HEALTHY DIVERSITY?

Report on research into workplace diversity in a New Zealand District Health Board

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

SCIENCE
SCHOOL OF ENVIRONMENT

MEDICAL AND HEALTH SCIENCES
SCHOOL OF POPULATION HEALTH

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

National Institute of Demographic and Economic Analysis
Te Rūnanga Tātari Tatauranga

Sandy Lee, Francis L. Collins and Rachel Simon-Kumar

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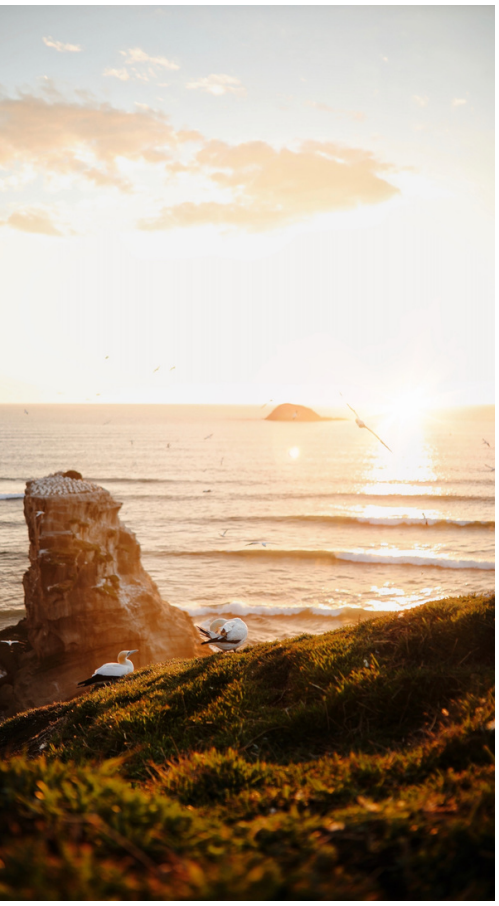
CONTACT

Any queries related to this report or the *Healthy Diversity?* research project should be directed to Francis Collins (francis.collins@waikato.ac.nz) or Rachel Simon-Kumar (r.simon-kumar@auckland.ac.nz).



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NOTES

The research team has made every effort to anonymise the District Health Board and all individuals that participated in this study. All names used in the report are pseudonyms.

More detailed discussion of the findings introduced in this report are available in the following two publications:

Lee, S., Collins, F. L., & Simon-Kumar, R. (2020). Healthy Diversity? The Politics of Managing Emotions in an Ethnically Diverse Hospital Workforce. *Journal of Intercultural Studies*, 41(4): 389-404. doi: 10.1080/07256868.2020.1778655.

Lee, S., Collins, F. L., & Simon-Kumar, R. (2020). Blurred in Translation: The Influence of Subjectivities and Positionalities on the Translation of Health Equity and Inclusion Policy Initiatives in Aotearoa New Zealand. *Social Science & Medicine*, doi: j.socscimed.2020.113248.

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Bottom left image by SRITBB (https://pixabay.com/photos/waterfall-nature-landscape-fall-2363282/)

EXECUTIVE SUMMARY

Population diversity in Aotearoa New Zealand has increased significantly over recent decades. Some of its major cities such as Auckland are now regularly cast as 'superdiverse', and this diversity is said to bring a range of social, cultural and economic benefits. However, this increasing diversity has also created particular challenges in ensuring a socially inclusive and equitable society. Feelings of belonging and inclusion are uneven amongst the range of ethnic groups residing in the country as are experiences of discrimination in situations of contact with different others (Statistics New Zealand, 2012). Exploring the experiences of day-to-day encounters with diversity and the impact of policy is important in understanding the everyday realities that contribute to and/or hinder the realisation of a truly inclusive and equitable society.

'Encounters' is a useful frame to examine diversity. Looking at everyday encounters allows an understanding of the actual potentials and challenges in reducing discrimination, tension and intergroup conflict in the lived spaces where different people interact (Fincher 2003; Noble 2009; Wise & Velayutham, 2009). Sites of contact are also particularly important in the face of increasing segregation and at a time where ethnic minorities and migrants are regularly portrayed in problematic ways in the mainstream media (for example, Chisari, 2015). Thus, encounters focus on situated experiences of living as diverse peoples where perceptions of difference are shaped by broader societal influences and enable an exploration of what impact diversity policy initiatives have on enhancing greater understanding and acceptance in a given context.

In the settler colonial context of Aotearoa New Zealand, Māori, white settler and ethnic differences inflect social interactions and political responses to diversity. These patterns of diversity are most notable in the country's largest city, Auckland, though questions of equity and inclusion and the politics of identity are significant across society (Terruhn & Rata, 2019).

This report describes the findings from a research project that explored the lived experiences of everyday encounters among diverse population groups in a hospital workplace in Auckland. Healthcare workplaces in Aotearoa New Zealand employ a high number of overseas migrants and hospitals incorporate the breadth of a city's population as patients and as workers in integrated but stratified occupations. Thus, the study took into account ethnic differences as well as variations in migration history, occupation and gender when examining the contours and potentials of encounters.

The research project reported here was conducted by a team of three researchers at the Universities of Auckland and Waikato. Methodologically, it involved an in-depth case study of hospital settings in a New Zealand district health board (DHB) involving interviews with senior management and clinical and non-clinical staff and analyses of institutional diversity and health equity policy documents.

The aim of the research was to investigate the potentials and challenges of enabling forms of encounters that enhanced understanding, respect and inclusion of ethnic and cultural differences in workplaces.

THE RESEARCH HAD THREE OBJECTIVES

01 **TO EXAMINE HOW INTERSECTIONS OF ETHNICITY, NATIONALITY, GENDER, AGE, CLASS AND PROFESSIONAL POSITIONS INFLUENCE ENCOUNTERS IN THE WORKPLACE.**

02 **TO SCRUTINISE INSTITUTIONAL DIVERSITY POLICIES AND PROGRAMMES AND THEIR POTENTIALS IN ADVANCING DEEPER UNDERSTANDING, RECOGNITION AND INCLUSION.**

03 **TO EXAMINE HOW DIVERSITY POLICIES AND PROGRAMMES ARE ENACTED BY STAFF IN THEIR EVERYDAY WORK PRACTICES AND INTERACTIONS, AND THE FACTORS THAT INFORM DIFFERENCES IN ENACTMENT.**

KEY FINDINGS: OBJECTIVE 1

TO EXAMINE HOW INTERSECTIONS OF ETHNICITY, NATIONALITY, GENDER, AGE, CLASS AND PROFESSIONAL POSITIONS INFLUENCE ENCOUNTERS IN THE WORKPLACE.

- Staff experience the hospital workplace as a site of significant ethnic diversity and this is generally viewed positively. However, the structure and pace of the hospital workplace limits the depth of encounters with ethnic diversity.
- Relationships between staff, including between staff of different ethnicities, is primarily professional and contained to the workplace rather than extending into social lives.
- Orientation programmes provide opportunities for the building of deeper cohort-based social relationships. However, orientation programmes also separate staff by occupation, career stage and migrant and non-migrant status for some occupations. The separation of orientation programmes can deepen differences between staff from different ethnicities who are more likely to be in certain occupations, career stages and more or less likely to be migrants or non-migrants.
- Professional position influences the kinds and character of encounters with diversity that staff have. Staff in particular positions – nurses, managers, doctors, etc. – are more likely to know well and socialise with others in similar positions. Because many occupations have particular ethnic characteristics – for example, many managers are New Zealand-born Pākehā or recent European migrants – these patterns of interaction and socialisation do not necessarily increase contact with diversity.
- There is a curiosity amongst many staff to learn about the culture, practices and preferences of the patients they interact with. Staff regularly referred to cultural competence and safety guidelines and gave examples of the ways in which they operationalised these learnings in care practices.
- Engaging with cultural and linguistic diversity of patients sometimes manifests as ‘benevolent othering’. Staff regularly discussed patients through homogenous ethnic categories such as Asian and Māori wherein stereotypes were used to understand how to interact with patients.
- Stereotyping patients led to empathy and compassion in some instances but it also appeared to reinforce misunderstanding of health inequities. Staff sometimes accounted for health inequities through problematic explanations of cultural difference such as particular ethnicities’ ignorance of health. The use of stereotypes was a barrier to recognising the persistent societal problems that generate health inequities.

- Staff also reflected on how stereotyping of patients could shape clinical practice whereby patients were understood to respond to health conditions or treatments differently because of their ethnicity. These stereotypes demonstrate prejudice that can have very problematic outcomes for the treatment of patients, particularly in the resource-constrained health environment.

KEY FINDINGS: OBJECTIVE 2

TO SCRUTINISE INSTITUTIONAL DIVERSITY POLICIES AND PROGRAMMES AND THEIR POTENTIALS IN ADVANCING DEEPER UNDERSTANDING, RECOGNITION AND INCLUSION.

- The DHB places a strategic emphasis on creating a culturally responsive institution. The focus on equity, diversity and inclusion is not uniform, however. There are specific plans and guidelines aimed at Māori, Pacific and other ethnic groups, respectively, but each has a distinct focus. Only Māori health strategies are are mandated in formal policy.
- Policy programmes for Māori respond to the DHB's obligations under Te Tiriti o Waitangi with a focus on addressing health disparities. This focus on the rights of Māori and the centrality of Te Tiriti is distinct from the diversity agenda and strategies developed for other ethno-linguistic groups.
- Guidelines for Pacific health and wellbeing are holistic, community-centred and spiritually focused.
- Diversity strategies focused on the needs of other ethno-linguistic groups, effectively Asian and other patient communities, emphasise cultural sensitivity to reduce barriers to seeking help and service provision. This includes language translation and enhancing cultural competency of staff through training.
- There is no emphasis on rights, workforce participation or representation in leadership structures in diversity strategies for people from Asian and other ethno-linguistic communities.
- Diversity policies for Asian and other ethnicities centre on the the values, attitudes and skills needed to appropriately engage with colleagues and patients from different cultural backgrounds. In this framework, certain emotions, such as curiosity and patience, are deemed positive for staff to express, whereas others, like frustration and embarrassment, are deemed problematic. Through these emotions, staff are encouraged to be caring and compassionate towards patients and colleagues, to be good human beings.

- The limitations of emotions-led diversity include the following: (a) the emotions of some people are privileged over others; (b) the focus on emotions can overlook other structural inequalities; (c) the training of appropriate workplace emotions often centres 'mainstream' New Zealand society and 'Kiwis', reinforcing the idea that some cultural groups are fundamentally different from 'us'.

KEY FINDINGS: OBJECTIVE 3

TO EXAMINE HOW DIVERSITY POLICIES AND PROGRAMMES ARE ENACTED BY STAFF IN THEIR EVERYDAY WORK PRACTICES AND INTERACTIONS, AND THE FACTORS THAT INFORM DIFFERENCES IN ENACTMENT.

- The diversity and equity agendas of the DHB are interpreted and put into practice by staff in ways that support their particular personal circumstances and backgrounds. There were notable differences in interpretations in relation to whether staff positioned themselves as insiders or outsiders in Aotearoa New Zealand, and whether they aligned their identities with privileged populations.
- These interpretations can contribute to a blurring of the distinct agendas that the DHB has around its Treaty obligations and equity initiatives on the one hand, and diversity programmes on the other.
- Staff interpretations sometimes saw Te Tiriti as a basis for all diversity programmes even though the DHB makes clear distinctions; others framed Māori culture and health concerns as one of many equal types of needs; and some saw Treaty-specific training as problematic because it addressed structural issues.
- These different interpretations demonstrate that diversity training is not put into practice in uniform ways but, rather, reflects the particular position of staff in social hierarchies. Diversity training does not have much effect on the existing relations of power and privilege that shape encounters with cultural difference in the DHB. Staff interpreted diversity programmes depending on their occupational position within the institution. Staff in managerial positions placed more emphasis on distinctions between different diversity and equity agendas and their potential impact on healthcare delivery.
- Staff in patient-facing roles, by contrast, were more likely to draw attention to specific culturally appropriate practices as the key dimensions of diversity agendas. These responses appeared to reflect the time pressure of the hospital floor where making small accommodations for patients can be a priority. The effect of this emphasis is further blurring of the more structural emphasis of the DHB's obligations under Te Tiriti and the equity agenda and the behavioural focus of cultural competency.

These findings contribute to broader knowledge on the way in which encounters with diversity manifest in workplaces, with the healthcare setting being one of particular importance in Aotearoa New Zealand given its staffing and patient make-up. The findings highlight in particular how diversity takes shape in relation to intersectional identity positions, the significance of emotions in the management of encounters with diversity, and the impact of policy translation on the enactment of diversity initiatives in the workplace.

Based on these research findings, a number of challenges have been identified that may be useful for this DHB, as well as for other health providers and workplaces more generally in Aotearoa New Zealand. To create enhanced contexts for encounters among people of diverse ethnic, gender, migrant and professional backgrounds, it is important to carefully scrutinise routine processes that inadvertently create homogenous institutional spaces in the hospital and that form a barrier to meaningful interactions. In workplaces with significant occupational variety and hierarchy, such as hospitals, diversity policies and practices need to take account of the different professional and personal positions that staff hold within the institution and how this influences their exposure and responses to people of different backgrounds. Effective implementation of institution-wide diversity policies and programmes need to take into consideration the specific work processes and conditions within different departments and the challenges they present.

Diversity training focused on behaviour and emotional management can be beneficial in enhancing staff understanding of ethnic, cultural and linguistic differences. However, without linked emphasis on structural inequities and power imbalances, including those that benefit majority groups of staff and patients, the outcome of diversity training can be a greater belief in and reliance on stereotypes about other people. There is a need to consider how approaches to diversity training and inclusion can be more substantively linked into structural changes in workplaces. Diversity policy is not only a matter of behavioural changes to enhance service delivery but needs to influence all other dimensions of the institution to be effective; for example, rosters, human resources, career progression and leadership structures.

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1.0 INTRODUCTION

Aotearoa New Zealand's population has diversified significantly over recent decades with some of its biggest cities such as Auckland now regularly cast as 'super diverse'. With a national population of approximately five million, there are 95 ethnic communities with more than 1000 people; 16.5% of the population are Māori, 70.2% Pākehā/New Zealand European, 8.1% Pacific, while the Asian ethnic group is the third largest at 15.1%, and more than a quarter of the total population (27.4%) are born overseas (Stats NZ, 2019). Though this diversity is often touted as a major strength bringing social, cultural and economic benefits (Chen,2015; The Office of Ethnic Communities, 2016), there are also challenges associated with creating a socially inclusive and equitable society (Human Rights Commission, 2012). Feelings of belonging and inclusion as well as experiences of discrimination are uneven among the range of ethnic groups residing in the country. Asian (24%) and Pacific people (45%) are least likely to feel a strong sense of belonging in Aotearoa New Zealand, while Asian people are also three times more likely to report experiences of discrimination than Europeans, and more than a quarter of recent migrants (26%) have been discriminated against (Ministry of Social Development, 2016). There are also ongoing and increasing inequalities and exclusions among and between diverse residents (Groot et al., 2017; Simon-Kumar et al., 2020). Exploring the experiences of diversity on the ground and the impact of policy is important in understanding the everyday realities that contribute to and/or hinder the realisation of a truly inclusive and equitable society.

This report presents the findings of a research project conducted by a team of three researchers at the Universities of Auckland and Waikato that explored the day-to-day experiences of diversity in healthcare sector workplaces. The study examined the interactions between ethnically and culturally diverse staff and patients in the hospital settings of a district health board (DHB), including examining how the DHB's diversity policies and programmes shaped interactions. The overall aim was to understand what potential and challenges there are in advancing deeper understanding and respect for differences through regular contact in sites of significant diversity, informed also by strategic diversity management, and the implications for enabling more meaningful forms of inclusion and belonging. Hospitals and other healthcare workplaces are ideal locations for examining these issues because the health workforce is one of the most ethnically diverse in Aotearoa New Zealand, patients represent the full breadth of society's diversity, and healthcare and needs are both imbued with cultural specificities and reflect societal inequities and power relations that have a bearing on diversity.

The aim of this research specifically was to investigate what potential and challenges there were in enabling forms of contact that enhanced understanding, respect and inclusion of ethnic and cultural differences in workplaces.

THE RESEARCH HAD THREE OBJECTIVES

01 **TO EXAMINE HOW INTERSECTIONS OF ETHNICITY, NATIONALITY, GENDER, AGE, CLASS AND PROFESSIONAL POSITIONS INFLUENCE ENCOUNTERS IN THE WORKPLACE.**

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This report begins with a literature review (Section 2.0) that canvasses research on encounters with diversity and the specific characteristics of diversity in the health workplace. This section also includes a brief discussion of the significance of emotions and policy translation as themes that are taken up in our discussion of our findings. The following section (Section 3.0) discusses the study design, including a brief overview of the general characteristics of the research site and the research methods used in the study. The discussion of findings (Section 4.0) covers three key themes that address the three objectives outlined above: intersectional identities and their impact on encounters; institutional diversity policies and programmes; and the translation of diversity policies and programmes in work environments. The conclusion provides an overview of the key findings and identifies areas for future consideration for enhancing diversity, equity and wellbeing in health workplaces.

2.0 LITERATURE REVIEW

2.1 ENCOUNTERS WITH DIVERSITY

A major challenge in many cities and nations today is ensuring that the diversity of people living within their borders can live together as equals in difference. While there is evidence of successful integration and intercultural sensibilities (Noble, 2013; Wise & Velayutham 2014), there are also signs of conflict and tension. Media depictions of international events around terrorism and asylum seekers, Brexit and the Trump election have shaped particular discourses of migrants, portraying some as competitors for jobs and resources and others as threats to national security (Bleich et al., 2015), while increased diversity is touted by conservative politicians as challenging national identities and values (Chisari, 2015). Against negative stereotypes and discrimination, there is urgent need for greater understanding, acceptance and respect for difference. Geographers, and other social scientists, have been particularly interested in the potential of encounter in reducing intergroup conflict and tension (Fincher, 2003; Noble, 2009; Wise & Velayutham, 2009).

These challenges are very apparent in the settler colonial context of Aotearoa New Zealand where Māori, white settler and ethnic differences inflect social interactions and political responses to diversity. These patterns of diversity are often deemed particularly apparent in Aotearoa New Zealand's cities, most notably Auckland which is regularly cast as 'super diverse', but questions of equity and inclusion and the politics of identity are significant across society (Terruhn & Rata, 2019). To date, researchers have documented growing diversity and policy responses in cities (Collins & Friesen, 2011; Meares & Gilberston 2013), and have begun to explore different experiences of encounters (Bell, 2016; Higgins, 2019; Wang & Collins, 2016; Witten et al., 2019). There is also increased attention on the challenges of advancing inclusive difference amongst government (Makhlouf, 2017), community (Belong Aotearoa, 2019) and private sector organisations (Chen, 2019). There remains, however, considerable gaps in understanding under what conditions people in Aotearoa New Zealand encounter diversity in their daily lives. Moreover, there is a need to examine such diversity and the encounters that emerge in relation to differences in wealth, age, education and occupations that unevenly characterise different ethnic communities (Simon-Kumar et al., 2020). It is also necessary to ask how these axes of social difference intersect with gender, race and sexuality, and, as such, play a role in shaping the contours and potential of encounters.

2.1 ENCOUNTERS WITH DIVERSITY IN THE HEALTH WORKPLACE

The focus of this report is on how encounters with diversity occur in workplaces. Internationally, research has examined the experiences of everyday encounters in various public spaces of cities (Hemming, 2011; Neal et al., 2016; Watson, 2009; Witten et al., 2019 with growing interest in how meaningful encounters are in the sense that they disrupt power relations and challenge existing perceptions and stereotypes of the 'other' that extends beyond the immediate site of contact (Mayblin et al., 2016). To date, however, specific research focusing on workplaces as micro-public sites of contact is limited or has been undertaken in an evaluative manner that reduces wider theoretical insights. This is so despite the fact that work is where many adults spend most of their time outside of the private space of the home (Estlund, 2005), and workforce diversity is celebrated for its purported benefits to innovation and creativity (Florida, 2002). The emerging body of research on encounters at work is currently limited to jobs that are typically marked by racial concentration, such as building sites (Datta, 2009; Gawlewicz, 2015), abattoirs (Leitner, 2012), and hospitality in restaurants (Wise, 2016). Class identities intersect with ethnicity, race and nationality and influence the type of work individuals engage in (McDowell, 2009; Wills et al., 2010), and thus the problem here is that the workplaces studied so far offer few opportunities for interactions across multiple social differences and the unequal relations of power they operate through.

In this research, we have focused specifically on the healthcare sector as a set of workplaces in Aotearoa New Zealand wherein the significance of ethnic, cultural and linguistic diversity is particularly pronounced. While widely recognised as sites of considerable diversity (Medical Council of New Zealand, 2018; Ministry of Health, 2016; Walker et al., 2012), hospitals and other health workplaces have not featured in recent scholarship on encounters. In Aotearoa New Zealand, hospitals are shaped by a thick and extensive institutional framework that incorporates DHBs, the Ministry of Health, professional bodies and educational institutions, amongst others. The health sector is also already well established in terms of developing policies and programmes for managing diversity, but it remains unclear how training staff for ethnically, culturally and linguistically diverse patient populations extends to either encounters amongst staff or to examining the wider potential and challenges of workplace diversity (Came, 2014; DeSouza, 2008). Our research identifies the hospital as a site for examining diversity and encounters in a way that advances beyond culture and language to consider how these align with other axes of social difference such as gender and occupational status, and through which the potential for meaningful and positive encounters and attitudes to diversity might be enhanced.

There are two aspects that we focus on that specifically influence encounters: emotionality and meanings. Given the emotional intensity of hospitals for staff and patients alike, we focus particularly on identifying the role of emotions in the conceptualisation of diversity as well as the significance of translation of diversity policy into practice. The importance of emotional intelligence in successful cross-cultural interactions has been highlighted (for example, Gardenswatrz et al., 2010; Imose & Finkelstein, 2018), but in the context of Aotearoa New Zealand, prioritising emotional management of diversity also potentially undermines the deeper historical and structural challenges that have emerged within settler colonialism.

Similarly, diversity is also impacted by meanings that inviduals attach to it. Drawing on the body of work called 'policy translation' (Lendvai & Stubbs, 2009; Mukhtarov, 2014; Stone, 2012), the main idea is that all policies – including diversity policies – are involved in a dynamic exchange with individuals in an institutional setting. As individuals are exposed to policy, they dynamically reconstruct it by adding their own meanings to it, so policy is never received homogenously by actors. Meaning mutates the original policy and its intent and so policy is continually evolving as it moves from person to person. The factors that influence encounter – age, sex, education, ethnicity and occupational position, or what are called 'personal' and 'professional' biographies – also influence the way people interpret and add meanings. Movement of policy ideas can involve changes in core principles, new sets of practices and adaptations, the creation of new social contexts and new relationships between actors, as well as the establishment of different practices.

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3.0 METHODOLOGY

The research design involved a multi-stage qualitative case study approach. The study was located in a hospital DHB in Aotearoa New Zealand. This hospital was selected given the diversity of its client and staff populations and its extant diversity management programmes and policies. Figures 1 and 2 present information on the ethnic makeup of the DHBs patient population and workforce respectively. At the time of the research (2018–2019), around two thirds of the patient population was classed as 'other' (including Pākehā and other European ethnicities as well as Middle Eastern, Latin American and African (MELAA), with smaller proportions of Māori, Asian and Pasifika ethnicity. Workforce ethno-cultural diversity was relatively similar although it is notable that there are proportionally fewer Māori and Pasifika DHB workers than amongst the patient population, while there is a greater proportion of Asian ethnicity. This staff diversity varied depending on the health profession; for example, in line with national trends around 40% of nurses are from overseas Asian countries.

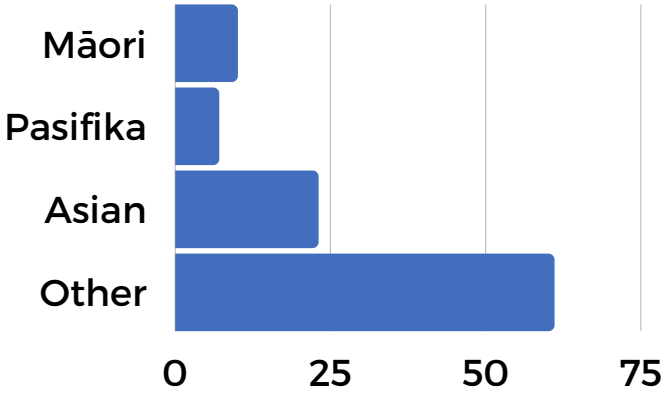


Figure 1: Patient Population by Ethnicity

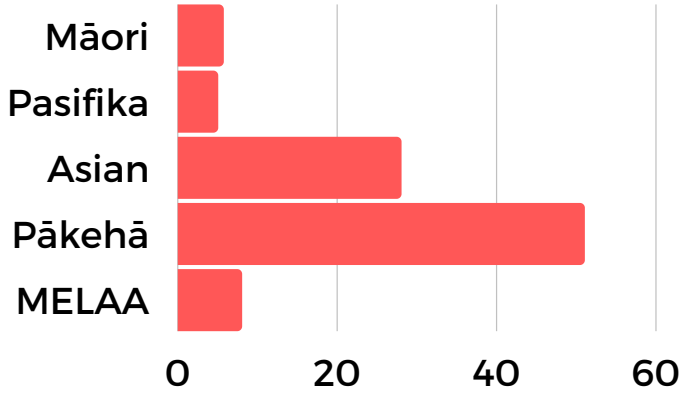


Figure 2: DHB Workforce by Ethnicity

The study was granted ethics approval from the University of Auckland's Human Participants Ethics Committee (Approval No. 020333). The study also received approval from the DHB's research office after undergoing a subsequent review.

Data collection was completed in two stages. The first stage included the gathering of institutional diversity-related documents and conducting interviews with senior leadership and management, while the second stage consisted of interviews with staff working in the hospital setting of the DHB.

3.1 STAGE ONE: DOCUMENT ANALYSIS

Documentary data were collected through an Official Information Act request to the DHB for information regarding cultural and linguistic diversity as well as through an internet search for relevant information available through the DHB's public website. Where possible, documentary data were also gathered during our interviews with senior management and leadership. Documents collected included best practice principles and training material for cultural competency, as well as statements of organisational values that provide a context for these.

Hospitals are recognised as places of intense emotions due to them being places of illness, treatment and care. Thus, the embodied and emotional dimensions that characterise all encounters with diversity are foregrounded and often intensely felt in hospitals. As such, in our analysis of the stage one data, we paid particular attention to what emotional accommodations were being encouraged in how diversity is managed by the DHB.

3.2 STAGE TWO: INTERVIEWS

Semi-structured interviews were conducted in both stages of the data collection. The first stage entailed interviews with members of senior management and leadership and took place over a three-month period between June and September 2018. The second stage of interviews were with clinical and non-clinical staff working in hospital settings at the DHB and were conducted between November 2018 and February 2019.

3.2.1 Senior management and leadership interviews

The senior management and leadership participants for stage one of the data collection were recruited through email after relevant individuals were identified from the DHB's public website. Individuals were selected based on their position in the senior leadership team and the potential insight they would have on the DHB's diversity policies and programmes. An email invitation was sent to each individual. The email contained a Project Information Sheet which provided details of the research and a Consent Form with information on what their participation in the research would entail. Seventeen individuals were contacted and invited to participate with follow-up emails sent to those who did not respond after approximately one to two weeks. Through this process we recruited 12 participants who were either in executive leadership or senior management positions or in roles specifically dealing with the health of particular ethnic groups.

Stage one interviews lasted approximately one hour and were conducted by at least two of the research team members. The general focus of the interviews was to gauge participants' knowledge of and involvement in diversity policies and programmes in the specialist sector they worked in and/or in the hospital more broadly. The interviews provided data on the subjective operationalisation of diversity as well as insights into the process by which the diversity documents were developed. At the end of these interviews, participants were also asked whether they had any recommendations of departments in the hospital that they thought would be a good place to conduct the second stage interviews on staff experiences of diversity.

3.2.2 Clinical and non-clinical staff interviews

Thirty participants were recruited for stage two of the research, using two methods. The first method was through contacting the department head and/or managers recommended by the stage one senior leadership and management participants and inviting them to participate in the research. Email contact was made with three department heads/managers, with one department successfully recruited to participate. Once participation was confirmed, the manager assisted in the recruitment of interviewees by posting information flyers around the department and making announcements at staff meetings. Fifteen interview participants were recruited from this department. Twelve of these participants were nurses and three were doctors, and their experience levels ranged from new graduates through to senior managers.

The second method of recruitment for stage two was through a LinkedIn advertisement targeting profiles that listed the DHB as their current employer. Interested staff members were asked to fill in a short survey registering their interest after which a member of the research team made contact via email to arrange the interview. Fifteen participants in a variety of clinical and non-clinical roles across a broad range of departments in the DHB were recruited through LinkedIn, including a handful through subsequent snowballing.

The 30 participants recruited for stage two consisted of a diverse range of ethnicities and nationalities and differing levels of seniority (see Figure 3). Eight identified as European (including British), seven Asian (including Indian, Filipino, Chinese and Korean), one African, two North American, ten Pākehā, one Māori, and one non-Pākehā New Zealander. Twenty-one were clinical staff while the other nine were in a range of business service and administrative roles. Twenty-two of the 30 participants (73%) were women; there were only eight men. This difference reflected the dominance of women in the healthcare sector in New Zealand where three-quarters of the workforce are women (76% women and 24% men in the DHB).

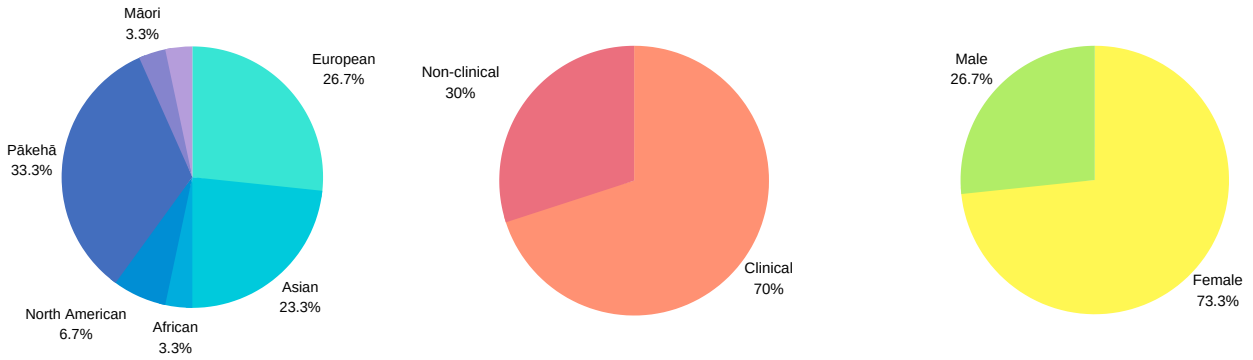


Figure 3: Ethnic, occupational and gender makeup of interview participants

The focus of the stage two interviews were on the everyday realities of diversity in the hospital setting of the DHB. The interviews focused on the participants' experiences of working with diverse patients and colleagues as well as their understanding of diversity policies and programmes at the DHB and how they put them into practice. Introductory questions around where they trained and worked in the past prior to their current position at the DHB were also included. The interviews provided data on how personal and professional biographies influenced how participants interpreted, responded to and enacted the diversity policies and programmes as well as the significance of intersectional power on these processes.

3.2.3 Analysis and presentation of findings

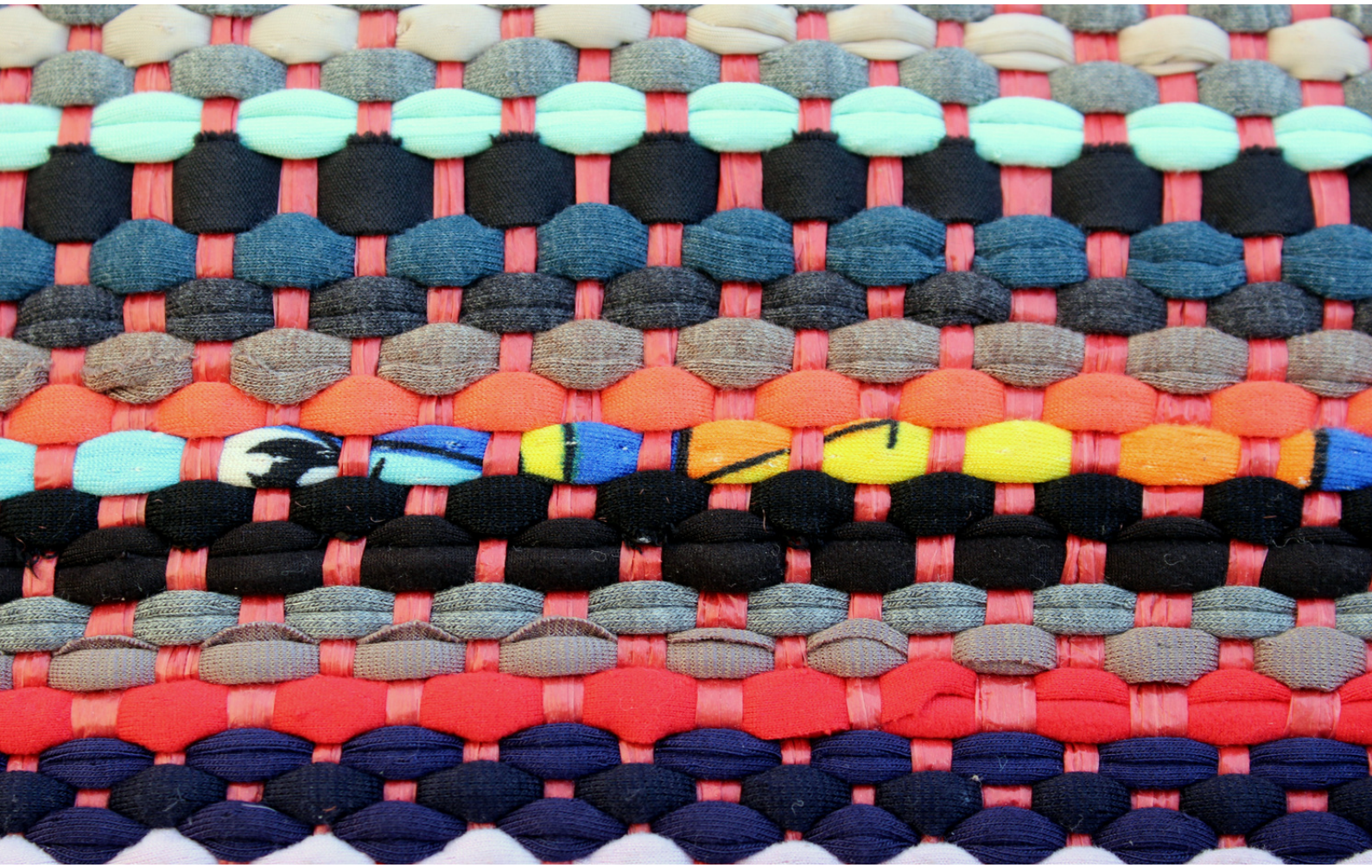
The interview data from stages one and two were transcribed verbatim. The DHB's diversity documents and interview transcripts were analysed thematically by the research team. Nvivo was used for the analysis of some of the transcripts.

For objective (1), themes were identified from the interview transcripts from the department participants, enabling an analysis of encounters in a particular physical setting with its specific modes of practice. All transcripts were read through and coded. Broad themes were identified from the codes, paying particular attention to the impact of intersectional subject positions on individuals' experiences of contact, how departmental practices conditioned the types of interactions between staff and with patients, and the implications for enhancing deeper understanding and respect for difference.

For objective (2), both the diversity documents and transcripts from senior management and leadership interviews were analysed. A close reading of the data was undertaken by the research team, identifying emotion-related discourses in the institution's management of different minority groups and analysing the implications for addressing structural inequalities and systemic exclusions in the DHB.

For objective (3), transcripts from the participants who had had exposure to diversity-related policy and training at the DHB were analysed. The focus was on how staff made sense of and translated the distinct equity and competency agendas in their interactions with culturally different others. Themes were identified in relation to the influence that the intersecting positionalities of staff have on translations.

The findings from the analyses are presented in three sections, each addressing a specific research objective. Verbatim quotes from interviewees are used to support/illustrate the arguments being made in the analyses. All quotes appear in italics and are followed in brackets by a pseudonym, professional role, and ethnicity if these details are not given in the text. At the beginning of each section, bullet points provide a summary of the key findings.



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4.0 FINDINGS

4.1 OBJECTIVE 1: INTERSECTIONAL IDENTITIES AND THE IMPACT ON ENCOUNTERS

A hospital is a place of constant flux. Not only are there continuous flows of patients into, out of and around the hospital, there is also the myriad movements of the vast diversity of staff across the range of departments. Undeniably, there is an immense variety and number of sites in which workers interact with those who are ethnically and culturally different to themselves throughout the work day. But the conditions and contexts of these dynamic encounters are related to occupational roles, career progression and personal migration as well as the power and authority associated with particular personal and professional identities.

In the proceeding section, we discussed how these various identities shape collegial and staff–patient interactions. Occupational, career and personal mobilities tend to create particular conditions of contact between colleagues that accentuate ethno-cultural differences, leading to convivial but relatively superficial interactions, while time constraints and professional obligations give rise to benevolent, and not-so-benevolent, forms of othering towards patients. Thus, while the hospital workplace may indeed be superdiverse, more nuanced understandings of difference are constrained by the contact conditions, limiting the potential of encounters to enhance understanding, acceptance and respect for difference as equals.

KEY INSIGHTS: OBJECTIVE 1

- Staff experience the hospital workplace as a site of significant ethnic diversity and this is generally viewed positively. However, the structure and pace of the hospital workplace limits the depth of encounters with ethnic diversity.
- Relationships between staff, including between staff of different ethnicities, is primarily professional and contained to the workplace rather than extending into social lives.
- Orientation programmes provide opportunities for the building of deeper cohort-based social relationships. However, orientation programmes also separate staff by occupation, career stage and migrant and non-migrant status for some occupations. The separation of orientation programmes can deepen differences between staff from different ethnicities who are more likely to be in certain occupations, career-stages and more or less likely to be migrants or non-migrants.
- Professional position influences the kinds and character of encounters with diversity that staff have. Staff in particular positions – nurses, managers, doctors, etc. – are more likely to know well and socialise with others in similar positions. Because many occupations have particular ethnic characteristics – for example, many managers are Pākehā or recent European managers – these patterns of interaction and socialisation do not necessarily increase contact with diversity.
- There is a curiosity amongst many staff to learn about the culture, practices and preferences of the patients they interact with. Staff regularly referred to cultural competence and safety guidelines and gave examples of the ways in which they operationalised these learnings in care practices.
- Engaging with cultural and linguistic diversity of patients sometimes manifests as 'benevolent othering'. Staff regularly discussed patients through homogenous ethnic categories such as Asian and Māori wherein stereotypes were used to understand how to interact with patients.
- Stereotyping and 'othering' patients are strategies employed in the face of transient encounters in the hospital. They lead to empathy and compassion in some instances but also appeared to reinforce misunderstanding of health inequities. Staff sometimes accounted for health inequities through problematic explanations of cultural difference such as particular ethnicities' ignorance of health. The use of stereotypes was a barrier to recognising the persistent societal problems that generate health inequities.
- Staff also reflected on how stereotyping of patients could shape clinical practice whereby patients were understood to respond to health conditions or treatments differently because of their ethnicity. These stereotypes demonstrate prejudice that can have very problematic outcomes for the treatment of patients, particularly in the resource-constrained health environment.

4.1.1 Encounters with 'mobile' colleagues

Collegial encounters in a particular hospital department took place across a vast range of personal and professional differences. Providing the appropriate care to patients involves a raft of professions working together at different times, including specialist doctors, social workers, mental health nurses, allied health professionals, healthcare assistants, registered nurses and nurse specialists and managers, while security guards, clerks, interpretors and cleaners also provide important non-clinical services. Due to the common alignment of gendered and racialised norms with occupational categories, as well as the internal diversity that exists within categories, these moments of contact and collaboration also involve interacting across differences in ethnicity, culture, gender, age and class. For some interviewees, working in the hospital gave them exposure to people with whom they would otherwise not have interacted. Diversity was spoken about fondly where the co-presence of difference created opportunities for learning. Kamal (RN) from India likened working in the hospital to travelling around the world and experiencing other cultures:

> ***"After coming here, I can experience Koreans without being to Korea, the Philippines, all those kind of experiences. It's a little bit of what you get when you travel, that kind of experience. People travel to get experience to different cultures and different people and I don't have to travel here when I'm in Auckland. I can experience all of that even though I don't see it. I can see all the people and experience culture and everything. That gives you a lot more understanding and things like that."***

The nature of the work, however, meant that interactions with fellow colleagues, as well as with patients (discussed in the following section), were often limited to work-specific interactions that were time-constrained. With the constant churn of patients, there was often little time for casual socialising in these collegial encounters. As Judith (MD, Pākehā explains:

> ***"It's not actually discouraged but I think it's a busy work day, obviously you go and eat your lunch but we don't have any breaks or anything like that. There's always the churn, so you wouldn't really sit around chatting because there's always more patients to see."***

The time and space for socialising is contracted by the constant movement and 'busyness' of the job, and Judith reflected on the fact that despite knowing a colleague from the Middle East for a number of years, she has "only occasionally" talked to him about things of a personal rather than professional nature. Opportunities for deeper forms of engagement across occupational boundaries were also difficult due to the different rhythms of movement. Both doctors and nurses, particularly those in the more junior positions, rotate regularly around various departments and areas within them. House officers and registrars spend three and six months, respectively, in a particular area before moving on to a different department or hospital, while the orientation for new nurses takes 12 weeks split evenly between two different areas. Many of the nurses spoke about this constant flow and movement of staff as well as the everyday mobility that hinders opportunities for social contact across disciplines:

> ***"...it just really depends on where and when they take their breaks. Doctors, they will take their breaks whenever they can. Nurses, we plan our breaks in terms of, 'Who's going next? Who's leaving first? You go for your break first.' There's always someone in the break room in terms of a staggered break, whereas five doctors, you will only see them spotted around. You can't actually catch the same doctor in the same time break. That's the main issue as well. It's like, 'I wanted to catch up with this doctor' but you can't really do it on the floor because he's busy, they're busy or she's busy." [Christine, RN]***

The frequent inflow of new staff into the department, particularly new graduates and migrant health professionals, contribute to the diversity of workers in terms of age, nationality and ethnicity. A large proportion of locally trained nurses are Pākehā while migrant nurses from overseas Asian countries make up around 40% of the nursing staff. The orientation process for new staff provides opportunities for getting to know other staff outside the immediate demands of the job. As one Pākehā graduate explained, even while rosters and shift work make it rare for him to be working with the same people regularly, going through similar processes during the entry year into practice helps to form friendships based on shared "struggles" and experiences:

> ***"There's a group of about four new grads that are six months ahead of me and they're really easy to get along with 'cos [because] they know what stuff I'm doing at the moment, where I'm at and what I'll be struggling with or what they found really helpful and are just a little bit more open to advice."***

Orientation for new graduates includes regular study days with the same cohort of people outside the hospital, increasing the amount of more stable time they spend together. While migrant nurses also share the experience of being new to the hospital, a separate, more accelerated orientation, however, splinters the two groups:

> ***"...only the new grads have gone through the same process that I would've gone through, whereas if you come from a different hospital, they have a shorter orientation time, whereas each area, I'll have to go into for 12 weeks, they'll go in and it's more accelerated. It'll be four to six weeks in each area 'cos [because] they're expected to know a lot more."***

While both groups are new to the hospital, differing levels of experience mean that their movement through the areas of the department are out of step with each other. This constrains regular opportunities for bonding between migrant workers and local graduates and thus also the potential for getting to know others on a deeper level. Where they do exist, interactions tend to be much more fleeting. As the same graduate notes, socialising with some of his Filipino colleagues is often "just chatting at the nurses' station" during the course of the work day.

More 'meaningful' forms of contact between graduate and migrant nurses may also be constrained by the different meanings associated with their arrival into the hospital. There was a general view that for local graduates, working in the department was more of a stepping stone to gain a few years of experience before leaving. Describing the "high turnover of nurses", particularly in the Emergency Department, another Pākehā nurse explained how "many are going over to Aussie for contracts... leaving to travel or... going on maternity leave or honeymoons". In contrast, migrant staff were often less transient and more inclined to settle in New Zealand after arriving. Christine described how Filipinos are "now the backbone or the furniture of our place because they are comfortable here. They're gonna stay here for maybe 10 or 15 years until their kids are grown up." The contrasting career paths of these two broad groups, associated with their age and stage in life, heighten differences between these colleagues. The differences also lead to preferences for different social events where, as another interviewee noted, annual staff social events tend to be divided between those who "go out drinking at the pub" and those who prefer to attend more family-orientated events such as BBQs.

Having the shared experience of not being from New Zealand did help to leverage some friendships among the diversity of migrant workers. But professional position and seniority in the hospital were also influential on top of age and life stage. Upward career mobility influence the types of interactions and relationships that people have and the spaces they occupy. Vanessa, a migrant from the UK in a leadership position, noted that the "couple of really good friends" she had were also in the "leadership group", though she had met them when they were all in more junior roles. The combination of being migrants, having kids, and in similar positions of seniority helped solidify their friendship regardless of differing ethnicities and nationalities. As Vanessa explains:

> ***"I think the fact that we see the issues with the health system in comparison to where we've worked and the issues with how slow things get done over here from a DHB perspective and trying to move stuff forward, just having that common ground of kids as well and having a life outside of work."***

But the opportunities for these similarities to facilitate deeper connections across ethnic and cultural differences were limited by the varying career mobilities often experienced by different migrant groups. From the interviews, it became evident that managers and leaders were predominantly white, though from a range of countries. One senior manager spoke about having some "girlfriends from here…[who are] all the same age and stage", but also noted that, "we are all still European, middle-class, white women". A couple of the Asian interviewees observed the relatively low number of Asian managers and leaders and feel it is more difficult for Asian staff to move up into these positions. This discrepancy in seniority between white and non-white staff creates conditions of contact that are structured by institutionalised power relations that make it difficult to interact as equals. In fact, for those occupying senior positions, social distance from their staff is actively maintained as they enact their professional identity with some intentionally removing themselves from the staff Facebook group.

Everyday contact with ethnically, culturally and linguistically diverse colleagues do indeed normalise 'commonplace diversity' (Wessendorf, 2013) in the hospital. But the varied mobilities of staff in terms of their occupational movements as well as career progression related to migration reinforce social and physical distances and create conditions of contact that are often transient and structured by uneven relations of power. Differences in age, life stage and seniority compound dissimilarities in ethnicity and nationality and lead to collegial interactions that are convivial and friendly but often relatively shortlived and superficial. Thus, the potential for developing deeper, more nuanced understandings of difference is limited in such encounters.

4.1.2 Categorising the 'Other' in transient encounters with patients

Interactions with patients from a vast range of ethnic, cultural, linguistic and socio-economic backgrounds were typically more transient than interactions between colleagues due to the need for clinical staff to attend to all patients efficiently. Despite the brevity, the frequency with which they were working with diverse patients, and needing to understand how to effectively do so, prompted curiosity and learning about different cultural norms and practices related to health. Equity and diversity training programmes (discussed in the next section), information flyers, as well as knowledge shared by fellow colleagues often aided the learning process. Interviewees gave examples of what they had learnt, including the culturally safe and respectful ways of providing care to Māori patients. Some also spoke about what they had learnt about Asian cultures. For example, Natalie, a Pākehā nurse, explained the concerns that patients from Asian backgrounds have around fevers and how she deals with the situation:

> ***"A lot of the things you learn on the job or from other people... Something I learned working is that for people from Asian background, that fever is such a huge thing that they stress about and patients always bring their children in with fevers. They stress so much and we're like, 'It's okay, we'll just give them paracetamol and they'll be fine.' I've been told that for their grandparents, it was a lot of people died from fevers in the past. Maybe it came with an actual illness and they say all the time, 'It's gonna fry their brain.' I'd never really thought that that was such a huge deal and a lot of people bring their children in. A lot of people from Asian backgrounds bring their children in with fevers and are very stressed about it. For me, I was like, 'Just give them Pamol.' That was something that I learned but I hadn't really known about."***

Acknowledging that patients from different cultures interpret health issues in dissimilar ways is no doubt useful in recognising that their experience of the world, which evokes their concerns, may be markedly different to one's own. But, given the power imbalance between staff and patients, there is also the potential for this to slide into a form of 'benevolent othering' (Grey, 2016) that overgeneralises a population. As we see from Natalie's comment, 'Asian' is seen as a homogenous group that tend to get particularly stressed about the potentially fatal consequences of a fever. Not only does this neglect the vast diversity of nationalities and ethnicities encompassed within the Asian descriptor, it also overlooks individual nuances and differences. With the constant churn of patients, the opportunity to engage with individual patients and to understand the nuances in how cultural conditioning manifests is constrained. Instead, in these transitory encounters, patterns observed in patients of similar backgrounds lead to generalisations about an entire ethnic group as a way to facilitate the assessment and treatment of patients' symptoms.

Other frontline clinical staff also engaged in benevolent othering as they sought to understand the health issues observed in Māori patients and to contextualise the poor health outcomes in these communities. Rosamie, a Filipino Allied Health worker, explained how the "very difficult life" that Māori have is the reason "why most of them, [have] got social issues" – an understanding that bears similarities with the way another staff member expressed empathy for the "rough upbringing" that has led to negative health outcomes:

> ***"I think everyone is very open and we see a lot of sad cases that come in here, that have had hard lives, that have impacted heavily on their health. We don't judge them for things they can't have helped. If someone's had a rough upbringing here, it's not their fault that they have a low health literacy and aren't looking after themselves properly. They don't know any better." [Douglas, RN, Pākehā]***

Showing empathy and compassion is necessary in allowing space to understand conditions that give rise to health issues and inequities. But without acknowledging how Māori and others have been disadvantaged by systems that benefit Pākehā world views and practices, the benevolence reinforces their marginalisation. Stereotypes are created with overly simplistic understandings of issues that overlook the complexity of the situations and the varied experiences of individuals within the group (Grey, 2016). Because their 'difficult lives' are understood to have led to their ignorance around health, Māori are effectively constructed as a disempowered other that needs particular help from the healthcare system and services. This benevolent othering also reaffirms the role and status of the healthcare worker who presumably, also, 'knows better'. While health equity programmes may educate staff on the broader context of the health issues that Māori patients may present with in the hospital, and in doing so, reduce judgement and blame, the surface-level utilitarian interactions between staff and patient leads to broad generalisations of Māori. Difference is reified and the lives of Māori portrayed as homogenous.

Inevitably, there were also times when patients challenged the authority of staff. Verbal abuse and racial discrimination from patients were not uncommon experiences, particularly – though not exclusively – for Asian clinical workers. A number of interviewees talked about patients being overtly racist and, in some incidences, demanding a different healthcare worker. The need to adhere to professional codes of conduct in these challenging interactions at times led to benevolent forms of othering. Explaining how he and some of his colleagues deal with racism from patients, Christopher, for example, emphasised his role as a nurse and the need to be understanding:

> ***"The thing that sets nursing apart from other professions is that if something happens to us, we have to understand that he is sick, even if they hurt us, even they violate us. We're always saying that he is sick."***

A similar approach to dealing with a racist patient by a junior nurse was relayed by another interviewee who witnessed the encounter and encouraged the nurse to report the issue. The nurse, however, convinced that reporting the issue was not going to help, rationalised the situation by saying "She's unwell, she's ignorant and she doesn't know. That's just her, you can't fix it." The racist comments directed at the nurse challenges the power dynamic between staff and patient. But by not validating the racism through officially reporting it, the nurse is able to portray himself as better than the patient who is "ignorant" and obstensibly "doesn't know". This othering allows the nurse to reinstate a sense of control in a situation where his professional obligation to be understanding and compassionate puts him in a relatively disempowered position in the face of verbal abuse and discrimination.

Patients seeking help in the hospital are typically in vulnerable situations requiring the skills and knowledge of the healthcare staff. With the need to make quick decisions about the health situation of patients, however, there were also incidences where stereotypes about culturally different patients were used to determine who gets attended to and when. Melanie, a Pākehā nurse, for example, relayed a situation in which comments were made about Middle Eastern patients by the senior medical staff she was working with:

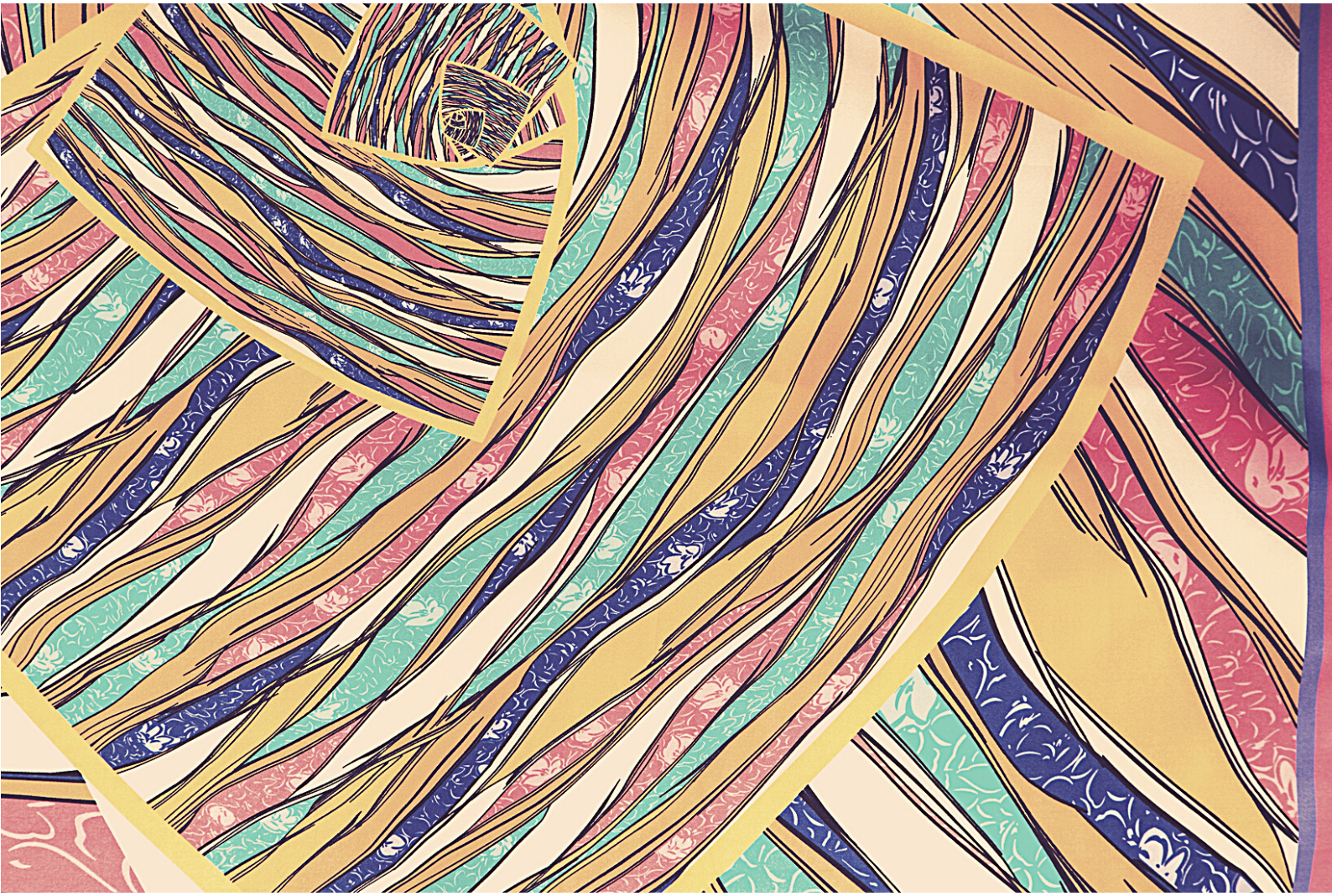
> ***"...I just put someone into resus [resuscitation] 'cos [because] she'd come in with severe abdo [abdominal] pain and she'd also had a period of loss of consciousness for 10 minutes in the car driving. I went to them and I told them, 'I've put this young girl in resus with abdo pain.' They immediately asked what race she was. I said, 'I think she's Middle Eastern.' They were like, 'Okay, dying swan.' I'm like, 'What do you mean?' She's like, 'Middle Eastern, they're dramatic. I'm not as concerned. It's lovely that you're not prejudiced but I'm not as concerned because typically, they're dying swans', which is a term that we use for dramatic patients."***

'Dying swan' echoed stereotypes made about other ethnic groups, including towards "Indian people" and how "they're gonna have a lot of pain", as relayed to us by another interviewee. In these examples, it is clear that regular, though surface-level, contact with patients from Middle Eastern and Indian backgrounds have led these clinical staff members to make broad generalisations. With the time pressures on staff, the stereotypes are used to assess the urgency with which to attend to a patient. However, the stereotypes also belittle and invalidate the patients' experiences of pain by casting all Middle Eastern and Indian people as other who have a low(er) pain threshold, assessed against an unstated and invisible norm. On top of the potentially serious consequences on health outcomes, these comments also highlight the limited capacity for transient encounters to facilitate any deeper understanding of the particular expressions of distress and pain by individuals from different cultural groups. Instead, the power relation between staff and patient lead to overly simplisitic generalisations of these ethnic groups before the specificities of the issues are seen in person and understood.

While the constant churn in the hospital provides opportunities for healthcare professionals to interact with a diversity of patients, the contact conditions constrain deeper, more meaningful encounters. Professional and culturally competent conduct that emphasises compassion and non-judgement (discussed in the next section) and the authority associated with different ethnicities, age groups and gender that intersects with or challenges the power dynamic between patient and staff member, as well as the transience of these encounters, give rise to benevolent, and not-so-benevolent, forms of othering. As a consequence, overly simplistic generalisations are made which reify categorical differences and create a distinct other. Thus, not only is the diversity of individuals within an ethno-cultural group neglected, the othering also reinforces social distances and constrains the possibility of understanding and respecting others as equal.

The findings demonstrate that meaningful encounters were contingent on: (a) multiple institutional structures and procedures, such as professional job descriptions, occupational hierarchies, career mobility, work pressure intensities, the make-up of rosters and work schedules, and ethnic diversifications in recruitment processes, and (b) individual characteristics and personal biographies that include both professional and occupational roles as much as personal backgrounds.

Thus, workplaces are more than inert settings where diversity occurs and workers are not blank slates whereupon new skills are learnt or substituted in place of old habits. Rather, each workplace is a unique setting. The complex institutional structures and procedures actively define possibilities for meaningful interactions among staff and patients. For this reason, diversity responses cannot sit alongside 'business as usual' as an add-on. Rather, the minutiae of everyday structural and procedural 'churns'/flows and the spaces it opens or encloses for staff and patient interactions must be scrutinised for the ways in which diversity encounters are shaped.



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4.2 OBJECTIVE 2: INSTITUTIONAL DIVERSITY POLICIES AND PROGRAMMES

The previous section highlighted the dynamic nature of multi-ethnic encounters in hospitals and its connection to routine structures and procedures. As suggested, the complexity of encounters have implications for the design and implementation of diversity programmes. The DHB places emphasis on creating culturally responsive institutions through specific diversity management policies but often these are designed with a singular focus on ethnicity. There are multiple diversity programmes at the DHB and each addresses the three main New Zealand minority groups: Māori, Pacific Island communities, and Asian/ethnic.

In this section we examine the strategic approaches to diversity for different minority groups at the DHB and the different objectives that underpin these initiatives. The underlying diversity objectives and goals for each minority group establish distinct practices and outcomes. Most explicitly, diversity policies for Māori centre on equity whereas for Asian/ethnic groups, they are framed as 'cultural competency' programmes with a focus on emotions as a means of addressing workplace diversity. Our findings further highlight the implications of emotions and cultural competency in the DHB's equity and inclusion diversity agendas.

KEY INSIGHTS: OBJECTIVE 2

- The DHB places a strategic emphasis on creating a culturally responsive institution. The focus on equity, diversity and inclusion is not uniform, however. There are specific plans and guidelines aimed at Māori, Pacific and other ethnic groups, respectively, but each has a distinct focus. Only Māori health strategies are mandated in formal policy.
- Policy programmes for Māori respond to the DHB's obligations under Te Tiriti o Waitangi with a focus on addressing health disparities. This focus on the rights of Māori and the centrality of Te Tiriti is distinct from the diversity agenda and strategies developed for other ethno-linguistic groups.
- Guidelines for Pacific health and wellbeing are holistic, community-centred and spiritually focused. Diversity strategies focused on the needs of other ethno-linguistic groups, effectively Asian and other patient communities, emphasise cultural sensitivity to reduce barriers to seeking help and service provision. This includes language translation and enhancing cultural competency of staff through training.
- There is no emphasis on rights, workforce participation or representation in leadership structures in diversity strategies for people from Asian and other ethno-linguistic communities.
- Diversity policies for Asian and other ethnicities centre on the the values, attitudes and skills needed to appropriately engage with colleagues and patients from different cultural backgrounds. In this framework, certain emotions, such as curiousity and patience, are deemed positive while others, such as frustration and embarrassment, are problematic. Through these emotions, staff are encouraged to be caring and compassionate towards patients and colleagues, to be good human beings.
- The limitations of emotions-led diversity include the following: (a) the emotions of some people are privileged over others; (b) the focus on emotions can overlook other structural inequalities; and (c) the training of appropriate workplace emotions often centres 'mainstream' New Zealand society and 'Kiwis' reinforcing the idea that some cultural groups are fundamentally different from 'us'.

4.2.1 Diversity policy: Strategic management perspectives

The DHB under study actively works to create culturally responsive institutional environments for diverse population groups that include both patients and their workforce. Their commitment to diversity across population groups is not uniform and encompasses different discourses.

In relation to Māori, the institution recognises the need to ensure 'health equity' as exemplified in the health disparities and in responsiveness to Te Tiriti o Waitangi commitments. To this end, cultural sensitivity entails integrating principles of tikanga into everyday healthcare practices, recognising, for example, the holistic nature of health, the customs surrounding death and dying, recognition of individual patients in relation to their whānau needs, and acknowledging the rights of Māori within the socio-political, cultural and environmental dimensions of health and wellbeing.

Alongside, the DHB is also committed to system-level measures as part of cultural responsiveness to Māori. This includes doubling the Māori workforce within the hospital by 2025, both within clinical and non-clinical roles, partnerships with Māori and iwi at the governance levels, and representation of Māori within the leadership structure of the institution.

The commitments to Māori echo notions of 'cultural safety' (kawa whakaruruhau).[1] As stated in a clinical practice manual, the DHB is committed to developing healthcare workers who "are sensitive to the needs of Māori people using health services" but equally also recognise "Māori custodianship regarding their rites/rights, needs and interests" (DHB Document A). Thus, as noted by the senior manager below, diversity for Māori is an agenda that is distinct from and incomparable to a generic set of 'diversity' strategies.

> ***"The Maōri population is a priority population for the organisation because it is different from other diversity groups. What makes it different is the Treaty, so the Maōri population is a priority because not only do they have priority from a needs perspective, they also have a priority from a rights perspective."***

[1] Cultural safety was first articulated in the 1990s by the Nursing Council of NZ and refers to practices "beyond cultural awareness and cultural sensitivity". Among its principles includes an understanding of the "power relationship between the service provider and the people who use the service" and "empowering the users of the service", "relating and responding effectively to people with diverse needs in a way that the people who use the service can define as safe", "recognising inequalities within health care interactions"(p. 9), recognise "their own realities and the attitudes" that they bring to their practice, and "evaluate the impact that historical, political and social processes have on the health of all people" (p. 10). The principles of cultural safety specificially require knowledge of the Treaty of Waitangi, specifically "critiquing the relationship between Maōri and the Crown based on the Treaty of Waitangi", and using Treaty-based models in practice. (Nursing Council of NZ, 2011.http://pro.healthmentoronline.com/assets/Uploads/refract/pdf/Nursing_Council_cultural-safety11.pdf).

Alongside, the DHB also has a special focus on Pacific communities, recognising the unique Pacific identity and sense of belonging in health and wellbeing. As noted in a DHB document, the DHB seeks to create an "environment that supports their [Pacific] identity and to make sure they have a sense of belonging which validates their Pacific identity " (DHB Document B), which underpins the DHBs effort to provide excellent care for all patients. This commitment translates into services that recognise holistic, community-centred and spiritually focused facets of Pacific Island health and wellbeing. At the workforce level, a range of strategies include the establishment of a council comprising elders to provide cultural advice, workforce development programmes, mentoring and spiritual leadership programmes, and representation at the senior leadership level.

The DHB also addresses cultural diversity in relation to other ethno-linguistically diverse communities – viz. those categorised as Asian and ethnic populations – who engage with the DHB as its clientele and its workforce. Guided by the Health Practitioners Competence Assurance Act (HPCAA 2003), the ethno-cultural diversity strategies centre around access to services: the identification of the barriers to seeking help, and the promotion of culturally appropriate/sensitive services.

In contrast to the vocabulary of rights, cultural diversity strategies focus on services such as language interpretation, availability of translated health information, and culturally matched caseworkers to address any inequities in healthcare access. It also includes adopting a set of skills broadly labelled 'competencies' that encompasses understanding and responding appropriately to culturally different beliefs and values expressed in a variety of situations. A senior staff member explained the objective of diversity programmes [2]:

> ***"The purpose of cultural competency training is to improve cultural understanding and awareness of different practices and beliefs and not impose one's own beliefs or practices or view or values on others... There is a need to be culturally aware and inquisitive and be mindful how we enquire and respond."***

Thus, cultural competency is about 'understanding and awareness' and being 'inquisitive and mindful'. These latter competency skills are imparted through training in structured situations using prepared resources, where staff are exposed to concepts such as ethnocentrism, unconscious bias, cultural stereotyping and cultural typologies. Simulated workplace situations are presented as part of the training to help staff to identify and learn appropriate culturally sensitive responses.

[2] As of July 2018, approximately 3000 DHB staff had completed preliminary levels of diversity training with an additional 2000 if NGO and primary healthcare workforce are also counted (interview, 2018).

In summary, strategic responses to managing diversity are distinguished by the underlying objectives for different minority groups. Initiatives for Māori and Pacific peoples do require staff to be culturally sensitive and competent, like for ethno-cultural diversity, but the knowledge and skills are supported by the more substantive focus on rights and equity with system-level measures particularly for Maori, which include efforts to ensure representation and leadership from the top-down.

4.2.2 Emotional labour in diversity management

As noted, the emotional dimension of encounters in the hospital are often foregrounded due to the circumstances under which the public require hospital services. Accordingly, institutional requirements for cultural sensitivity and competency when dealing with diverse patients are also, implicitly, requirements to practise emotional management vis-à-vis one's own emotional expressions. Cultural competence involves holding and exhibiting certain values, attitudes and skills relating to diversity rather than merely attaining culturally specific facts and knowledge. A DHB manual for diversity training, for example, emphasises positive attributes like tolerance, compassion, genuineness, optimism, patience, sensitivity, self-awareness, non-judgemental behaviour, respect and trust alongside problematic attributes like embarrassment, prejudice, avoidance and shame, which should be averted. These terms highlight emotionally contoured behaviours, indexing how staff should feel about others and how individuals might work on their feelings to construct a more culturally competent self. One Asian hospital manager gave the example of staff asking about other people's cultures to ascertain their preferences:

> ***"That is really culturally sensitive, you're offering an option, you're aware but yet you're not offensive. The purpose of the whole training is being more aware of people's practices and still do not feel strange in saying, "Are you not Chinese? Do you not practise this?" You need to be culturally aware but at the same time, be culturally inquisitive whether you got it right, reflect on your practice, how you work with your clients, your encounters."***

This positive rendering of cultural sensitivity highlights the responsibility of individual staff to work on their competence but also prioritises positive emotionally contoured expressions. As noted in the training manual, staff need not necessarily agree with or like different cultural beliefs and practices but it is simply expected that they demonstrate curiousity and responsiveness. In other words, staff should be inquisitive about difference but not express valuation of the differences that they learn about while also reflecting on their practices in each encounter.

Cultural competence is about having not only the right attitude but also the skills to manage emotional responses in relation to cultural difference. This aspiration for healthcare staff can also manifest as a striving to be "good human beings" who are "caring and compassionate" towards patients and each other, as noted by another senior manager:

> ***"What we're actually looking for and even beyond cultural competence [...] is strengthening our current and future [workforce], just to be good human beings. What we need more of is people who care about caring for other people and it's quite surprising that in a system like the health system, which is meant to be based on caring and compassion, that it's not always the case. I'm not only talking about caring for patients and whānau [family], I'm also talking about caring for each other. We'll never become a high-performance system if we don't have staff within our system that care about caring for people."***

The emphases on positive emotionality for cultural competency and being "good human beings" are constructed as core attributes necessary for the functioning of a healthcare system characterised by diversity. The limitation of positive emotions is that they can ignore or reiterate conditions of systemic marginalisation and exclusion.

Our data showed that behaviour-focused training reinforced the difference of some cultural groups, and constructed diversity management as an individual problem while overlooking the everyday forms of exclusion faced by minority groups. In the training documents,'Other' cultures were positioned as different from 'mainstream New Zealand society' and 'Kiwis'. In contrast to Western cultures, non-Western cultures – namely Asian, African and Middle Eastern – were portrayed as being more feminine, collectivist and hierarchical, and scenarios provided in training manuals appeared to be about how to accommodate them (in practice, these generalisations are used to encourage a conversation across differences). Unlike approaches to addressing Māori health inequities and gender diversity, which were both based on substantive notions of rights, equality and justice, accommodating 'other' cultures was largely about emotional competencies in collegial relationships. In effect, the realities of institutional race disparities that may be uncomfortable to highlight are masked by a focus on improving individual competencies. In training materials, staff are encouraged to monitor their own progress along a 'cultural continuum', shifting at one end from cultural 'destructiveness', through 'incapacity', 'blindness', 'pre-competence', 'competence' and finally 'proficiency'. Along with significant gaps in policies around recruitment, retention and career development for the Asian workforce or cultural support information,[3] the DHB's approach to cultural diversity articulates a clear message that any issues arising from this diversity can be overcome with individual diligence in learning cultural competency.

[3] As of July 2018, approximately 3000 DHB staff had completed preliminary levels of diversity training with an additional 2000 if NGO and primary healthcare workforce are also counted (interview, 2018).

Furthermore, though the agendas and emotional work articulated for cultural competency and Māori health equity were distinct, the privileged emotions of the white majority conditioned both their operationalisation in practice. Our data indicated how the desire of managerial staff to maintain positive colleagial relationships often resulted in responses to situations that appease the majority. This included reframing issues in order to avoid negative reactions from racial privileges being either explicitly or implicitly highlighted. One manager spoke directly about the importance of being "good at framing things" to have "constructive relationships". Another manager described his dislike of the term 'cultural safety' because of the ostensibly unhelpful reactions from staff:

> ***"I think it's [cultural safety] a bit like the word bullying, which has been a real problem for us. The risk is of it leading to labelling people or things which tends to set up an antagonism, which I don't find helpful in terms of resolving issues. That's more the issue but I don't think, technically, it's necessarily the wrong thing to be talking about. I think, when I go and communicate with somebody, if I go to them and say, 'We think you're culturally unsafe …' I've lost them by just saying that word. In the same way, if I go to one of my people who are having problems and say, 'People say you're a bully', I've lost them. I may as well not even continue the conversation, whereas if I go and say, 'There's a behavioural issue here, which is impacting on the patients in a way that could be better. What do you think?' then we've got a conversation where you can make something work."***

As both cultural safety and bullying are linked to ongoing power imbalances that enable the unsafe and bullying practices to occur, reframing the problems as "behavioural issues" side-steps any acknowledgement of privilege and, in doing so, individualises the issues.

Strategies used by those in managerial positions to avoid tension and discomfort in staff render the system that maintains racial privileges invisible. In upholding positive collegial relations, the deep power inequalities and conflict experienced by culturally diverse groups are downplayed. Little room is left for constructively challenging accepted, taken-for-granted normative practices that maintain inequalities and exclusions in the DHB.

In summary, the design intentions around diversity programmes entail the following key points. First, that cultural sensitivities for Māori are distinct from those for other groups, particularly in recognition of the political obligations around historical and current health disparities and inequities. Second, that cultural sensitivities for Asian and other minorities focus on linguistic barriers and practice grounded in improved awareness of own and other cultures. Alongside, in all instances, there is a focus on improved emotional responsiveness that, while effective for smoothing cross-cultural interactions, hinders progress towards a more inclusive and equitable healthcare system.

4.3 OBJECTIVE 3: ENCOUNTERS AND ENACTING DIVERSITY POLICIES/PROGRAMMES

In this section, we report on the way that staff at the DHB interpret and enact diversity policies in their everyday work environment. This analysis highlights if, and in what ways, diversity policies foster meaningful encounters at the hospital. Our focus is specficially on the way in which diversity policy and programmes for Māori (with an emphasis on cultural safety, equity and rights agendas) and non-Maōri (cultural competencies and awareness of own and other cultures) are interpreted and enacted by staff at the DHB.

Our interviews revealed that personal and professional biographies influence the way that staff interpret diversity programme goals. Staff do not merely reproduce cultural competencies in their everyday work environments; they 'translate' them. In other words, they add meaning to what diversity is and how it is to be enacted, coming from their own institutional, personal and occupational positions.

These factors go beyond simple identification with a cultural group. Instead, they include individuals' personal aspects of ethnic identity as a marginalised or dominant group (privileged/non-privileged) and their journeys and relationship to New Zealand, viz. whether staff perceived themselves as integral to New Zealand society and its values or if they positioned themselves as an outsider (insider/outsider), as well as the professional roles they hold in the institution (management/non-management). Depending on where individual staff were positioned on these dimensions, they interpreted diversity and translated it in their everyday work differently. Thus, Asian staff can be non-privileged insiders (New Zealand-born) or non-privileged outsiders (migrants), while staff of European identity can be privileged insiders (e.g. Pākehā) or privileged outsiders (overseas-born).

An overarching outcome of translating diversity policy in this way is that staff tended to 'blur' the distinct agendas for Maori and non-Maōri. This blurring is not intentional but reflects the complex and intersectional nature of identity in a diverse work environment, as we explain below.

In this section, we show how diversity is enacted through vastly different personal biographies. This is done through the stories of three staff – Jasmine, Chris and John – who are positioned differently in terms of being privileged/non-privileged, and in relation to being insiders/outsiders. We then go on to examine the impact of occupational and institutional roles on staff interpretation of diversity. Specifically, we compare interpretation of diversity policies at the 'management' level and on the 'hospital floor'.

KEY INSIGHTS: OBJECTIVE 3

- The diversity and equity agendas of the DHB are interpreted and put into practice by staff in ways that support their particular personal circumstances and backgrounds. There were notable differences in interpretations in relation to whether staff positioned themselves as insiders or outsiders in Aotearoa New Zealand, and whether they aligned their identities with privileged populations.
- These interpretations can contribute to a blurring of the distinct agendas that the DHB has around its Treaty obligations and equity initiatives on the one hand and diversity programmes on the other. Staff interpretations sometimes saw Te Tiriti as a basis for all diversity programmes even though the DHB makes clear distinctions; others framed Māori culture and health concerns as one of many equal types of needs; and some saw Treaty-specific training as problematic because it addressed structural issues.
- These different interpretations demonstrate that diversity training is not put into practice in uniform ways but rather reflects the particular position of staff in social hierarchies. In this way, diversity training does not have much effect on the existing relations of power and privilege that shape encounters with cultural difference in the DHB.
- Staff interpreted diversity programmes depending of their occupational position within the institution. Staff in managerial positions placed more emphasis on distinctions between different diversity and equity agendas and their potential impact on healthcare delivery.
- Staff in patient-facing roles, by contrast, were more likely to draw attention to specific culturally appropriate practices as the key dimensions of diversity agendas. These responses appeared to reflect the time pressure of the hospital floor where making small accommodations for patients can be a priority. The effect of this emphasis is further blurring of the more structural emphasis of the DHB' obligations under Te Tiriti and equity agenda and the behavioural focus of cultural competency.

4.3.1 Personal identities and translating diversity

We analysed staff responses to diversity based on their personal positioning as 'insiders/outsiders' and 'privileged/non-privileged'. Our data reveal that diversity is not interpreted as a pure and isolated concept, but instead in ways that reflects the individual's own personal and occupational positioning. This finding is demonstrated through the personal narratives of three staff: Jasmine, Chris and John.

Jasmine, a nurse at the DHB, was born in the Philippines but raised in New Zealand so she is both an 'insider' and a 'non-privileged' staff member. According to her, "growing up Asian [in Aotearoa New Zealand]... made a massive difference in terms of how I perceive things."

For Jasmine, all diversity efforts in New Zealand begin from Te Tiriti, as she notes, "The Treaty of Waitangi sets up a basis or a foundation for us as a stepping stone to widen our understanding." For her, the principles embedded in the Treaty, such as participation, must be applied to all intercultural interactions. Thus, for her the Treaty and other cultural diversity actions are therefore not "separate" but "essentially the same thing", as seen below.

> ***"Basically, although it's focused towards Māori, the Treaty of Waitangi rights, it's actually all throughout the whole population, [...] for all the other ethnic groups ... I think they're essentially the same thing, it's just being culturally aware and culturally sensitive .... I just don't exactly see it as separate, but I see it as a stepping stone."***

For Jasmine, therefore, diversity actions entail equalising outcomes for all minority groups regardless of whether they are Māori or non-Māori, in part reflecting her interests in deploying the Treaty in relation to her own minority status.

Christopher was also born in the Philippines but came to New Zealand as an adult following a five-year stint working in the Middle East. Thus, Christopher represents a 'non-privileged outsider'. His diverse cultural exposures have influenced Christopher's understanding of diversity; for him, all cultures and cultural difference must be addressed equally and notions of cultural safety, cultural competency, the experiences of Māori and non-Maōri are all interchangeable, if not the same. As he states from his nursing experience:

"Cultural safety, I've encountered a lot of this when I was in the Middle East because it's a very strict country. I'll always give you an example about two cultures. Let's start with the Māori culture. It has been taught to us that you never put your feet or any dirty things on the table, you never just touch the head, you ask permission 'cos it's disrespectful and then more sensitive issues. Then, for Arab Muslims, [...] if you're a male nurse, it's all right to look after a male patient but not a female patient but if you're a female nurse, you can look after both."

For Christopher, cultural safety is something he has encountered "a lot of ... in the Middle East". His explanation of diversity is largely focused on practice: it is an exercise in matching appropriate cultural practice to the patient presenting in front of him, which he learnt from his time working in the Middle East. In that sense, then, the historical and the socio-political dimensions of Treaty-based practice and specific issues of equity for Māori are lost as he blurs any distinctions between cultural competencies for Māori and for other groups.

John is Pākehā New Zealander, and so both 'privileged' and an 'insider'. He was born and raised entirely in New Zealand. He went to a school in an area dominated by Māori and Pacific Island children and saw himself as "the minority as a white kid there".

In his interviews with the research team, there were references to the insight that John had received from diversity training that helped him acquire an equity perspective in relation to Māori health outcomes. The training helped him shift from victim-blaming perspectives to being "less judgemental", so as not to "blame Māori for any of their outcomes and stuff". Along with insight from the diversity training he received, John also expressed his discomfort and resistance as a Pākehā at being positioned as part of the history of health inequities faced by Māori. In his interviews, he mentioned a Treaty training session he had done outside the DHB that centred colonisation's effect on health inequities (in a "challenging" way). As he notes: "No, I always think that, in some part, I think it is difficult being a Pākehā and carrying some burden of shame or guilt for that." Despite this recognition, he felt that historical blame placed on all Pākehā is counterproductive: "Hang on a minute, I didn't actually do anything." Treaty training, from John's position, should focus on empowering Māori and changing disparities, but he was less comfortable about the focus on Pākehā privilege and role in perpetuating inequity as a counter to Māori empowerment.

Overall, our analysis points out that individual staff interpretation is strongly related to their subject position. This suggests that the knowledge gained from diversity training is translated in ways that reinforces their place in social hierarchies. In some respects, this might reinforce rather than disrupt relations of institutional 'power privilege'.

4.3.2 'Management' and the 'hospital floor'

Our analysis focused also on the differences between management and staff who work in patient-facing roles on the 'hospital floor', highlighting institutional hierarchies and workplace roles in the translation of diversity.

We spoke to three staff members – Vanessa, Sue and Katherine – all in management roles in the DHB, and all from 'privileged' backgrounds but with different migration identities.

Vanessa, of North American origin, is a team leader of a health team. Thus, she is simultaneously 'management', 'outsider' and 'privileged'. She notes her understanding of diversity for Māori is that it is not about "just ticking a box" but rather about equity. She also recognises the unique place of the Treaty and the obligations it entails. As she notes:

> ***"... some of the reading and some of the discussions I've had since coming here, is that it's not about just ticking a box for Māori. It's about the fact that we've got this Treaty obligation and it's about trying to ensure equal outcomes to a group that we know for a lot of conditions and a lot of diseases already start in a disadvantaged way.... It's a comment that sticks with me, [...] a Māori health educator said, 'We don't have a Treaty with everyone else.' "***

Similarly, Margaret is a nurse manager and also an outsider, having migrated to New Zealand from the UK. She reflects on the Treaty training she received when she first came to the job. Initially, she was disappointed with the training she received because she had gone in with a particular idea of what she wanted: " 'This is [sic.] the things I want to learn' and this was not what was on offer." She was, perhaps, looking to learn a set of practices that could be applied pragmatically in real-life circumstances. It was only upon reflection later that she realised that the core of the Treaty training is something beyond practice; as she notes: "What they were trying to show me is this is what it means to be Māori."

Katherine is also a team leader and, as a born-New Zealander, 'privileged'. Her view of diversity training is that its main role is to facilitate changes in the way that work in the DHB is undertaken so as to ensure long-term positive health goals for Māori and Pacific people; that is:

> ***"I reckon they're [diversity courses] really important ... We know our Māori and Pacific people's health outcomes aren't as great as what other cultures are. We need to look at the way that we work in terms of diversity and what is it that we're not doing and what is it that we need to do to achieve those outcomes. It could be that we're culturally not meeting their needs."***

Katherine, too, reflects on diversity in relation to outcomes, not merely as a set of surface-level practices to be applied in different circumstances.

Despite being 'privileged', these three managers' relationship to diversity differs from John's above. Diversity for Māori is not "about just ticking a box" but about understanding disadvantage in a deeper way, especially in relation to the Treaty. Katherine and Margaret both refer to the need to create a "safe place" for ethno-cultural minority groups. Their particular interpretation may be related to their management role, where they are closer to, and can better align their interpretation with, the institutional discourses of diversity which emphasise an equity and rights understanding of diversity.

As a contrast to staff in management roles, we also asked patient-facing staff how they translated diversity in their everyday work environment. In response to our questions, interestingly, several staff relied on the same example of 'different coloured pillows', appropriate in Māori culture, to demonstrate cultural diversity in the wards. Examples of these excerpts include:

> ***"It would be more just about making sure you involve the family, I offered to involve the Māori health worker and stuff like that, making sure that you're only using the correct pillow, just for the head – not that we do in ED but if it's removal of body parts, you offer that it can be returned to the patient so they can do what they like to do with them." [Daniel, RN]***

> ***"Yeah, we can see differences, like pillowcases. Over there, it's very culturally inappropriate if I use a different colour pillow because we have got a blue and white. Over there, blue for leg and those body fluids when you use that and white is absolutely for the head, so that you can keep them both separate. However, in here, even in Māori culture, people from the same culture, they don't consider it as a big issue." [Kamal, RN]***

> ***"It's important to recognise that balance and boundaries, that different cultures have different needs. With Māori, you don't put the same pillow for the head as the feet and understanding that if you do, then you may get some backlash. It's little things sometimes that make the big difference in things." [Charlotte, RN]***

The reference to the pillow locates diversity as a set of culturally appropriate practices rather than as strategic efforts in equity and changing power disparities. The ready use of this example possibly suggests the immediate response by staff on the hospital floor where time and work pressures are intense. It might also be a repetition of specific skill learned during training. The end effect in either case is that by focusing on diversity as a practice, there is a blurring of the distinction between cultural competency and cultural equity outcomes within the DHB.

In summary, based on our data, the following conclusions can be drawn from this analysis. Broad categories of social identities – ethnicity, gender, class, language, age – do not predict how staff respond to diversity and inequality in the workplace. Instead, staff deploy their own unique positioning or personal biographies to translate diversity differently. A foremost finding is that staff translate overarching strategic policies based on their own personal investments in diversity and inequality discourses; i.e., whether they see themselves also as discriminated against, or on the margins seeking integration, or if their social position is challenged by equity. In the process of translating diversity from individuals' multiple positioning, there is a 'blurring' of the cultural equity and cultural competency agendas for Māori and non-Maōri, respectively, so that the distinction between them was unclear – Māori equity and rights assigned to cultural safety risk getting lost or diluted in translation.

The closest interpretation of cultural safety and cultural competency to the DHB's values seemed to be by staff in management. This may be explained by their ability to maintain a strategic distance from the everyday and immediate needs of culturally diverse patients, allowing them the opportunity to reflect on broader goals of the institution and of marginalised communities. Overall, these findings reiterate the need to closely examine diversity as an outcome of a close interplay of institutional, professional and personal aspects.

5.0 CONCLUSIONS

Healthcare workplaces are some of the most ethnically diverse employment settings in Aotearoa New Zealand, and in turn, healthcare provision impinges on diverse cultural values and meanings as well as being influenced by and reproducing societal inequities and power relations. Understanding how healthcare workers experience and enact diversity is thus critical to building insight into how ethno-demographic changes in Aotearoa New Zealand will affect people's lives as well as grappling with the difficult questions associated with providing healthcare that is inclusive and enhances wellbeing.

This report has provided an overview of the key themes that emerged in the research project Healthy Diversity? Urban diversity and the potential of workplace encounters. There are three key overarching findings that have emerged through this research and that provide a basis to identify key challenges for healthcare institutions in Aotearoa New Zealand, and also internationally.

Firstly, the character of encounters with diversity are heavily influenced by the broader structures and systems of the DHB. Staff are positive about the significant ethnic diversity they encounter amongst their colleagues and in interactions with patients, but the type and quality of interactions that people have are substantially influenced by their occupation and career stage. Encounters and relationships with staff from varied ethnic backgrounds were also shaped by staff experiences of entering the institutions wherein there were observed differences in the orientation and induction of staff coming through local graduate programmes and those of migrant background who had existing healthcare experience. Many clinical staff have undertaken diversity training programmes and can articulate key messages around the significance of cultural differences in values, attitudes and skills. The discussion of cultural diversity also often took on the form of stereotyping, however, wherein staff expressed understanding of colleagues and patients from different backgrounds that reinforced cultural differences and sometimes were given as explanations for differences in health and wellbeing that are actually associated with inequities.

Secondly, there is substantial variation in the way in which the DHB develops strategies and practices related to diversity, responsiveness to communities and equity. Anchored in its obligations under Te Tiriti o Waitangi, a significant emphasis is rightly placed on providing healthcare that integrates tikanga from te ao Māori, there are substantial workforce strategies for increasing Māori participation, and the DHB partners with Māori in governance and includes Māori in the leadership structure. The efficacy of these strategies and practices in addressing Māori health inequities is not the subject of this research (see HQSC, 2019). While strategies for enhancing Pacific peoples' health and wellbeing have some similarities to these approaches, the focus on cultural competency for other ethnic and linguistic groups differs notably. Rather than a focus on rights, equality and justice, cultural competence approaches have emphasised service delivery in a culturally sensitive manner that forgoes either structural changes or the inclusion of other ethnic and linguistic communities in DHB leadership structures. Emotions are a significant feature of these cultural competence approaches wherein staff exposed to training and guidelines are encouraged to manage their emotional expressions in relation to cultural differences in order to smooth relationships with colleagues and patients. While generating empathy in some cases, we also observe that the emphasis on emotions and behaviour can reinforce the differences between ethnic groups and sometimes reinforces the privileged position and emotions of dominant groups, namely Pākehā/New Zealand Europeans.

Thirdly, there is a notable blurring of the diversity and equity agendas advanced by the DHB, which has the potential to undermine their efficacy. Our research with staff demonstrated different interpretations of diversity policies and strategies that reflected both the socio-cultural position these staff held in Aotearoa New Zealand (in terms of ethnicity and upbringing) and in relation to their occupational position within the DHB (particularly in terms of managerial roles). Alongside the observation noted earlier that even empathetic approaches to diversity can be built around stereotypes, it appeared that this blurring diluted the more structural imperatives of addressing health inequities that are particularly significant to the DHB's Treaty obligations. Moreover, staff who are in patient-facing and particularly in high-pressure roles are often only able to incorporate quite specific practices focused on cultural sensitivity while the broader agendas associated with equity and diversity were less prominent. Staff in managerial roles appeared to have more time and space to articulate these broader agendas and their relationship to their role in the DHB.

These three key findings are not intended to form part of an evaluation of how the DHB operates and the efficacy of diversity and equity agendas, or to serve as a basis for specific recommendations. Rather, our focus in this research has been to contribute to broader knowledge on the way in which encounters with diversity manifest in workplaces, with the healthcare setting being one of particular importance given its staffing and patient make-up. Our conclusions, thus, relate more broadly to how diversity takes shape in relation to intersectional identity positions, the significance of emotions in the management of encounters with diversity, and the impact of policy translation on the enactment of diversity initiatives in the workplace. Nonetheless, the findings, and this research more broadly, do identify challenges that may be useful to the work of this DHB, as well as for other health providers and workplaces more generally in Aotearoa New Zealand:

1. To create enhanced contexts for encounters among people of diverse ethnic, gender, migrant and professional backgrounds, it is important to carefully scrutinise routine processes that inadvertently create homogenous institutional spaces in the hospital and that form a barrier to meaningful interactions.

2. Diversity training focused on behaviour and emotional management can be beneficial in enhancing staff understanding of ethnic, cultural and linguistic differences. However, without linked emphasis on structural inequities and power imbalances, including those that benefit majority groups of staff and patients, the outcome of diversity training can be a greater belief in and reliance on stereotypes about other people.

3. In workplaces with significant occupational variety and hierarchy, such as hospitals, diversity policies and practices need to take account of the different professional and personal positions that staff hold within the institution and how this influences their exposure and responses to people of different backgrounds.

4. Effective implementation of institution-wide diversity policies and programmes needs to take into consideration the specific work processes and conditions within different departments and the challenges they present.

5. There is a need to consider how approaches to diversity training and inclusion can be more substantively linked into structural changes in workplaces. Diversity policy is not only a matter of behavioural changes to enhance service delivery but also needs to influence all other dimensions of the institution to be effective – rosters, human resources, career progression and leadership structures.

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