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Delivering on Outcomes
the experience of Māori health service providers

Abstract

This article explores the service delivery experience of Māori health service providers within the context of contracting. It draws on selected findings from a three-year Health Research Council-funded study and discusses how Māori health service providers are evidencing that their service delivery is contributing to positive outcomes for whānau. Although generally outcomes contracting appears to be fraught for providers, the foundations of a policy platform for effective outcomes contracting 'by Māori for Māori' has been established through the Whānau Ora policy.

Keywords Māori health service providers, outcomes contracting

This article explores the service delivery experience of Māori health service providers (MHSPs) within the context of contracting, particularly contracting for outcomes. It draws on selected findings from the final two phases of a three-year Health Research Council-funded study. In the first phase, we partnered with three MHSPs, in Taranaki, Whanganui and on the West Coast of the South Island, to define the specific chronic conditions prevention model of service delivery being developed by each (Gifford et al., 2017). We have since used these models as a primary vehicle for exploring how MHSPs are evidencing that their service delivery is contributing to positive outcomes for whānau.

We begin by outlining the characteristics of MHSPs and their unique role in chronic conditions prevention. We then overview recent key shifts in the state's approach to service provision and consider the impact of these for MHSPs. Issues we explore include contracting, and the more recent introduction of contracting for outcomes and commissioning for outcomes in the specific context of MHSP Whānau Ora service provision. Finally, we outline study data collection methods, before presenting results and discussion.

Background

Boulton et al. (2013) observe that MHSPs are typically 'owned' by a tribal or community-based group, and have inextricable links to their communities and a focus on putting in place services responsive to the cultural needs of Māori service users. MHSP governance and service delivery reflect tikanga Māori, or Māori-defined, frameworks (Crengle, 1999). The combination of these factors is likely to enhance MHSP efficacy for

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Māori. Across New Zealand there are a range of MHSPs: some with a few, small contracts with state agencies, and others holding much larger contracts and offering services including medical, allied health and community care (Abel et al., 2005).

MHSPs are uniquely placed to promote Māori well-being, including through addressing the critical gaps in chronic conditions prevention (Gifford et al., 2017). There is some urgency around the prevention-related work they do, given the devastating impact on indigenous peoples of chronic conditions, which is significantly contributing to health disparities (Anderson et al., 2016). In the New Zealand context, health outcomes for Māori are poorer than for non-Māori, with pronounced disparities related to chronic condition outcomes (Ministry of Health, 2013).

MHSPs are responsible for tracking, assessing and reporting on the impact of their service delivery for whānau, including prevention interventions related to chronic conditions. That activity does not occur in isolation; it is influenced by the broader approach of the state, and state agencies, to determining the needs of populations, along with related service provision, funding and success measurement. Since the mid-1980s New Zealand, along with other Western nations, has adopted a neo-liberal approach to social service provision, which has been extensively documented (Cheyne, O'Brien and Belgrave, 2008; O'Brien, 2016; Ryan, 2011; Stace and Cumming, 2006). Defining characteristics of neo-liberalism include a focus on contracts-based funding (O'Brien, Sanders and Tennant, 2009), along with limited public provision and an emphasis on individual responsibility for personal well-being (O'Brien, 2016).

While neo-liberalism brought with it unsettling changes for the social services non-profit sector generally, it can be argued that for MHSPs new opportunities emerged. MHSPs burgeoned in number during the 1990s precisely because of the neo-liberal preference for devolution of service provision beyond the state sector, which allowed a more diverse range of organisations to enter into contractual relationships for provision (O'Brien, Sanders and Tennant, 2009; Rickard, 2014). The growth in MHSP numbers reflects the state's acceptance that, in some instances at least, services developed and delivered 'by Māori for Māori' are best placed to meet the needs of Māori (Crengle, 2000; Ellison-Loschmann and Pearce, 2006).

Tension exists, however, and it appears that much of that tension can be traced to the nature of the relationship between the state and providers inherent in contracting arrangements. Key characteristics of that relationship include its formality and narrow parameters (Nowland-Foreman, 2015). For MHSPs, additionally, balancing the demands of state contracts that do not necessarily take account of a Māori world view with a commitment to indigenous philosophy and practice is particularly challenging (Boulton, 2007; Walsh-Tapiata cited in Rickard, 2014).

Accountability in contracting arrangements was initially focused on the outputs generated by providers, but more recently outcomes-based contracting has re-emerged as a state preference in contracting arrangements (Nowland-Foreman, 2015; O'Brien, Sanders and Tennant, 2009). Outcome priorities are predominantly determined by the state rather than by communities using services or by providers themselves (O'Brien, 2015). Moore and Moore (2015) observe that the move to outcomes-based contracting is influenced by the state's ongoing commitment to a market-led approach to service provision. Outcomes contracting requires services to effectively evidence the positive changes occurring within their client groups as a 'product' of their intervention. Change in this context may include increases in client knowledge and skill acquisition, along with shifts in attitude, behaviour or well-being (Nowland-Foreman, 2015).

Although attributing causality in this way may sound simple enough, Boston (2017) observes that understanding of causality in the social sciences, in terms of identifying the relationships between input, outputs and outcomes, remains underdeveloped. Nowland-Foreman in turn cautions that the measuring of outcomes 'is neither simple nor straightforward, but a sophisticated and specialised skill, and inherently difficult' (Nowland-Foreman, 2015, p.13). Moore and Moore add that the preferred service outcome measures of the contract purchaser and the provider may well be markedly different: whereas the former may seek 'evidence which "scientifically" proves efficacy' (Moore and Moore, 2015, p.5), a provider may prioritise the narratives and feedback of service users (Boulton, 2005; Moore and Moore, 2015). Whether contracting for outcomes can readily accommodate the diverse interests of the contracting parties is contentious.

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Contracting for outcomes thus appears fraught with challenges, primarily in relation to determining how outcomes are measured, by whom and for what purpose. Nevertheless, there has been some development in the use of an outcomes approach that is confronting these challenges: namely, the Māori-specific outcome measures that have been more formally adopted at all levels of the health system in the last decade, and, most notably, the outcome framework associated with the Whānau Ora policy. Whānau Ora as an approach to service provision emerged from the work of the Whānau Ora Taskforce

(Taskforce on Whānau-Centred Initiatives, 2010). It includes MHSP capability building, integrated contracting and government agency support for whānau integration, innovation and engagement (Office of the Auditor-General, 2015). The Whānau Ora Outcomes Framework was developed jointly by iwi leaders and Crown ministers under the auspices of the Whānau Ora Partnership Group, building on the work of the taskforce. Māori concepts of well-being, including broader social, cultural and economic indicators, are utilised which focus on collective, whānau-level outcomes, ensuring an approach 'that is intimately connected to Māori values and practices' (Moore, 2014, p.iii). Dwyer et al. discuss the accountability attributed to MHSPs for outcomes under Whānau Ora, identifying an opportunity here for effectively 'rebalancing accountability to funders with accountability to community' (Dwyer et al., 2014, p.1102).

Commissioning has now emerged as a model for the purchasing of outcomes under Whānau Ora. The state has established three Whānau Ora commissioning agencies, with the documented aims of reducing the provider compliance burden as well as improving funding and accountability mechanisms, to support the success of Whānau Ora (Whānau Ora Partnership Group, 2014). These commissioning agencies are contracted to invest directly into their communities. Unique within the non-profit sector, MHSPs and Pasifika providers are the primary organisations contracted by the commissioners, with the contracting focus being specifically on outcomes. All three agencies are developing their own commissioning styles.

Boulton et al. (2017), in recent research with Te Pou Matakana, the North Island commissioning agency, examined a specific model of Whānau Ora commissioning as an approach for the purchasing of outcomes. They found that the indigenous principles outlined in the Whānau Ora policy, and their underlying values, benefited overall commissioning practice. There was some evidence, for example, of service design by consumers, of working closely with providers towards shared goals, of a focus on agreed outcomes and on flexibility, of being whānau-centred and of adopting a concerted cross-sector approach. Despite a broadly positive assessment of the Te Pou Matakana commissioning model, however, Boulton et al. also draw attention to challenges inherent in commissioning, including responding effectively to providers' expectations of greater levels of financial and performance information transparency. Inadequate resourcing of the model, along with inordinate levels of state scrutiny, were identified as having a negative impact on both the commissioning agency and its commissioned providers in a variety of ways.

We found evidence of the Whānau Ora Outcomes Framework not only being implemented by MHSPs, but also being adapted to suit local settings.

Having now set the wider policy stage for exploring the ways in which our MHSPs are experiencing relationships with funders, we present the study itself, our data collection methods, results and discussion.

The study

Informed by a kaupapa Māori approach,[1] and using a case study design, our preventing chronic conditions research drew on qualitative and evaluation-based research methods (Patton, 2015) to examine three prevention models. The preventative principles and emerging practices manifested by each case study have previously been delineated (Gifford et al., 2017). Phases two and three of the study include an examination of the recent MHSP experience of state contracting for services with a focus on funding for outcomes.

Multiple data sources informed the analysis in these phases of the study, including a review of the outcomes literature in relation to MHSPs, complementing the broader review of the literature conducted in phase one; face-to-face MHSP key informant and focus group interviews with whānau participants, kaimahi, practice supervisors and managers; case study organisational document review; observations; and field notes, along with the detailed internal case record (Patton, 2015) prepared by case study site lead researchers.

The data were independently analysed by all eight members of the research team. The team then met face to face to carry out a mahi a rōpū process, further refining the independent analyses. The mahi a rōpū process involves the thematic analysis of data at a group level (Boulton and Gifford, 2014). Data synthesis was later conducted by two senior research team members, with the synthesis being taken back to the research team for final mahi a rōpū consolidation. Analysis of the data, at each stage in the process, was carried out across three interrelated nested environment levels (Berkeley and Springett, 2006): *policy* (government), *practice* (provider) and *whānau* (community). Multi-level analysis included exploring understandings of service delivery outcomes; outcomes expectations, including reporting requirements; diversity in perspectives; and experiences among informants.

Findings and discussion

Utilising all data sources, we defined five key theme areas when reviewing the data on outcome frameworks within the MHSP case study sites. Data is considered under the areas defined as: control, complexity, conscience, consideration and capacity. Themes are presented using a nested environments approach, discussing how outcomes have an impact at various levels of the system, including policymakers, providers and whānau.

Control

In contrast to some of the concerns identified in the literature, which highlight state control in determining

how outcomes are measured, we found at least one example where control was largely in the hands of Māori at policy, provider and whānau levels. We found evidence of the Whānau Ora Outcomes Framework not only being implemented by MHSPs, but also being adapted to suit local settings. For example, each of the seven outcome domains for Whānau Ora are clearly described in the overarching Whānau Ora Outcomes Framework (Whānau Ora Partnership Group, 2015). Te Pou Matakana has in turn conducted a significant amount of work to incorporate these outcomes into their own outcomes matrix, noting the need to develop a shared framework in collaboration with whānau and with service providers (Te Pou Matakana Commissioning Agency, 2015). Two of our case study sites hold contracts with Te Pou Matakana. One of these sites has a strong history of developing Whānau Ora service models and outcome measurement prior to the work occurring nationally under the taskforce (Boulton, Tamehana and Brannelly, 2013), and has continued this work under the now widely adopted Whānau Ora policy. The site is continually adapting to more closely align outcomes with local need and to better support whānau to realise their Whānau Ora aspirations.

The overarching framework therefore appears to be able to accommodate some level of flexibility without losing its integrity. The values underpinning the framework include, but are not limited to, notions of collective well-being at a whānau level, strengths-based practice that looks for solutions to complex issues, being whānau driven through self-identification of outcome goals, and a cross-sector approach required to resolve what are complex issues facing Māori whānau.

This theme of control is significant in the context of our findings. There is some evidence that for MHSPs, Whānau Ora reflects initial progress towards enhanced Māori control over what counts as outcomes and how outcomes are measured. Within the specific context of Whānau Ora contracting for outcomes, we recognise the potential opportunity for Māori despite also having some misgivings with respect to the neo-liberal approach to social provision generally and its impact on Māori well-being. O'Brien, Sanders and Tennant (2009) suggest that outcomes-focused contracting could potentially provide a vehicle to 'achieve an improved, more consultative engagement between government agencies and non-profit services' (O'Brien, Sanders and Tennant, 2009, p.24). The recent work of Boulton et al. (2017) identifies some level of outcomes-focused progress with specific reference to Whānau Ora commissioned services. For our MHSPs, it would appear that the potential of Whānau Ora outcomes contracting may be beginning to be realised. We are mindful, however, of the myriad issues surrounding influence in relation to outcomes, including who determines what outcomes are meaningful and how, as outlined above in the background section of this article.

> For our MHSPs, the complexity of outcome measurement is further exacerbated by the recent addition of Whānau Ora commissioning to the mix.

Complexity

Outcome measurement, within the context of the case studies, is complex not only for providers but also for funders and policymakers. There are multiple competing demands at a variety of levels. These include the state's need to ensure accountability in relation to the use of public funds and to satisfy expectations that services will deliver clearly identified outcomes (Moore and Moore, 2015); the requirement for funders, or government agents, to develop a range of outcome measurement tools appropriate for operationalising across multiple sectors; and the pressure on providers to implement the various measurement frameworks.

For our MHSPs, the complexity of outcome measurement is further exacerbated by the recent addition of Whānau Ora commissioning to the mix. These new additions to the outcome environment do create yet another layer of accountability for MHSPs. Despite that development, and other state initiatives to promote integrated contracting for outcomes, the MHSPs we partnered with in the preventing chronic conditions research continued to hold multiple contracts, including output-focused contracts, across the health and social services sector; sometimes, even, several contracts were held with a single funder. The multiplicity of contracts in turn creates a multiplicity of accountability lines, with MHSPs being required to report in various ways, and many times, often against similar measurements, creating a sometimes overwhelming sense of duplication. O'Brien, Sanders and Tennant (2009) note that state initiatives to promote contracting for outcomes had been expected to simplify the process of contracting, as well as reduce the reporting burden for providers. For our MHSPs, however, the contracting environment was akin to that described, almost a decade ago, by the non-profit sector as being both 'onerous and demanding' (O'Brien, Sanders and Tennant, 2009, p.28), suggesting limited progress is being achieved.

Conscience

Conscience, in the context of this article, refers to the overarching values and principles informing the implementation of policy such as that concerned with outcome frameworks. As has been noted above, outcomes definition and measurement is neither neutral nor value free. Indeed, over the last decade the emphasis on measuring outcomes has been imposed largely in a top-down manner, informed by priorities including accountability in the use of public funding and the requirement for data to assist in prioritising services and purchasing services at a time of fiscal constraint. The top-down drive to generate data for

outcomes tends to focus at a personal level, assuming an individualistic responsibility by at-risk groups for demonstrating outcomes. There is a tension between the principles underpinning this approach, and a broader systems-level view which sees the responsibility for change coming from a need to improve social cohesion, enhance environments and improve system responsiveness to individuals. That broader systems-level view sits more comfortably with the principles and whānau-focused Māori well-being aspirational goals of He Korowai Oranga, the Māori Health Strategy (King and Turia, 2002), and indeed with the aspirations of Whānau Ora.

The narrow descriptors favoured by state agencies, somewhat a necessity in outcome measurement, do not capture the richness and depth of change over time for collectives such as whānau, nor do they capture the breadth of the work undertaken by MHSPs in contributing to social change for whānau. We note, too, a concern about privacy issues regarding the use of individual and whānau data to measure outcomes. Some of the 'stories' collected from whānau are being used as exemplars to demonstrate outcomes; this type of data used in this way is potentially traceable back to specific whānau. Further discussion is therefore required to ensure that whānau are fully informed about, and consent to, the potential wider use of their personal information in the process of the refinement of outcomes measurement in services provision beyond Whānau Ora.

Consideration

There are significant missed opportunities, at all levels of the system, to review outcome data more regularly and consistently to improve health service delivery. Generally, our research with the three MHSPs showed that outcomes are largely determined at funder level. Reports are then populated from the bottom up, with little interaction and reflection on the data as it moves through the system. Whānau and individuals provide information to their provider, and case-level workers collect the data and feed it up through the system to provider managers, who collate the data across a range of contractual reports and then deliver this to district health boards (DHBs) and government ministries. There are multiple points at which the data can be used for reflection and improvement. However, it appears that the lack of engagement with, and reflection on, the data is driven by a strong 'reporting to funders' ethos, as opposed to an iterative quality improvement process, where data is included as part of a cycle of reflection, change and reassessment. Both approaches are needed.

MHSPs are well placed to work effectively with Māori, including through addressing critical gaps in Māori chronic conditions prevention.

Concern around the dearth of feedback from DHBs to non-profit service providers is not new. For example, over a decade ago that very concern was highlighted in response to a survey by the working group of member non-government organisations regarding their relationships with DHBs (Stace and Cumming, 2006). Boulton, similarly, in the Māori mental health provider context, found that DHBs rarely used reporting information, whether output or narrative outcome reports, to address or respond to provider concerns (Boulton, 2005). Tight time frames for reporting, which are often quarterly, the workloads of individuals at all levels in the system, the capacity for analysis and the restrictive narrow measures used in outcomes discourage the use of outcome data as a quality improvement tool. With respect to the outcomes reporting required of the MHSPs to Whānau Ora commissioners, we similarly noted some room for improvement in the outcome/reflection cycle.

Capacity

Our study identified variable capacity across the three MHSPs to develop, measure and utilise outcome data for analysis. Some of that variability was due to provider size and maturity, with larger providers managing the complexity and demands of outcome reporting more confidently than smaller, less well-developed providers. Two of the cases had internal capacity both to respond to outcome data requests and to be involved in the design and development of locally tailored outcome measurement tools specifically in relation to Whānau Ora services. However, for providers struggling with outcome measurement it was a challenge to collect data, and there appeared to be virtually no in-house capacity for analysing and utilising outcome data for service improvement. Four components were identified as influencing outcome measurement capacity at the provider level: financial resources, training opportunities, workforce capacity and information technology capacity. Some providers struggle to fund the purchase of the tools necessary for collecting and collating data for outcomes, along with the training required to strengthen the workforce capacity to collect outcomes data. Two of the three MHSPs had no in-house specialist analyst capacity that could enhance regular review of the data.

Conclusion and issues for further consideration

MHSPs are well placed to work effectively with Māori, including through addressing critical gaps in Māori chronic conditions prevention. The work they do takes place within the broad context of the neo-liberal transition, from the mid-1980s, that has seen varying degrees of state focus on market-driven solutions, limited provision and individual responsibility for personal well-being. Contracts-based funding opened up doors to forge relationships with a diversity of non-state actors, including MHSPs. Tensions for MHSPs exist, however, despite the opportunities afforded by neo-liberalism. Much of that tension can be traced to the nature of contracting itself, with contracts still being

time-bound, formalised, prescriptive and predicated on compliance. For MHSPs, balancing the demands of contracts that do not necessarily take account of a Māori world view is particularly challenging (Boulton, 2007).

In recent times, contracting for outcomes has become increasingly popular, raising its own set of challenges for MHSPs, given the tensions around who gets to determine what outcomes are important, how these outcomes are 'measured' and by whom. While it appears that the state is driving much of the outcomes decision making across contracting with the health and social services sector, contracting for Whānau Ora is apparently forging a unique direction. The high-level outcomes the Whānau Ora Outcomes Framework identifies have been directly influenced by Māori leaders, with commissioning emerging more recently as a model for the purchasing of these outcomes. Whānau Ora commissioning agencies have the documented aim of reducing the compliance burden, as well as improving funding and accountability mechanisms, to support the success of Whānau Ora. The indigenous principles outlined in Whānau Ora policy, and their underlying values, may potentially benefit overall commissioning practice. Recent research with one of the commissioning agencies (Boulton et al., 2017), for example, highlighted service design by consumers, close work with providers towards shared goals, a focus on agreed outcomes and flexibility, being whānau centred and adopting a concerted cross-sector approach. Despite a broadly positive assessment, however, significant commissioning challenges were also highlighted.

Though the overall outcomes contracting space appears to be fraught for providers, the foundations of a policy platform for effective outcomes contracting 'by Māori for Māori' has been established with the advent of the Whānau Ora services commissioning model. We found evidence of the Whānau Ora Outcomes Framework being implemented by MHSPs and being adapted to suit local circumstances. For our MHSPs, the potential of Whānau Ora outcomes may be beginning to be realised. We are mindful, however, of the many issues surrounding competing interests in relation both to Whānau Ora outcomes and to outcomes generally. Our findings highlight complexity of outcomes measurement, and of contract reporting overall, that remains problematic. MHSPs 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.

The outcomes space is clearly values driven and is vigorously contested, including by the state, Māori interests and the broader non-profit sector. Making explicit the values driving state outcomes contracting, and taking account of these, is important if the work of MHSPs is to be adequately and safely framed and recognised. We note the ongoing lack of opportunities being utilised to reflect on outcomes data at all levels of the system, from central government through to flax-root service delivery. Our study reinforces that there continues to be a lack of useful and timely feedback to MHSPs from state sector service contract purchasers, along with an ongoing tendency for outcomes to be largely determined in a top-down manner. Finally, we note that larger and more mature MHSPs may be in a better position to absorb some of the costs invariably associated with outcomes reporting. Others are likely to be considerably disadvantaged in relation to effective outcomes reporting.

In response to these findings, we note that if MHSPs are to actively participate in the outcomes space it is critical that:

- the work already being done, under Whānau Ora, to enhance Māori control of outcomes decision making be consolidated and extended beyond Whānau Ora;
- a simplified contracting and reporting environment, more commensurate with funding levels, is established;
- they be adequately resourced to usefully reflect on results, at all organisational levels, and can benefit from improved contractor feedback loops; and
- they be appropriately supported to access and effectively utilise measurement tools; this is especially so in the case of smaller providers.

1 Meaning that the study was Māori-driven, focusing on issues of concern to Māori; drew on methods and practices consistent with tikanga, Māori knowledge and contemporary realities; privileged Māori research aspirations; and looked to build Māori research capacity (Gifford et al., 2017).

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