in the governance of mainstream health services.

Australian workplaces generally appear to be moving towards building relationships and opportunities with Aboriginal people through initiatives such as Reconciliation Action Plans.[27] This move is similarly occurring in health services. For example, the National Safety and Quality Health Service Standards[16] and associated User Guide for Aboriginal and Torres Strait Islander Health[28] suggest, under Standard 2: Partnering with Consumers, that 'The health service organisation involves consumers in partnerships in the governance of…health care'. Despite these directions, limited information or case examples are provided regarding how Aboriginal peoples' participation in organisational governance and decision making[16,28] can be achieved in mainstream health organisations.

This case study describes our experience of developing and implementing a shared governance structure to value the principles of self-determination, leadership and empowerment for Aboriginal people in a mainstream health organisation (Box 1).

Case study setting

Hunter New England Population Health (HNEPH) is a unit of the government-funded public health organisation Hunter New England Local Health District (HNELHD). HNELHD covers a large geographical area of New South Wales, Australia (Fig. 1), providing health services to 912 352 people, including 64 333 Aboriginal people.[29] Aboriginal people make up 7% of the total population of the HNELHD, and represent 24% of the state's Aboriginal population.[29] The HNELHD has implemented initiatives to improve the delivery and appropriateness of its services to Aboriginal peoples.[30]

HNEPH provides health promotion and health protection programs and employs approximately 130 staff, including 22 (17%) Aboriginal staff. HNEPH operates using an integrated health service delivery and research model, focusing on the implementation of evidenced-based services and the delivery of culturally appropriate services for Aboriginal communities.[31]

Developing the cultural governance model

The development of a unit governance model that embeds Aboriginal perspectives evolved over many years. In 2006, the unit experienced a restructure where three sites across the region merged and subsequent meetings occurred to establish ways of working. In the subsequent planning meetings, HNEPH Aboriginal staff identified inconsistent consideration of cultural appropriateness and safety in the unit's decision making and services. In addition, many non-Aboriginal staff lacked understanding of Aboriginal culture and history, risking the effectiveness of the unit's services for Aboriginal communities and the safety of Aboriginal staff. In response, Aboriginal staff suggested mechanisms be strengthened to ensure implementation of cultural appropriateness across the unit, increasing the employment of community-connected Aboriginal staff, aligning with the recommendation to build a strong Aboriginal workforce to drive change for culturally safe, appropriate and collaborative health services.[7,32,33]

In 2007, HNEPH Aboriginal staff established an informal network group to provide a safe space for cultural support in dealing with culturally challenging experiences in the workplace. Network group membership was voluntary and staff were invited by word of mouth. To address the issues raised by Aboriginal staff, management undertook organisational change to improve the unit's capacity to provide a safe working environment for Aboriginal staff and to deliver culturally appropriate services to Aboriginal communities. To achieve this goal, management needed a clear pathway to seek cultural advice and develop an understanding of issues identified by Aboriginal staff. In 2008, Aboriginal staff established an Indigenous Advisory Group (IAG), whereby the HNEPH Management Committee (executive) could seek advice regarding the management of the unit and Aboriginal staff could raise issues. The need to provide cultural advice to the unit had grown to dominate IAG meeting agendas, leaving no time for networking or cultural debriefing. Aboriginal staff sought to realign time allocation to all functions of the group, including a name change: Population Health Aboriginal Network Group (PHANG). These arrangements continued for the following 8 years.

HNEPH staff and management initially developed an Aboriginal employment strategy to address barriers to increasing the employment and retention of Aboriginal staff. To support these objectives, HNEPH formed the Racism and Discrimination Group (later renamed the Cultural Redesign Advisory Group (CRAG)) to lead, direct and monitor the implementation of strategies to reduce racism and discrimination within the unit's services.

The demands from both the Management Committee and CRAG for the provision of cultural advice (Fig. 2) became difficult to manage and affected the workload and capacity of PHANG, resulting in staff burnout, disengagement, reduced productivity in staff substantive roles and insufficient time for networking. Under this structure, the Management Committee remained the sole organisational decision making body. The Management Committee recognised the risk of such a structure

Fig. 1. Map of Hunter New England Local Health District.

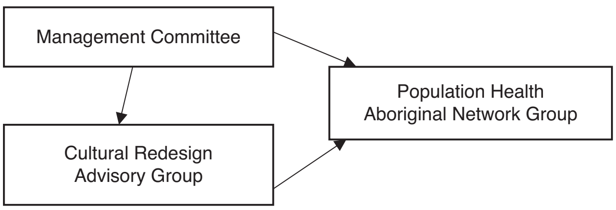

Fig. 2. Hunter New England Population Health cultural governance structure 2006–17.

to the transparency of its decision making and sought alternative solutions. Given such challenges and issues, PHANG proposed a new governance structure, setting role and task boundaries to maintain a level of cultural safety and transparency of organisational decision making.

In 2015, PHANG and the Management Committee reviewed the existing governance structure and identified the need for a more integrated approach to ensuring cultural appropriateness and safety in the organisation and its services. An agreed approach was needed that respected Aboriginal knowledge and processes, and one in which Aboriginal people were included in organisational decision making.

The review involved several iterations of proposals, including reallocation of existing Aboriginal staff to support a new governance model. Some of the proposed recommendations were rejected by the Management Committee on cost or resource grounds. Subsequently, Aboriginal staff led numerous meetings with the Management Committee where it was identified that a structural solution was required to address: (1) the need for ongoing cultural support and networking; and (2) a governance model to ensure Aboriginal staff participation in organisational decision making alongside unit leaders. The Joint Governance Model addressing both elements was approved in 2016.

Joint Governance Model

The model organically evolved through open conversations and negotiation between Aboriginal staff and management, without regard to the position, status or power of individuals. The model aligns with and builds on the principles of polycentric governance, promoting learning and trust, with recognition of the diversity[34] of Aboriginal people and Aboriginal and non-Aboriginal ways of working. The model, referred to as the Joint Governance Model (Fig. 3), involves a shared strategic leadership approach, ensuring the delivery of effective population health services to the community generally and the delivery of culturally appropriate services for Aboriginal communities. The model bridges the gap between Aboriginal and Western governance approaches by: (1) embedding Aboriginal governance principles and processes into the overarching governance of the unit; (2) respecting Western organisational governance processes and broader local, state and national governmental contexts; and (3) integrating both perspectives into a shared governance and decision-making approach.

The model involves two pillars of governance, cultural and organisational, and includes a central Joint Governance Group (JGG) bringing both together in a joint decision-making forum.

The cultural governance pillar comprises:

- the Aboriginal Network Group, which provides a culturally safe collaborative platform for Aboriginal staff to network to share and listen to matters relating to workplace issues, and to promote cultural and professional development opportunities
- the Aboriginal Cultural Determinants Committee (PHACDC), which is the peak cultural advisory group providing advice to the joint HNEPH strategic decision-making forum (JGG).

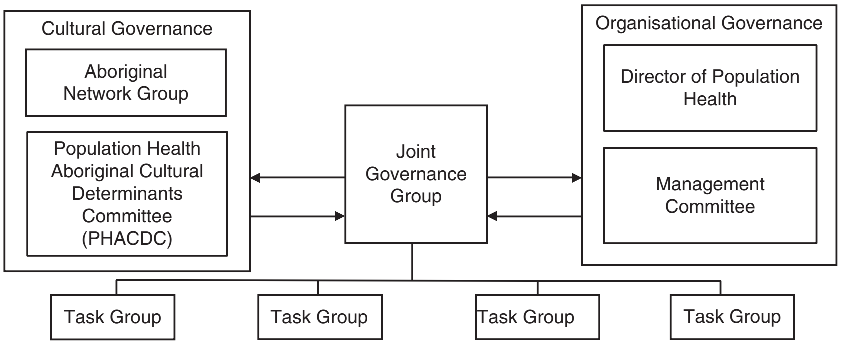

Fig. 3. Hunter New England Population Health governance structure since 2017.

The organisational governance pillar comprises the Management Committee, through which HNEPH executive leaders are accountable for directing, resourcing and monitoring the delivery, performance, outcomes and governance of population health programs, services and unit operations.

JGG and task groups

The JGG is the central leadership group with responsibility for developing HNEPH strategic directions to deliver culturally appropriate services for Aboriginal communities, as well as services to the community generally. The JGG has eight members, five Aboriginal and three non-Aboriginal, and an Aboriginal secretariat. Aboriginal and non-Aboriginal members are selected from the cultural and organisational governance pillars respectively. The JGG is co-chaired by the Director of Population Health and an Aboriginal staff member. Regardless of organisational position, title or hierarchy, all members have equal status and voice in decision making.

Agenda items can be brought to the JGG by individual group members, as well as members of the Management Committee, PHACDC and PHANG. Decisions regarding cultural governance are referred to PHACDC. Decisions regarding organisational governance are referred to the Management Committee. All population health staff can engage in developing organisational policies and procedures through time-limited JGG task groups. The membership and processes of the task groups follow the principles of the JGG.

Outcomes and achievements

Since its inception in 2017, the JGG has provided ongoing strategic direction for the unit and implemented key strategic innovations to mitigate the risk of institutional racism in decision making, as detailed below.

Cultural assessment of services

Cultural assessment (CA) of services is designed to address the need for culturally appropriate population health service delivery for Aboriginal communities. The CA process assesses services and programs against cultural appropriateness criteria, as per the New South Wales Aboriginal Health Plan 2013–2023.[35] The process supports services to consider and address the potential benefit, impact and risks to Aboriginal communities of proposed service delivery initiatives. All population health services are assessed by PHACDC, with feedback for service improvement integrated into service delivery. The CA process enables services to work with Aboriginal staff and partners. The CA tool process has resulted in changes across services, including: the development and implementation of cultural governance models for individual services; fostering cultural inclusion in service planning and implementation; and identifying opportunities to increase the Aboriginal workforce.

Aboriginal recruitment

Since 2006, the number of Aboriginal staff employed by HNPEH increased from 3 to 22. To maintain and strengthen this success, the JGG developed recruitment guidelines to address recruitment processes and actions. The JGG monitors all employment vacancies to identify opportunities to increase the number of Aboriginal people employed.

Wellbeing Strategic Leadership group

The Wellbeing Strategic Leadership group is overseen by the JGG to develop and implement initiatives supporting HNEPH staff safety and wellbeing. The scope of the group remit is to address: (1) organisational structures and governance processes; (2) information and communication processes; and (3) wellbeing programs and resources.

Budget allocation

The JGG monitors, via an organisational key performance indicator (KPI), that the commitment of a minimum of 10% of the HNEPH annual budget being allocated to Aboriginal-specific expenditures is achieved.

Cultural respect training

The JGG monitors, through an organisational KPI, that the commitment to 80% of new HNEPH employees undertaking cultural respect education is achieved.

Staff/Office allocation

A JGG member contributes to decisions regarding the allocation of staff to work spaces to ensure efficient and effective service delivery, as well as the safety (health and wellbeing) of staff, clients and visitors.

Aboriginal data management protocol

An Aboriginal data management protocol was developed to provide a standard for collecting Aboriginal data on services and outcomes for Aboriginal clients, ensuring the safety of reporting data in reports, peer-reviewed publications and conference presentations. The protocol is inclusive of authorship requirements and acknowledgement of the contributions of Aboriginal people.

Planned initiatives

Although the JGG model has been successfully implemented at the strategic level of HNEPH, similar mechanisms are required for the operational portfolios of the organisation. To achieve this, further joint governance initiatives are currently being developed to embed cultural inclusion and governance processes at operational levels. The JGG is overseeing the development and approval of these joint governance structures and processes and their impact.

Discussion

Ensuring Aboriginal people have the opportunity to participate in organisational decision making presents ongoing challenges for Aboriginal people working in mainstream organisations, and for such organisations themselves.[36] To address these challenges, the functions of Aboriginal staff networking and the provision of cultural advice to management needed to be integrated into the organisation's governance structure. In 2006, the organisational culture of HNEPH was neither inclusive nor supportive of addressing Aboriginal health from a cultural appropriateness perspective. Various strategies were implemented and reviewed, culminating in the current model embedding Aboriginal governance principles and processes into the decision making of the mainstream health organisation. The model facilitates shared decision making based on mutual understanding, respect and shared understanding of both Western and Aboriginal perspectives.

Central to the success of the governance model is Aboriginal staff persistence and leadership in the development of the process, as well as non-Aboriginal managers giving up space and power, and respecting other worldviews and practices. The success of the model is also contingent on the ongoing willingness and ability of non-Aboriginal JGG members and non-Aboriginal staff generally to challenge and adapt existing organisational systems and processes and to provide space for Aboriginal staff to participate in organisational decision making. In addition, the model has created organisational leadership and development opportunities for Aboriginal staff.

The model or its principles has the potential to be replicated by other mainstream organisations tailored to their individual contexts, and to inform the operationalisation of state and national engagement guidance, such as that published by the National Safety and Quality Health Service Standards.[16,28] The feasibility of the model or its principles being replicated is enhanced by its implementation in HNEPH occurring within the existing budget and staff profile of the unit, with existing staff positions and roles reallocated or modified to support the governance structure and processes.

Reflection

We acknowledge the model is not without challenges and is evolving throughout its implementation. The unit monitors and revises the model. Organisational change is fraught with challenges, especially in managing power shifts from disempowerment to empowerment, and the reverse. There is an ongoing need to ensure staff understanding of and ability to act according to the core elements of the model and joint decision making via the JGG. Negating the risks to this core element arising from differences between and within Aboriginal and non-Aboriginal staff regarding acceptable cultural or organisational governance practices requires ongoing communication and engagement. The diversity of individuals, teams and services can similarly be a challenge to achieving a commonality of purpose and practice, particularly when the model extends to the operational portfolios. With this latter development, the capacity of Aboriginal staff to support the model's objectives will require strategies to enable their active participation without adding to their risk of burnout.

Importantly, responding to change and differences between staff is acknowledged to be a key opportunity for reviewing and improving the model. At times such circumstances have created challenges for individuals and the organisation. Despite these challenges, there is an ongoing commitment to the principles and purpose of joint governance, and a shared sense of pride in the progress of the unit in this regard.

Data availability

Data sharing is not applicable as no new data were generated or analysed during this study.

Competing interests

The authors declare that they have no competing interests.

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