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Commissioning health services for First Nations, regional, and remote populations: a scoping review

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Abstract

Background Commissioning for health services has been implemented as one approach to improve the quality and access to healthcare for First Nations, regional and remote populations. This review systematically scoped the literature for studies that described or evaluated the governance, funding, implementation and outcomes from health service commissioning targeting these groups in Canada, Australia, Aotearoa/New Zealand and the United States (CANZUS nations).

Methods Seventeen databases were searched for relevant peer reviewed and grey literature studies published in English from 2010 to 2023. Grounded theory methods were used to identify the enablers and strategies or processes that support commissioning and any challenges to implementation.

Results Overall, 29 Peer reviewed and 18 grey literature studies remained after screening. The studies reported enabling conditions for effective commissioning including operating models that were responsive to beneficiary needs, workforce and technical capability, flexibility and duration of contracts, adequate funding, and achievable health outcomes and indicators. Supporting strategies focussed on multi-actor collaboration, relationship building, and service innovation. Reported impacts included improved access to care, and self-determination and wellbeing for First Nations populations. Challenges related to inflexible funding, high transaction costs, overcompliance, and poor relationships. Most studies were process evaluations or descriptions of the application of commissioning to various health areas, with comparatively limited assessment of the impacts across the health system, or on health status.

Conclusion Findings suggests that a relational model drives success in commissioning for health and wellbeing services for First Nations, regional and remote populations. The relational model presented in this review is supported by the following attributes: responsive, resourced, collaborative, equitable, innovative and self-determined: and when applied by multiple actors in the commissioning process can address the complex health and wellbeing needs of end users.

Keywords Commissioning, Healthcare, First Nations peoples, Regional, Remote

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Background

Funding of health services can be highly complex, involving diverse sources and delivery models. Multiple health subsystems also operate at different levels of the wider health system and are funded and administered by different tiers of government [1]. These include public hospitals, as well as private health providers, allied health services and non-government organisations. To address these complexities, some governments have introduced reform initiatives that aim to enhance the delivery of care across the health system. Commissioning has emerged as one approach to simplify funding models and encourage system efficiencies that improve the quality-of-care people receive [2]. Conceived in the era of New Public Management (NPM), commissioning requires organisations to plan and make purchasing decisions by assessing local health needs and responding to service priorities and demand in the system [2, 3]. Joint commissioning or co-commissioning involves collaboration between funders, providers and end-users in the planning, specification and contracting of services [4, 5]. Commissioning aims to improve service delivery, and to enhance care pathways and the patient experience by linking funding to health and wellbeing outcomes, rather than service specifications [6]. Commissioning is flexible and can be applied to any population group. For First Nations, regional, and remote populations, it can address equity and access issues by ensuring services respond to community and evidence-based need, as well as fund holistic and cultural based models of care [7, 8].

This paper describes a scoping review of published literature to explore what is known about commissioning for health services for First Nations, regional, and remote populations in Canada, Australia, Aotearoa/New Zealand and the United States ('CANZUS nations'). These four settler countries were selected due to commonalities in population health and colonial history [9]. The scoping review was conducted as part of a process evaluation for the establishment of an independent community-controlled commissioning entity in regional north-Australia, the Cape and Torres Healthcare Commissioning Ltd (CaTHC). CaTHC was established by First Nations community leaders in partnership with governments with the objective to deliver self-determination over health funding and to drive improved health system performance and whole of population health and wellbeing outcomes. CaTHC will be financed by governments through the pooling of public health investment into commissioning of services across the regional population. First Nations peoples comprise approximately 70% of the remote Torres Strait and Cape York regions of north-Australia and are represented by two ethnically distinct populations—Aboriginal peoples of Cape York and Torres Strait Islander peoples. Despite high per capita health investment, the population experiences marked health disparities, including a 19-year gap in life expectancy compared to the wider population, and higher rates of premature deaths and chronic disease [10].

Commissioning for First Nations, regional and remote populations across CANZUS countries include Australia's Primary Health Networks (PHNs), established in 2015 as a mainstream model to commission specified primary healthcare services. There are 31 PHNs covering all geographical regions, and they are funded by the Australian Government to commission for mental health, First Nations health, population health, digital health, workforce, aged care, and alcohol and other drugs [11]. Australian and state governments have introduced policies to encourage co-commissioning through alliances between PHNs, public hospitals and other service providers [4, 6]. Aotearoa/New Zealand adopted commissioning in the 1990s, leading to the advent of multiple mainstream commissioning models [3]. Major reforms over this time introduced Whānau Ora (translated as 'family wellbeing'), focussed on Māori health and community outcomes [12]. In 2014, three Māori controlled commissioning agencies were appointed: Te Pou Matakana in the North Island, Te Pūtahitanga o Te Waipounamu in the South Island, and Pasifika Futures to support the health of Pacific Island communities [8, 13]. In 2022, the government introduced Commissioning for Pae Ora Healthy Futures, aiming to bring the Whānau Ora commissioning approach into the wider health system [14]. Similar government health commissioning reforms have not been undertaken in Canada or the United States, although health contracting is prevalent in Canada [15].

This review was positioned to understand the implementation and impact of health service commissioning in various jurisdictions. The key research question was: What are the enablers, strategies and processes that support the establishment and implementation of health commissioning for First Nations, regional, and remote populations? The objectives of the review were to:

- examine the various operational models for commissioning, and systems enablers such as governance and capacity, funding, monitoring and reporting frameworks, and contract design.
- examine supporting strategies such as relationships and collaboration between governments, commissioning agencies, service providers and end users, and learning and innovation.
- report on health and wellbeing impacts and successes, including benefits for First Nations communities.

- outline the challenges and limitations to commissioning.

Methods

The review followed the updated Joanna Briggs Institute (JBI) methodology for conducting a scoping review [16]. A written protocol for the scoping review was developed and circulated to a cross-section of the project and research team to reach consensus on the parameters of the proposed review, the definitions of key terms used, methods for the search, screening processes, extraction of data, and analysis and synthesis of the literature.

Inclusion/exclusion criteria

Publications were included if they met the following criteria:

a. Peer reviewed and grey literature studies published in English between 1 January 2010 to 31 December 2023 inclusive. The start date matched/preceded the establishment date of Whānau Ora in Aotearoa/New Zealand (2010) and Primary Health Networks and other health commissioning approaches in Australia (2015).
b. Described First Nations, regional, remote and very remote populations. The United Nations definition of Indigenous peoples was used, that is: "the descendants of those who inhabited a country or a geographical region at the time when people of different cultures or ethnic origins arrived and later became dominant through conquest, occupation, settlement or other means" cited in [9]. Remoteness was based on road distances residents need to travel to access health services, inclusive of the following categories from the Australian Modified Monash Model: MM5, small rural towns; MM6, remote communities; MM7, very remote communities.
c. Evaluation or description of commissioning and/or contracting for health and wellbeing services, including health promotion, prevention, and primary, community and tertiary healthcare across the life course. Studies that addressed multiple elements in the commissioning process, including needs assessment and planning, contracting, and monitoring and reporting frameworks with indicators. Studies that documented enablers and strategies including workforce development; funding and governance models; and outcomes or impacts such as service access, and consumer health and wellbeing.
d. Qualitative, quantitative, economic and/or mixed methods studies.

Search strategy

Following consultation with a librarian experienced in health sciences scoping reviews, a multi-step search strategy for electronic databases was employed. For peer reviewed literature an initial exploratory search was conducted in Scopus/Elsevier, PubMed, and Wiley Online Library to identify relevant studies and any index words that could be used; these were downloaded for reference. A comprehensive search of databases including Medline, PubMed, Embase, Cochrane Library, Joanna Briggs Institute, CINAHL, Scopus, Web of Science, Informit Indigenous Collection, Health Collection, Aboriginal and Torres Strait Islander Health Bibliography (ATSIHEALTH), Wiley Online Library, Taylor and Francis, ProQuest, and EbscoHost was then completed. A manual search of screened publication reference lists was subsequently conducted to identify any additional peer-reviewed publications. Grey literature searches for reports and evaluations were conducted in all four CANZUS countries using customized google search terms, with the first 10 pages (100 records) examined and ranked for relevance. All searches were conducted between March – April 2024. Completed database searches can be found in the supplementary material. Search terms are listed in Appendix 1.

Screening and selection

Results of database searches were imported into the bibliographic citation management software, EndNote 21, with duplicates then removed. Titles and abstracts were initially screened by lead author HB. Full text assessment of the remaining publications was conducted by three pairs of reviewers (BM and JM; HB and CD; AR and HB) using the detailed inclusion/exclusion criterion. Inconsistencies between reviewers were resolved by discussion until consensus was achieved. Reviews, systematic literature reviews, conference papers and opinions and perspectives on programs were removed. Grey (unpublished) literature included evaluations, reports and reviews of commissioning that used primary data. Plans, strategies and guidelines were excluded.

Search results

The collective searches yielded a total of 1103 peer reviewed and grey literature studies, from which 322 duplicates were removed, leaving 781 studies for initial screening via title and abstract. From these, 49 peer reviewed publications and 55 grey literature studies were retained for full text review, yielding 29 peer reviewed and 18 grey literature studies which met the criteria for

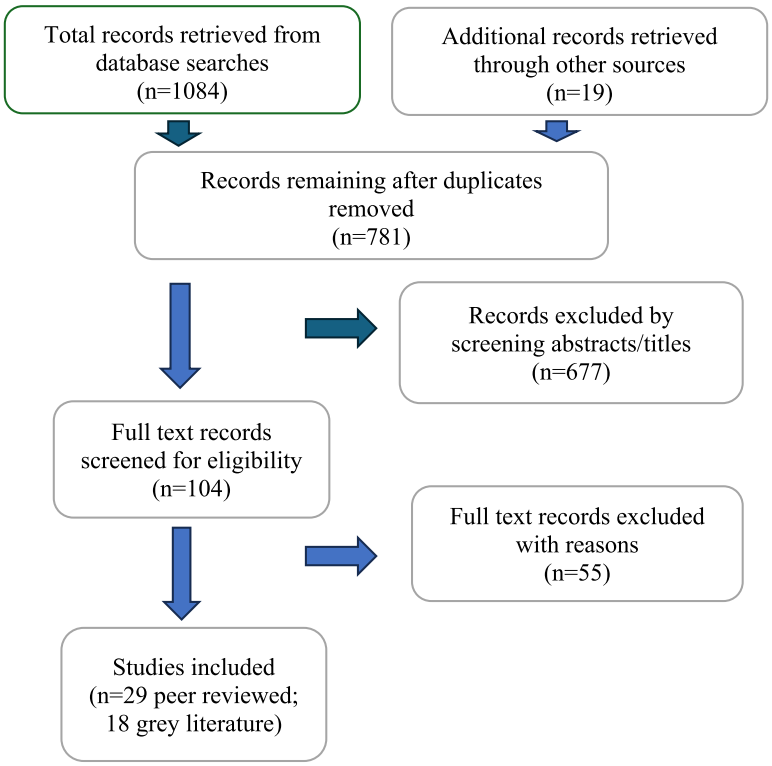

Fig. 1 PRISMA flowchart

inclusion. Study selection follows the PRISMA reporting guidelines (Fig. 1) [17].

Data extraction and analysis

Data on authorship, publication year, study design, year/s of data collection, study setting, study aim, population, and population and sample size if relevant were extracted from full texts to determine the quality and nature of the literature. The data were imported into NVIV0 and coded. Grounded theory methods [18] were used to develop codes that reflected the enablers and strategies employed in health commissioning and/or contracting in different jurisdictions, and the outcomes and challenges. Grounded theory methods are suited to conducting exploratory scoping reviews and can be applied to complex system-wide interventions designed to address structural issues within the health system [19]. Initially, five publications were reviewed using open coding to identify and build a set of concepts and insights that could be drawn from the publications, including theoretical and methodological constructs or properties [18]. These concepts were then organised into code categories, and their emerging relationships identified. As more publications were reviewed, axial coding was used to develop higher order code categories and sub-categories from the synthesised data, which were revised and reorganised as new concepts and relational insights emerged.

Description of the studies

Of the 29 peer reviewed publications, 13 were published in Australia, 14 were from Aotearoa/New Zealand, one was from Canada, and one was a comparative study of Canada, Aotearoa/New Zealand and Australia. No publications that met the inclusion criteria were identified from the United States. Of the studies included, 19 focused on commissioning, with four appraising policy, models and governance for commissioning [8, 12, 20, 21]. One study focused on costs [5], with other studies evaluating the application of commissioning and contracting to primary healthcare [7, 11, 21, 22], or specific areas including mental health [23–25]; chronic pain [22, 26]; chronic conditions and prevention programs [27]; after hours services [28]; regional workforce planning [29]; and social determinants of health including social work [20]; and community services [30]. Fourteen studies described the application, outcomes and challenges with commissioning and/or contracting for First Nations communities and families, including improved health and wellbeing [13, 31, 32]; equity, diversity and models of care [33, 34]; and the experiences, outcomes and challenges for Aboriginal Community Controlled Health Organisations

(ACCHOs) in Australia [15, 35] and Māori Health Providers (MHP) in Aotearoa/New Zealand [27, 33, 36, 37], including racism [38, 39] and cultural competency [40].

Of the 18 grey literature reports, three were from Australia and 15 were from Aotearoa/New Zealand. All three of the Australian studies were independent program evaluations, with one study on the early implementation of PHNs [41], services commissioned through PHNs including psychosocial supports [42] and regional outreach programs commissioned through multiple fundholders [43]. Literature from Aotearoa/New Zealand comprised evaluations and reviews of Whānau Ora Commissioning Agencies [44–47], including delivery, outcomes and impact of commissioned services and programs [48–51]. A further five reports assessed implementation of various commissioning approaches [47, 52], sub-regional applications [53], and prototypes that benefit whānau, including child and youth interventions [45], mental health and addiction services [54], chronic disease [55], and a national telehealth service [56]. Other reports described best practice commissioning models/approaches for Māori [57], and evaluated an MHP delivered vaccination programme [58].

Characteristics

The studies encompassed various geographic locations (very remote, remote, regional and/or urban First Nations population), with the majority evaluating or describing the application of new models for commissioning and contracting in health care. Study aims, and enablers, strategies and processes, impact and success are summarised in Table 1 for peer reviewed studies and Table 2 for grey literature.

Enablers

Collectivley, the enablers supporting commissioning and/or contracting in the delivery of health or social services included: (1) operating model; (2) capability building; (3) contract design; (4) funding and costs; and (5) monitoring and reporting.

Operating model

Various models and governance structures were adopted by commissioning agencies in Aotearoa/New Zealand and Australia. The majority operate as independent non-government and not for profit organisations governed by an independent board. Literature on commissioning models in Canada and United States was not cited. PHNs in Australia replaced Medicare Locals and were designed as mainstream primary healthcare commissioning bodies, that cover services for regional, remote and First Nations populations. Priorities are determined by the Australian Government expressed through annual funding schedules [41]. Their objective is to address local need, improve service integration and coordination, reduce duplication, and support practice improvement of private providers. PHN membership is drawn from Local Hospital Networks, service providers, clinicians and community representatives, with many including Aboriginal Community Controlled Health Organisations (ACCHOs) [7, 21, 28]. PHNs are supported by skills-based technical, community and clinical advisory groups [7, 21] who can provide expertise on key health program elements [26, 41].

PHNs commission via a cycle involving joint regional needs analysis, activity planning, contract design, market shaping, performance reporting and evaluation [11]. PHNs are encouraged to co-commission, working with state and territory health departments and Local Health Districts to jointly plan and fund services [5, 41]. PHN co-commissioning can involve pooling of funds between funding bodies to strategically procure services together, such as through a single contract. The objective is that PHNs, health departments and service providers plan and agree on the activities and outcomes that collectively meet objectives of each organisation [5, 21]. Co-commissioning aims to drive efficiency and integration of medical services and patient care. It also operates from the bottom up through participation of service providers and consumers in designing evidence-based care pathways [5].

In Aotearoa/New Zealand, the three Whānau Ora Commissioning Agencies were established by existing Māori or Pacifica authorities or by alliances of Māori tribal groups or iwi in the South Island [12, 13, 33]. They are Māori led but contracted by the central to government to invest directly to meet the needs and aspirations of whānau. The Agencies are overseen by the Whānau Ora Partnership Group, comprising six Ministers of the Crown and the chairpersons of six iwi (tribes). The Partnership Group sets direction and annual priorities for commissioning, and monitors progress against Outcome Agreements and Annual Investment Plans [8, 12, 33]. The Whānau Ora commissioning approach has resulted in the transfer of significant resourcing and decision-making from government to Māori, evidenced by move from top-down service specification towards bottom-up service redesign [33, 52].

Community, whānau and provider self-determination are core principles of the Te Pou Matakana and Te Pūtahitanga o Te Waipounamu commissioning agencies approach. Each agency has adopted commissioning models that build whānau capability based on the priorities of the communities, whānau and families they serve [8, 46, 47, 52]. The aim is to devolve responsibility to a local level, and subsidiarity to community-based

Table 1 Characteristics of studies: peer reviewed publications

Publication	Description	Methods	Enablers				Strategies			Impact and Success	
	Focus areas	Study design, data collection	Model & capability	Funding & costs	Outcomes, monitoring & reporting	Contract design & flexibility	Relationships & trust	Collaboration & codesign	Innovation & learning	Service access, efficiency	Self determination
Bates 2022 [11]	PHN commissioning model analysis, strengths and limits	Qualitative, case study, interviews PHN staff, document analysis	x	x	x	x	x				
Bates 2023 [5]	PHN co-commissioning transaction cost analysis	Qualitative, case study, interviews PHN staff, document analysis		x	x		x	x			
Boulton 2018 [33]	Whānau Ora commissioning model and implementation, barriers	Qualitative, Kaupapa Māori approach, in-depth interviews document analysis	x	x		x	x	x		x	
Boulton 2019 [12]	Whānau Ora commissioning policy implementation and context	Qualitative document analysis	x		x				x	x	x
Boulton 2022 [20]	Whānau Ora application to Māori health and social work	Qualitative, document analysis – descriptive									x
Briggs 2019 [7]	PHN establishment and innovation in delivery of PHC	Qualitative, case study, PHN insider perspectives, document analysis	x	x	x		x	x	x	x	
Came 2018 [39]	Health contracting, racism and bias between MHPs & mainstream PHC	Mixed, national survey with service providers, statistical analysis		x	x	x	x				
Came 2022 [38]	Health contracting, experiences of MHPs & mainstream PHC	Mixed, national survey with providers, statistical & inductive analysis		x	x		x				

Table 1 (continued)

Publication	Description	Methods	Enablers				Strategies			Impact and Success	
	Focus areas	Study design, data collection	Model & capability	Funding & costs	Outcomes, monitoring & reporting	Contract design & flexibility	Relationships & trust	Collaboration & codesign	Innovation & learning	Service access, efficiency	Self determination
Carlisle 2016 [28]	PHN commissioning after hours services using activity-based model	Qualitative, case study, document analysis	x					x		x	
Cheverton 2016 [24]	PHN commissioning for mental health services	Qualitative, value co-creation process with organisations and partners					x			x	
Coombs 2018 [35]	PHN commissioning and experiences of ACCHOs	Qualitative, interviews ACCHOs, decolonising, First Nations voices					x				
De Morgan 2022 [26]	PHN commissioning pain programs, implementation enablers, COVID-19	Mixed, survey managers, emails, content & document analysis	x					x	x		
De Morgan 2022 [22]	PHN chronic pain, implementation enablers, solutions to commissioning	Mixed, interviews, survey executives, workshop, deliberative dialogue						x		x	
Dwyer 2011 [15]	PHC contracting, ACCHOs and funders, contract theory	Qualitative, interviews First Nations health managers, document analysis		x		x	x				x
Dwyer 2014 [32]	PHC contracting, First Nations, New Public Sector Management	Comparative case studies, Australia, Canada, Aotearoa, documents				x	x				
Eggleton 2022 [59]	Contracting MHPs, disempowering Māori, deficit discourse	Kaupapa Māori congruent methods, documents, discourse analysis				x	x				x

Table 1 (continued)

Publication	Description	Methods	Enablers				Strategies			Impact and Success	
	Focus areas	Study design, data collection	Model & capability	Funding & costs	Outcomes, monitoring & reporting	Contract design & flexibility	Relationships & trust	Collaboration & codesign	Innovation & learning	Service access, efficiency	Self determination
Freeman 2021 [21]	PHN collaboration with PHC actors, enablers and barriers	Qualitative, interviews PHC staff & health agencies, documents, thematic		x			x	x		x	
Gifford 2017 [27]	Prevention programs, MHPs, practice, outcomes, contracting	Kaupapa Māori approach, case study, interviews managers & staff, thematic				x				x	
Gifford 2018 [36]	Contracting, Whānau Ora, MHPs, outcomes for Māori	Kaupapa Māori approach, case study, interviews, focus groups managers			x	x	x				x
Henderson 2018 [34]	PHNs commissioning, ACCHOs service access equity & limitations	Qualitative, case study, interviews staff & board, & advisory groups	x		x		x	x			
Henderson 2019 [25]	PHNs, mental health, planning & enablers for service delivery	Qualitative, document analysis, interviewsmanagers & board								x	
Humpage 2020 [13]	Whānau Ora Commissioning, outcomes, innovation, limits	Qualitative, document analysis	x	x	x				x	x	x
Kolapo 2018 [40]	Commissioning mental health Canada, culturally competent care	Qualitative, document analysis	x								
Oakden 2021 [37]	Contracting, PHC, Māori, flexibility, relationships & trust, learning	Qualitative, interviews managers, thematic analysis				x	x	x	x	x	

Table 1 (continued)

Publication	Description	Methods	Enablers				Strategies			Impact and Success	
	Focus areas	Study design, data collection	Model & capability	Funding & costs	Outcomes, monitoring & reporting	Contract design & flexibility	Relationships & trust	Collaboration & codesign	Innovation & learning	Service access, efficiency	Self determination
Panzera 2016 [29]	PHN, regional health workforce, needs based planning, improvements	Qualitative, action research, clinical reference group, needs mapping, model	x							x	
Reweti 2023 [31]	Whānau centred initiatives, health promotion & Māori outcomes	Māori mātauranga and tikanga, case studies, thematic analysis			x	x				x	x
Riboldi 2021 [30]	Commissioning, community services, relationships, learning	Qualitative, interviews service provider staff & managers		x			x	x	x		
Smith 2019 [8]	Whānau Ora, commissioning agencies, implementation, programs	Qualitative, interviews leaders & decision makers, document analysis	x	x	x			x		x	x

Tabel 2 Characteristics of studies: grey literature

	Description	Methods	Enablers				Strategies			Impact and Success	
	Focus areas	Study design, data collection	Model & capability	Funding & costs	Outcomes, monitoring & reporting	Contract design & flexibility	Relationships & trust	Collaboration & codesign	Innovation & learning	Service access efficiency	Self determination
AIKO 2020 [45]	Report: lessons from program implementation Whānau Ora	Kaupapa Māori approach, interviews program participants	x	x				x	x		x
Allport 2014 [57]	Report: best practice review Māori commissioning & funding	Qualitative, Kaupapa Māori approach, documents, interviewsfunders	x		x		x	x	x		x
Ihi Consulting 2023 [53]	Report: case studies of equity focussed commissioning in NZ	Qualitative, interviews DHBs, provider, community, document analysis								x	x
Health Policy Analysis 2022 [43]	Evaluation: impacts of health outreach services Australia	Mixed, stakeholder interviews, surveys, case studies, monitoring reports		x		x	x	x		x	
Matheson 2023 [55]	Evaluation: summative family program implementation	Mixed, outcomes narratives, staff interviews, surveys, monitoring reports			x		x				x
Whānau Ora Review Panel 2018 [46]	Report: review of Whānau Ora commissioning approach	Qualitative, community engagement sessions, document analysis	x	x	x						x
Lane 2018 [41]	Evaluation: PHN program implementation and impacts	Qualitative, interviews, survey, case studies, workshops, program documents	x	x	x			x	x	x	
Leonard 2023 [51]	Evaluation: impacts & outcomes Wave 16 Whānau Ora programs	Kaupapa Māori approach, interviews, survey, document analysis					x				x

Tabel 2 (continued)

	Description	Methods	Enablers				Strategies			Impact and Success	
	Focus areas	Study design, data collection	Model & capability	Funding & costs	Outcomes, monitoring & reporting	Contract design & flexibility	Relationships & trust	Collaboration & codesign	Innovation & learning	Service access efficiency	Self determination
Nous Group 2021 [42]	Evaluation: PHNs commissioning of psychosocial support programs	Mixed, literature review, consumer interviews, group consultation, datasets	x	x		x	x	x		x	
Research Evaluation 2023 [54]	Report: Māori commissioning mental health and addiction services	Qualitative, case study: interviews, focus group, documents, multimedia	x			x			x		
Savage 2016 [48]	Evaluation: impacts Wave 1 Whānau Ora programs	Qualitative, interviews program staff & commissioning agencies							x		x
Savage 2017 [50]	Evaluation: impacts & outcomes Wave 2–3 Whānau Ora programs	Qualitative, interviews program staff & commissioning agencies			x						x
Savage 2019 [49]	Evaluation: impacts & outcomes Wave 6 Whānau Ora programs	Qualitative, interviews program staff, contract document analysis								x	x
Te Puni Kōkiri 2023 [47]	Report: analysis of Whānau Ora commissioning agencies model(s)	Mixed, surveys & reports, statistical analysis, action research, thematic	x	x	x				x		
Te Pūtahitanga o Te Waipounamu 2023 [52]	Report: Direct Whānau commissioning approach	Qualitative case study: interviews, funding documentation, previous cases	x				x		x		x
ThinkPlace 2023 [56]	Report: case study national telehealth service long contract	Qualitative, website information, interviews service staff				x	x			x	

Tabel 2 (continued)

	Description	Methods	Enablers				Strategies			Impact and Success	
	Focus areas	Study design, data collection	Model & capability	Funding & costs	Outcomes, monitoring & reporting	Contract design & flexibility	Relationships & trust	Collaboration & codesign	Innovation & learning	Service access efficiency	Self determination
Wehipeihana 2022 [58]	Evaluation: impact Māori Influenza and measles vaccination program	Mixed methods: surveys, interviews, sense making meetings, health data	x	x		x	x	x	x	x	x
Wehipeihana 2016 [44]	Evaluation: formative Whānau Ora commissioning agencies model(s)	Qualitative, document review, interviews, hui, group discussion	x	x	x		x	x			

organisations. This has enabled culturally anchored commissioning models based on Māori knowledge to reframe whānau wellbeing [8, 12, 52]. A direct approach includes flexible models for placed-based commissioning that engages with remote whānau and service providers [7, 33, 52]. This is the preferred pathway for whānau to plan appropriate initiatives to realise their aspirations, and drive change in their communities [7, 12, 44]. Initiatives aim to be highly contextual, utilising local resources, experience and capabilities to implement responses and address immediate challenges [52].

Other mainstream models in Aotearoa/New Zealand, have evolved from meso-level bodies, such as District Health Boards, and via direct government commissioning to MHPs for specific prevention programs [58]. MHPs commonly deliver healthcare by applying Māori cultural values, processes and beliefs, and concepts of holistic health and wellbeing as defined by Māori frameworks [27]. Several case studies show how Māori priorities have been applied in commissioning direct to MHPs. For example, mental health and addition services and measles vaccination programs applied new processes based on Kaupapa Māori (the Māori way of doing things) and tikanga Māori, or appropriate principles and practices [54, 58]. The models support community-led service design, primacy of Māori leadership, and familiar Kaupapa processes for engagement [54, 58]. MHPs then work closely with local whānau community organisations to understand and build on strengths, and to engage their ideas, knowledge and capabilities in creating solutions and shared outcomes [27, 31, 58].

Capability building

Capability development was highly valued by commissioning agencies and service providers, however it required considerable time and resources [7, 11, 12, 22, 41]. Technical capability includes integrated data management and reporting systems. These systems were required to capture data across domains including education, employment and health; to track outcomes and indicators over time; and to contribute to the evidence base [44]. Analytical capability is needed to inform service planning and refinement, estimate the quantum of supports, and fulfil accountability reporting, all of which are critical to the long-term viability of commissioning [44, 52]. Investment into training and education of staff, executives and boards was valued in all aspects of commissioning and population health planning, as well as for specific health programs [7, 22]. An example was an intensive training program delivered by the Hunter, New England and Central Coast PHN. The program covered national performance indicators and collective practices for primary healthcare workers, and included 162 education courses delivered over six months, and attended by 2600 people [7].

Capacity needs for ACCHOs in Australia and MHPs in Aotearoa/New Zealand included being well resourced to participate in the commissioning process [33, 34, 36]. Workforce capability was particularly important for service providers working with First Nations, regional, and remote populations [29, 47, 58]. This is reinforced by a study by Panzera et al. who concluded that broadening the skillsets of healthcare workers could address regional labor shortages and deliver more efficient and equitable care [29, 40]. For the PHN commissioning model, Bates et al. noted that continuing success was contingent upon the recruitment and retention of skilled and knowledgeable staff [11] who were capable of working collaboratively towards meeting outcomes, and communicating effectively with First Nations peoples [22, 33]. ACCHOs also reported that PHNs lacked expertise and were unattuned to the culturally specific health requirements of First Nations peoples [35]. In Canada, commissioning for mental health services amongst First Nations populations required a workforce with advanced cultural competency skills to provide person-centred care that is attuned to cultural variance in illness and treatment pathways [40].

Contract design

Commissioning involves service contracting, where '… funders specify the services or other activities they are 'purchasing' on behalf of the community, the amount of funding, and the reporting and other accountability requirements [15]p.35'. There are various contracting options available to commissioning agencies [37] including open and selective tenders, expressions of interest, and direct approaches to existing or approved providers [7, 34]. In complex social environments, contracting options offer opportunities to meet beneficiaries needs, such as increasing service provision to groups requiring specialised care, and matching providers to meet demand [34, 37]. Contracting needs to be flexible, responsive, agile, adaptive, and draw on joint learning [13, 30, 33, 37, 38], and enable providers to apply holistic approaches that better respond to issues facing First Nations communities [13, 15, 27, 37]. Options such as multiyear 'high-trust' contracts and bundling of contracts from multiple funders can increase provider commitment/security, enable effective and coordinated delivery of services, and reduce administrative burdens, particularly for MHPs and ACCHOs [32, 38, 56, 58]. In Canada, a significant shift towards longer-term and more integrated or bundled contracts has improved responsiveness to First Nations and Inuit community aspirations [32]. Similarly in Aotearoa/New Zealand, long term contracts with a single provider allowed greater focus on innovation for

patient outcomes, the testing and refinement of options, and time to train a First Nations workforce [56]

Contracting choices made by funders either aided or hindered service provision, with more flexible and relaxed control over programs leading to locally generated solutions, and the capacity to change contract terms [13, 27, 44]. Duration and number of contracts was a significant issue for service providers, as well as contract administration and satisfying contract demands [5, 11, 27, 38, 39]. Short term contracts, often on annual cycles, as well as contract renewal and negotiation processes [5, 7] created uncertainty in workforce retention and service continuity, and reduced lead times for planning and joint implementation of services [5, 15, 38, 39, 58]. In Aotearoa/New Zealand, inconsistency with short term contracts further limited the ability of MHPs to change the wider environment supporting whānau wellbeing [27]. Service providers holding multiple contracts, sometimes with the same funding agency, reported added complexity and administrative burdens. This led to duplication or fragmentation, and multiple and inconsistent reporting requirements [15, 36, 38, 42].

Contracts administered for prescribed services, and to meet efficiency standards, or mitigate service risks may not be adaptive to the unique requirements of the recipients, or account for service provider capacity and diversity of care models [11, 36, 39]. Conventional practices and accountability requirements set by government funders based on standard health criteria were often in tension with service providers responding to community health needs [15, 32, 54]. MHPs and ACCHOs, often subject to such constraints, suggest a level of institutional racism prevalent in contracting designed to meet government service and funding requirements [35, 39]. Contracting requirements or policies controlled by government agencies and District Health Boards in Aotearoa/New Zealand were viewed as imposing a Pakeha (non-Indigenous) perspective [59]. Assessment of multiple health contracts suggests that the content was often not matched by corresponding structural change; imposed paternalistic thinking and deficit framing; or limited the ability of Māori to set independent health priorities and aspirational goals [59].

Funding and costs

Funding is reported as a challenging component to commissioning and an important enabler for sustainability [22, 30, 41]. In both Australia and Aotearoa/New Zealand, the level of investment provided to commissioning agencies was a relatively minor proportion of the total available health budget [12, 21]. Funding increased significantly for Whānau Ora Commissioning Agencies post establishment [21, 33], however inadequate funding was widely viewed as a constraint on effective program delivery [8, 13, 21, 26, 28]. Demand was often greater than available funding, and at times scarce resources were required to be diverted into crisis responses [5, 46]. For commissioning agencies, meeting the performance outcomes required by government was perceived to be challenging with the quantum of funding provided [5, 33, 43, 44]. Insufficient funding for providers translated to an inability to offer adequate health and social services, as well as contributing to workforce instability [43, 58]. This limited the reach and impact with communities [44, 46, 52], and the capacity to scale-up to meet future expectations [41]. MHPs reported insufficient funding to solve the intergenerational experiences of Māori that are shaped by social and political determinants (such as colonisation, employment, housing, and education) [13].

Flexibility of funding was also viewed as an opportunity and challenge for commissioning agencies and service providers. Whānau Ora Commissioning Agencies were seen to offer more responsive funding models, consulting with whānau on priorities and investment streams, and contracted milestones and outcomes [8, 13, 33]. Examples include resources to encourage diverse groups to work effectively together to reach intended beneficiaries, and short-term crisis funding for families [33, 38]. However, a lack of government funder responsiveness to the aspirations of MHPs and an emphasis on accountability expressed as outputs were cited as constraints [8]. Whānau Ora Commissioning Agencies perceived the government's funding approaches as tied to prescribed services, rather than having the flexibility to achieve a set of agreed outcomes [44]. Inflexibility was also viewed as a constraint for PHNs, where the majority of funding was allocated to operational requirements and to specified programs or streams, with the purpose defined in annual contracts [7, 21, 43]. A comparatively limited pool of flexible funding available to PHNs and other commissioning bodies, led to calls for streamlining and greater flexibility in order to respond to local needs in innovative ways [7, 21, 34, 41–43].

Transaction costs are a further barrier that can be particularly burdensome on First Nations health providers who hold multiple short-term contracts with different funding agencies [15, 34]. PHNs and providers also reported higher transaction costs of services delivered in regional and remote areas [42]. Additionally there were significant compliance costs to meet contract requirements, including frequent reporting and performance monitoring that were often compounded by inconsistencies in the data collection and reporting systems required by different funders [5, 38, 39]. This created increased administrative demand that was not factored in contract agreements [15]. Service co-commissioning involving

fewer contracts, multiple funders on the same contract, and longer-term agreements offered solutions to reduce compliance costs and provide greater security of funding streams [5, 15, 43]. Co-investing or cross-subsidising with other programs that share mutual interests or parallel administrative systems were also reported to alleviate costs [42, 46].

Monitoring and reporting

Outcomes frameworks drive commissioning of services and are used to monitor change in the quality of care, and patient health and wellbeing [5, 8, 12, 36, 37]. Whānau Ora Commissioning Agencies, for example, are contracted to develop initiatives that deliver against the Government's legislated Whānau Ora outcomes framework [8, 12]. The framework is based on high-level principles of Māori values, beliefs, obligations and responsibilities, whānau opportunities, whānau integrity, best outcomes, coherent service delivery, effective resourcing, and competent and innovative service provision [12, 44]. Values of collective wellbeing, strengths-based practices, and adopting a cross sector approach to resolve complex service issues underpin the framework [36]. Commissioning agencies were able to exercise a degree of autonomy to plan and develop services, provided they met outcomes and related targets [50], with incentive payments for delivering above agreed targets for hard-to-reach populations [8, 36]. Additional benefits included reducing the compliance burden on service providers and improving funding and accountability mechanisms.

Commissioning agencies are encouraged to work with a range of providers and consumers to develop a broad set of goals and shared outcomes matrices [5, 21, 36]. These outcomes frameworks can incorporate a series of performance indictors and metrics, linked to data and information to measure outcomes across short, medium, and long-term timeframes. For PHNs, key performance indicators incorporate patient reported outcomes and patient reported experience measures, with these linked to payments [7]. Performance metrics and reporting requirements aim to meet the needs of consumers, providers, and funders without imposing undue costs [5], but also to align more closely with community need [36, 40, 50]. Services or products being commissioned must deliver against the principles and the determined outcomes measures [33, 46], however frameworks should also accommodate some level of flexibility without compromising on integrity [5, 36]. Commissioing agencies periodically report to government funders on performance and progress towards achievements against outcome indicators and expenditure [33, 36]. Regular performance reporting also responds to demands for greater accountabiity and transparency in commissioning and contracting processes [20, 31, 34, 36, 37, 46].

Outcomes identification and measurement is challenging for government funders or commissioning agencies, where a range of outcome measurement tools appropriate for operationalising across multiple sectors must be designed [36]. For Whānau Ora Commissioning Agencies and MHPs, measuring any aggregate outcomes proved problematic, including the development of measures that captured both collective and individual outcomes, and complex change in people's lives [8, 37, 44]. Factors impeding assessment included inflexibility in how outcomes are achieved, determining clinical outcomes versus other measures of service performance, and innovative programs that are difficult to ascribe performance metrics [8, 12, 37]. Proving longer term impact and attribution was problematic, particularly when linked to short term performance payments [15]; and was particularly challenging when considering factors exogenous to the program, coupled with conflicting views on outcomes between commissioning agencies and service providers [12, 44]. Reporting on outcomes was considered overly restrictive, prescriptive and prohibitive by service providers and commissioning agencies, contributing to claims of over-compliance and top-down regulation by governments, which hampered innovation and was not aligned with whānau aspirations [13, 33, 37, 44, 46].

Strategies and processes

Studies identified several strategies and processes that facilitated successful commissioning and the barriers that were encountered: (1) relationships and trust; (2) collaboration and engagement; and (3) innovation and learning.

Relationships and trust

Relationships between actors underpins successful commissioning, across all elements or stages including needs assessment, planning, service coordination, contracting, and monitoring and evaluation processes [5, 11, 22, 24, 30, 35, 37, 44]. Commissioning requires relationship building and maturing between commissioning agencies, service providers, clinicians, community, and government regulatory bodies [21, 30]. Relationships between Whānau Ora Commissioning Agencies and service providers were highly valued as the main conduit to community. Strong networks were seen to support change management and to advocate and educate government agencies about commissioning [44, 47, 51]. Relationship elements that contributed to success included the degree of maturity [5]; prevalence of existing relationships and networks, such as Local Health Networks in Australia that operated prior to the PHNs [21, 26, 37]; and adopting a cross-sector approach [28] that facilitated working

towards shared goals and agreed performance outcomes [7, 35, 36]. A study assessing the quality of different PHN relationships found that service innovations and coordination were more prevalent when relationships were well developed, equitable and accountable between governance committees, clinical advisory groups, community providers and local hospitals [21].

PHNs also identified a need to establish formal partnerships with stakeholders in government, hospital and health services, non-government agencies and with ACCHOs to enable shared goals and performance outcomes, and joint planning and ownership [7, 22, 24, 35]. Partnerships contributed to the combining of funding sources; maturity to develop and test models of care; and the integration of care across clinical treatment or program areas [7, 41, 42, 45]. Relationships contributed to trust in the commissioning process at critical junctures [28], and to trust and legitimacy of the commissioning agency amongst service providers and community [24, 28, 37]. This led to a willingness to share resources and power [24, 26, 37]. Healthy working relationships, shared responsibility and open dialogue with ACCHOs was considered particularly important to elicit understanding of issues and challenges in First Nations health at organisational and community levels [24, 35, 37].

Relationships between commissioning agencies and providers at the contracting stage aided joint program design and deeper understanding of the practicality of service delivery [37, 38, 51]. This encouraged value adding to service interventions [37, 38, 52], and co-generation of contract milestones and outcomes. Relational based contracting improved negotiation, reduced compliance costs and led to mutual accountability between funding agencies and First Nations service providers [15, 32]. Trusting relationships during contracting reduced information asymmetry and uncertainty, encouraged problem solving, with funding agencies more adaptive to program challenges so that outcomes could be adjusted in response to patient or community requirements [11, 15, 37, 56]. Factors influencing the degree of trust included funding agencies being open, responsive and transparent, with experienced and personable managers, and relationships built at an organisational level rather than between select individuals [37–39].

Inequitable or unbalanced relationships were a barrier to effective and equitable commissioning. Poor and damaged relationships resulted from a lack of trust, inadequate time, staff turnover, and a transactional emphasis on service efficiencies rather than a participatory approach [30, 37–39]. Several studies noted that hierarchical relationships between government regulators, commissioning agencies and service providers created power imbalances [15, 21, 35, 38]. Service providers, including ACCHOs and MHPs, highlighted issues with top down decision-making processes, an emphasis on confidentiality and vertical accountability [30, 59], and governments dictating outcomes with limited negotiation [35, 38]. Exclusion from decision making forums reduced transparency for First Nations service providers [35, 46]. Limited understanding by some PHNs of First Nations health issues eroded trust, created inflexibility to changing needs, and reduced the flow of valuable knowledge from community upwards [21, 34, 35].

Collaboration and engagement

Collaboration was identified as a valuable strategy. Particularly for PHNs and the more mainstream co-commissioning approach adopted in Australia but was also employed in Aotearoa/New Zealand. Co-commissioning involving funding bodies and commissioning agencies working with service providers aims to overcome policy and service delivery siloes and work across organisational boundaries [7, 45]. Collaboration could also improve intra-organisational planning amongst personnel in larger public health bureaucracies, and when operating across different levels or different stages of the commissioning process [5, 37]. Collaboration through joint planning and contracting aims to create shared ownership of programs and their outcomes [5, 21], foster co-design and co-creation of new care pathways [24, 33], and contribute to capacity building and knowledge sharing and learning [22, 26, 37]. Collaboration between service providers and consumers during planning can help tailor services to patient demand rather than service specifications [12, 23, 27]. One study noted greater need of collaboration in rural and remote areas due to the prevalence of 'thin' markets and a limited number of providers [21].

Various formal and informal mechanisms can enhance the quality of collaboration. Examples from PHNs included governance arrangements, such as reciprocal board membership between organisations, employment of coordinators, staff secondments, formalised partnerships, bilateral agreements and memorandums of understanding, online engagement platforms, clinical councils, service networks, First Nations leadership groups and funding to encourage diverse groups to work together [7, 21, 41]. With PHNs, co-commissioning was more effective when established relationships existed between the public health system and other service providers [5, 41]. Sufficient time and resources were recommended to support collaborative processes leading to organisational change and innovation [5, 29]. Reported benefits from collaboration included increased PHC service efficiencies [5, 11, 41], and a greater focus on solving complex problems [7]. Co-planning and co-funding across providers contributed to systems integration, including data and

continuity of care [27], and reduced service duplication and fragmentation [5]. It was also conducive to positive cultural change in the wider health system [21, 52].

Engagement and collaboration with wider sets of stakeholders and/or end users was also valuable, although the timeframes and resources required were often restrictive. For PHNs, engagement occurred primarily through community and clinical advisory groups. Wider engagement with end users, clinicians and providers was considered valuable if it advanced new or significant improvements to service models [7, 21, 24, 28], when negotiating changes to existing programs [28], and during the implementation, monitoring and reporting cycles for contracts [24]. Engagement across multiple levels and organisations contributed to increased capabilities and wider impacts [24, 41], and assisted in change management to support new processes and streamline reporting [28]. It also facilitated deeper listening with community in order to serve the needs of beneficiaries [8, 27, 30, 37] and the development of approaches and models of preventive care better suited to community values [27].

Implementing the co-commissioning process can be challenging. In Australia, collaboration was affected by unclear division of responsibilities between federal and state governments, commissioning agencies and Local Hospital Networks. This included overlapping geographical boundaries, leading to added complexity and fragmentation in service delivery [5, 34, 41, 42], coupled with limited development of shared goals and priorities [21]. Where governments aimed to demarcate and prioritise state responsibilities, this hindered collaboration [21]. Organisational misalignment between tiers of government and commissioning agencies in policies and priorities [42], risk appetite, planning/funding cycles, governance, cost savings, and probity requirements affected the co-commissioning of services [5]. Tensions between collaboration, and competition and service evaluation, were reported to undermine trust in the process. These tensions also affect existing service relationships [21, 30, 35], leading to uncertainty over future contracts, particularly for ACCHOs [34].

Engagement and collaboration with ACCHOs continues to be a specific focus for PHNs, with approaches such as capacity funding and communities of practice used [7, 24, 26]. However, PHNs encountered problems consistently engaging with the ACCHO sector, including community representation on governance structures, and insufficient resourcing [35, 41]. Limited collaboration or consultation with ACCHOs in needs assessment and planning, and increased bureaucratisation contributed to claims that PHNs set funding priorities without adequate information on First Nations people's health [34, 35]. Others felt that the mainstream PHN approach to co-commissioning was incompatible and infringed upon how ACCHOs operate, and contributed little to service coordination, particularly in remote areas [34, 35, 41]. Critically, PHNs may limit self-determination and health benefits for First Nations populations [35].

Innovation and learning

Innovation and continual learning were emphasised widely as strategies for effective commissioning. The model of Whānau Ora was viewed as an approach to drive innovation and learning in service delivery [12, 37, 48, 52]. It was adopted in the design of funding models [13, 33], or in the case of PHNs, as a key purpose within organisational governance arrangements and work practices [7]. Commissioning agencies encouraged innovation by directing funding at providers who could design service specifications that engaged hard to reach groups [13, 37], and implement new and holistic models of care [7, 31, 54]. Innovation within the commissioning cycle was viewed as a longer-term data analysis, learning and evaluation process, to design, test and refine new programs and contribute to the evidence base [7, 41, 44, 48]. Shared learning and joint problem solving contributed a robust form of accountability between funders and providers [37]. Knowledge and continual learning across the system provided interactive and iterative processes that made commissioning effective [7, 43], as well as adaptive to the constant changes in people's lives [30].

Impact and success

Studies reported a range of impacts or outcomes from commissioning on service delivery, and health and wellbeing, as well as factors that contributed to success. These were grouped into: (1) service efficiency and accessibility; and (2) self-determination, health and wellbeing.

Service efficiency and accessibility

The range of impacts vary from commissioning and contracting for First Nations, regional, and remote populations. Studies from both Aerotoroa/New Zealand and Australia show commissioning for some programs increased service accessibility and efficiency, widened geographical distribution of services, and increased the numbers of people receiving services [8, 13, 24, 28, 37, 43, 49, 56]. Evaluations of Whānau Ora Commissioning Agencies indicate success across programmatic and process criteria [8], providing an institutional framework for MHPs to deliver services that better align to whānau health [12]. A greater commitment to meeting complex community and individual need [37], supported by the integrated service knowledge of 'navigators' [13], has improved the connection of whānau to mainstream services and reduced fragmentation [8, 53]. For example,

a whānau based healthy lifestyle promotion program increased adoption of nutrition, diet and exercise-based activities amongst Māori participants [31]. Drawing on more providers led to increased service provision to groups requiring specialised care [37].

With PHNs in Australia, assessments of health needs have created greater objectivity in decision making over the selection of services [29], whereas planning and evaluation have led to improved service performance [34], and health system improvements [24]. Further, competitive tendering processes specified the type of service approach, and ensured that providers had the necessary relationships to deliver preferred models of care [34]. PHN funded programs to rural and remote communities reported a 17% increase in bulk-billed after hours services and increased clients accessing those services [28]. Commissiong of outreach services through multiple public and private fundholding bodies resulted in improved access to allied health of 13.1% and specialist services by 16.4% [43]. Results of commissioning for mental health programs in regional and remote areas of Australia indicated a reduction in unmet needs of clients and fewer reported problems accessing services [24]; improved GP capacity to provide patient centred services [23]; and increased consumer satisfaction with the support provided, and reduced psychological distress [42].

Self-determination, health and wellbeing

Whānau Ora commissioning delivered measurable outcomes and benefits through active self-determination by Māori [12, 13, 20, 31], and by empowering whānau with the responsibility, resources and skills to improve their own health, cultural and socio economic wellbeing [8, 46, 48]. Reported outcomes include enhanced self-confidence, secure cultural identity and belonging, enduring social wellbeing, and reduced mental health and socio-economic hardships [31, 46, 53]. Evaluations of the Te Pūtahitanga o Te Waipounamu investment in multiple initiatives over successive years indicated that whānau have experienced positive health outcomes, and stronger social networks [44, 48, 50, 51]. Sustained program investment delivered individual and collective impact, evidenced by increased physical activity, reduction in smoking, drug and alcohol use, and better management of chronic conditions [50, 52]. Analysis also indicated a positive return on investment from social entrepreneurship programs, in addition to economic independence and job creation [51, 55]. Eighty-three initiatives were funded through the 'Wave 16' round, with 5083 whānau members participating.

For MHPs, Whānau Ora has enhanced their control in setting outcomes, and their measurement through whānau-defined wellbeing indicators [36, 55]. Culturally anchored commissioning enables MHPs to create pathways and flexible and innovative approaches to realise whānau aspirations and to instill Māori values, cultural practices and worldviews within health and social programs [8, 20, 44, 55, 58]. It also aligned to Māori self-determination, defined as the ability to choose one's own path in life through increased self-reliance [31]. The program Healthy Families New Zealand, for example, met success in chronic disease management by shifting from a narrow Western clinical approach to focusing on Māori health equity, an approach that facilitated community defined solutions and Māori based systems thinking [55].

Discussion and conclusions

This review considered the current evidence for health commissioning for First Nations, regional, and remote populations, aiming to identify the enablers and strategies, and impacts and limitations from commissioning and contracting health and wellbeing services. Like other reviews [48, 49], there was relatively limited evaluation research that aimed to test the effectiveness of commissioning on health and wellbeing outcomes for specific population groups. Most of the published research comprised process-based evaluations and descriptive analyses of the introduction and application of commissioning models, and the experiences and challenges facing service providers, including MHPs and ACCHOs. Grey literature was similarly evaluative and process oriented, focusing on service delivery improvements. These were supported by evidence of positive impact on health and wellbeing, socio-economic stability, capacity building, and empowerment. The grey literature provided promising evidence of efficiencies delivered through programs focusing on community and family wellbeing [43, 49, 58]. A significant gap in the evidence was the application of commissioning across the health system, covering primary, tertiary and acute care for the identified population groups. Research is limited by the fact that commissioning for First Nations, regional, and remote populations in Australia, Aotearoa/New Zealand and Canada applies to select interventions comprising a relatively small allocation of overall health investment.

Evidence presented in multiple studies suggests that a relational model drives success in the establishment and operation of commissioning for First Nations, regional and remote populations. A relational model drives improved coordination and outcomes from the commissioning and contracting of health services. A relational model can be applied to the enablers and strategies/processes that support successive stages of commissioning including governance and operations of commissioning agencies, service co-design, funding and

contract development, and monitoring and reporting. The model outlined in Fig. 2 places relationships at the core of commissioning processes, and between all agents: funders, commissioning agencies, service providers, clinicians, clients, communities and families. Six attributes of a relational commissioning model are presented: (1) Responsive: flexible and agile to meet diverse and changing needs; (2) Resourced: build and mature networks/partnerships and workforce capabilities (3) Collaborative: mutually agreed goals and outcomes, co-planning and co-funding (4) Equitable: joint decision making and power sharing amongst multiple agents; (5) Innovative: knowledge generation and learning oriented to drive system change; and (6) Self-determined: commissioning led and informed by First Nations leaders, communities, and families.

The relational model to commissioning and contracting is highly relevant for regional and remote populations, where innovative solutions are required to address systemic problems encountered with current models of care [7], and the prevalence of poor health outcomes. The reviewed studies indicate the conditions and strategies likely to strengthen and support 'trusting' relationships between multiple actors during each stage of commissioning, including open dialogue and exchange of knowledge and expertise [5, 22], sharing of resources and possible co-funding, robust co-design and co-creation of programs and their agreed outcomes [24], and frequent and formalised mechanisms and techniques for engagement [7, 21, 24]. More established and mature relationships encouraged wider co-commissioning amongst service providers [21], and contributed to deeper understanding and flexibility displayed by governments and commissioning agencies, particularly during planning, contract renegotiations, and reporting. Direct investment and resources for relationship building, and more formalised networks and partnerships, is essential.

Like other research on health services for First Nations populations, commissioning and contracting requires a series of strategies to realise community-control and self-determination [12, 15, 27, 60]. Effective models that support First Nations leadership and decision making are necessarily at each stage of the commissioning cycle to co-create health services and programs that are accountable and adaptive to communities and families. Evaluations indicate that commissioning led and controlled

Fig. 2 Relational commissioning

by First Nations organisations delivers demonstrable health and wellbeing impacts across multiple metrics [44, 48, 51]. Whānau Ora Commissioning Agencies have provided significant insights on how community and whānau led and self-determined models, based on Māori Kaupapa concepts and practice application, can empower people to improve their own health and wellbeing [31, 49–51]. Governments need to co-create highly flexible and potentially new funding mechanisms, contracts, and reporting systems that provide autonomy for First Nations controlled commissioning agencies to evolve to accommodate the requirements of service providers and the needs of beneficiaries.

By comparison, mainstream commissioning models such as PHNs in Australia, have struggled to accommodate the health needs for First Nations populations, or support equity and development of the community-controlled health sector [34, 35]. This can exacerbate existing barriers and service fragmentation. However, case studies from Aotearoa/New Zealand indicate that engaging Māori practices in program co-design, and setting of performance goals and outcomes metrics, can improve how services are commissioned by various bodies [52, 55, 58]. Studies indicate that MHPs and ACCHOs are particularly adept at providing culturally appropriate holistic care informed by First Nations peoples worldviews, values and thinking [27, 31, 36, 40, 58, 60]. Formal processes for collaboration between First Nations service providers, commissioning agencies and other health providers is key, particularly in regional and remote areas constrained by small populations and high service costs. Involving the wider community in the planning and needs assessment phases is also recommended and should be culturally anchored, equitable, empowering and suited to the context or setting.

A variety of other strategies contribute to innovation in commissioning and are consistent with, and build upon, other reforms in the health system. Commissioning offers opportunities for new investment models and contracting approaches that are flexible and adaptive, but also streamlined and consolidated across funding bodies to reduce transaction costs [5, 8, 12, 13]. Challenges arise from insufficient funding to meet identified health needs, multiple and often short-term contracts, and prescriptive outputs that create complexity and are not aligned to beneficiaries needs [15, 27, 32, 36, 59]. Education/training for service providers and clinicians, and a suitably skilled workforce were valued during all stages of commissioning [7, 21]. A persistent challenge for service delivery in regional and remote areas is recruitment and retention of skilled staff, including First Nations health practitioners, and a wider culturally trained workforce [29, 60]. The impact of commissioning on workforce turnover is viewed as a significant risk to service continuity [29, 34, 35]. For regional and remote populations, long distances and variable access to services, infrastructure and transport issues, and geographical variance in clinical practices and capabilities are key issues that need to be addressed [21, 43].

Outcomes and performance reporting remains a critical component to effective commissioning at scale. The adoption of outcomes based payment models in healthcare relies on the development of suitable indicators designed to incentivise outcomes in the health status of people and populations [61]. Like other components to commissioning, outcomes assessment requires collaborative design and shared indicators, and a level of flexibility and scope for service providers to report achievements in the quality of care [55]. Reported outcomes in the surveyed commissioning literature were mostly process or activity based, such as participation rates amongst target population groups, and patient views on the quality of the service or program activity. Other reported improvements relate to process and structure issues such as integration and coordination of care pathways as viewed by service providers. Comparatively few studies provide any comparative measures of outcomes on various care domains, healthcare costs, or population health and wellbeing. This indicates a need for wider research and analysis of a broad range of outcomes and impacts from commissioning.

Appendix 1

Search terms:

Indigenous OR "First Nations" OR "First People" OR "First Peoples" OR Aboriginal OR "Torres Strait Islander" OR "Torres Strait Islanders" OR ATSI OR Māori OR "Tangata Whenua" OR Inuit OR Métis OR "Native American" OR "Alaska Native" OR "Native Hawaiian" OR "American Indian" OR "Native Canadian" OR rural OR remote OR region*

AND

"community control" OR community-base* OR "health commissioning" OR self-determination* OR "competitive tendering" OR "contracting services" OR "health commissioners" OR co-commission* OR "commissioning agencies" OR "commissioning model" OR "health contractors" OR "health service providers" OR "contracting model" OR "health service commissioning" OR "health care commissioning" OR "health service purchasing" OR "health service procurement" OR "health funding" OR "health contracting" OR "health services contracting"

AND

"Aboriginal Community Controlled Health Organisations" OR ACCHO* OR "Allied health services" OR "primary healthcare networks" OR PHN* OR "Whānau Ora" OR "Te Pou Matakan" OR "Te Pūtahitanga o Te Waipounamu" OR "Pasifika Futures" OR "Indian Health Service" OR Nuka OR NCCIH OR "Indigenous Services Canada"

Abbreviations

ACCHO	Aboriginal community-controlled health organisation
CANZUS	Nations: Canada, Australia, New Zealand and the USA
CaTHC	Cape and Torres Healthcare Commissioning Ltd
LHN	Local Health Networks
MHP	Māori health provider
PHC	Primary healthcare service
PHN	Primary Health Network
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses

Supplementary Information

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Supplementary Material 1.

Supplementary Material 2.

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Data availability
Data is provided within the manuscript or supplementary research files.

Declarations

Ethics approval and consent to participate
Ethical approval was provided by: Central Queensland University, approval number Human Research Ethics Committee (ID: 0000023943) and; Queensland Health, Far North Queensland Human Research Ethics Committee (HREC/2023/QCH/97970 (Jun ver 2) – 1723).

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