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Beginning to address institutional racism within the public health sector: Insights from a provider survey

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Keeping up to date - Edition 38

Welcome!

This edition begins to address institutional racism within the public health sector: Insights from a provider survey. We are thankful to Dr Healther Came, the author of the article. We also acknowledge the reviewers of this paper. Heather has an extensive background in public health and health promotion.

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Introduction

In the last twenty years the health sector has seen a plethora of reforms and changes to the way public health services are purchased (Quinn, 2009). Most recently, these reforms have been driven by the pressure to be more efficient and cost effective (Ryall, 2008). Anecdotal evidence from public health practitioners across the sector suggest nationally public health planning and funding capacity of health funders such as the Ministry of Health and local District Health Boards (DHB) has become gravely compromised. I contest these capacity issues, combined with both the failure of quality assurance processes and compromised public health leadership, have contributed to an environment where institutional racism has been allowed to flourish.

This paper is based on a survey of public health providers (Came, 2011) and, informed by a wider study (Came, 2012) into institutional racism, highlights sites of racism and privilege within the public health contracting environment. These sites are markers for public health providers navigating the contracting environment and to incite collective action to reduce, and ultimately eliminate institutional racism within our sector.

Institutional racism within this paper is defined as "a pattern of differential access to material resources and power determined by race, which advantages one sector of the population while disadvantaging another" (Came, 2012, p. 5). Jones (2000) argues such racism can manifest itself as both action and inaction in the face of need. Within the context of the public sector in Aotearoa institutional racism against Māori is a contemporary breach of *Te Tiriti o Waitangi*.

Public Health Provider Survey

As part of a Health Research Council summer studentship (Came, 2011), I undertook a telephone survey of public health providers to bench-mark their experiences in dealing with the Ministry of Health and their respective District Health Board funders. The survey focussed on the broad areas of contracting and monitoring, relationships and levels of influence and these questions were informed via collaborative storytelling with Māori health stakeholders (Came, 2012, pp. 40-43). The design of the survey enabled both quantitative and some qualitative analysis, some of which is presented within this paper.

Data collection occurred via a telephone interview with senior managers who had oversight of their respective organisations public health activity and engagement with Crown officials. This approach enabled the renewal of connections with public health providers, and the opportunity to talk more broadly about the wider study. Participants were sourced through existing networks and included a broad cross section of currently contracted public health providers. Ethical approval was obtained through the Waikato University Management School ethics committee.

Of those invited to be part of the research two declined to participate; they were both organisations undergoing restructuring during the data collection period.[1] All (thirteen) of the Public Health Units (PHU) agreed to participate in the survey, as did fourteen Māori health providers, nineteen

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[1] *At the time of the survey there was a major restructuring of the PHO sector which meant several of the PHO/Community Health Trusts surveyed were being merged into larger organisation within days/weeks of data collection.*

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local or national Non-Governmental Organisations (NGOs) and ten Primary Healthcare Organisations (PHO) / Community Health Trusts. In total there were fifty six participating public health providers from the far North to the far South; both large providers and boutique smaller ones.

Relationships

Structurally there are entrenched power imbalances between funders and providers of public health services; particularly for smaller providers (Te Puni Kōkiri, 2000). Funders typically control considerable human and financial resources and have access to both technical information and decision-makers. Providers usually have considerably less resources and capacity. These power imbalances are moderated by relationships between individuals and organisations. The Ministry of Health currently engage in what they call 'relational' contracting (Controller and Auditor-General, 2008b).This process recognises the trust (and/or critically the absence of trust) that has been established over time with public health providers.

Research commissioned by the World Health Organization confirms relationships can have profound impact on providers' experiences of the contracting environment (Ashton, Cumming, McLean, McKinlay, & Fae, 2004). This is echoed by a survey participant:

> It comes down to if the Ministry knows what you are doing really well, which comes down to good monitoring and good people relationships, then your likelihood of being able to put your hand up and say we want to do this extra over here. The likelihood of that being successful is much higher because they know exactly what you would do with it, whether you can be trusted with it, whether you will achieve what you say you are going to achieve (NGO provider cited in Came, 2012, p. 230).

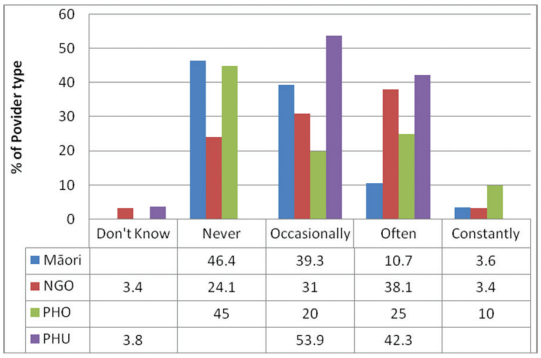
The public health sector in Aotearoa is small and tight knit so it is not uncommon for personal relationships to co-exist alongside professional relationships. Practitioners often work in a variety of organisations across the span of their careers. This movement of staff creates a web of connections and carries forward understandings of organisational culture and practice. See this comment from a survey participant:

> The public health portfolio manager is a friend of mine, we get on very well. So we talk on a weekly basis (PHU provider cited in Came, 2012, p. 214).

Within the survey, from a quantitative perspective, relationships were examined in relation to providers reported access to funders and their representation on steering and advisory groups. The survey found Māori providers described their access to DHB funders 'as limited' six times more than other types of providers. Moreover over 50% of Māori providers also described their access to Ministry funders 'as limited'. Beyond these individual provider experiences, collectively both PHUs and NGOs have established forums[2] to regularly meet with the Ministry of Health. No such forum exists for Māori health providers nationally.

Being represented on advisory and steering groups allows public health providers access to privileged information, contact with decision makers and critical input into the shape and content of policy and funding directions. The survey revealed significant discrepancies in providers' representation on advisory and steering groups (see table 1). Māori providers were least likely to be represented, while PHUs were most likely to be. An interview with a Senior Crown Official (as cited in Came, 2012, p. 198) confirmed from a Ministry perspective at least, these decisions were 'highly arbitrary'.

Table 1: Reported Representation of Providers on Crown Advisory Groups



	Don't Know	Never	Occasionally	Often	Constantly
🟦 Māori		46.4	39.3	10.7	3.6
🟥 NGO	3.4	24.1	31	38.1	3.4
🟩 PHO		45	20	25	10
🟪 PHU	3.8		53.9	42.3	

(Came, 2012, p. 216).

The findings of this survey in relationship to access and representation show significant variations in the experiences of Māori providers versus other providers. Some of this variation is normal and can be explained away in a case by case basis, the rest I assert is evidence of institutional racism. To reiterate: institutional racism occurs when there are patterns of behaviour that advantage one group while disadvantaging another. The following suggestions for health funders could reduce, minimise and/or eliminate racism within this realm of contracting.

- Develop an e-bulletin or similar mechanism to brief public health providers about developments in the sector rather than distribute information in an ad hoc basis – this will ensure providers get the same information at the same time.
- Ask Māori health providers if and how they might like to engage with health funders at a national and/or DHB level? Then implement this advice in a timely fashion.
- Develop a mechanism for ensuring equitable representation of groupings of public health providers on steering and/or advisory groups that is published on-line and is consistently followed. In addition ensure decision-making processes within the group are sophisticated enough to be structurally inclusive of minority perspectives.

Contracting Practices

Contracting is the core mechanism by which the government purchases public health services. This procurement process is guided by an intricate web of guidelines, benchmarking, mandatory practices and legislation (see Controller and Auditor-General, 2008a; Ministry of Economic Development, 2007; Ministry of Economic Development, 2010), which collectively provide a detailed scope of practice for Crown officials and their managers. Underpinning this web of documentation lie the core principles that are expected to govern all public spending; that is accountability, openness, value for money, lawfulness, fairness and integrity (Controller and Auditor-General, 2008a). Missing from all this documentation is a consideration of the *Treaty of Waitangi*.

Survey participants were asked to comment on their contract timeframes and experiences of both monitoring and auditing as key markers of their experiences of the contracting process.

Unique to the primary healthcare sector is the existence of ever-green contracts with no expiry dates; instead PHOs are required to submit annual health promotion plans to the DHB for approval. Over 80% of PHU providers and over 60% of NGOs reported having three year contracts. Māori providers were most likely to have annual contracts (65%) with those retaining longer terms expecting to have those reduced in forthcoming negotiations.

A review of Crown procurement documents found no clear guidelines/or rationale for variation in the length of public health contracts. As part of the wider study I asked a Senior Crown Official (as cited in Came, 2012, p. 201) to clarify operational practice. They explained contract length was a discretionary decision based on both the stability of particular funding streams and the (perceived) risks associated with

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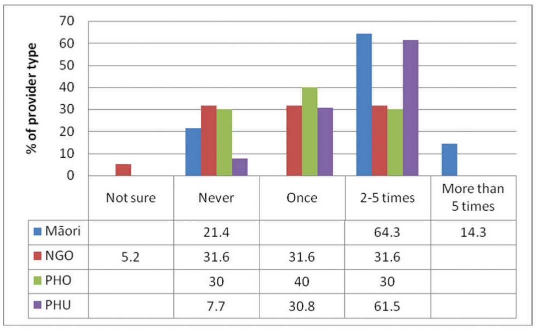
[2] PHUs have the Public Health Leaders Network and NGOs have the Health and Disability NGO working group

funding particular providers. Specifically they were concerned with "...whether the provider is reliable and has the capacity and capability to continue to provide the service for a longer period".

Treasury, the State Services Commission and the Auditor-General (Office of the Controller and Auditor-General, 2006; Treasury & State Services Commission, 2006) all require health funders to monitor contract service delivery. The survey confirmed frequency of monitoring was consistent across providers. Counter narratives from the wider study however suggest Māori providers have more intense experiences of monitoring (and auditing) processes than other providers (Berghan and Maori provider CEO as cited in Came, 2012, pp. 222, 224). At an operational level the Senior Crown Official (as cited in Came, 2012, p. 223) confirmed that the Ministry of Health did not have the capacity to monitor 'mainstream' providers service delivery to Māori; despite the existence of a range of tools specifically designed to enable such processes (see Cunningham, 1995; Durie, 1993).

Alongside monitoring, auditing is a mechanism used by the Crown to ensure contracted services have been provided, financial processes are robust and quality assurance systems are operating well. Within the survey, providers were asked how frequently they had been audited over the last five years (see table 2). Māori providers were most likely to be audited, with over 14% recalling being audited more than five times. In contrast PHOs and NGOs were least likely to report being audited. In findings that were echoed in the wider study, some Māori providers also reported their funders threatened them with audits in what they considered an intimidating way (Maori Health Provider as cited in Came, 2012, p. 224).

Table 2: Recollections of Frequency of Auditing



	Not sure	Never	Once	2-5 times	More than 5 times
■ Māori		21.4		64.3	14.3
■ NGO	5.2	31.6	31.6	31.6	
■ PHO		30	40	30	
■ PHU		7.7	30.8	61.5	

(Came, 2012, p. 224).

The survey findings showed variations in providers' experiences of contracting processes which often disadvantaged Māori providers. This variation is inconsistent with Crown procurement policies and practices and when examined as a pattern of behaviour is evidence of institutional racism. The following suggestions for health funders could reduce, minimise and/or eliminate racism within contracting.

Develop transparent criteria for determining the length of public health contracts; publish it on-line and consistently follow it.

Ensure auditing and monitoring processes are proportional and consistently applied across all public health providers.

Access to Funding

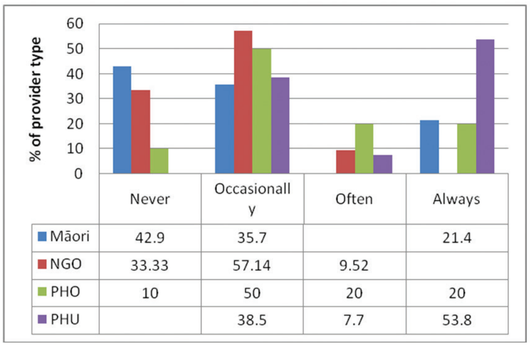
Reducing health inequities between Māori and non-Māori and working with the *Treaty of Waitangi* has been a long-term goal of the Ministry of Health (Salmond, 1986). Both DHBs and Ministry of Health have prioritisation processes in place to ensure health inequities are addressed (Joint DHB and Ministry of Health Working Group on Prioritisation, 2005; Ministry of Health, 2004). Counter narratives from the wider study (Kuraia as cited in Came, 2012, p. 227) however contest the claim that these processes are consistently applied by Crown officials.

Survey participants were asked to comment on their access to discretionary and annual cost of living and/or future funding track adjustors over the last five years as markers of the funding environment.

Both DHBs and the Ministry of Health from time to time have access to discretionary and one-off public health funding. The survey findings showed over 40% of Māori providers reported rarely or never receiving discretionary funding; compared with all PHOs and PHUs occasionally or often receiving such funding (Came, 2012, p. 231). One PHU provider explains, "Ministry quite often encourage us to go after one-off funding particularly recently", another confirmed "DHBs have been coming to us, to get us to do things quite frequently". One NGO provider reported that they often received discretionary funding; his organisation regularly pitched ideas to funders and then the funder worked up the business case for them. Several Māori providers reported producing what they considered robust evidence and business cases that did not result in securing discretionary funding.

Within the health sector providers variously secure and/or negotiate an annual cost of living adjustment that enables them to accommodate rising petrol costs etc and continue to deliver the services they are contracted to provide without hardship. The survey findings (see table 3) showed that NGOs and Māori providers reported access at the "never" or "occasional" end of the spectrum over the last five years. Moreover Māori providers were the provider grouping most likely to report they had never received a cost of living adjustment. Providers that were successful were more likely to be large, and report strong relationships with their funders.

Table 3: Recollections of Access to Cost of Living/ FFT Adjustor



	Never	Occasionall y	Often	Always
■ Māori	42.9	35.7		21.4
■ NGO	33.33	57.14	9.52	
■ PHO	10	50	20	20
■ PHU		38.5	7.7	53.8

(Came, 2012, p. 229).

The survey findings in relation to funding practices confirmed the pattern of Māori providers being disadvantaged by how the Crown administers public health funding. The following suggestions for funders could reduce, minimise and/or eliminate racism within contracting.

- Develop transparent criteria for the allocation of discretionary and/or one-off public health funding. Publish it on-line and consistently follow it.
- Make the application of prioritisation guidelines mandatory in funding decisions and ensure Crown Officials have access to the relevant training to apply these guidelines.
- Ensure a consistent approach is taken to the allocation of cost of living and/or FFT funding.

Call to challenge institutional racism

The existence of institutional racism within the public health sector is inconsistent with stated public health and/or health promotion ethical principles (see Health Promotion Forum, 2011; Public Health Association, 2012) and is a contemporary breach of the *Treaty of Waitangi* and/or *Te Tiriti o Waitangi*. The findings presented in this paper are part of a wider piece of work (Came, 2012) that describes in detail how institutional racism and privilege manifest within public health policy making and funding practices. This confirmation of racism within the public health sector presents a collective ethical challenge to the public health community echoing and amplifying the wero (challenge) to the

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public sector from *Puao te Ata Tu* (Ministerial Advisory Committee, 1988) and other key reports from the 1980s (Berridge et al., 1984; Herewini, Wilson, & Peri, 1985; Jackson, 1988).

The Public Health Association (September 2012) picked up this challenge last year at their Annual General Meeting in which they pledged to take action. Structural discrimination within the health sector is currently a focus of work within the Human Rights Commission (2011, 2013)New Zealand and was noted in the Committee for the Elimination of Racism's (2013) recent concluding comments on the New Zealand government's compliance report in relation to the *International Convention on the Elimination of Racial Discrimination* (United Nations, 1966). With international interest in our efforts now is the time for deeper conversation and collective action.

This paper has focussed on some of the multitude of actions health funders can take to address institutional racism. I maintain the responsibility to eliminate racism and the reorientation of our funders belongs with the entire sector and our best chance for lasting change is planned collective anti-racism action. The Public Health Association is in the process of forming a special interest group to lead this work and will develop a strategy to eliminate racism in our sector within five years. The Health Promotion Forum has also pledged their support. No one is funded to do this work but to meet this deadline we will need support from across the sector. Get in touch if you are interested in contributing to this important campaign.

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