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Strengthening public health contracting: findings of a follow-up nationwide survey from Aotearoa

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ABSTRACT

In 2010 and 2015 nationwide surveys monitored government management of public health providers. These surveys found evidence of inconsistent management which disadvantaged Māori providers, consistent with institutional racism. In Dec 2019 to March 2020 a follow-up nationwide telephone survey was completed. Public health units, primary health organisations, Māori health providers and non-governmental organisations with public health contracts responded (72%). This paper focuses on the findings about (i) contracts, and (ii) relationships. Descriptive statistical analysis was applied to quantitative responses and explanatory and combinatory analyses informed by thematic analysis were applied to qualitative data. The 2019–2020 quantitative data identified no statistically signficant variations. There was no evidence Māori provider experiences improved, but generic providers reported less favourable conditions. Qualitative data revealed providers remain dependent on individual managers and there was inconsistency across providers that could be addressed by transparent quality assurance. Māori providers were frustrated by contracting environments. They wanted to be recognised as Te Tiriti o Waitangi partners, with flexibility, certainty of investment (longer contracts), support (infrastructure investment) to be able to meet the high needs of their communities. This nationwide survey was completed prior to the current health reforms but implications are considered for the Māori Health Authority.

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Introduction

Under Te Tiriti o Waitangi (a foundational document of the colonial state in Aotearoa), the Crown (government) has responsibilities articulated within the *New Zealand Public Health and Disability Act 2000*, and other policy documents (Ministry of Health 2020), to uphold and protect Māori health (Durie 1998). However, these obligations have failed to manifest as ethnic health equity and the burden of disease lies disporportionately with Māori (Cram et al. 2019).

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Research has shown Indigenous people frequently receive lesser quality and quantity of care from colonial health systems (Anderson et al. 2016; Cormack et al. 2020). Racism is internationally recognised as a critical modifiable determinant of health inequities (Williams et al. 2019; Talamaivao et al. 2020).

In Aotearoa, key agencies such as the Ministry of Health (2020), the Health Quality and Safety Commission (2019) and district health boards (DHBs) agree there is racism within the administration of the health system and this is well-documented (Harris et al. 2019; Anderson and Spray 2020; Hunter and Cook 2020; Talamaivao et al. 2020). We define institutional racism as patterns of behaviour, that involve differential treatment of Māori providers resulting in racial disadvantage (Came et al. 2017).

Findings from the WAI 2575 Waitangi Tribunal (2019)[1] investigation into breaches of Te Tiriti within the health system, noted a systemic failure to deliver effective health services to Māori whānau (extended families).

> The Crown's failure to abide by its Treaty obligations, and ensure that its agents and the health sector as a whole are doing the same, has contributed to the dire state of Māori health outcomes. It cannot continue to evade its obligations … the health inequities experienced by Māori compel an urgent, and thorough, intervention. (163)

In 2021, the New Zealand Government accepted the need for change that was articulated in the WAI 2575 Waitangi Tribunal investigation and agreed to a substantial reform of the New Zealand Health and Disability System. Including the establishment of a Māori Health Authority that would lead hauora Māori in the health and disability system alongaside a new public health entity and Health New Zealand (Department of Prime Minister and Cabinet 2021).

Our earlier study (Came et al. 2017) quantified racism within public health contracting by comparing data from different groups of health providers. Length of contracts, intensity of monitoring, compliance costs and frequency of auditing were found to be statistically significant sites of discriminatory differences reported between generic and Māori health providers in their treatment by funders. Internationally, Indigenous health providers face challenges with disparate policies and underfunding that impede their full ability to meet the needs of their communities (Baeza and Lewis 2010).

Oakden et al. (2020) used complexity theory as a pathway to improve contracting and enhance equity. They recommended contracting be more relational and entail joint learning by funder and provider, with a focus on community service, arguing that rigid legal and accounting-informed approaches discourage innovation.

Gifford et al. (2018) found contracting, when practised as a time-bound, formalised, prescriptive process predicated on compliance, had limited intersection with Māori world views. High-level outcomes-based contracting, as practiced by Whānau Ora Commissioning agencies, seemed more promising for Māori providers who:

> … continue to juggle multiple contracts and experience 'report fatigue', despite state resolutions, initiated almost a decade ago, to simplify contracting. The potential for 'unbundled' contracts and of cross-sector and 'high trust'contracting remains far from being realised. (63)

Whānau Ora (Whānau Ora Taskforce 2010) is a major Indigenous-led social policy initiative designed to build the capacity and capability of Māori whānau. Strengthens-

based approaches and Indigenous values have been critical to its success and Boulton (2019) advocated leveraging Whānau Ora commissioning across the public sector.

With the election of a centre-left government in 2017, major health system changes were proposed (Health and Disability System Review 2020), resulting in restructuring the Ministry of Health, the appointment of a new Director-General of Health, a sector-wide review of the health and disability services. A Māori select committee enquiry into health inequities (Māori Affairs Committee 2020) and investigation of mental health and addiction (Government Inquiry into Mental Health and Addiction 2018) added to calls for transformation of the health sector to address ethnic inequities.

Futher changes occurred under the Labour-led Government with a major Health and Disability System Review and the Waitangi Tribunal WAI 2575 inquiry, the outcomes of which are now driving major health and disability system reforms (Department of Prime Minister and Cabinet 2021).

Given the dynamic state of the health system, it was timely to resurvey providers to determine their experiences of public health contracting, particularly Māori providers. We investigated racism embedded in contract length, intensity of monitoring, compliance costs and auditing frequency.

Methods

This survey is part of research focussed on monitoring and strengthening public health policy and funding practices to enhance equity and eliminate institutional racism. An initial nation-wide telephone survey of public health providers carried out in 2010 (Came 2012) was expanded and repeated in 2015 (Came et al. 2017). This survey consists of qualitative and quantitative elements, refined from earlier versions, designed to track racism and Crown engagement with Māori providers.

Details of providers (public health units (PHU), primary health organisations (PHO), non-governmental organisations (NGO) and Māori health providers (MHP) with public health contracts) were obtained from the Ministry of Health. Over the recruitment period (December 2019 through to March 2020), these were approached via telephone and email and 129 of 179 (72%) agreed to participate. Thirty-six declined to participate explaining they were undergoing restructuring, were in current contract negotiation, or were responding to the beginning of the COVID pandemic. A further 14 providers could not be contacted; nine responses, from Pacific providers, were removed from this analysis as the point of comparison was between Māori and generic providers; and one provider was removed given it had no present contracts on which to base further responses. This left 119 responses reported here.

PHUs returned a response rate of 55%, the NGO response rate was 82%, 68% of PHOs replied and 85% of Māori providers (including Māori PHOs) responded.

Ethical approval was granted (AUTEC 19/271) and informed consent was obtained from providers participating in the 15–20 min telephone survey. The instrument included details about the provider (size, type, funder), contracts and service delivery (contract length, monitoring, transaction costs, auditing, cost of living adjustments and discretional funding), relationships and influence. Generic providers were asked about their engagement with Te Tiriti o Waitangi (Kidd et al. 2021).

Quantitative data were cleaned and descriptive statistical analysis applied with comparison between Māori and other providers, with Chi-square (signficance $P < 0.05$) assessing differences between groups. Led by the Māori team member, analyses of open-ended responses in the survey were separately examined using explanatory and combinatory analyses (Jansen 2010), informed by Braun and Clark's (2006) thematic analysis. Exemplar excerpts, short quotes and data syntheses describe features of the qualitative materials and constitute our analysis of pattern and variation in the data set. Direct quotes from participants have been italicised and the providers deliberately not identified. We end the findings with a Māori provider's final comment to amplify Indigenous voice.

This interpretative approach was informed by critical understandings of anti-racism. We introduce ourselves so our standpoints are transparent to the reader (Cram et al. 2018).

HC is tangata Tiriti (a person of Te Tiriti), an activist scholar with expertise in institutional racism, Te Tiriti application, and critical policy analysis. Her professional background lies in public health.

MB is Māori, with connections to the northern most tribes in Aotearoa. She works with her people to strengthen Māori hauora. She has a special interest in Māori mental health.

BM is a Pākehā who holds an academic joint appointment between a tertiary education provider and a regional forensic mental health service. He has extensive experience in undertaking mixed method research.

TM is Pākehā working in a Māori public health research unit. He has a history of critical, qualitative, discursive investigations of racism, health disparities and Te Tiriti centred scholarship.

Results

The findings are presented in relation to MHP versus other providers (PHOs, PHU and NGOs) experiences of contracting and relationships with funders, with the quantitative analyses followed by the insights available from the open-ended qualitative data.

Contracting, monitoring and auditing

There was no statistically signficant difference between MHP and other providers as to whether they had received a contract in the last five years. The length of the most recent contract was less than two years for a third of providers. Monitoring for the majority of providers occurred within a one year cycle. A third of both samples found the monitoring processes burdensome (Table 1).

Contract length

Open-ended responses from MHP confirmed that the length of contracts remains a contentious issue. Short-term contracts led to uncertainty in workforce retention, strategic planning and achieving meaningful outcomes in an annual timeframe. Several MHP indicated their desire for high-trust, multi-year contracts with adequate resourcing to enable effective delivery to Māori.

Table 1. Contracting, monitoring and auditing.

Item	PHU/PHO/NGO ($n = 84$) n (%)	Māori providers ($n = 35$) n (%)	X^{2*}	p-value
Contract with the MOH within the last 5 years	79(94)	34(97)	.494	.48
Contract with a DHB within the last 5 years	44(52)	22(63)	1.098	.3
Length of most recent contract >2 years[a]	30(36)	10(29)	.486	.49
Monitoring in less than one year	66 (79)	24(69)	1.340	.25
The monitoring process is somewhat or very burdensome	38 (45)	12(34)	1.216	.27
Auditing is frequently occurring	58(64)	22(63)	.430	.51

*df = 1.
[a]Missing data = 2.

> It leaves me with a feeling of can I trust you? It leaves me with a feeling of why isn't there a higher level of transparency here, why aren't we being trusted to be an equal partner at the table?

However, some MHP felt funders lacked an appreciation of inequities and Māori capacity and capability of addressing these if resourced appropriately.

> There needs to be an understanding by the funder that our connection with the community allows us to know what they really need. We understand there are procurement processes – but we need to be able to respond to the issues facing Māori.

Some generic providers shared the frustration in regards to short contracts and the administration burden and human resource implications, noting that over time they perceived the length of their contracts had become shorter. Others reported delays in contract confirmation. One provider shared it took seven months to negotiate their one-year contract, which meant they were under pressure to deliver 12 months of work in five months. Another generic provider noted:

> We had a point where our contract had expired technically and we were on a month to month roll over, which was incredibly stressful and we actually hadn't been paid for a six month period.

Roll-overs and variations in contracts were reported as commonplace with providers reporting automatic renewal for as much as 16 and 30 consecutive years. PHOs continue to have open-ended contracts with DHBs. While, Healthy Family (Ministry of Health 2021) contracts were generally for four-years.

Performance monitoring

Most public health providers continue to engage in six monthly reporting to Ministry, with quarterly reporting to DHBs. Receipt of these reports is usually acknowledged by email and feedback is sometimes provided via email, and/or a phone call and/or a site visit to discuss the report.

Some MHP reported regular face to face visits resulting in constructive feedback and exchange. One provider noted *they loved the scrutiny and the feedback*, while others recognised the usefulness of monitoring as a *learning opportunity*. Others noted less frequent visits after the centralisation of Ministry staff.

Some MHP experienced monitoring as a *tick box exercise* or *robotic* and *fatuous* processes. Others felt *micro-managed* which they experienced as a lack of trust, while for

others monitoring was rare unless there were problems. Some believed reports were not read. One explained:

> It's almost like a non-event, you send it off and you don't get anything back. It would be preferable to have some feedback.

Some MHP noted the orientation of the monitoring process was in tension with their holistic kaupapa Māori service model. Consistently MHP reported monitoring *depend [s] on whom is on the other end* with some managers experienced as *more sensitive to the needs of Māori communities than others*.

Many of the generic providers found monitoring *straightforward*. They acknowledged reporting was labour-intensive, but felt it was *pretty fair and reasonable* given they were being accountable for government funding. They noted processes had improved over time and provided the funder with benchmarks of service performance. Some described it as *fairly routine and there is a well defined template which we fill in*.

Others experienced monitoring as *formulaic*, or showing *what they got for their money*. Several generic providers described monitoring as *hit and miss* or *draconian,* while others felt micro-managed and wanted to be *left to get on with it,* if they were going well. There was criticism of the limited feedback on reports, which some felt were not acted upon. One generic provider noted:

> [the] only time that we ever had any engagement or report monitoring was when the MAPO (Maori Purchasing Authority) was in place and as soon as that went, we've had no other monitoring.

Formal auditing

Several MHPs welcomed auditing and external acknowledgment they were delivering the best possible service to whānau and contract obligations were being fulfilled. Many MHPs shared the perception they had a disproportionately high audit burden. Others noted central government began to co-ordinate auditing, which reduced the auditing burden. MHPs reported funders requiring them to pay auditors historically, something funders had done.

Some MHPs detected a tension between Western audit tools and the realities of delivering a kaupapa Māori service. Some reported getting auditors that *don't really understand what it means to be a Māori provider, the way we work and how we do things.* Another shared their focus was on building capacity through whānau, hapū (sub-tribe) and iwi (tribe). However, when they were audited, the focus was on finances and staff compliance, rather than the outcomes and successes. One noted:

> I think the auditing compliance is over the top and they come in and they want a cultural approach, so they audit our cultural provisions. We're a kaupapa Māori organisation, so I've said to them, that's fine, but in the same way you bring in accountants in terms of looking at our financial documents I expect a cultural expert to come in here to look at the cultural aspects.

Some generic providers described auditing as a *reasonable requirement* in exchange for funding. A number of providers had regular internal and external audits independently of their funders, as part of their quality assurance processes. Some described health funder-led audits as *fair, objective,* and *reflective,* while others spoke of valuing the

transparency and accountability. Among other positive comments one provider described a recent audit as *beautiful* reporting; that it helped build the capacity and capability of their organisation.

Several providers maintained there was a centralised auditing schedule that funders adhered to, but others contradicted this, indicating they had not been audited in years.

> I don't feel they need to do an audit, we have a comprehensive budget, outgoings expenses etc. My feeling is that they probably haven't felt the need to, but it's probably good practice.

Another provider interpreted this absence of auditing as an illustration of a high-trust relationship.

Others found the process intimidating and anxiety-provoking, with *unreasonable* timeframes and inflexible demands. One provider shared that the approach taken by the auditors was such they felt they had to prove that they had not misappropriated funding. One provider raised concerns with the Minister of Health about a public health issue and in quick succession, that same Minister ordered an audit on their contract.

Funding

Compliance costs

Providers were asked about compliance costs for their contracts; that is the expenditure of time or money required to conform with Ministry requirements related to contracts. Almost half of MHPs and generic providers perceived the financial arrangements entailed in contracting to be burdensome and there were no significant differences between them in terms of additional funding (Table 2).

MHPs rarely had the opportunity to negotiate contracts, as the Ministry usually prescribed service specifications and rolled contracts over. Reporting and performance monitoring become the main compliance costs finanically. *We have it down to a fine art.* Other times there were tensions with what was valued culturally through these proceses.

> The main problem that we have is when the contracts are offered to us, there has been little thought about how they fit into our organisational structure. No infrastructure funding (is provided). It is not partnership, its just supporting their initiatives with inadequate funding.

Generic providers found compliance costs were *not proportional* to the value of contracts. *It is something you're just obligated to do*. Others wanted a management fee to

Table 2. Contract funding.

Item	PHU/PHO/NGO ($n = 84$) n (%)	Māori providers ($n = v35$) n (%)	X^{2}*	p-value
Contract compliance costs are somewhat or very burdensome	37(44)	19(54)	1.039	.31
Little or no access to discretionary funding received in the last 5 years	64(76)	26(74)	.049	.83
Little or no success in receiving discretionary health funding in the last 5 years	65(77)	30(86)	1.006	.3

*Df = 1.

cover the signficant administrative costs of reporting and one-off costs of setting up new programmes. Some noted that compliance costs rose when health funders reviewed a particular area, as they requested additional information often in short-timeframes.

Cost of living

Providers were asked if they had accessed cost of living adjustments in the last five years and reported inconsistencies in obtaining the funds. Some were offered increases, some had to request them, and others had received nothing for more than a decade.

Many public health providers reported struggling to maintain services, due to the lack of government investment. One described no funding increase in twenty years of service delivery, saying *at the end of the day something has gotta give,* struggling to meet the contract expectations and running a sustained deficit. Other providers spoke of managing the short-falls through charities to provide essential public health services. Another worried about broader impacts of austerity on public health, which requires community engagement:

> it takes along time to build up knowledge and expertise in the field and [when] you lose people you lose more than a person. They take a lot of intellectual knowledge with them, which is hard to replicate … that is a threat we have to live with.

One provider described this provision as a *bone of contention* that amounted to an effective decrease in funding over time, as costs such as staff salaries rose. PHOs continue to get annual adjustments called 'future funding' tracked at the discretion of their DHBs.

Additional funding

Several MHPs accessed capacity and capability building funds through the Māori Provider Development Scheme (MPDS). This fund facilitates equitable participation in the delivery of effective health services (Ministry of Health 2020), via organisational and workforce development opportunities. MHPs reported reliance on MPDS and some secured funding from Te Puni Kōkiri (Ministry of Māori Development), Ministry of Social Development and local trusts.

The lack of flexibility and responsiveness of funders to MHPs aspirations was identified as a major barrier. Several reported wanting the opportunity to access appropriate levels of funding and support to meet the needs of their community, without burdensome procurement. *We want to give meaningful effect for our community beyond the service specifications.*

Several generic providers reported accessing one-off funding when they could evidence a community need. One provider secured funding after completing an evaluation that informed a budget bid. Another described *working in a frozen funding environment for a decade now,* while others reported that their DHBs were in deficit, so funding for innovation was short and most new money came through requests for proposals. Despite this climate, many providers persisted in pitching new programmes directly to funders and found these were supported where there were positive relationships with portfolio managers, or in times of crisis.

Relationships with funders

Quantitative data on provider access to funders and representation on advisory groups showed no statistical difference across generic and MHPs, with both expressing general satisfaction with access to MOH and DHB staff. Approximately half of both groups were involved in an advisory capacity to DHB, but both indicated that involvement in this capacity with the MOH was limited (see Table 3).

Ministry of health

Continuity of portfolio managers remains a problem for all providers dealing with the Ministry. *It is complex as Ministry restructures and changes. Changes affect connections*. This represents a profound loss of intellectual and historical knowledge and makes it difficult to form meaningful relationships. There was a shared perception that managers were stretched, which made access difficult. Frequently when managers exit, outgoing Ministry staff are unable to provide a new contact for the provider.

MHPs reported variable relationships with funders, complicated by having to deal with multiple Ministry portfolio managers. Some described relationships as *open*, *responsive* and *transparent*. Regular kanohi ki te kanohi (face to face) contact was valued. It was positive when managers *wanted to listen and understand our perspectives* or *when we can say what we need to say*. It helps when the manager is *passionate* about Māori health or is indeed Māori themselves.

Several providers reported a *disconnect* between portfolio managers and other policy and leadership staff of the Ministry; who were seen as *stuck in a timewarp*, missing the big picture in terms of Māori health. Others described the Ministry as transactional rather than relational, citing a nationwide public health function that was centrally funded, devolved to DHBs, resulting in a change of providers, which increased inequitable outcomes. One provider noted:

> They look to the bottom line and where they can cut and what is behind them. How they write it down in their books makes them feel better. That is what happened in [removed to protect provider], we are back at square one and trying to get [community engagement] rates back up again.

MHPs raised concerns about the implications of the Ministry not understanding how to work with whānau. They felt this lack of knowledge would be bridged by strengthening relationships with MHPs, rather than *dealing with us at arms length,* forcing the use of official information requests and formal complaints to the Minister.

Table 3. Contract relationships.

Item	PHU/PHO/NGO ($n =$) n (%)	Māori providers ($n =$) n (%)	X^2*	p-value
Access to MOH public health staff is satisfactory[a]	58(74)	36(79)	.247	.62
Access to DHB funding and planning staff is satisfactory[b]	33(75)	16(80)	.192	.67
On a MOH advisory group last 5 years[c]	16(20)	5(15)	.330	.56
On a DHB advisory group last 5 years	35(42)	17(49)	.479	.49

*df = 1.
[a]Missing data: Only applied to $n = 111$
[b]Missing data: Only applied to $n = 64$.
[c]Missing data = 5.

Some generic providers described their engagement with Ministry as positive, accessible, collaborative, responsive and excellent; pro-active open-door relationship, where there is a two-way process of reflection and the ability to adapt to a changing environment. Others felt managers could elevate local perspectives and experienced engagement as a true partnership, where they could innovate and engage in co-design. Some reported strong access to anyone from the Director-General down, while another had a senior Ministry representative on their stratetgic leadership group.

Several providers noted that public health (pre-Covid19) was not a priority for the Ministry, making it difficult to advance issues. Constant restructuring made it difficult to get responses from managers. Some providers were actively discouraged from making direct contact with Ministry staff and encouraged to go through their local DHBs. For some, this meant *delivering on a contract with limited information and at times a complete lack of direction or communication*.

District health boards

DHBs usually consist of a provider arm and a corporate funding and planning arm. There is often some separation between the two, but PHU structurally have close relationships with their DHB funder to the extent some of them work out of the same office and have shared reporting lines. *We work alongside each other … we share a tea room.* Some generic providers reported *positive* relationships and noted improvements in engagement. They described their relationships as *supportive, approachable* and *workable*. The DHB provided a *listening ear,* but their ability to act was limited.

A number of generic providers found the DHB *responsive* and that they proactively kept them in the loop in relation to planning. Some reported mutual respect and *healthy debate* that ensured *transparency* and *openness*. A number of the managers interviewed for this survey disclosed they had previously worked within DHB funding teams, so had long-standing relationships.

Some generic providers reported *dysfunctional, inadequate* and *strained* relationships with funders. There was complexity in dealing with more than one DHB. The relationship was a contractual one, rather than a partnership where you work to achieve outcomes together.

There was a perception by some that the DHB favoured their own provider arm (PHUs). Several generic providers reported a negative dynamic:

> I think there's still an element of a big brother type, master servant type relationship with the DHB … for example, we faced a claw back on one of our contracts, … there was just absolutely no negotiation at all around any of the issues and difficulties that was going to cause us, including all of our responsiblities then to our sub contractors … that was really difficult, but we have worked really hard at trying to move that relationship forward in the last couple of years.

MHPs reported being proactive at developing and maintaining relationships that could withstand robust discussion. Some noted the managers might benefit from engaging in deeper whanaungatanga (active relationship building) and attending public health events, so they could see programmes in action and understand more deeply the needs of whānau.

MHPs had variable relationships with DHBs. Some reported *strong* or *excellent* relationships, particularly with DHB Māori health teams. Some felt confident their

portfolio managers *carried their voice forward,* but they knew their funders' financial *hands were tied*. At times, portfolio managers agreed to adapt service specifications, so programmes could be *fit for purpose* for the local community. The consistent refrain was *It all depends on the portfolio manager*.

Staff turnover within DHBs was problematic and negatively impacted relationships. Several smaller providers reported that under the National-government, DHBs had attempted to get them to amalgamate with others to increase efficiencies, which led to difficult dynamics. One provider explained:

> They tried to kill us off. They said "we don't have issues in terms of service delivery milestones". They said "we weren't a viable business so [tried to] exit our contract".

Some MHPs characterised the communication as one-way engagement when the DHB wanted something. Others reported short-notice appointments from DHB staff.

Advisory groups

MHPs had variable involvement in Ministry and DHB advisory groups. Some were consistently appointed. *The DHB does like to use the expertise of my staff*. Others raised concerns about the lack of transparency over who was recruited to such committees and who they were representing. *We participate when we think there is a need*. Māori voice at the table locally, regionally and nationally was considered important, particularly the evidence-based insights Māori bring about community needs and aspirations. *We should be at the table more*. Sometimes small rural providers were invited, but didn't have capacity to participate. For those who released staff to committees, they frequently wanted greater recognition of this unpaid work. Some also expressed the importance of partnerships based on Te Tiriti and authentic representation of Māori.

Generic providers reported inconsistent representation on advisory groups. Smaller local providers had limited involvement in national steering groups, while PHO and PHU staff were often appointed to DHB committees. *It's always the same types of stakeholders around the table*. National NGOs were often called on to share their technical expertise in advisory groups. Other providers were keen to get involved in this strategic area. One noted *Only just appointed recently after pushing for it*.

Māori provider final comment

Within the survey, MHPs were given the opportunity for a final assessment of their experiences of their Crown funders over the period 2015–2020. Some wanted a clear commitment to implement the recommendations of the WAI 2575 report (Waitangi Tribunal 2019) and sought a Māori-led health system.

> I think that the system is beyond redemption. The racism is so embedded in the culture and the minds of the people that work within it they are beyond change. There is not enough will from people in the sector. We are overdue for a Māori owned and operated system of health delivery and services.

Some were seeking more robust recognition of Te Tiriti and expressed concerns about funders *lack of commitment to addressing ethnic health inequities*. They wanted to see more authentic engagement with MHPs.

> We would like a genuine partnership instead of the ridiculous system the Ministry follow. It is a tick box consultation.

MHPs noted there was a *lack of flexibility within the system* around contract lengths, which made it difficult *to future-proof their organisations*. Others noted the amount of *unpaid work* MHPs undertook to serve their people. They wanted the flexibility to *respond to the need* they observed on the ground. The contracted environment needs to be transformed:

> we don't silo out conversations about sexual health, nutrition, and physical activity. We design programmes that cover off all and report on them separately.

Discussion

There was a strong response rate to the nationwide survey despite the demands on public health providers in the later stages of data collection, as they prepared to respond to the COVID 19 pandemic. In contrast to the 2015 nationwide survey, the 2020 survey, which was substantively the same survey tool, questions and protocols, found no statistical difference in treatment of Māori and generic providers. However the 2015 and 2020 findings showed no improvements in the experience of MHPs and that the generic providers reported less favourable conditions and outcomes (Table 4). While these changes created an equivalence in 2020, it is one that has masked the systemic problems and sustained the instutitional racism experienced by MHPs.

There are opportunities to improve public health contracting practices that would benefit all providers.

MHPs and generic providers were united in wanting longer term contracts ideally 3–5 years. Shorter contract timeframes put staff and providers in precarious financial

Table 4. Comparison public health provider nationwide survey 2015 and 2020.

	2015	2020
Contract lengths	Māori had shorter contracts	Ethnic equivalence across providers. This still presents a risk to some Māori (and other) providers.
Contract auditing	Māori had more frequent auditing	Ethnic equivalence of auditing. Māori sought cultural competent auditing
Contract monitoring	Ethnic equivalence in frequency of monitoring. Māori reported higher intensity.	Ethnic equivalence. Māori providers reported variable experiences.
Portfolio managers	All providers concerned staff turnover. Māori more likely to describe negative experiences.	All providers concerned staff turnover. Variable experiences from exceptional to non-existent relationships.
Compliance costs	Māori perceived higher costs.	Ethnic equivalence. Unless proportional disadvantages smaller providers.
Cost of living adjustment	Ethnic equivalence in variable access. PHOs were outlier with cost of living adjustments.	Ethnic equivalence. PHOs remain outliers with access.
Access discretionary funding	Ethnic equivalence	Ethnic equivalence. Waitangi Tribunal (2019) continues to show chronic underfunding of Māori health.
Representation on advisory group	Ethnic equivalence	Ethnic equivalence in representation. Related research (Came et al., 2019) has found racism on health advisory groups.

(Came et al., 2017).

positions that affect service sustainability'. Providers shared a frustration that the funding of public health services appeared to be impacted by the three-year political election cycle. This short-term approach frustrates the art and science of public health to be effective achieving positive equitable health outcomes and fails to align with the long-term engagement with communities needed to build trust, tailor and refine interventions (Waters et al. 2011). Over time, communities seem to have been decentred in current contracting in favour of the needs of the neoliberal bureaucratic centre (Skegg 2019).

Despite the lack of statistically significant differences in contract lengths, qualitative data from both Māori and generic providers, confirms the ongoing inconsistent treatment of providers. Specifically the best-served cohort, the PHOs, continues to have open-ended contracts and Healthy Families seem to have consistent four year contracts, while others continue with annual contracts. If shorter contracts are required, for particular programmes (or providers) on a case by case basis, it would be helpful if funders were explicit in their rationale for this practice, so it can be interrogated. If longer contracts are possible for one part of the sector, it would seem equitable that it is consistently available across the sector, which would serve to reduce administrative burdens and alleviate a longstanding inequity.

Providers shared examples of practical difficulties around contract negotiations and renewals. Many providers had contracts extended on the same contractual terms, driven by limited capacity of Crown officials, rather than contract negotiations. This lack of capacity is manifest in tardy contract negotiations and communication about contract renewals. For smaller, mostly Māori providers, this creates particular pressure on their limited resources to retain staff and the continuity of services during these times of transition.

MHPs are philosophically and practically orientated to Māori communities, beliefs, values and knowledge (Gifford H et al. 2018). Several reported lack of alignment between Māori values and priorities and the processes and content of Crown-led monitoring and auditing. This tension seemed to be impacted by the cultural and political competencies of individual managers and auditors. There are opportunities for Crown officials to deepen engagement with te Ao Māori (the Māori world) through agreed site visits with MHPs and embracing the relationship principle of utu (exchange and restore balance).

Some providers spoke positively of the northern-based MAPO (Māori co-purchasing strategy), which involved its iwi governance board making funding decisions with the local DHB and the Ministry. This structural mechanism appeared to address Te Tiriti responsibilities in terms of monitoring service delivery to Māori for all providers. The independent Māori Health Authority proposed by the Waitangi Tribunal (2019) and now adopted by the Crown, will build on the success of that tradition of Māori involvement but will have the power to commission, monitor and contract hauora Māori services.

Providers reported a continuum of practice in relation to performance monitoring (from micro-management to laissez-faire) contributed to stress and uncertainty in the sector. It would be beneficial to a develop a clear, explicit, consistent performance monitoring approach that would provide certainty for everyone involved This could include exemplars, training and mentoring to improve performance monitoring practice.

Providers valued being accountable for public monies and for the quality of the services they delivered, but expressed concern at the lack of feedback from funders. Most

providers valued continuity in key staff within the Ministry and DHBs. This helped facilitate meaningful relationships and trust. Expertise in public health was desirable.

Providers wanted audits to be a positive learning opportunities for understanding what they were doing well and constructive feedback about practice that was meaningful to them. Although it seems likely there is a centralised audit schedule for contracts, qualitative data indicated some providers felt there was discretion with the schedule. Providers that had not been audited, explained this was because of the trust they had established with funders through long-standing relationships.

Providers sought opportunities to reduce compliance costs. It would be beneficial for Crown funders to consider a holistic integrated approach to contracting. Consolidation of providers' multiple contracts could service to streamline reporting, monitoring and auditing that approximately a third of providers found burdensome. Unless proportionality is applied to contracting, smaller providers continue to have higher compliance costs than larger providers.

Since the last nationwide survey, Whānau Ora commissioning process is more fully embedded in the health sector, opening up new Indigenous-led ways of procuring health and social services (Boulton 2019). There are lessons from this well-evaluated Whānau Ora work about taking a relational and high-trust approach, that have yet to be adopted in the context of public health. Such an approach might lead to more culturally responsive contracting and a reduction of compliance costs.

The Controller and Auditor-General (2008) in their procurement policies require Crown funders to engage in open and transparent decision-making. Several providers reported a lack of access to information about discretionary funding within the sector. Many providers noted there was a tight fiscal environment and discretionary money was hard to access, except through formal 'request for proposal' opportunities with competitive tendering.

Cost of living adjustments were applied inconsistently across the sector; PHOs had their adjustment negotiated centrally. There would be greater equity if all providers were offered adjustments or provided with a justification when withheld. Without adjustments, rising operational expenses mean providers battle annual funding cuts, while trying to maintain delivery levels. This exacerbates chronic under-funding of public health services (Skegg 2019).

For the period 2015–2020 the Ministry of Health (2021) invested 2.48% of the overall health sepnd into Māori Health Providers. These obsevations sit alongside the strong recommendations of the Waitangi Tribunal report (2019) for the Crown to proactively address chronic underfunding of Māori health. Though, MHPs appreciated the opportunities of the MPDS, which they felt was essential to maintaining quality clinical service delivery. The Government investment in MPDS shows a reduction in the last five years (Ministry of Health 2021).

It is pleasing to see parity in Māori representation on Ministry and DHB advisory groups. However, given the demographics of providers, this means Māori remain a minority voice on most advisory groups and their involvement is not an explicit recognition of Māori as Te Tiriti partners. Research by Came et al. (2019) found Māori and Pacific leaders felt their knowledge and expertise were not always recognised on advisory groups. They experienced racism and tokenistic cultural enagement. The study recognised the need for deeper engagement and greater recognition of Indigenous knowledge.

Some relationships between funders and providers have broken down to the extent official information requests have had to be issued to receive information and formal complaint procedures have been activated. The sector needs strong relationships and good will to address the substative public health challenges ahead.

Conclusion

This nationwide survey shows no statistically significant variation in treatment of MHPs versus other providers consistent with institutional racism. However, the results of this survey show complex, frustrating contracting environments for MHPs, who want certainty of investment (contracts), support (by the funder and of their infrastructure) and resource (assets and people) to be able to meet the needs of their communities. Different levels of funding, allocated on the basis of policy or priority set by government, then imposed by government agents (Ministry of Health, District Health Board) within changing political cycles do very little for sustainability of MHPs delivering health care.

Our findings emphasis the need for the Māori Health Authority to be the catalyst for change in the health and disability system in 'commissioning, monitoring and contracting' and decision-making at every level. Māori do not enjoy equitable access to health care, though there is a continual effort to build a public health system that can meet Māori needs. It has taken years of development, to create an environment that is conducive to addressing Māori health needs. We are not there yet. But there is sufficient evidence that the investment in MHPs has contributed to improvements in Māori health outcomes, even when the investment is signficantly less than mainstream services. What needs visibility is the poorer health and social outcomes of Māori, and that equitable access to health care will mean higher than average use of MHPs. This means that the cost of providing services to address the inequities of Māori, and to provide culturally appropriate programmes, will cost more. Though, it is beyond the scope of this paper and no data was captured in this survey of contractual amounts, we maintain total health spending in MHPs needs to be increased more than the current 2.48% health spend into MPS that seeks to rectify a more equitable benchmark of funding for all MHPS to achieve equitable access to effective care consistent with the findings of the landmark WAI 2575 (Waitangi Tribunal 2019) report.

Though, Māori wellbeing is not determined by health care alone, there are initiatives (e.g. Whānau Ora) that have strengthened Māori community capacity, with investments in Māori that are successful in addressing some of the social determinants of ill-health. It is in these Whānau Ora and MAPO examples of Māori organisations self determination; of Māori-led commissioning and procurement arrangements supported by the Government, that have fostered environments that in turn are enabling Māori to be more active in taking collective leadership for well-being.

Notes

1. A permanent commission of inquiry into breaches of Te Tiriti o Waitangi.

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