



## Indigenous Peoples' Health Care: New approaches to contracting and accountability at the public administration frontier

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## Abstract

This article analyses reforms to contracting and accountability for indigenous primary health care organizations in Canada, New Zealand, and Australia. The reforms are presented as comparative case studies, the common reform features identified and their implications analysed.

The reforms share important characteristics. Each proceeds from implicit recognition that indigenous organizations are 'co-principals' rather than simply agents in their relationship with government funders and regulators. There is a common tendency towards more relational forms of contracting; and tentative attempts to reconceptualize accountability. These 'frontier' cases have broad implications for social service contracting.

## Key words

Third sector organizations, indigenous primary health care, public management, contracting, accountability

# INDIGENOUS PEOPLES' HEALTH CARE

## New approaches to contracting and accountability at the public administration frontier

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## INTRODUCTION

In the 'settler societies' of Australia, New Zealand, and Canada, indigenous peoples live shorter lives compared to the total population, and carry a higher burden of disease (Australian Bureau of Statistics 2011; King *et al.* 2009; Ministry of Health 2010). Official attempts to address indigenous health inequalities have frequently been judged as failures by governments, indigenous communities, and researchers (e.g., Australian Indigenous Doctors' Association 2010; Browne *et al.* 2011). At the same time, primary health care (PHC) initiatives that emerge from indigenous communities themselves have been accommodated through government policy and funding programmes that enable care to be delivered by community-based third sector organizations (TSOs). These organizations also function as the base (of knowledge and resources) for communities to advocate for health rights and priorities.

Governments in these countries, applying New Public Management (NPM) practices to varying degrees, have imposed requirements for contracting, performance, and accountability that have been shaped for other contexts (Lavoie 2005) and emphasize the imperatives of government funders (Boulton 2005; Christensen and Laegreid 2001).

In response, indigenous TSOs, aiming to provide comprehensive PHC services to meet community needs, have little choice but to 'patch together' many precisely targeted funding programmes. Evidence indicates that the constraints of these funding programmes can undermine responsiveness to communities (Christensen and Ebrahim 2006; Ospina *et al.* 2002), align poorly with the imperatives of professional staff (Hwang and Powell 2009), create high transaction costs for TSO recipients (Tenbensen *et al.* 2013), and potentially threaten the sustainability of the indigenous PHC sector (Lavoie *et al.* 2010).

In response to these concerns, new discourses and approaches to contracting and accountability have emerged in Canada, New Zealand, and Australia over the past 5 years. While they are informed by public administration theory, particularly new public governance and public value (O'Flynn 2007; Osborne 2007), they confront governance and accountability challenges that have not yet been satisfactorily addressed in theoretical debates (Ryan 2011).

This article analyses emerging reforms in each country, as comparative case studies in the development of alternative approaches to government–TSO relationships. Our goal is to contribute to efforts to address the policy and practice challenges that must be resolved if alternative methods of contracting and accountability are to be accepted.

## THEORETICAL FOUNDATIONS

The relationships between indigenous PHC organizations and governments in the three countries have been shaped by two radically different frameworks. The indigenous PHC sectors arose from community activism in the 1970s to 1990s, in pursuit of the goals of

better health and health care as well as self-determination (Anderson 2006; Durie 1994; Lavoie 2004). These initiatives echo (and sometimes precede) broader debates on the value of public engagement in PHC (World Health Organization 1978). Indigenous health movements arose because of experiences of exclusion from health care; and of poor quality care that failed to recognize the health impacts of colonization and continuing social disadvantage, or the importance of indigenous culture and identity (Durie 2001; Lavoie et al. 2009). Around the world, indigenous minorities continue to place a strong emphasis on health, often using the concept of health as a human right and a right of indigenous peoples in particular (United Nations 2007).

At around this time, governments in English-speaking industrialized countries began to adopt the practices known collectively as NPM in the pursuit of public sector reform (Hood 1991), including the use of contracts to govern service delivery and ensure a narrow concept of accountability. Thus, in the health sector, the funder is seen to act on behalf of taxpayers, ensuring that services are effective and targeted to patient needs; and that providers make efficient use of taxpayer funds. This approach underlies the move towards explicit contracts for services, with the funder (the 'principal' in agency theory (Eisenhardt 1989)) determining the performance targets (cost, volume, and quality), and the provider cast as an agent of government policy.

There are several problems with the NPM approach to contracting for health and other social programmes, including the problem of information asymmetry, with the funder often unable to determine the best approach to services or the best use of resources (Sabel 2004). When this approach is applied to services for marginalized populations, the casting of community-based TSOs as agents of government is particularly problematic. Governments contracting with indigenous TSOs generally acknowledge that the TSOs know more about the needs of, and are closer to, the client groups; and further that they have at least some legitimacy in their claims to represent the communities (Sullivan 2011, ch. 5). There are also significant problems with reconciling the NPM-inspired contracting goals of competition and ease of withdrawal, with the PHC goals of continuity of care and long-term treatment relationships (Palmer and Mills 2003).

Contracting is characterized on a continuum from classical (traditional form of contracting to purchase discrete and well-defined goods or services) to relational contracting (Williamson 2000). The term 'alliance contracting' is used in the private sector – 'an agreement between parties to work cooperatively to achieve agreed outcomes on the basis of sharing risks and rewards' without 'the adversarial relationships common in more traditional contracts' (Clifton et al. 2002). Attempts to implement quasi-classical contracting to purchase health care services have been consistently problematic, and shifts towards relational approaches first emerged in the 1990s (Ashton 1998; Goddard and Mannion 1998).

In health care, longer-term relational contracts aim to preserve the benefits of separating the roles of funder and provider, while offering relative security to support

a robust health care system. The need for workable levels of trust between the parties to a relational contract runs counter to the agency thinking typical of NPM, although there is evidence that the risks arising from the need for trust in relational contracting for PHC can be minimized (Liu *et al.* 2007). However, a significant gap remains with regard to both theoretical foundations and effective methods for meaningful accountability in relational contracting frameworks.

Accountability, in this context, is generally defined as a power relationship where an accountability holder has the right to information, auditing, and scrutiny of the actions of an accountability giver (Mulgan 2002, p. 3). The obligations on both parties to NPM-style contracts (the exchange of money for information and compliance) align well with this sense of accountability. While the NPM conceives the accountability relationship as being one-sided (accountability of the provider to the funder who represents the clients), recent research has recognized the complexity of accountability relationships for TSOs, among others (Williams and Taylor 2013), and the difficulties of making NPM-style accountability requirements work effectively (Romzek and Johnston 2005). For many TSOs, accountability is a complex interplay among the requirements of communities, funders, and professionals (Tenbensen *et al.* 2013); and the providers' accountability to the funder may not be seen as the most important accountability relationship (Boulton 2005, p. 263).

Tension about accountability measures arises partly from differences in the ways that funders and providers use activity and financial data – funders to meet their upward reporting requirements; and TSOs for management and reporting to boards and communities as well as to funders. On the other hand, some standardization is useful to all for performance monitoring. While these problems have been substantially resolved for financial data, data about service delivery is both more complex and more contested. The ideal of 'collect once, use often' is seldom achieved in practice (Auditor General of Canada 2002; Digiacomo *et al.* 2010).

But accountability tensions also have deeper sources (Williams and Taylor 2013). Sullivan (2009, p. 66) offers an alternative understanding in which accountability is 'the activity of rendering an account within a group and between groups so that the actors negotiate their identity, obligations and commitments in relation to each other, producing an environment of reciprocal accountabilities'. In this article, we suggest that the problem of reconciling different interpretations of accountability, and developing methods that are workable and acceptable for funders, providers and communities, is a major hurdle for reformers, and a significant barrier to improvement in health care for indigenous communities.

## METHODS

We conducted a comparative case-study analysis of emergent reforms in Canada, New Zealand, and Australia. The reforms are current attempts to address the funding and

accountability relationship between government funders and indigenous TSOs providing PHC and social services.

The case studies are designed to test the proposition that the reforms are based on recognition of shortcomings in the dominant (NPM-based) methods of contracting with TSOs. More specifically, we analyse ways in which the reforms tend to move away from tight specification of deliverables towards more 'bundled' or integrated longer-term contracts; and whether the dominant accountability regime is modified in ways that recognize reciprocal responsibilities for common goals and desired outcomes.

The case studies are based on analysis of policy documents, relevant research, and direct observation by the authors, who were involved in separate studies of each of the reforms. We describe the context and the reform policy instruments, and present an analysis of the implications for more integrated and longer-term contracts and for shifts in accountability and related reporting requirements.

## **EMERGING FUNDING AND ACCOUNTABILITY MODELS FOR FIRST NATIONS IN CANADA**

In Canada, the federal government has assumed authority over 'Indian' (First Nations) affairs since 1867. The Indian Act 1876, while decried as an instrument of oppression (Gabriel et al. 2011), nevertheless created a point of contact between the state and First Nations. The Act required each Nation to elect a Chief and Councillors, who were then tasked to act as a government for the Nation. This imposed model has, in some cases, displaced traditional forms of governance. In other cases, both forms coexist (Imai 2012; Mackie 2012).

While the powers of the imposed form of governance were initially trivial, Canada has, for more than a century, legally recognized and engaged with a form of First Nations local governance. Since 1982, Section 35 of the Canadian Constitution recognizes Aboriginal and treaty rights, and has been widely interpreted as recognition of Aboriginal peoples' right to self-government (Lux 2009). This implies the transfer of responsibility for health and social programme planning, management, and delivery to First Nations governments. Competitive contracting has no place in this framework.

Two federal departments, the First Nations and Inuit Health Branch (FNIHB) of Health Canada and Aboriginal Affairs and Northern Development Canada, have responded to First Nations aspirations for self-government with a range of funding and contracting options.

Thus, First Nations ('on-reserve') communities receive PHC in one of two governance models: from community-controlled health services which are accountable to community local government authorities; or from clinics operated by FNIHB. More complex and acute care, and PHC provided off-reserve, is funded by the province. For

the general population, most health care is provided by public services funded by provincial universal health insurance, and in the case of hospitals, operated by the provincial government or regional health authority.

## **Policy instruments: Cumulative reform increases integration**

Since 1982, multiple approaches to contracting have emerged. Communities have three main options: multi-department funding agreements (MDFAs), block funding agreements (BFAs), and flexible funding agreements (FFAs), which bring varying degrees of flexibility. MDFAs are the most flexible, as they bring together multiple social programmes (health, education, child welfare, economic development, income assistance, infrastructure, housing, and local governance) under a single relational agreement between the First Nations government and the federal government.

In contrast, BFAs and FFAs relate to health services only. BFAs are block-funded flexible agreements offered for periods up to 10 years, with opportunities to add new programmes as they emerge. In contrast, communities who sign an FFA must secure the federal government's permission before moving funding between budgetary lines (Health Canada (FNIHB) 2012a). These options have been relatively well received by First Nations, with 89 per cent of the eligible 610 First Nation communities involved in one or other type of agreement, as of 2008 (Health Canada (FNIHB) 2008b).

## **Integrated contracting, with exclusions**

While these opportunities have been portrayed by governments and some scholars as an expression of self-government (Chartrand 1999; Magallanes 1999), many limitations have been noted (Lavoie et al. 2005, 2009). These arrangements are only available to discrete First Nations and Quebec/Labrador Inuit communities, while services for Métis and Aboriginal people living in urban areas are provided by mainstream organizations, with few urban Aboriginal health clinics available. Some of these services are resourced through relational contracts, while others depend on a collection of classical contracts (Lavoie et al. 2013). More research is needed to map funding and accountability pathways off-reserve.

On-reserves, both BFAs and FFAs exclude some programmes from the flexible framework (e.g., the Aboriginal Diabetes Initiative, the First Nations Home and Community Care programme, and the recently implemented Maternal and Child Health programme) (Health Canada (FNIHB) 2008a). Some of the excluded programmes have been introduced as a pilot phase. Once implemented nationally and shown to be worthwhile (Health Canada (FNIHB) 2012b), these programmes are then integrated into the flexible contractual framework.



## Accountability

Some of the exclusions noted above arise from a reporting problem with national programmes. Although the First Nations and Inuit portion of these programmes is managed by a separate authority (FNIHB), standardized national reporting frameworks nevertheless apply to the funding. Thus, accountability requirements prevent the inclusion of these programmes in a flexible contractual arrangement.

Further, accountability frameworks under all models of contracts remain fragmented and onerous. For example, although the high number of separate reports required in British Columbia (BC) (Lavoie et al. 2005) has been reduced since 2003/04, this consolidation has not involved a meaningful reduction in the number of items to be reported (Lavoie et al. 2011).

The challenges outlined above reflect the accountability processes set in place to ensure that all federal department programmes provide returns on investments (Phillips and Levasseur 2004). While accountability is key, the former Auditor General of Canada has acknowledged that federal government processes may be ill-equipped to meet the needs of local PHC organizations: 'there's not much point in First Nations exchanging data for dollars with the federal government when the information is of no real benefit to either party' (cited in Yourk 2002).

The Canadian approach, which has focused on administrative arrangements between the federal government and a single community or group of communities, has effectively imposed accountability frameworks designed for very different kinds of procurement. As noted by the Auditor General of Canada (2002), there are 'several problems with the use of this funding mechanism for the provision of core government services', including poor definition of services, lapses in funding related to delays in contract renewals, lack of accountability to First Nations members, and reporting overburden. Similar issues have been noted in contractual relationships between the federal government and the NGO sector more broadly (Phillips and Levasseur 2004).

For these reasons among others, new approaches to contracting and accountability for health are emerging. In BC, the federal government has implemented a transfer of its budget and responsibilities for health funding and service delivery to a province-wide consortium of First Nations (First Nations Health Council et al. 2010). The newly created BC First Nations Health Authority (FNHA) now assumes what were previously federal responsibilities, including the funding of First Nations TSOs.

Although, at the time of writing, it was unclear how this transfer will be structured, the FNHA has some latitude to rethink the administrative instruments used to contract out services to individual First Nations community providers; and to develop alternative approaches based on mutual accountability. However, while the agreement between the FNHA and the federal and provincial governments (Government of Canada, Government of British Columbia and First Nations Health Society 2011) uses the

language of mutual accountability, the accountability framework currently focuses solely on the FNHA's responsibilities to its funder.

## Key points

There has been significant progress towards more integrated, longer-term funding contracts both nationally and in BC. This shift has created new opportunities to improve responsiveness and thereby to close the gap between community aspirations and service delivery. Reporting requirements to governments have been harder to shift.

Canadian First Nations health organizations see their role both as advocates and as service providers. They are able to use data gathered through their contractual role, and other activities, to deliver evidence-informed critiques of policies. They are thus working to shift accountability from a top-down to a mutual process, where accountability is required of both parties. While it is clear that not all First Nations organizations are equally skilled in this art, it is also clear that developing such a skill is an integral part of the self-government project, and essential to the refinement of approaches to accountability and to contractual instruments.

## NEW ZEALAND: TOWARDS WHĀNAU ORA AND INTEGRATED CONTRACTING

### Background

In New Zealand, the Treaty of Waitangi establishes the relationship between the state and Māori, providing a constitutional basis for efforts to improve Māori health status (Durie 1994; Robson and Harris 2007). Starting in the 1980s, the principle of biculturalism required all organizations delivering health services to give effect to the principles of the Treaty of Waitangi in their operations (Durie 2001) and be responsive to Māori priorities in their policy and practice. By the mid-1990s, it was evident that 'responsiveness to Māori' had produced only token changes (Cunningham and Durie 1999, p. 240). Consequently, Māori challenged the concept of 'mainstreaming', arguing that Māori themselves were better placed to manage and deliver their own programmes and act as guardians for their own people (Royal Commission on Social Policy 1988).

During the same period, extensive government reforms encapsulating a radical NPM programme reshaped the public sector (Boston *et al.* 1996). In health, fundamental restructuring allowed services to be outsourced through contracting with the third sector. These reforms enabled approximately 250 Māori- and iwi (tribe)-led TSOs to develop as service providers, with structure and governance arrangements that varied from community-based entities (with directors being both Māori and non-Māori

members of the local community), to tribally based services operating under the ownership of government-recognized Rūnangas (tribal authorities) (Abel et al. 2005).

The reforms to the state sector produced a complex patchwork of contractual relationships between a variety of national government agencies (social service, health, education, justice) and non-government service providers. Many Māori providers held multiple small contracts with one or more funders (Lavoie 2005). Contractual accountability centred on measurable outputs (i.e., activities delivered) that could, in theory, be controlled by the provider. The prevailing orthodoxy was that only Ministers could be held accountable for outcomes (results of the activities) (Boston et al. 1996), discouraging inter-agency cooperation which would blur lines of accountability.

A change of government in 1999 led to a shift in thinking towards joined-up government and accountability for outcomes (Chapman and Duncan 2007). However, the government also decentralized funding of health services to twenty-one District Health Boards in 2001 (Gauld 2009). New Primary Health Organizations (PHOs) were introduced to improve access to PHC services and coordination among providers (Barnett and Barnett 2004) and ensure community participation in priority setting (Abel et al. 2005).

The introduction of PHOs and subsequent policy shifts changed the structure and organization of Māori health providers. Those with a sufficiently large enrolled patient population transformed directly into stand-alone PHOs, while smaller providers became part of larger mainstream PHO organizations. Māori providers now range from being part of mainstream PHOs, to small, single entity organizations serving discrete communities of people, and large Māori-led organizations collectively delivering PHC and social services to hundreds of thousands of New Zealanders through an array of contracts.

### **Policy instrument: The Whānau Ora model of health and social service delivery**

The concept of whānau ora (family health) emerged as the primary goal of He Korowai Oranga, the Māori Health Strategy in 2002 (Ministry of Health 2002). Defined as 'Māori families supported to achieve their maximum health and well-being', whānau ora is an inclusive, culturally anchored approach, based on a Māori worldview of health which holds that changes in the well-being of an individual can be brought about by focusing on the family collective or whānau, and vice versa (Families Commission 2009).

The Whānau Ora approach introduced in 2010 (Taskforce on Whānau Centred Initiatives 2010), obliges services to work collaboratively across traditional sector boundaries; to place whānau needs at the centre of all care plans; and ultimately to improve whānau (family) well-being (Boulton et al. 2013).

The government's Whānau Ora approach thus requires the development of new governance and contracting arrangements, to ensure community, service providers, and funders meet their respective responsibilities and obligations. These arrangements must be flexible enough to achieve measurable whānau ora (well-being) outcomes, yet robust enough to work across disparate sectors of government which largely continue to operate separate budgets and portfolios.

Twenty Māori health and social service providers were selected in 2010/11 to lead the Whānau Ora model in their communities. A budget appropriation was made in 2010 for \$134.3 million over 4 years, with participating providers retaining existing funding and contracts (with many being reconfigured). Initial efforts at 'joined-up' service provision, with several government agencies providing integrated pools of funding to enable Māori TSOs to meet the health and social care needs of families (whānau), then commenced.

## **Contracting reforms**

Integrated contracts (single agreements with the provider that incorporate funding provided by several government departments) that focus on shared outcomes are recognized as essential for the achievement of whānau ora outcomes. In part, the Whānau Ora approach is a response to public sector interest in integrated contracting that emerged first in the Ministry of Social Development in 2007 (Pomeroy 2007; Ryan 2011), and is now the focus of government attempts to streamline contracting with non-government service providers (Ministry of Business, Innovation and Employment 2013). Some Māori health sector organizations are also developing integrated contracting initiatives outside the Whānau Ora umbrella. However, these developments are in their early stages, and results are yet to be seen. Importantly, the funding environment is more complex than ever with no rationalization of public sector funding agencies.

## **Accountability**

While the focus on measurable outcomes for families and communities is a strength of recent developments, there is a risk that more rigorous use of outcome-based performance indicators in the implementation of the Whānau Ora approach may effectively set performance benchmarks for Māori TSOs that are inequitably high when compared to those for mainstream health services (still largely accountable for outputs).

The expectation of outcome-reporting represents a significant shift in thinking about performance and accountability; one made even more challenging by the recognition that whānau ora outcomes may be *iwi* (tribe), *hapū* (sub-tribe), or even community-specific. Considerable investment has also been made in evaluating the new model. An

intensive programme of action-research is gathering evidence of service reconfiguration; whānau-centred service delivery; greater inter-agency collaboration; and the achievement of improvements in whānau well-being.

## Key points

The Whānau Ora approach to health and social service delivery is, in many ways, more consistent with the approach of Māori health care providers, which have always worked across the somewhat artificial boundaries that construct and define ‘social’, ‘health’, ‘education’, and other human services (Boulton 2005, 2007; Crengle 1997). Working across these boundaries is necessary for services that have emerged from a cultural understanding of the well-being of the whole whānau (family) (Boulton 2007).

The intended shift to accountability for outcomes rather than outputs is also promising, if risky, and may provide the basis for rebalancing accountability to funders with accountability to community. However, concepts of whānau ora are likely to differ across organizations, regions, funders, and providers, and even between providers and whānau themselves (Boulton et al. 2013). Flexibility is needed in the design, operation, contracting and evaluation of the services, which are necessarily locality-specific. Care must be taken, for example, that moves to establish national outcomes do not undermine the community-driven approach that underpins the Whānau Ora model.

## **PATHWAYS TO COMMUNITY CONTROL IN AUSTRALIA’S NORTHERN TERRITORY**

Unlike the situation in comparator countries, in Australia, there is no legal basis in treaties or constitutional recognition on which to build national legislative responsibility for indigenous health (Howse 2011), although formal recognition of the original inhabitants has been included in some jurisdictional constitutions.

The third sector in Aboriginal and Torres Strait Islander PHC in Australia was initiated in the 1970s, with the emergence of organizations owned and ‘controlled’ by local communities, and now constitutes a significant part of the Australian health system, providing PHC services to between one-third and half of the Aboriginal population (NACCHO 2009, pp. 2–3; NHHRC 2009, p. 87) in rural, remote, and urban settings. There are approximately 150 Aboriginal Community Controlled Health Services (ACCHSs) in Australia (Martini et al. 2011).

ACCHSs aim both to provide health care and to advocate for and represent their communities in health policy and access to resources. Their relationships with government are characterized by heightened political sensitivity, at least partly as a result of this combined role of service provider and representative organization (Sullivan 2009).

The combined role has been formally accepted by all national and jurisdictional governments, which have committed to a policy framework that endorses comprehensive PHC provided by organizations that 'maximize community ownership and control' (NATSIHC 2003, p. 1). However, these policy positions are not consistently supported in public administration or policy debate (Anderson 2006; Sullivan 2011, ch. 5).

Since the 1980s, Australian Governments have embraced the contractual methods of NPM vigorously (O'Flynn 2007), and the current arrangements for funding are fragmented and complex, with excessive administrative and reporting requirements (Australian National Audit Office 2012; Department of Finance and Deregulation 2010).

The relative roles of the national and jurisdictional (state/territory) governments in health policy and health care delivery are overlapping and accountabilities are contested (NHHRC 2009). This includes responsibility for Aboriginal health, with both levels of government providing direct funding for Aboriginal-specific health care providers. The sector is funded and held accountable through a complex array of short-to-medium-term funding contracts, a situation that contrasts with the mainstream health system, where essential basic care is either provided directly by government or funded through long-term fee-for-service arrangements. Mainstream TSOs are also subject to the burden of complex contractual environments, and this situation is the subject of increasing concern and policy attention (McGregor-Lowndes *et al.* 2009; Productivity Commission 2010).

The cost and efficiency problems caused by the complex contractual environment for Aboriginal services are well documented (Dwyer *et al.* 2011; Eagar and Gordon 2008). The current arrangements also work against the goal of delivering comprehensive PHC that is responsive to community needs (Dwyer *et al.* 2011). Problems with the governance of Aboriginal PHC community providers receive public attention from time to time (e.g., Office of Registrar of Indigenous Corporations 2012), and reinforce a lack of trust among government funding bodies, overshadowing the good practice of the majority of service providers. The need to strengthen local governance has been acknowledged by the sector, while the need to reform the funding and accountability relationship so that it supports the development of a robust PHC system for Aboriginal people is recognized by all parties (Department of Finance and Deregulation 2010; Dwyer *et al.* 2011). Reform efforts have been initiated by several jurisdictions. This case study focuses on the Northern Territory (NT), the jurisdiction with the highest proportion of indigenous people in its population (30 per cent compared to the national average of 2.6 per cent, MacRae *et al.* 2013).

### **Policy instrument: The regionalization project**

The NT Aboriginal Health Forum (NTAHF), a tri-partite body (with representatives of both levels of government and the community-controlled sector) has been working to

improve health services and the funding relationship for more than 15 years. In 2009, the NTAHF, adopted *Pathways to Community Control* (NTAHF 2009), a plan for the development of a comprehensive regional PHC system for Aboriginal communities. The goal is to provide reliable access to an agreed platform of PHC services (Tilton and Thomas 2011), with regional governance in the hands of Aboriginal communities – to the extent that they decide to take it on, and are able to demonstrate capability according to agreed standards (Department of Health and Families 2010).

Community control of PHC services is already a reality in some communities; whereas others are served by NT government clinics. Five stages of community control are articulated, and it is expected that communities will make decisions about where to locate along a continuum, with ‘advisory only’ community bodies and continuing NT government PHC delivery at one end, and full regional community governance and PHC delivery at the other (NTAHF 2009). Of a total of sixteen regions, five were already under community governance and delivery (including three urban areas); and six others with some community-controlled service delivery have commenced regional planning and/or development.

### **Contracting reform?**

There is an intention, as yet enacted only for two PHC providers, to ‘bundle’ government funding into a single contract. It is intended that the negotiated establishment of a regional board taking responsibility for the delivery of PHC to the Aboriginal people of the region would result in longer-term certainty in funding levels and simplification of reporting requirements (NTAHF 2009). The allocation of funds at the regional level implies greater flexibility in decisions about local service delivery and resourcing within the region. In the two rural regions currently operating in this model, governance arrangements have been tailored to ensure local constituencies have a voice (e.g., Katherine West Health Board 2003).

### **Accountability**

While a shift in accountability arrangements towards a more relational approach is an explicit intention, it is not yet possible to detect any general change in practice. Neither is it possible to discern progress on recognition of ACCHS accountability to their communities in formal accountability arrangements. However, the overall approach contrasts with previous tendencies (on both sides) for Aboriginal community governance to be cast as a form of separatism, and thus for providers to be seen as being isolated from the mainstream health system and from government and its resources. This is evidenced in the collaborative development of the regionalization project itself,

its specification of core PHC services, and the negotiated standards for assessing the readiness of a regional organization to take responsibility for PHC governance and delivery.

## Key points

Progress has been slower than expected, and there are tensions over the timing, cost, and processes of development (Allen and Clarke 2011). The additional funding for implementation is tightly controlled; the capacity of the Forum to lead the project has been questioned; and media coverage of problems in the governance of some existing community-controlled health services has given weight to concerns about capacity. However, the long-term policy commitment to this direction remains; and progress, albeit slow, continues. It is too early to report on outcomes.

These reforms suggest a shift from the principal–agent contracting approach in two ways. First, the provision for jointly negotiated progress towards community governance and delivery on the basis of agreed standards (and transfer of some service delivery) represents a significant step towards a genuine partnership approach between communities and governments. It also brings the potential for patient care provided by both the community-controlled sector and the mainstream health system to be better integrated.

Second, while compromises are required from communities that seek to take on the governance and delivery of PHC services, in this reform process, the principle of community governance is entrenched in the overall health system design in a practical sense, rather than simply being honoured in the rhetoric of high policy principles. The problem of reform in accountability regimes remains.

## **SYNTHESIS: EMERGING TRENDS AND THE NEED FOR A NEW THEORY AND PRACTICE OF ACCOUNTABILITY**

The approaches adopted in Canada, New Zealand, and Australia each have distinctive features, but share some important characteristics. They all represent attempts to resolve or reconcile the competing imperatives of indigenous community-based providers of comprehensive PHC with those of government funders. In BC, existing authority to govern health care in discrete indigenous communities is being transferred to the provincially based FNHA, in the hope of side-stepping limitations of the federal government's systems. In New Zealand, the need for family-centred health and community care supported by integrated funding has provided the impetus for reform. And in Australia's NT, reforms aimed at establishing a regionalized system of PHC delivery are expected to result in a shift towards relational approaches to contracting and accountability.



In spite of these differences, there are three major common themes in these emerging approaches: two that represent significant challenges to entrenched NPM practices; and one important barrier against the development of new approaches.

First, these case studies provide empirical observation of an incremental departure from 'principal-agent' approaches in contracting policy and practice. Each proceeds from recognition of indigenous communities and organizations as long-term partners rather than simply agents in the relationship with government funders and regulators. The priority given to indigenous concepts of health and family (especially in the New Zealand case); recognition of the continuing sovereignty of the indigenous polity (especially in the Canadian case); and acceptance of the role of community-based TSOs as both PHC providers and representatives of their communities (especially in the Australian case), all represent important departures from the 'principal-agent' concept of the relationship between funders and providers. That is, in accepting that indigenous communities and organizations have a substantive and independent role in defining the parameters of health policies and programmes, governments are effectively recognizing them as advocates and policy-makers in health and health care, rather than simply contract-takers, as is their ideal role in the NPM framework. We suggest that this is more correctly seen as a 'co-principals' relationship; and that it represents an approach to shared governance, as envisaged in new public governance theory (Osborne 2007).

The second common theme is the tendency to move towards more relational forms of contracting. 'Integrated contracting' in New Zealand, 'flexible funding' in Canada, and 'bundling' in Australia are all steps towards longer-term, more integrated funding contracts. This is most clear in the Canadian situation, with explicit pooling and integration of funds already in place. The intended pooling of separate funding lines in New Zealand has the creation of 'wrap-around services' (that cross portfolio boundaries) as its goal, and taken together with the emphasis on evaluation, offers the potential for the development of workable levels of trust among funders and providers on the basis of shared goals. Movement towards community control in the NT on the basis of a shared policy on regionalization, an agreed delineation of essential PHC services and standards of community capacity also provides the basis for an approach to the contractual relationship based on shared goals and functional trust.

However, the case studies also indicate that reform of accountability regimes is more difficult. The sense that accountability is an 'accounting' matter (and fundamentally about the exchange of money for information and compliance) is deeply entrenched, and we found less evidence of practical reform in this regard. While other accountability pulls (to community and other stakeholders) are recognized, they do not (yet) compete as the focus of effort and consequences. Neither is there any place in NPM-style contracting for recognition of the indigenous communities, in many cases the owners of provider organizations, as accountability holders in relation to government.

We suggest that competing views of the standing of funders and providers in relation to communities are an important source of accountability tensions in all three countries.

NPM approaches are based on the idea that the purchaser is acting on behalf of citizens as 'customers', to ensure that providers meet their needs well. The indigenous health movements, and the indigenous TSOs they created, are explicitly acting as the representatives of communities, and the TSOs enact this role in structures and practices of direct accountability to their communities as 'owners'. Resolving these competing claims to the role of protecting the interests of citizens/communities may not be possible – neither party can be absolved of this responsibility. However, we suggest that work to clarify the distinctions between these claims, and to accommodate both in accountability arrangements that apportion rather than duplicate measures accordingly, may be an important next step.

We also suggest that the trust between funders and providers, that is required in relational contracting and lubricates accountability relationships, is particularly fraught in the inter-cultural/inter-racial setting of indigenous health care, reflecting the historical tension between indigenous communities and settler populations (Havemann 1999). This reality tends to heighten the importance, as well as the difficulty, of finding alternatives to principal–agent approaches to accountability.

The need for accountability is universally accepted by all the actors in these case studies, but reform is elusive. The concept of reciprocal accountability described by Sullivan (2009) may provide the basis for redesigning accountability regimes in ways that recognize the complex accountabilities held by each party. The reforms reported here suggest the possible foundations for an alternative approach to state–TSO relationships. However, we conclude that a fundamental re-thinking of accountability regimes is a critical missing element.

We suggest that indigenous PHC is a case in which the inadequacy and contradictions of NPM-based approaches to funding and accountability are heightened, as is the potential for meaningful alternative methods to contribute to better performance. If this is correct, then the experience of indigenous PHC TSOs has implications for broader state–TSO relationships and both further theory development and a new programme for action are required.

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