Abstract

Public institutions within New Zealand have long been accused of mono-culturalism and institutional racism. This study sought to identify inconsistencies and bias by comparing government funded contracting processes for Māori public health providers (n = 60) with those of generic providers (n = 90). Qualitative and quantitative data were collected (November 2014 - May 2015), through a nationwide telephone survey of public health providers, which achieving a 75% response rate. Descriptive statistical analyses were applied to quantitative responses and an inductive approach was taken to analyse data from open-ended responses in the survey domains of relationships with portfolio contract managers, contracting and funding. The quantitative data showed four sites of statistically significant variation: length of contracts, intensity of monitoring, compliance costs and frequency of auditing. Non-significant data involved access to discretionary funding and cost of living adjustments, the frequency of monitoring, access to Crown (government) funders and representation on advisory groups. The qualitative material showed disparate provider experiences, dependent on individual portfolio managers, with nuanced differences between generic and Māori providers' experiences. This study showed that monitoring government performance through a nationwide survey was an innovative way to identify sites of institutional racism. In a policy context where health equity is a key directive to the health sector, this study suggests there is scope for New Zealand health funders to improve their contracting practices.

Research Highlights

- Nationwide survey revealed inequities within health contracting practices in New Zealand
- Key areas of inequities were contract length, monitoring intensity, compliance costs and auditing frequency
- This constitutes empirical evidence of institutional racism in government contracting practices

- Monitoring government performance is an innovative way to identify institutional racism

Key words: Institutional racism, health equity, Māori, New Zealand, public health, Māori providers, contracting, nationwide survey

Introduction

New Zealand prides itself on being a country of social equity, racial harmony and 'fair play' (Rashbrooke, 2014). However, our history, economic stratification and social and health statistics tell a different story (Ministry of Social Development, 2010; Spoonley, Macpherson, & Pearson, 2004). Western colonisation (particularly from 1840 onwards) introduced a British cultural system that marginalised and severely disrupted long-established indigenous Māori economic and social infrastructures, while favouring the settler population and producing and entrenching significant social inequalities (Belich, 1986; Walker, 1990). This is particularly apparent in health with inequities in morbidity, mortality and quality of care; as exemplified by a life expectancy gap of 7.3 years between Māori and non-Māori men and 6.8 years for women (Robson & Harris, 2007; Statistics New Zealand, 2013).

Te Tiriti o Waitangi (1840) is the founding treaty of the colonial state of New Zealand, negotiated between the British Crown and Māori rangatira (chiefs) at a time of peace and Māori dominance. te Tiriti, the Māori text of the treaty, established a partnership between the Crown and Māori, reaffirmed Māori sovereignty, enabled British governorship and guaranteed Māori the same rights and privileges as British subjects (Healy, Huygens, & Murphy, 2012). Within months, the promises of te Tiriti were broken by the British. Settler government policies of colonisation, and assimilation led to an ongoing cycle of treaty breaches, warfare and one-sided development which have contributed to poor social, economic, and health outcomes for Māori. More recently te Tiriti has been integral to moves to redress and recompense, in both symbolic (recognition, apologies) and material ways (restitution,

resourcing, legal acknowledgement, governance and policy development), some of the ravages of these breaches (Durie, 2009; Walker, 1990).

The Waitangi Tribunal formed in 1975, is an independent ongoing commission of inquiry, set up to deal with treaty breaches. It has produced thorough and scholarly public accounts and provided a public forum for hearings into injustice and grievances dating back to 1840. Through this mechanism, te Tiriti has been accorded appropriate status and is used to legitimise redress and progressive change over lands, fisheries, rivers, Māori language, flora and fauna, intellectual property and rights to broadcasting transmission frequencies (Waitangi Tribunal, 2011; 2014). We note the Tribunal's (2014) substantive finding that the signing of te Tiriti by rangatira in 1840 and subsequent years, cannot be read as surrender of Māori sovereignty. This is something that the Crown attempts to downplay on the grounds of entrenched practice. This point is vital to understandings of responsibility for redress over the damage to Māori caused by colonisation and the institutional racism established in Aotearoa.

Under a scenario in which Māori sovereignty has been intact since 1840, with genuine partnership agreement, it is highly unlikely that the disparities of the last 100 years would be the key feature of contemporary Māori health (Hunn, 1961; Marriott & Sim, 2014). Government arrogation of substantive sovereignty (Belich, 1986) from about the mid-1850s, with the waging of war, the large scale alienation of land and destruction of Māori social/cultural institutions through colonial imposition of British common law and practice are the original and long lasting insults to the health and wellbeing of Māori.

The treaty provisions have been widely interpreted as meaning that long-entrenched health inequities represent breaches of te Tiriti (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003; Becares, Cormack, & Harris, 2013; Came & McCreanor, 2015; Robson & Harris, 2007). The authors argue breaches of te Tiriti are examples of institutional racism against Māori and their prevention is a legitimate focus of responsibility for the health sector. Approximately 100 health-related deeds of claim, related to Crown

Ministers and/or Crown Officials, of breaches of te Tiriti have been combined and will appear before the Waitangi Tribunal (Isaac, 2016).

Internationally, racism has become recognised as a modifiable determinant of health (Harris et al., 2012b; Paradies et al., 2015; Priest et al., 2013; Ramaswamy & Kelly, 2015; Ziersch, Gallaher, Baum, & Bently, 2011). Inequities resulting from racism can harm both the affected communities and the wider society through harms to national identity, social cohesion, productivity, creativity and diversity (Houkamau & Sibley, 2015; Pickett & Wilkinson, 2011; Priest & Paradies, 2010; Robson, Cormack, & Cram, 2007). Health inequities are by definition damaging, unjust and avoidable (Woodward & Kawachi, 2000). LaVeist, Gaskin, & Richard (2011) found that for the United States, eliminating inequities for all minorities is also cost effective: it would have saved more than US$230 billion in direct costs and in excess of US$1 trillion over four years, from 2003-6. While no equivalent studies are available for New Zealand, there have been some explorations of the cost of inequalities associated with specific conditions and groups. For example, Mills, Reid, & Vaithianathan (2012) found that the conservative estimate of the cost of child health inequities between Māori and non-Māori, was NZ$62 million per annum.

Along with all other sections of the health system, public health practitioners in Aotearoa (New Zealand) have a responsibility and growing commitment to reducing health inequities and advancing social justice. However, despite concerted efforts in recent decades, health and social inequities persist between Māori and Tauiwi (settlers) (Marriott & Sim, 2014). These imperatives are variously articulated in competency and policy documents and ethical guidelines that are underpinned by health and human rights legislation, the *Declaration on the Rights of Indigenous Peoples* (UN, 2007) and *te Tiriti o Waitangi* obligations (Health Promotion Forum, 2011).

The causes of these inequities are complex and contested but the social determinants of health frameworks (Commission on Social Determinants of Health, 2008) highlights multiple important systemic factors that perpetuate inequities, including government social and economic policies that

enable racism (and other forms of exclusion). Van Ryn and Fu (2003) suggested that institutions can contribute to and perpetuate health inequities. Salway et al. (2015) noted that examinations of how health funders contribute to racism and/or inequities has received limited attention.

Ford and Airhihenbuwa (2010) argued racism has become normalised within society. This contributes to the difficulties in detecting such racism. Krieger, Smith, Naishadham, Hartman, and Barbeau (2005) noted a paucity of validated instruments to measure racial discrimination. Work by Paradies and Cunningham (2008) and Marrie and Marrie (2014) is developing validated instruments to measure racism with input from indigenous communities. Self-reporting and implicit association tests are widely utilised as a means of measuring racism; as are vignette based studies, attitudinal surveys, discourse analysis and statistical analyses of over and/or under representation (Krieger, Carney, Lancaster, Waterman, & Kosheleva, 2010; Paradies, Truong, & Priest, 2014; Satzewich, 2010)

Within our study institutional racism has been defined as a pattern of differential access to material resources and power and/or differential treatment determined by race, which advantages one sector of the population while disadvantaging another (Jones, 2003; Paradies, 2006). The three key elements of this definition are a *pattern* of behaviour, a *differential* element comparing two or more groups, and advantage/*disadvantage*. The authors concur with Paradies (2007), that definitions of (institutional) racism are not dependent on the intentions of those working within institutions; rather on practices and outcomes.

In neoliberal democracies, such as New Zealand, the effective state is considered by many as neutral or benevolent (Helliwell & Huang, 2008) however in a critical approach and driven by an emancipatory and transformative agenda, critical theorists assert that those holding political, social and economic power have a vested interest in supporting the status quo. Thomas and Veno (1996) argue power is maintained for dominant groups through "the routine application of effectively unchallenged assumptions of social institutions" (p. 89), supporting privilege for the dominant group.

Māori academics Reid and Robson (2007) have challenged the health sector to turn their gaze from a deficit analysis of indigenous peoples onto the Crown (government). They advocate for the monitoring of government behaviour and contributions regarding Māori health and health inequities. This study responds to this challenge, and to Paradies' (2006) contention that actions and/or behaviours cannot "be objectively determined as racist without comparison with another experience that is, at least for practical purposes, identical except for the race of actors involved in the situation or event" (p. 47).

The rhetoric of the New Zealand government procurement policy (Controller and Auditor-General, 2008a) and health policy (Ministry of Health, 2016) establishes a funding environment where all providers are theoretically treated equitably. However, Sheridan et al. (2011) have identified gaps between policy rhetoric and operational practice and noted that systematic measuring, monitoring over time, and proactive action are needed to close equity gaps. Cram's study (2014) recommended the articulation of a broad-based commitment to the elimination of health disparities via universal Māori health targets. She advocated for local level equity plans: strengthening engagement with Māori and reviewing health funding strategies. Furthermore, Came's (2014) study of the administration of the public health sector identified institutional racism within the development of public health policy.

Since the introduction of the funder and provider separation in health management in New Zealand in 1993, contracting has become a central health management tool (Ashton, Cumming, McLean, McKinlay and Fae, 2004). Legislation, government regulations, procurement and policy documents define the scope of these practices (Came, 2012). The Ministry of Health and district health boards (DHB) using public funding, contract a range of providers to deliver specialised public health services with a specified timeframe, funding and contract conditions.

The aim of this novel study was to use a combination of historical analysis, self-report and statistical analysis through a nationwide survey to identify inconsistencies and biases by comparing government funded contracting processes for Māori-led public health providers and generic providers. This paper fills a gap in the literature by providing indicative empirical evidence of sites of institutional racism in

contracting practices impacting adversely on Māori health providers. Māori providers are contracted to provide culturally appropriate Māori services. The specificity of these sites of racism will allow tailored anti-racism interventions.

Method

This paper is part of a wider body of work looking at how institutional racism manifests within the government's administration of the public health system in New Zealand and how this might be transformed. This body of work includes an historical analysis (Came, 2012) that traced institutional racism back to 1840 through government policies of colonisation and assimilation. For this paper we used a mixed methods approach to identify inconsistencies and bias between government-funded contracting processes for Māori-led public health providers (predominately working with Māori) and generic providers whose services are designed for the overall population. We sought to investigate the extent to which government health funders were consistent in their treatment of providers during public health contracting processes–particularly for Māori as compared to generic providers. Open and closed questions were asked, resulting in qualitative and quantitative data. The study, informed by an earlier review of government procurement and contracting documents, (Came, 2012) assumed that public health providers should be receiving similar levels of service from their funders regardless of their size, geographic location, or designation as a Māori provider.

Public health in the context of this paper refers to population oriented services such as health promotion, health protection and illness prevention, rather than publicly owned clinical services. Came (2012) noted public health services in New Zealand are delivered by non-governmental organisations (NGOs), primary health organisations, public health units, Pacific health providers and Māori and/or iwi (tribal) providers. Public health units tend to have the larger public health contracts than other providers due to their specialist public health staff and skills. Primary health organisations tend to have small contracts, as the core focus of their work is delivery of clinical care. NGOs range from small local providers to large national providers. Māori and/or iwi providers tend to be more boutique organisations with a broad development and tino rangatiratanga (self-determination) focus.

These organisations are all unique but share the experience of contracting for public health services, using the government procurement frameworks.

Over the recruitment period (November 2014 - May 2015), public health providers were approached via telephone and email and 161 of 214 agreed to participate, giving a response rate of 75%. Eleven responses were removed from the study given they were from Pacific providers and the point of comparison was between Māori and generic providers, leaving 150 reported here. The research team were unable to contact the relevant manager at 29 providers with a public health contract, despite repeated attempts via phone and email within the data collection timeframe, and a further 23 declined to participate. Those that declined, tended to be small to medium sized providers and indicated they were, undergoing restructuring, negotiating their contracts or in one case were involved in a Waitangi Tribunal claim. Public health units had a perfect response rate (13 of 13), the NGO response rate was 60 of 83 (72%), while the numbers of primary health organisations was the lowest at 17 of 30 (57%). Māori providers' response rate was 60 of 75 (80%).

A nationwide telephone survey of public health providers (Came, McCreanor, Doole & Simpson, 2016) was conducted utilising Came's (2013) survey tool. The survey had twenty questions related to relationships with portfolio contract managers, contracting, monitoring and funding practices and took 15-20 minutes to complete. Data were gathered from public health managers listed with the New Zealand Ministry of Health as holding public health contracts with the Ministry and/or a district health board. As with any commercial enterprise it is valuable for providers to have funding from multiple sources such as having both Ministry and district health board funding. However, having two funders is also problematic as you have double the bureaucracy in compliance costs and reporting. Ethics approval for the study was secured through the Auckland University of Technology Ethics Committee (No. 14/229).

The study was administered from Auckland but participants were located across New Zealand. The survey consisted of a mixture of closed-ended questions to enable quantitative analyses and open-ended

sections to secure qualitative data. Participants were asked to rank their responses in question-specific rating scales. For instance, providers were asked to consider the level of scrutiny and intensity of their contract monitoring, by indicating whether it was light, reasonable or burdensome and then comment on that selection. The questions addressed the domains of i) contracting and monitoring processes, ii) access to funding, iii) levels of access to, and relationships with funders, and iv) responsiveness to Māori. The analyses here focus on (i), (ii) and (iii).

Quantitative data were cleaned and descriptive statistical analyses undertaken. Comparisons were undertaken between providers based on whether the service was a Māori or generic provider. The generic category was inclusive of public health units, NGOs and primary health organisations. A Chi-square (significance $p<0.05$) was used to test differences between provider groupings. Note the Pacific data are reported elsewhere and thus excluded from the analysis of this paper. Likewise, the data about generic provider's responsiveness to Māori were published separately (Came et al., 2016).

As per Came et al. (2016), qualitative data were examined using Braun and Clarke's (2006) steps of thematic analysis as a way of categorising participant's perspectives into significant themes. Firstly, two authors independently familiarised themselves with the data and generated and populated codes, which were then used to search for data excerpts common to themes and check for connections among themes. Discursive analyses of pattern and variation in the thematic data were used to define and name themes and to guide the description and write-up of the analysis. This interpretative work was informed by critical understanding of anti-racism praxis.

Findings

The findings are presented in relation to i) contracting and monitoring processes, ii) access to funding, iii) levels of access to, and relationships with funders.

i) *Contracting and monitoring processes*

Government contracts in the New Zealand health sector are negotiated with health providers to deliver specified public health services. Monitoring is a mechanism for funders to engage with providers and ensure contract delivery is on track. It is a two-step process whereby the providers submit reports and then the funder provides written and or face-to-face feedback. Auditing is a more formal and rigorous process, undertaken on occasion by a third party. Participants were asked about their contracting experiences under the key areas of contract length and intensity of monitoring, and auditing.

Contracting

Based on the survey responses, Māori providers were significantly more likely than generic providers to have a contract with both the Ministry and a district health board. The length of Māori providers most recent contract was more likely to be of shorter duration (for two years or less) than other providers (see Table 1).

Table 1: Contracting and Auditing

[Table 1 here]

Monitoring

Of the 150 respondents to the survey, 121 (81%) responded to the item on the frequency of monitoring. There was no significant difference between Māori providers and other providers for frequency of monitoring – this usually occurred every six months. Māori providers however were more likely to perceive the process as burdensome, compared with generic providers (see Table 1). Provider types reported differences in the qualitative experience of monitoring.

Larger established generic providers reported engaging in exception reporting with the Ministry of Health – that is they reported when they were behind in a plan/contract or when they had made a significant achievement. One Public health unit explains

We're only required to report when we are behind or something significant happens.

This augmented a fuller annual report that provided more details. The ease of exception reporting was reflected in comments such as *light, smooth, positive, helpful, supportive* from generic providers.

A couple of Māori providers with high levels of political connections reported similar ease of reporting.

A potent theme across all the providers was the importance of the competencies and personability of their respective portfolio managers. Many had observed frequent staff changes within their funders which they found problematic and frustrating. Generic providers described how their relationship with their funders was like a partnership, with some portfolio managers collaborating with providers on the drafting of their monitoring frameworks. When 'partnerships' were achieved, there was high trust between the partners and monitoring was experienced as light. Māori providers rarely spoke of positive partnerships, but some reported positive interactions with their portfolio managers.

Māori providers commented monitoring often occurred at a distance via email and phone, whereas face-to-face would have been culturally their preferred way of working. Māori providers commented on the lack of positive attention they received. One provider noted that the funder just wanted the numbers and not the stories behind those numbers. A Māori provider mentioned:

"I think monitoring of a contract should be a two-way thing because we have entered into a contract so we are in a relationship but it is very one-sided in terms of communication".

Another Māori provider experienced their district health board funder as: *"...aggressive in their monitoring".*

Generic providers did not report such negative experiences.

Auditing

Providers were asked how frequently their public health contracts had been audited in the years from

2009 to 2014. Table 1 shows that Māori providers were audited more often compared to generic providers.

Most generic providers reported that when auditing occurred it was a positive routine process. Some generic providers reported never being audited, or conducting their own in-house auditing. They explained they had a *"high trust"* relationships with their funders. One generic provider went further and noted their CEO had declined to participate in an audit.

Some generic providers argued their six-monthly report received *"a lot of scrutiny and conversation and correspondence"* which was equivalent to an audit. Those who delivered both clinical and public health services found public health auditing *"quite full on"*, *"a challenge"* but they noted the auditors were "very pleasant".

Māori providers, frequently had multiple contracts with multiple government agencies, often found auditing "*burdensome*". They reported the scope of government audits would often overlap and lacked coordination. Māori providers expected to be audited as part of 'standard practice' and reported specific problems in relation to auditing. For instance, a lack of "*notification*" about audit dates and a lack of clarity of what was "*required and expected*". Some were disappointed to find auditors were: "*not interested in the results we achieved; he was only interested in the financial outputs*".

The following response shows some of the frustration among some Māori providers:

> *"I didn't understand why we were being regularly audited - the outcomes we were having were minimal risk ... After we were audited, areas identified were recorded as low risk and they were easily corrected or implement[ed] ...[yet] we were still audited again. "*

Another Māori provider shared their experiences of an unsafe and painful audit. They reported that the auditor lacked empathy and for their staff the experience was described as "*quite traumatic*". Another described auditing as: *"harrowing, it was not a pleasant experience at all"*.

ii) *Access to funding*

An analysis of public health investment in Māori and generic providers was not undertaken as part of this study as accurate information across the entire public health sector is notoriously difficult to obtain (Came, 2012). Significant variation was found in participants' comments on their funding experiences in relation to perceived compliance costs. No variation was found in access to cost of living adjustment and discretionary funding (see Table 2).

Compliance costs

Providers were asked for their perception of compliance costs for their contracts; that is the expenditure of time or money in conforming with government requirements related to contracts. Of the 150 respondents, 139 (92%) replied to this item in the survey. Of these, Māori providers perceived the compliance costs of their contracts as more substantial compared to generic (see Table 2).

Table 2: Contract funding

[Table 2 here]

Access to cost of living adjustment

Providers were asked if they had received a cost of living adjustment on their contracts in the last five years. A cost of living adjustment is an adjustment to a contract price to allow for increases in the consumer price index. Of the 150 respondents, 143 (95%) replied to this item in the survey. Of these, there was no significant difference in the receipt of these costs between Māori and generic providers (see Table 2).

The qualitative data were aligned to the quantitative findings in that some providers reported being

offered a cost of living adjustment, other providers had attempted unsuccessfully to negotiate for one and others were "*not aware*" that a cost of living adjustment existed (regardless of being a Māori or generic provider).

Discretionary funding

Providers were asked what success they had in the last five years obtaining discretionary or one-off funding from their usual public health funder. Table 2 shows no significant difference in the receipt of discretionary funding between Māori and generic providers.

The qualitative data echoed the responses to the cost of living question. Generally, responses ranged from being unclear of the process, or unaware that it was an option, through to those that had consistent successes in securing access. Some providers reported working hard and putting forward ideas and projects that went unfunded, which was "*very frustrating and unproductive*". The rationale for acceptance and rejection was not considered transparent.

iii)   *Access to and relationships to funders*

The quantitative data around provider access to their funders and representation on advisory groups showed no statistical difference across provider cluster groupings (see Table 3). However, the qualitative data paints a complex picture of a continuum ranging from positive longstanding relationships, to the absence of relationship, to challenging and difficult dialogue.

Table 3: Contract relationships

[Table 3 here]

Most providers agreed the quality of their relationship with portfolio managers was central to their experience of public health contracting. Participants identified funder processes, practices and their past experience of working with government funders as critical factors that influenced their relationship with funders. Issues surrounding the frequency and quality of contact with portfolio

managers was a common concern across many providers. There was also general recognition by many of the workload pressure upon portfolio managers.

Many generic providers noted they found their portfolio managers (as professionals) were *"personable"*, had *"good intentions and were skilled"*. Positive relationships were described using adjectives such as *"respectful"*, *"collaborative"*, *"beneficial"*, *"responsive"* and *"warm"*. *"Openness"*, *"forward thinking"*, and *"transparency"* were also valued. Some Māori providers also reported positive relationships with particular portfolio managers. One Māori provider noted: *"We've had mature, progressive contract managers who operate with integrity that understand public health"*.

However, difficult relationships, were also described and characterised as showing a lack of trust and respect from their funders. Some generic and Māori providers noted a significant power imbalance between themselves and their funders. Māori providers were clearer on this imbalance and described the funder-provider relationship as *"one-sided"*. A generic provider described a tone of arrogance from funders: they *"tend to think they know better what services will meet the service users' need - but often they don't"*.

Some Māori providers reported being patronised and *"told off"* by their funders. Māori providers reported their aspiration to work with Māori staff. This desire was grounded in concerns that non-Māori staff may not have adequate understanding of Māori worldviews. Some Māori providers shared specific examples of difficult interactions and relationships with funders. These conflicts appear to be in the context of a trend by funders to exit relationships with smaller providers and to contract with larger entities. A couple of Māori providers felt that their funder was: *"asserting their power to bully Māori providers"* and *"to play games"*.

Discussion

Harris et al. (2012a; 2012b) have comprehensively documented the widespread experiences of racism encountered by Māori individually, collectively and cumlatively. In New Zealand racism against

Māori at micro, meso and macro levels has become normalised everyday experiences for many (Came & McCreanor, 2016).

Māori health service providers range from large to specialised smaller providers. They have different levels of capacity, political connection and agency that filters their experiences of institutional racism. We offer some interpretation of our findings but note the findings need to be interpreted within the complex racial climate of Māori innovation, resilience and fatigue.

The response rate to this survey by all types of public health providers was strong, with the exception of primary health organisations. Primary health organisations have a focus on providing clinical services and as privately owned entities have a high sensitivity related to contracts. This study found statistically significant variations in contract length, frequency of auditing, intensity of monitoring, and perception of compliance costs between Māori and generic providers. There was no statistical variation in access to discretionary funding and cost of living adjustments, the frequency of monitoring, access to Crown funders and representation on advisory groups.

Contract lengths are an issue for all services and provide an objective measure of differential treatment. Short contracts make it difficult for providers to engage in adequate strategic planning and make it more challenging to recruit and retain senior staff, especially for Maori where workforce pools are constrained (Te Puni Kōkiri, 2000; Cram & Pipi, 2001). The variability we found may reflect unconscious (or conscious) bias or a general lack of trust or confidence from government officials individually and/or collectively, in Māori providers. This occurs despite Māori providers often being high-performers in terms of working with a population with complex and high health needs and the effectiveness of their work (Chant, 2006).

Frequency of audits is another objective measure of racism. Audits are often stressful for staff. Came (2012) reported that the threat of audit has been used by funders to intimidate, undermining morale and efficiency. While audits can provide quality assurance and strengthen practice, Māori health

leader, Wano (cited in Came, 2012) observed, over decades in the sector, health funders' low tolerance to risk with Māori providers, compounded by funders' strong emphasis on compliance.

Intensity of monitoring is a measure of differential treatment that dovetails with frequency of auditing. Quantifying these measures showed differences between how Māori felt about the processes and the experience of other providers. From earlier work, Came (2012) found that Māori understood these differences in terms of privilege and double standards as well as overt and covert expressions of discriminatory insitutional power.

Non-significant statistical findings included access to discretionary funding and cost of living adjustments, the frequency of monitoring, access to Crown funders and representation on advisory groups. These results suggest that in particular domains Māori providers receive equitable treatment from their funders.

A limitation of the current study is that it relies exclusively on self-report from participants who worked for health providers, for both its quantitative and qualitative dimensions. The response rate across providers was strong but uneven across provider types. The statistical analyses are indicative rather than conclusive. Future research needs to test a variety of potential confounding variables that may have impacted on the primary analyses undertaken in this research. Likewise, it may be useful to identify what makes a positive contracting experience for Māori providers to inform future quality improvement efforts.

Institutional Racism in Health Funding

The three key elements of the definition of institutional racism used in this study were a i) pattern of behaviour, ii) differential treatment and iii) disadvantage. We argued all three elements are present echoing the preliminary work by Came (2012; 2013) that documented differential treatment of Māori health providers and racism within the administration of the public health sector.

Pattern of behaviour

Since 1840 particularly through policies of colonisation and assimilation, Māori have experienced a pattern of disadvantage at the hands of the New Zealand government (Came, 2012; Hill, 2009; Jackson, 1988; Lange, 1999; O'Sullivan, 2015). Our findings provide a snapshot of how contracting practice in one important sector of the health system, contributes to and perpetuates such systemic disadvantage.

Differential treatment

Government policies and guidelines (Controller and Auditor-General, 2008a; Ministry of Economic Development, 2007; 2010) provide no rationale for inconsistencies in treatment of cohorts of public health providers. The differential treatment uncovered in this study may reflect i) the pressure of portfolio managers juggling large workloads, ii) the impact of perpetual restructuring of the New Zealand health sector (Ashton, Mays, & Devlin, 2005; Gauld, 2009) or iii) unconscious bias (Ross, 2014). The authors maintain that whatever the rationale, circumstances, motivations or intent of the government officials, their bureaucratic superiors and political leaders, the outcomes remain consistent with definitions of institutional racism. As with the landmark Macpherson Report (1999) on racism within the police force in the United Kingdom; these outcomes appear enabled by the failure of systems and processes to produce equitable treatment and the inability of the chain of management to detect and prevent racism.

Disadvantage

Māori leaders have begun speaking out about their experiences of racism within the health system and the disadvantage this involves (Came, 2012). In response to these statements on Radio New Zealand (Smale, 13 September 2016; 29 August 2016) and the *New Zealand Doctor* (Brown, 12 September 2016), Ministry of Health spokespeople have maintained their position that Māori and other providers are treated equitably.

Dame Tariana Turia (cited in Smale, 14 September 2016), a former Associate Minister of Health, concurred that this racism is causing damage and has called for an inquiry into institutional racism across the public sector as a way forward. Jones (2003) argued the first step in transforming racism is to name racism. Within the New Zealand public health sector, we recognise racism as a determinant of health and the harmful effects of colonisation but the racism within the administration of the public health sector remains unacknowledged by health funders.

Our study serves to reinforce and elaborate upon the arguments of the Commission on the Social Determinants of Health (2008) that government policies and practice, and government action and inaction, contribute to health inequities, particularly in relation to indigenous peoples' health. To achieve health equity, those that administer the health system have a duty to address inconsistencies in practice for all citizens, including indigenous citizens (O'Sullivan, 2015).

The Controller and Auditor-General (2006a, 2006b, 2008a, 2008b) outlined a principles-based approach to procurement involving managing risk and open and transparent decision making, while achieving the best possible public benefit from the resources invested. Bearing in mind that the Ministry of Health's (2003) quality assurance strategy emphasises "quality can always be enhanced" (p. iii), we believe this study is an opportunity to strengthen government contracting practices. Ideally, senior managers would take professional responsibility for having systems in place that identify, prevent and remove institutional racism within the administration of the system. Such actions could be branded an anti-racism or equity intervention and be enabled by discreetly refocussing existing quality assurance activities.

Within any system, it is important to track performance and set targets and/or outcome measures to demonstrate efficiency and effectiveness. The authors believe gathering and analysing empirical evidence of racism, in a policy environment driven by evidence, seems a strategic pathway to leverage the political will necessary to end institutional racism (Paradies, Harris, & Anderson, 2008). The authors have undertaken to periodically monitor our government's performance and engage with the

opportunities presented by the United Nations (1966) reporting processes around the *Convention on the Elimination of All Forms of Racial Discrimination.* We encourage others around the world to do likewise, and monitor not only health outcomes but also the administration of the health system by their governments.

This study fills a gap in the literature, by attempting to monitor the behaviour of government administration of the health system, in relation to indigenous health, to identify sites of potential racism. We have 'drilled down' into local practices to show one space where racism resides within the system. The study opens up possibilities for the transformation of racism and also implicitly challenges the notion that specific identified examples are an exception. In this way our work enables change toward equitable, ethical and consistent treatment of public health providers, thus contributing to national and international scholarly and policy debates while encouraging other researchers to take up the challenge of expanding collective understandings of the role and mechanisms of institutional racism in health service provision.

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