# *Patches of Equity:*

## *Policy and Financing of Indigenous Primary Health Care Providers in Canada, Australia and New Zealand*

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# ABSTRACT

This thesis investigates how the governments of Canada, Australia and New Zealand balance the ideal of indigenous self-determination with other pressures, such as current trends in public administration and accountability, pressures on the health care system, issues of and sensitivities around minority rights, equity in health and cost-efficiency. It is based on four case studies conducted in Australia and New Zealand. The Canadian material is drawn from both the literature and a period of twelve years working in indigenous-controlled health services.

All three governments have made some policy commitments to increased indigenous participation and self-determination, in the pursuit of health gains. The goal is a more responsive health care system. Self-determination is often mentioned. In Australia and New Zealand, the commitment extends to primary, secondary and tertiary care. Canada focuses exclusively on improving the responsiveness of on-reserve primary health care services.

The contractual environment in which providers operate bears a highly nuanced resemblance to official policies. Two broad categories of contractual environments have emerged. Indigenous providers who operate in an environment where the funder is an indigenous-specific government authority (First Nations and Australia's new PHCAP program) have access to a relational contractual environment that is advantageous administratively, financially and in terms of comprehensiveness of services. Indigenous providers that secure funding from non-indigenous specific funders (New Zealand, and Australian Aboriginal Health Services) operate in a classic contractual environment where funding is accessed via a multiplicity of fragmented, often proposal-driven, contracts with high administrative costs. Classic contractual environments lead to a patchwork approach to achieving health gains.

Indigenous aspirations for self-determination have been partially satisfied with increased opportunities for contracting in health. Although the link between increased indigenous participation and improved outcomes remains to be explored analytically, it is doubtful that classical contractual environments can yield the health gains expected.

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# STATEMENT

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Abbreviations & Glossary

| Terms/ Abbreviation | Country of use | Definition |
|---|---|---|
| ACCHS | Australia | Aboriginal Community Controlled Health Organisations: Contemporary term used to refer to what was previously known as AMSs. |
| AFN | Canada | Assembly of First Nations |
| AHW | Australia | Aboriginal Health Workers |
| AMS | Australia | Aboriginal Medical Services: the term emerged in the early 1970 and refers to Aboriginal controlled health organisations created as a result of community mobilization and activism. The contemporary term is ACCHS (above). |
| AMSANT | Australia | Aboriginal Medical Services Alliance of the Northern Territory |
| ATSIC | Australia | Aboriginal and Torres Strait Islander Commission. Replaced the Department of Aboriginal Affairs (DDA) |
| Band | Canada | The governance body of a First Nation (Indians of Canada), as defined in the Indian Act. |
| CCT | Australia | Coordinated Care Trial |
| CDEP | Australia | Community Development Employment Projects, program operating since 1977. Participants in the scheme subsidise two thirds of the scheme's costs by voluntarily working for their Income Support Benefits. CDEP provides work and community development, assists with employment creation and the establishment of successful businesses and assists Indigenous Australians to gain training and skills, which are necessary for employment in the mainstream labour market. |
| CDNANZ | Australia | Communicable Diseases Network Australia New Zealand |
| CHR | Canada | Community Health Representative |
| Commonwealth Department of Health | Australia | 2001, Department of Commonwealth Department of Health & Ageing (DHA). 1998 to 2001:Commonwealth Department of Health & Aged Care (DHAC). I have opted to use DHAC throughout the document as most of the research was conducted and most references produced under the former name. 1996 to 1996: Department of Health and Family Services. 1994 to 1996: Department of Human Services and Health. 1993 to 1994: Department of Health, Housing, Local Government and Community Services. 1991 to 1993: Department of Health, Housing and Community Services. 1987 to 1991: Department of Community Services and Health. 1921 to 1987: Department of Health |

| Terms/ Abbreviation | Country of use | Definition |
| --- | --- | --- |
| Danila Dilba | Australia | Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation in Darwin |
| DAA | Australia | See ATSIC |
| First Nation | Canada | Contemporary term and preferred self-referent for Canadian "Indians". |
| FNIHB | Canada | Stands for the First Nation and Inuit Health Branch, the branch of Health Canada that looks after indigenous health. Replaced the Medical Service Branch (MSB) in 1997. |
| *hapu* | New Zealand | Sub-tribe, in the Māori language Te Reo |
| HCA | Australia | Health Care Agreements, being the mechanism for transfer of payments from the Commonwealth Government to the States and the Territory |
| Health Canada | Canada | The national department of health, previously known as the Department of National Health and Welfare (1944 to 1997). |
| HIC | Australia | Health Insurance Commission |
| ICHS | International | Indigenous controlled health sector |
| INAC | Canada | Indian and Northern Affairs Canada, replaces the Department of Indian Affairs and Northern Development (1966). Prior to that (1867-1966) Indian and northern affairs administration was handled by various departments throughout the years, including the Office of the Secretary of State, Citizenship and Immigration, Mines and Resources, and Northern Affairs and National Resources. |
| *iwi* | New Zealand | Tribe, in the Māori language Te Reo. The *iwi*, or whole tribe, generally came together in times of conflicts. |
| KWHB | Australia | Katherine West Health Board |
| MBS | Australia | Medicare Benefit Scheme |

| Terms/ Abbreviation | Country of use | Definition |
|---|---|---|
| Medicare | Australia Canada | <u>Australia</u>: Medicare is financed largely from general taxation revenue, which includes a Medicare levy based on a person's taxable income. Commonwealth funding for Medicare is mainly provided as: subsidies for prescribed medicines (with a safety net providing free medicines for the chronically ill) and free or subsidised treatment by practitioners such as doctors, participating optometrists or dentists (specified services only); substantial grants to State and Territory governments to contribute to the costs of providing access to public hospitals at no cost to patients; and specific purpose grants to State/Territory governments and other bodies. <u>Canada</u>: Medicare provides access to universal, comprehensive coverage for medically necessary hospital, in-patient and out-patient physician services.  Most doctors are private practitioners who work in independent or group practices, enjoy a high degree of autonomy, and are generally paid on a fee-for-service basis. |
| NACCHO | Australia | National Aboriginal Community Controlled Health Services |
| NAHS | Australia | The 1989 National Aboriginal Health Strategy |
| NGO | | Non-government organisation |
| NNADAP | Canada | National Native Alcohol and Drug Addiction Program, funds alcohol and drug counsellors on-reserve |
| NNDSS | Australia | National Notifiable Diseases Surveillance System |
| Northern Territory Department of Health | Australia | This means to signify the Northern Territory Territorial Health Services as it was called until November 2001, and the Department of Community and Health Services, its new title. |
| NT | Australia | Northern Territory |
| OATSIH | Australia | The Office of Aboriginal and Torres Strait Islander Health, which is part of DHAC. |
| *Pakeha* | New Zealand | The non-indigenous population, generally of European origin. |
| PBS | Australia | Pharmaceutical Benefit Scheme |
| PHCAP | Australia | Primary Health Care Access Program |
| *rohe* | New Zealand | District / land |
| *Runanga* | New Zealand | Assembly |

| Terms/ Abbreviation | Country of use | Definition |
|---|---|---|
| *Tino rangatiratanga* | New Zealand | *Tino rangatiratanga* is the term used most often as the expression of Māori self-determination. *Tino* roughly translates as self. *Rangatiratanga* roughly translates as "evidence of breeding and greatness" Williams, H. W. (2002). <u>Dictionary of the Maori language</u>. Wellington, Legislation Direct. Māori traditional governance structures were based on *whanau*, the extended family |
| *Whaiti* | New Zealand | Board of directors |
| *Whakapapa* | New Zealand | Genealogy |
| *Whanau* | New Zealand | The extended family in the Māori language Te Reo. |
| *Whanau ora* | New Zealand | Family health and well-being |

# CHAPTER 1 INTRODUCTION

This thesis is concerned with the emergence of "by indigenous for indigenous" primary health care organisations in the Australian, New Zealander and Canadian health care systems. The health care literature generally acknowledges the government, the private sector and non-profit, non-government organisations (the so-called "third sector") as the three sectors involved in the delivery of health care services. "By indigenous for indigenous" services have now emerged with distinctive features. They are primary health care services tasked with providing services to an indigenous constituency that is invariably considered high risk. This is generally attributed to socio-economic marginalisation resulting from colonial interventions. Like other third sector organisations, indigenous services are involved in the delivery of non-commercial social goods. In addition, indigenous health services are often tied to an indigenous governance structure, are primarily designed by indigenous groups to serve the needs of that group, and are used by indigenous people to promote their political aspirations involving a renegotiation of their relationship with the nation-state. Other key features include increased responsiveness to local indigenous needs and increased opportunities for employment and cultural expression in service delivery, including health care. This sector developed over the past thirty years and is now endorsed and actively promoted by all three governments as a mechanism to increase indigenous participation in health care, improve access and reduce inequities.

Indigenous people appear to have seized upon the opportunity to become primary health care providers. In Australia, Hill et al (2001) report that the number of Aboriginal controlled health organisations has grown to over 120 since they first emerged in 1971. Health Canada reports that seventy-one (71) percent[1] of eligible communities, representing nearly one half of the eligible First Nation population, are now engaged in delivering on-reserve primary health care services. Another thirteen (13) percent are exploring this possibility (Health Canada 2002). In New Zealand, the sector grew from 23 providers in 1993 to 240 in 1998 (New Zealand Te Puni Kōkiri 2000).

In all three countries, policies have emerged validating "by indigenous for indigenous" health services and public funding has been allocated specifically to support these organisations. These policies have become understood as an

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[1] This figure includes 46 percent of communities under the Health Transfer Policy, 23 percent under the Community-based Health Services Agreements and another 2 percent under the Self-Government agreement for a total of 427 communities (2000 figures).

endorsement of indigenous self-determination. The words vary slightly: self-government in Canada, self-determination in Australia, and *tino rangatiratanga* in New Zealand. The discourses however are similar. Self-determination is to replace earlier policies of assimilation, by promoting indigenous participation in policy development and in service delivery. Although there is some discomfort with the idea of providing what can be seen as preferential support for services on the basis of ethnicity, and shifting levels of political commitment, all three countries defend their support of "by indigenous for indigenous" health services as the preferred mechanism for alleviating the health inequalities experienced by indigenous people in contrast to their national counterpart. The need to promote indigenous participation in policy and program design, as well as service delivery, is constantly emphasized (Lavoie 2004). It is a step towards the ideal of self-determination, the new ideal all countries now claim to be striving for.

The ideal of self-determination is at times at odds with public perception and government's administrative needs. Self-determination evokes choice and flexibility in indigenous organisations pursuing local priorities. Contracting in health has emerged as the main implementation mechanism for self-determination. However, the current Canadian government's accountability framework demands well defined contractual agreements, with standardised performance indicators that can be aggregated regionally and nationally to ensure appropriate performance monitoring (Deloitte & Touche & Health Canada 2001, Health Canada 2003). Securing additional funding for indigenous health from Parliament, and by extension the tax payer, is more readily achieved by identifying nationally-defined health gains that elicit sympathy (the elimination of Foetal Alcohol Spectrum Disease, for example) than by suggesting additional funding to be used by indigenous communities as they see fit. In the Canadian context, flexibility in contractual arrangements appears to go counter to prevailing ideas of accountability in public administration and public perception of appropriate interventions. As a result, the sphere over which choices may be exercised, and the right of the state to rule on the appropriateness of certain choices, remain matters of debates. These tensions have been reported in Australia (Rowse 2002) and in New Zealand (Durie 1998b). Self-determination thus remains an ideal with blurred and constantly redefined boundaries that builds on conceptual paradoxes rather than clear objectives. It remains a difficult concept to integrate into a public administration framework.

This study is informed by a period of twelve years working for and reflecting on Canadian indigenous-run health organisations. The earlier years were spent pursuing a Master's degree in Medical Anthropology (McGill University, 1993) and studying the

Nunavik Inuit primary and secondary health care structures that had emerged as a result of the James Bay and Northern Quebec Agreement, the first 'modern Treaty' in Canada's history (Lavoie 1993). This was followed by three years living in what is now known as Nunavut, the newly formed Inuit territory, and working as a Health Promotion Officer for the Keewatin Regional Health Board, one of the three Inuit Regional Health Boards then in existence in the region. The more recent period included six years spent working for First Nation health organisations operating their own on-reserve primary health care services as a result of the Health Transfer Policy. The debate that dominated these years centred around indigenous aspirations for self-determination, the government's interpretation and translation of these aspirations in administrative terms, and the predictable distance between the two. Both Canadian indigenous communities and the federal government appear to share a discourse that promotes indigenous control over indigenous health through indigenous control of primary health care. This discourse echoes the Alma-Ata declaration and international debates on community participation in primary health care. While both sides appear to converge on a common goal in their words and writings, on-going debates are taking place over indigenous control over priority setting, policy, programme definition and implementation, and appropriate indicators of performance and accountability (O'Neil et al 1998). The historical relationship that exists between First Nation and Inuit communities and the Canadian government often polarises debates and complicates relationships. One is left to wonder whether the result, a contractual environment, is optimally developed or whether other constraints overshadow appropriate decision-making. These issues are not unique to Canada. What is of interest and yet to be documented is how other countries with a similar history, such as Australia and New Zealand, manage these tensions.

The goal of this chapter is to provide an overview of the thesis. The first section provides a summary of the purpose and aims of the overall thesis. The second section explores the rationale for pursuing this study in the three countries selected. Section three provides a synopsis of the methods used in the research, and an overview of the overall structure of the thesis. The fourth section explores some of the key concepts used throughout the thesis.

## 1.1    Purpose, Aims and Objectives

This thesis focuses on the context and process of policy formulation, and analyses the resulting content of indigenous health policies in terms of the contractual environment that has emerged to support indigenous health providers. The main objective of this thesis is to investigate how governments balance the ideal of

indigenous self-determination with other pressures, such as current trends in public administration and accountability, pressures on the health care system, issues of and sensitivities around minority rights, equity in health and cost-efficiency. More specifically, the objectives are as follows:

1.  To describe the historical and political context of state-indigenous relations, as they relate to questions of access to and delivery of health care services;
2.  To analyse indigenous health policies, including the values they convey and mechanisms and processes they identify to implement their stated objectives;
3.  To document the level of decision-making authority being transferred to Indigenous PHC services, including opportunities and contingencies; and
4.  To assess the extent to which there is convergence between policy objectives and implementation mechanisms.

This enquiry thus involves analyses at four distinct levels. At the policy level (second objective), the analysis aims to identify what is being valued, pursued, and how. It must necessarily be nested in a discussion of the forces that shaped indigenous health policy development, which includes an overview of the national health care system (first objective). At the implementation level, which is the main focus of this enquiry (objective three), the analysis aims to document the space over which indigenous providers exercise control, a key term in the context of self-determination. The final analysis aims to evaluate the level of coherence between policy and implementation (objective four). These objectives will be explored in light of the literature reviewed in chapter 2 to develop specific study questions.

The indigenous environment has been fertile in international comparative analyses.  Examples include,

| On the political location of indigenous people within the nation state | • Paine and Dyck's edited books on Canada, Australia and Norway (Dyck 1989, Paine 1985); |
| --- | --- |
| | • Tremblay's report on self-determination and legislative frameworks in Australia, Canada, New Zealand and the United States (Tremblay 1993); |
| | • Havemann's edited book on indigenous rights in Canada, Australia and New Zealand (Havemann 1999c); |
| | • Thornberry's volume on indigenous rights (Thornberry 2002); |
| In matters of jurisdiction and infrastructure development | • Crough's and Kaufman's reports on the funding, organisation and accountability frameworks for indigenous organisations in Australia, the United States (Kaufman only) and Canada (Crough 1997, Kaufman Thomas and Associates 2001); |

| On history and social policy | • Armitage's comparison of policies of assimilation in Canada, Australia and New Zealand (Armitage 1995); |
|---|---|
| On health care organisation and policy | • Kunitz's comparative work on health policy and indigenous mortality (Kunitz 1990, 1994, Kunitz & Brady 1995); |
| | • Brady's and Gray's articles comparing addiction programs in Australia and North America (Brady 1995, Gray et al 1995); and |
| | • Gray's comparison of access to health care in Australia and Canada (Gray 1998). |

The analyses are invariably motivated by the need to look beyond one's national boundaries and compare histories, policies, strategies and outcomes. The methodology is generally that of the case study, although the precise methodology is not always disclosed. Scrimgeour's reports on participation and funding for indigenous run health care services in Canada, Australia, Norway and New Zealand (Scrimgeour 1995, 1996) remain the only references closely related to the focus of this thesis. Although his studies are valuable, they are based on a relatively short time in the field and limited number of interviews. They provide a good overview.

A number of national policy analyses have also been conducted. In Canada, analyses have focused on the context of policy development (Brant Castellano 1982, Culhane Speck 1989, O'Neil 1995), or localised case studies of implementation (Bird & Moore 1991, Gregory et al 1992, Warry 1998). In Australia, a few macro policy analyses have been published (Anderson 1997b, HealthInfoNet 1999). New Zealand has been somewhat more fertile in policy analyses (Cooper 2000, Dow 1999, Durie 1998b, 2001). Of all three countries, only Kiro provides a detailed link between health policy and implementation (Kiro 2001). These contributions are discussed in chapters 4 and 6. At this point, it suffices to note that indigenous health policy and implementation environments have remained remarkably unscrutinised. This is the gap in the literature that this study attempts to address.

It has to be noted that this thesis does not attempt to speak to the effectiveness of "by indigenous for indigenous" health services in addressing health inequalities. Although international comparative analyses of health inequalities are at times used to situate debates (see Table 1.1 for example), the comparative quantitative data needed to assess the effectiveness of "by indigenous for indigenous" services in contrast to other services is simply not available. It appears that in all three countries under study, the indigenous sector emerged in environments where baseline data was not collected. Indigenous health organisations do gather health information, but this information is not

collected following standard methods, nor channelled centrally for aggregation. The First Nation environment is the only one that provides some information. First Nations are required to gather health information and to undertake an evaluation every five years. Some of these documents were reviewed for evidence (Angees et al 1999, First Nations and Inuit Regional Health Survey National Steering Committee 2001, Martens et al 2002, Young et al 2000), but the organisations are small and the data scant. There is no equivalent process in Australia or New Zealand, where reporting requirements are limited to activity reports. These studies will be mentioned where appropriate, but lie largely outside the scope of this thesis, which focuses on policy and implementation.

Another limitation of this study is that it does not attempt to fully explain the forces that shape policy implementation over time, but rather focuses on the contractual environment that emerged as a result. Grindle and Thomas (1991) identify that policy adaptations may occur as a result of reactions in the public, the bureaucratic and the political arena. In the context of this research, the indigenous arena could be added to this list. Efforts were made to document the context in which policies emerged and shifted over time. The literature provided valuable insights (Anderson & Sanders 1996, 1997b, Durie 1998a, 1998b, Griew et al 2003, Rowse 1996), which were supplemented with interviews wherever possible.

In summary, the aim of this thesis is not to answer the question, "are indigenous health services able to improve indigenous health?" Or "under what conditions can policies of self-determination be successfully implemented?" The aim is rather to explore the question, "is the contractual environment implemented in a way that capitalises on the opportunities offered by 'by indigenous for indigenous' services, as defined in the policies, namely local priority setting and responsiveness, cultural appropriateness and relevance in service delivery?"

| Table 1.1, Health Inequalities in Canada, Australia and New Zealand | | | | | | |
|---|---|---|---|---|---|---|
| | Canada | | Australia | | New Zealand | |
| | FN Male (non-indigenous male) | FN Female (non-indigenous female) | Aboriginal Male (non-Aboriginal male) | Aboriginal Female (non-Aboriginal female) | Māori Male (non-Māori male) | Māori Female (non-Māori female) |
| Life expectancy | 66.9 (74.6)[2] | 74 (80.9)[2] | 56.9 (75.6)[3] | 61.7 (81.3)[3] | 67.2 (71.6)[2] | 72.3 (77.6)[2] |
| Age standardised Death Rate | 12.71 (8.49)[2] | 7.95 (5.28)[2] | 20.87 (8.39)[4] | 16.86 (5.42)[4] | 11.89 (9.33)[2] | 8.4 (6.05)[2] |
| Infant mortality rate | 12.3 (6.4)[2] | | 18.7 (6.05)[5] | 17.3 (4.95)[5] | 14.1 (7.1)[2] | |
| % population below 15 years of age | 34.4 (20.6)[2] | | 39 (21)[3] | | 33.1 (22.2)[2] | |

[2] For 1991. (Trovato & Werner-Leonard 1991)

[3] For 1991-96. (Australian Institute of Health and Welfare 2001)

[4] For 1992-94. (Anderson et al 1994)

[5] For 1995-97. (Cunningham & Paradies 2000)

Despite these limitations, the questions explored in this thesis are of significance to three, although not necessarily distinct groups: indigenous communities and nations, policy makers and researchers. Ever since contact with Europeans, indigenous communities and nations have sought to retain and regain control over areas of their life. For the past thirty years, indigenous communities have advocated to take control of government services offered in their community. This research addresses the mechanisms set in place in three countries to facilitate the transfer of publicly funded government responsibilities to indigenous authorities. Indigenous organisations have expressed a keen interest in this research. This interest appears to stem largely from wanting to extend the benefits that resulted from international pan-indigenous comparisons in the fields of indigenous rights, land, resource management and law, to issues of contracting in health care. Pan-indigenous comparisons have played an important role in providing indigenous groups with information they feel has intrinsic relevance to their circumstances (Armitage 1995, Crough 1997, Dyck 1989, Havemann 1999c, Tremblay 1993). New research agreements have emerged to ensure continued collaboration between Australia, New Zealand and Canada. Policy makers find themselves tasked with recommending mechanisms to engage indigenous minorities. While community control has become a leading ideology in primary health care delivery (World Health Organisation 1978, 1986), the transfer of government funding to indigenous organisations is not without challenges. Implementers are concerned with identifying the most cost effective and responsive way to structure the contractual environment with indigenous health providers in order to achieve the priority health gains identified by government, while managing political and financial risks. Researchers involved in indigenous health have so far focused on determinants of health, history, issues of power, cultural appropriateness of interventions, and health service utilisation. While many have suggested that community control may be the most appropriate mechanism to ensure responsiveness, a literature exploring the optimal contractual environment to ensure responsiveness has yet to emerge. This research will only go part way in answering these interests.

## 1.2    Choice of countries

For this study, Australia and New Zealand were selected as counterpoints to the experience garnered in Canada. Although significant differences exist, Australia, Canada and New Zealand share much in terms of history, interests and debates. First, indigenous people in all three countries self-identify as such and are internationally recognised as indigenous by United Nations' Working Group on Indigenous Populations because of their priority in time; the voluntary perpetuation of their cultural

distinctiveness; their self-identification as indigenous; and their experience of subjugation, marginalisation, dispossession, exclusion, and discrimination by the dominant society (United Nations Working Group on Indigenous Populations 1996). Second, each country shares a history of conquest by Britain and a permanent settlement by a majority of people who shared similar values.  Third, in each country, an imposed political economy turned land and natural resources into commodities, and incorporated them into an increasingly wider network of international trade that is expected to undermine national government's ability to respect its own laws and agreements with their respective indigenous population.  Fourth, in each country, English common law prevails, along with the Westminster model of majority representative democratic government, and these approaches displaced traditional forms of governance, at least at the official level.  Fifth, each country adopted some policies inspired by social Darwinism that were eventually displaced by post-assimilationist accommodations (Armitage 1995, Havemann 1999c).  Sixth, the history of conquest and of governmental response to deal with the indigenous "problem" show important parallels (Havemann 1999c). These themes are explored through the following three country-specific vignettes.

### 1.2.1   Indigenous people in Canada

In Canada, the collective term Aboriginal people (an umbrella term encompassing First Nations,[6] Inuit and Métis) entrenched in the Constitution as amended in 1982, glosses over cultural, legislative and administrative complexities. Table 1.2 shows the overall demographic situation.  The term First Nations is the preferred self-referent used by the indigenous peoples of Canada historically known as "Indians,"[7] to replace the word "Band"[8] used for the political and administrative unit that emerged as a result of the *Indian Act* of 1876.  The collective term First Nations veils a multiplicity of nations, including Nisg'aa, Cree, Ojibway, Salish, Mohawk, Micm'ac, and Innu, to name a few.  In administrative terms, there are currently 627 First Nations

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[6] In Canada, the use of the term nation is deliberate, and somewhat unique.  First Nations see themselves as sovereign nations, engaged in negotiations with another sovereign nation, namely Canada.  This understanding is entrenched in the Treaty process of the turn of the century.

[7] In the North-American context, the term "Indian" emerged out of colonial confusion (Columbus believe that he had arrived in India), but has become a bureaucratic construct defined in the Indian Act, first adopted in 1876.  An updated version of the Act remains in place to day, and defines who can and cannot claim to be an Indian (meaning a member of a First Nation), a label to which is attached eligibility to live on reserve, and certain individual-based benefits.

[8] The equivalent to the better known word "tribe" which is rarely ever used in the Canadian context.

recognised by the federal government (Indian and Northern Affairs Canada 2002). These are political and administrative organisations that emerged to satisfy the requirements of the Indian Act. They may or may not be members of one of the 79 regional Tribal Councils.  These numbers do not represent the whole of indigenous organisations, nor the number of indigenous cultures: Inuit and Métis are excluded. Further, it was the practice of the federal government at the turn of the century to divide large cultural groups into more "manageable" administrative subgroups, thus there are in fact considerably less cultural groups than there are First Nations.

| Table 1.2, Indigenous Population in Canada, Statistic Canada Census 1996 (Statistics Canada 1996)[9] | | | | |
|---|---|---|---|---|
| Total Canadian | First Nations | Non-Status Indians | Métis | Inuit |
| 28,528,125 | 461,510 | 92,780 | 210,190 | 41,080 |
| | 1.6% | 0.3% | 0.7% | 0.1% |

Inuit is also a collective self-referent that refers to the Arctic people previously known as Eskimos.[10]  Inuit themselves recognise local groups with different names (Pallurmiut, Inuvialuit, etc.) reflecting the complexity of Arctic history and subtlety in cultural differences glossed over by outsiders.  Finally, Métis refers to the descendents of French or Scottish traders and Cree women who settled on the Red River area, north of what is now Winnipeg, Manitoba, developing their own blended culture and their own language, Metchif.  After Confederation, the Métis were not entitled to sign Treaties.  Like non-status[11] Indians, themselves descendents of status Indians and non-Aboriginals, Métis do not benefit from the special provisions made by the federal government for economic development, health care, etc.  The Métis were for the first time recognised as Aboriginal people in the Constitutional reform of 1982 (Sawchuk 2000).

The Canadian information presented in this thesis relates to health services provided by First Nations themselves with funding from the federal government, for First Nations living on-reserve.  The expression on-reserve refers to Indian reserve land held in trust by the Minister of Aboriginal Affairs for Bands who were signatory of Indian Treaties at the turn of the century, in exchange for a surrender of Aboriginal rights over their ancestral territory.  Simply put, the British Crown issued the Royal

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[9] Participation in the Canadian census is not mandatory, and it is generally acknowledged that it underestimates the Aboriginal population .

[10] The term is still in use in the United States.

[11] A status Indian is a person registered as an Indian under the terms of the Indian Act. Status ensured the right to live on-reserve and access to Treaty and policy defined benefits.

Proclamation in 1763, following the 1759 conquest of what was known as New France (Eastern Canada), which had been under French rule since the early 1500s. The Royal Proclamation was an attempt to create an alliance between the Crown and the indigenous population in order to ensure the sovereignty of the British Crown. The Royal Proclamation essentially stated that the indigenous peoples of Canada were not conquered and retained title to their ancestral territory. Any encroachment on the part of settlers was to be approved by the Crown, negotiated through the Treaty process and duly compensated (King George 1763). Following Confederation (1867) and the push to create a sustainable agrarian economy, the Crown engaged in Treaty negotiations with First Nations throughout the prairie provinces. The 11 numbered Treaties, as they are known, are land surrenders agreed to in exchange for reserve land, calculated at 128 acres per family of four at the time of signature, as well as other provisions such as rations in time of famine, medicines, and agricultural implements.[12] The Royal Proclamation still has currency today. Modern Treaties, such as the James Bay and Northern Quebec Agreement (1975), the Nunavut Land Claim Agreement (1995) and the Nisga'a Agreement (1997) were motivated by the need to clarify (and/or legalise) the Crown's access to land and resources.

### 1.2.2   Aborigines in Australia

Like the concept of First Nation, the term Aborigine is a category born out of the need for an umbrella term to contrast with the term "white" used to signify "the others", the newcomers of European origin. Such sharp contrasts are obviously literary constructs that mask a much more complex situation. Australian Aborigines identify themselves with a variety of collective self-referents linking them to a specific linguistic affiliation and geographical area: Murris in Queensland, Nungas in South Australia, Pallawah in Tasmania and Nyoongas in Western Australia. In recent years, the collective term Koori has gained popularity among Aborigines in parts of New South Wales and Victoria. Although well established in Australian English, it has not gained Australia-wide acceptance. These self-referents add a layer of complexity to the term Aborigine, but in themselves hide other layers related to experience, locality, self-concept and history (see Holland 1999). They also gloss over an amazing diversity of cultures and languages. ATSIC reports that 200 to 250 distinct languages, and many more dialects existed prior to contact (Aboriginal and Torres Strait Islander Commission 1998). More recently, AIATSIS has documented 390 distinct cultural

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[12] First Nations signed the Treaties to ensure that some compensation would be received for the new settlers' inevitable encroachment on their ancestral territory.

groups (Australian Institute of Aboriginal and Torres Strait Islander Studies 1999). In Australia, the terms language groups or clans are used to designate culturally specific groupings. In legal terms,

> *An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community with which he or she lives* (National Health Data Committee 1998)*.*

Torres Strait Islanders are considered a distinct and relatively small group from Aboriginal people, located on the most northern tip of north-eastern Queensland. They are historically and culturally affiliated to Papua New Guinean people. Historically, the term Aborigines included Torres Straight Islanders. More recently, it has become customary to distinguish between the two groups. Recent official document titles now spell out Aboriginal and Torres Straight Islanders, and the abbreviation ATSI adopted in this thesis is widely used.

In contrast to the Canadian situation, the Australian government is satisfied with ATSI self-identification. This is however a change from earlier times when ATSI identity was defined by government in terms of full-castes, half-castes and quadroons. As mentioned above, the Canadian case study applies only to a selection of Canadian Aboriginal people as a result of jurisdictional issues introduced in the Constitution. In contrast, the two Australian case studies presented in this thesis can apply to all ATSI communities. The Australian inclusiveness has less to do with a more benevolent attitude, and more to do with the fact that unlike Canada, Australia has never allocated individual benefits to ATSI people on the basis of Treaty rights or policy. Thus Australia has never needed to define inclusion and exclusion criteria.

Contrary to Canada, Australia adopted a doctrine of *terra nullius* from the earliest days of contact, thereby denying the original inhabitants any rights to land (Reynolds 1982). The creation of Australia was really a coming together of separate colonies who wished to retain considerable autonomy. Aboriginal affairs thus remained the realm of the states, rather than the Commonwealth. In theory, each state had its own approach to ATSI health. In effect however, the practices ranged from benign neglect to coercive public health measures (Briscoe 1996, Harrison 1997, Hetzel 2000, Hunter 1993, Jebb 1984, MacLeod & Denoon 1991, Maguire 1991, May 1991, Reid 1990, Reynolds 1982, Ring & Elston 1999, Saggers & Gray 1991). By the 1960s, attitudes were shifting at all levels of the Australian society, leading to legislative changes to end discriminatory practices. Voluntary voting was extended to Aborigines in 1962. Constitutional changes in 1967 gave the Commonwealth government the authority to make laws in relation to all ATSI people. By the same token, the Commonwealth government was given the authority to enumerate Aborigines in the

yearly national census, a power that had been constitutionally denied since 1901 (Thomson 1984).

Table 1.3 shows the breakdown of Aboriginal and Torres Strait Islanders across the country. As with Canada, Aboriginal and Torres Strait Islanders make up for between 2 and 3 percent of the overall Australian population. As a result, ATSI people cannot hope to be heard through the democratic process alone, and must opt for alternatives. They have sought to find mechanisms for political self-expression since at least the turn of the last century (Bennett 1989). In many ways, a lack of access to health care associated with co-payments but also a lack of governmental commitment in ensuring access to services in rural and remote environments, provided a meaningful impetus for mobilisation.

| Table 1.3, Estimated distribution of indigenous/non-indigenous populations, 1995-96 (Deeble et al 1998) | | | | |
|---|---|---|---|---|
| State/Territory | Indigenous (000) | Non-Indigenous (000) | Total (000) | % Indigenous |
| New South Wales | 105.0 | 6,058 | 6,163 | 1.70 |
| Victoria | 22.3 | 4,516 | 4,538 | 0.49 |
| Queensland | 99.3 | 3,202 | 3,301 | 3.01 |
| Western Australia | 53.5 | 1,696 | 1,750 | 3.06 |
| South Australia | 21.0 | 1,451 | 1,472 | 1.43 |
| Tasmania | 14.5 | 460 | 474 | 3.05 |
| ACT | 3.1 | 303 | 306 | 1.01 |
| Northern Territory | 49.1 | 131 | 180 | 27.29 |
| Australia | 367.8 | 17,817 | 18,184 | 2.02 |

It is worth noting that access to services has been and somewhat remains problematic in the Northern Territory (Bartlett et al 1997, Bartlett & Duncan 2000, Wakerman et al 1997). This is partly due to the Australian government's satisfaction with relying on market forces to direct the deployment of general practitioners. As a result, sparsely populated areas and regions with higher ATSI concentration are less likely to receive services.

### 1.2.3   The Māori of Aotearoa (New Zealand)

According to Cheater and Hopa (1997), the term Māori is a colonial construct dating to the first week of February 1840, and created by missionaries tasked with translating the Treaty of Waitangi. They chose the term Māori instead of New Zealanders as they had been called before, to designate the 70 plus tribes of indigenous residents.  "Māoridom" (Cheater & Hopa 1997) has undergone significant changes since contact.  With 80 percent of Māori living in urban centres, Māori identity

appears to be no longer associated with a rural base.  It is therefore not surprising to find 30 percent of Māori no longer identifying with *iwi* [tribe] or *hapu* [sub-tribe].  In recent years, Government's compensation and economic schemes have validated certain Māori forms of political organisations, while ignoring and invalidating others, leading to tensions within the "Māori" community. This thesis utilises the collective self-referent "Māori" and its mirror image term "*pakeha*",[13] while recognising that both are themselves artifices of the colonial experience.

In many ways, the relationship of Māori with the Crown is very different to that of First Nations and ATSI. To begin, Māori share a common historical origin and a common language, Te Reo. Although divided into 70 plus *iwi* and *hapu*, with significant differences in protocol and practices, Māori nevertheless share more between themselves than do their Australian and Canadian counterparts.

As well, the Māori population nears 550,000 in total. The First Nation population is estimated at around 600,000. ATSI people are estimated at around 450,000. Although the population sizes are comparable in absolute numbers, Māori are in a different position compared to their First Nation and ATSI counterparts. As shown in Table 1.4, Māori amount to nearly 15 percent of the overall New Zealand population. Māori have the opportunity to influence New Zealand's development through the democratic process.

| Table 1.4, New Zealand Population as of 2001 (Statistics New Zealand 2001) | |
| --- | --- |
| | Percent |
| *Pakeha* (non-indigenous New Zealanders) | 80.0 |
| Māori | 14.7 |
| Pacific Islanders | 6.5 |
| Others | 4.6 |
| Total population | 3,737,277 |

Like their Canadian counterpart, Māori entered into a historical Treaty relationship with the Crown. Much is made of this commonality. In fact however, the background and context leading to the Treaty of Waitangi is very different from the Canadian experience. Although Māori experienced the sustained presence of missionaries from 1815 onward, New Zealand was in fact the last of the dominions to be annexed and settled.  European presence did not amount to more than two thousand when Britain officially claimed sovereignty in 1840.  According to Nicolson (1988), by the 1830s and 1840s, it was widely acknowledged in Europe than contact

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[13] The term *pakeha* is widely used as a substitute for the term European, to refer to New Zealanders of European origins. Both terms have their followers.

with indigenous cultures had detrimental effects on their health. While the reasons for such effects were debated, the experience of frontier violence by settlers in Australia left little doubt as to some sources. It appears that it was the British Government's intention at the onset to minimise the horrors experienced in its other colonies. The Treaty of Waitangi was signed from February until May of 1840 between the Crown, the Governor and around 500 Māori Chiefs. It was a requirement to New Zealand being granted self-rule. Moon contends that from the Crown's perspective, the impetus for the Treaty was the need to regulate and protect its British citizens living in New Zealand, and to exert territorial sovereignty. Discussions leading up to the Treaty made no mention of extending the protection of British common law to Māori. Māori were to retain their sovereignty:

> *"the Crown would not simply seize New Zealand unless there was full, free and intelligent consent from the natives to do so" (Moon 1999).*

From Governor Hobson's perspective, there was no need to extend British rule to Māori since he expected their demise at a pace that would not interfere with the settlement of New Zealand. He nevertheless presented the Treaty to Māori as an instrument of protection that would not affect their sovereignty. It appears that Māori understood the Treaty as such, this despite the inclusion of three articles which could be interpreted as a surrender to British rule.[14]

Whereas First Nations benefit from their Treaty relationship with the Crown mainly if living on-reserve, Māori benefit from a more broadly defined recognition of their rights. In 1975, the Treaty of Waitangi Act was passed by parliament, thereby removing the implementation of the Treaty from the realm of policy, and providing an advisory mechanism, the Waitangi Tribunal, to assist in resolving disputes. The Tribunal was later to rule that Treaty of Waitangi apply to both *iwi* and other Māori (urban, pan-*iwi*) communities, as long as they could demonstrate their exercise of *tino rangatiratanga* [self-determination] (New Zealand Waitangi Tribunal 1998).

The Treaty of Waitangi remains the core of the Māori-Crown relationship in New Zealand. It is brought forth in every discussion, and cited in all policy documents. What the Treaty actually means however, is a matter of debate. For a large segment of Māoridom, New Zealand is a coming together of two distinct nations that can co-exist, but as separate entities. The request for a separate parliament, which emerged in 1837, continues. The New Zealand Government has historically and appears to remain

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[14]The Treaty was written in both languages, but it appears that both versions were not equivalent in meaning (Durie 1998b).

uncomfortable with the idea of differentiated citizenship, and continues to favour integration.

## 1.3    Overview of Methodology and Thesis

This research relies on case studies conducted in indigenous primary health care organisations located in two countries.  The questions explored in this thesis are based on experience in the Canadian context. These are then probed through case studies undertaken in Australia and New Zealand.

Chapter 2 explores the literature and key concepts relevant to the objectives of this thesis. The aim of this chapter is to provide a theoretical context for the study from an international and broader perspective. The Canadian experience is also explored to provide the theory building required for this study. The Canadian situation was chosen for a number of reasons. First, the Health Transfer Policy has been in place since 1989. In contrast, "by indigenous for indigenous" policies in New Zealand and Australia are more recent. Second, administrative and organisational issues have been fairly well documented over the past 15 years. Third, the Health Transfer Policy has been the object of two national evaluations since its implementation, and is currently the object of a third.  The specific study questions are derived from this analysis.

Chapter 3 describes the approaches, strategies and methods used in carrying out this study. The aims of this chapter are to explore the strategy developed to answer the study questions, justify the case study site selection, explain why a case study methodology was adopted and provide an understanding of how results were generated. The exploratory approach developed by Yin (1994) was found particularly well suited to accommodate the complexity of this study.

Chapters 4, 5 and 6 present the findings of this study. Chapter 4 discussed the emergence of "by indigenous for indigenous" health policies in both Australian and New Zealand. For each country, the discussion begins with an overview of the health care system in place in the country. This is followed by a chronological overview of the development of health services for ATSI and Māori respectively. The discussion of the health care system and chronology serve as a backdrop to a detailed exploration of ATSI and Māori health policy development. In Australia, this development occurred in parallel to state and territorial health services until very recently. In New Zealand, Māori and non-Māori health services have always been more or less integrated.  Differences in context and resulting policies are highlighted and contextualised with the Canadian material presented in chapter 2. Chapter 5 provides an overview of the case study sites. Chapter 6 analyses the contractual environment that emerged as a result of "by indigenous for indigenous" health policies in Australia and New Zealand respectively.

This chapter draws on the case studies conducted in both countries, and revisits the Canadian experience. The strengths and challenges associated with each model are explored.

Chapter 7 is the concluding chapter of this thesis. It reviews the findings of chapters 4, 5 and 6, and explores the connection between policy and implementation. This is contextualised with a discussion of the international literature. Its objective is to summarise key findings, highlight policy implications and identify areas of priority for future research.

## 1.4    Terminology

This thesis includes research conducted in three countries. Each country has developed its own lexicon to refer to some of the issues discussed in this thesis. Some use the same word to mean somewhat different concepts. In New Zealand in particular, Māori terminology is preferred over English terminology to signify concepts that emerged from Māori culture and have gained currency in national policy. Some conventions were adopted throughout the text to facilitate reading.

Government Health Departments: All Departments of Health are identified not by their current names, but rather as country/state/territory Department of Health.  This convention has been adopted throughout the text to facilitate a reading by people who may not be unfamiliar with the country or region being discussed.  This convention also side-steps the issue of name changes, a prevalent feature of the Australian political domain.

"By indigenous for indigenous" health services:  The issue of what precisely constitutes a "by indigenous for indigenous" health services, and the challenge associated with identification are explored in more details in chapter 3. Suffice to say for now that each country has developed its own terminology, and that the cross-national analysis presented in this study requires the development of a pan-indigenous expression, thus the adoption of the expression "by indigenous for indigenous" health services. This expression is meant to include the following categories of organisations:

- In Australia, Aboriginal controlled clinics emerged in the 1970s under the label Aboriginal Medical Services or AMSs.  They have since become known as Aboriginal Community Controlled Health Services or ACCHS.  These labels however generally reflect membership with the National Aboriginal Community Controlled Health Organisation NACCHO.  Other organisations may be "ATSI controlled" but have opted not to become a member of NACCHO. These, such as the Tiwi Health Board, are understood as "by indigenous for indigenous" health organisations.

- In New Zealand, Māori health services may be *iwi*-based or pan-*iwi* [tribe]. Models have included MAPOs (Māori Purchasing Organisations), MICOs (Māori Integrated Care Organisations) and more recently MDOs (Māori Development Organisations).

- In Canada, First Nations have assumed a role in governing on-reserve affairs since the implementation of the Indian Act in 1876. Existing health services that have been transferred to First Nation administrative authority are included.

The expression <u>primary health care services</u> is used to signify community-based and community driven comprehensive primary health care services that span curative, preventive, promotive and rehabilitative health services. For the purpose of this thesis, these services may have a doctor on staff, or access to doctor services through partnership or referral. In the indigenous context, these services are not usually doctor-centred.

A list of abbreviations that recur in the text is provided at the beginning of this thesis. The list also provides definitions for technical terms used in the text and of Māori words. In New Zealand, Māori terminology is widely used to describe Māori-specific issues and concepts. This has been respected. A translation has been provided in [ ] when Māori words are first introduced to ease reading.

# CHAPTER 2, REVIEW OF LITERATURE

This thesis focuses on the relationship between official policies, the compromises related to implementation, and the reality of practice. At the theoretical level, this topic is informed by a number of key contemporary debates. The general backdrop of these debates is the international discourse on human rights and the equitable distribution of social goods, such as health. Since (and perhaps before) the Alma-Ata Declaration (World Health Organisation 1978), engaging marginalised populations in primary health care delivery has been core to the pursuit of equity. What constitutes "community" and "participation" however remains a matter of debate. In the context of the countries selected for this study, the chosen mechanism has been the government-supported development of indigenous health organisations, because it satisfied the conditions of participation, and echoed the concept of self-determination advocated by indigenous people. This choice is related to debates over the appropriate division of responsibilities between levels of governments and the non-government sectors in the provision of health services to vulnerable populations. The mechanisms set up to implement the transfer of responsibility over health care, the contracts, can be examined from a strictly administrative perspective, or can be contextualised in light of the larger debates already mentioned.

While all themes raised above have received considerable attention in the literature, they are at best loosely linked. The relationship between these layers of analysis is illustrated in Figure 2.1. The figure distinguishes between policy formulation, which is the process by which policies are developed, from the point of identifying issues to be addressed, to the point where an official policy position is taken. Policy makers are not necessarily the actors tasked to implement policy. Here, adaptation may be required to make the policy objectives fit within an existing context. Different interest groups within the system may influence implementation. As a result of interpretations and accommodations, the values reflected in practice may show considerable compromises from the values initially expressed in policy statements.

# Figure 2.1, Conceptual Framework

National Health Indicators

| COMPONENTS | OBJECTIVES | FOCUS OF INQUIRY |
|---|---|---|

**Central Government**
**(Regional Governments)**

Context → To describe the historical and political context of state-indigenous relations, as they relate to questions of access to and delivery of health care services → History of relations / Societal values / Health Care System

Government Department responsible for Indigenous health

Policy formulation → To analyse indigenous health policies, including the values they convey and mechanisms and processes they identify to implement their stated objectives → Indigenous Health Policy Analysis

Government Departments responsible to implement indigenous health policies

Policy Implementation → To track changes and compromises made in the process of implementing indigenous health policies over time → Indigenous Health Policy Analysis and Administration over time

Community-based Indigenous PHC Organisations

Practice → To document the level of decision-making authority being transferred to Indigenous PHC services, including opportunities and contingencies → Contractual environment for Indigenous PHC Services

**Scope of Study**

Health care consumers

Health Inequalities

32

This chapter will review the literature to answer three inter-related questions:

- What is the larger context and debates influencing indigenous health policies;

- What is the link between, and the factors influencing, the relationship between policy formulation and policy implementation; and

- What options exist in contracting in health, and how do there options relate to the needs of public administration and accountability, health care system management and local priority setting, and cost-efficiency.

This chapter does not provide a comprehensive review of all debates, but rather focuses on the themes explored above, drawing on four large bodies of literature. The organisation of this chapter echoes the map provided above. The first body of literature focuses on indigenous-state relations. This is a key body of literature for this study, as it raises and relates to issues of individual and collective representation, and participation in primary health care. It is part of the broader context informing indigenous health policy development today. Second, the literature on the processes of policy formulation and implementation is reviewed with a more specific focus on the linkages between the two. This body of literature provides the backdrop for exploring the relationship between a policy that promotes indigenous participation in policy, planning and delivery, and the actual mechanisms implemented to fulfil policy objectives. The third body of literature relates to practice and explores options in contracting in health, with a more specific focus on issues of health system management, accountability, public administration and cost-efficiency. A fourth section organises the findings into a theoretical framework. The final section summarises the key points explored and uses them to formulate the study questions. The Canadian literature and experience provides a backdrop for this study and is used throughout to illustrate points. The international literature is used to explore alternatives.

## 2.1    Context: Debates shaping indigenous health policy

This section reviews the debates shaping indigenous health policies. The endorsement of the ideal of self-determination by Canada, Australia and New Zealand reflects current international and theoretical debates in four key areas. First, there is increased recognition in international and theoretical debates of the need for neo-liberal societies to recognise and accommodate collective identities and collective rights. Second, in the case of Canada and New Zealand, the concept of collective rights is entrenched in historical documents and increasingly echoed in international covenants. Third, implementing self-determination is a complex matter, because there is no consensus as to the meaning of the principle. The term also implies the establishment of a parallel system, for a relatively small and sparsely distributed indigenous

population in the case of Canada and Australia, and for a larger and geographically integrated Māori population in the case of New Zealand. And fourth, alternatives to the establishment of parallel systems include varying degrees of participation in existing systems, each with strengths and challenges. Each theme will be addressed in turn.

### 2.1.1   Collective identity

The issue of minority and group rights has generated an impressive number of publications in the last decades.  Indeed, the international and national human rights forums, while emphasising individual freedom, have nevertheless called for increased tolerance and frowned over homogenising policies promoting a one-dimensional "national character".  Groups claiming specific rights include,

- National minorities, such as stateless nations and indigenous peoples;

- Immigrant minorities, whether voluntary immigrants or refugees;

- Religious groups; and

- *Sui generis* groups, for example, African Americans or Roma (Kymlicka & Norman 2000).

The way in which indigenous peoples or nations understand and define their sense of identity, and their place within the nation-state, is key to this thesis. A central issue is the expression of collective identity and protection of cultural identity.

> *Strangely, I do not define myself as a New Zealander except when the New Zealand national teams are playing the British Lions in rugby, or the Australians in netball or the Pakistanis in cricket.  At times such as those I am fiercely a New Zealander.  But as a general rule the term has no significance for me primarily because it denies my Maoriness [sic] and that of my peoples [sic]… No, New Zealander is not a label which has any real significance to me or my life except in the international arena.  I mean, for example, I probably couldn't move through passport controls with a passport issued by Ngati Hine, which is the main nation with which I identify* (Rika-Heke 1997, p. 137).

Rika-Heke's comment provides a concise summary of the complexity of the issue. Essentially, she defines a sense of identity that is layered:

1. A citizenship that defines her within an international landscape and has pragmatic implications, but that has limited meaning otherwise;
2. A sense of belonging to a national pan-indigenous constituency: the terms Indian, Aborigines and Māori were created as a result of the colonial encounter;
3. A local connection with a tribe(s) or community(ies): 627 different First Nations in Canada, 70 plus tribes or *iwi* in New Zealand, and between 200 and 390 different language groups in Australia; and
4. An individual.

Each layer complements the other. It is definitely the connection to a community, tribe, or pan-indigenous collectivity rather than the individual that defines the relationship with the non-indigenous majority and the nation-state. The importance given to each layer in

expressing a sense of identity is a matter of context. The sense of collective identity is more readily expressed in terms of the connection with the tribe or community, than at a national or pan-indigenous level.

Pan–indigenous and tribal identities are of particular interest for this study and are often misunderstood, or glossed over. As explored in the introduction, the collective terms indigenous, Aborigines, Indians, Aboriginal peoples, First Nations and Māori have emerged as a result of colonialism and have been rather vulnerable to reconstruction following the vagaries of the colonial imagination, and the demands of its administration. Until the 1940s or so, the theoretical narrative informing ethnographies and policies assumed that indigenous people were destined to disappear. Shortly after the Second World War, this discourse shifted to that of survival and resistance (Bruner 1986).[15] A new discourse emerged in the late seventies, with international discourses of cultural protection and participation.

This reshaping of pan-indigenous referents mostly serves governmental administrative purposes and occurs in realms distinct from where local indigenous identities operate. Local identity confers a sense of belonging to a community. It exists outside the realm of this pan-indigenous construct, changing as all cultures do, as a result of individual responses to new opportunities and demands, as well as outside pressures. While changes in mainstream cultures are understood as evidence of "progress," changes in indigenous cultures, whether due to the integration of foreign technologies or participation in the market economy, are often portrayed as a sure sign of the imminent disappearance of indigenous cultures as distinct identities, or worse, as confirmation of the superiority of the colonial culture.[16] This shifting governmental conceptualisation has at times been used to validate claims of illegitimacy, assimilation or improved socio-economic conditions, thereby justifying further erosion of rights and limiting differential access to resources and services.

> *Cultural distinctiveness is a key value and indispensable political resource for aboriginal peoples in Canada (Scott 1993, p. 311).*

As integration occurs, the place of cultural expression is expected to shift from public and institutionalised, to private and informal.

Legitimacy of identity is central to negotiating the political locality of indigenous peoples in their respective nation-state. Legitimacy of identity, when based on "tradition" and "authenticity" has been repeatedly challenged. Specific provisions, when

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[15] Although Bruner speaks of the United States, similar shifts in narratives are reported in Canada, Australia and New Zealand.

[16] See Sahlins (1999) for a brilliant exposé on this matter.

based on deprivation or needs, also have their limitations as needs change and deprivation may be construed as self-induced. Treaties, international covenants and debates on indigenous rights have provided indigenous people a measure of cultural protection that is less vulnerable to shifts in national popular and political discourses.

## 2.1.2   International support for indigenous collective identity

Anaya (1996) suggests that in the past three decades, international law has shifted its focus from acting as an instrument of colonialism to providing support for indigenous demands.  All three countries first signed and then ratified the *United Nation Declaration* (1963) and the *Convention on Elimination of All Forms of Racial Discrimination* (1966).  The 1966 *International Covenant on Economics, Social and Cultural Rights* (ICESCR) and *International Covenant on Civil and Political Rights* (ICCPR) further affirmed indigenous peoples' rights to self-determination and control over natural resources in their territory (United Nations 1965, 1966a, 1966b).  The covenants came into force in 1976.  Article no. 27 states,

> *In those states in which ethnic, religious or linguistic minorities exist, persons belonging to these minorities shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practise their own religion, or to use their own language* (cited in Magallanes 1999).

This article has been used by indigenous peoples to remind their nation-state of its duty to uphold and protect their culture.  Since the 1970s, international law has produced standards that nation-states are required to abide by, such as the right of indigenous peoples to exist as distinct peoples.  A Special Rapporteur on indigenous issues was appointed in 1972.  As a result, a series of reports on *The Problems of Discrimination against Indigenous Populations* were delivered in 1981-82, leading to the formation of the UN Working Group on Indigenous Populations.[17]  The role of the Working Group is to act as a world-wide monitor and to draft standards.  It is in this capacity that the Working Group began its draft of the Declaration of Principles of Indigenous Rights in 1985, a project that was completed in 1993.  While not yet ratified, indigenous peoples have succeeded in getting the notion of a right to cultural protection onto the international human rights agenda.

International covenants have validated the continued relevance of historical documents such as the New Zealand Treaty of Waitangi and the numerous Treaties signed in Canada. They have supported a concept of indigenous rights stemming from

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[17] The original name of the group, Working Group on the Indigenous Peoples, was changed to Populations in answer to protests.  Anaya mentions that the United States in particular remains firmly opposed to the use of the term people, preferring  "persons belonging to indigenous groups", thus reaffirming its commitment to individual over group rights (Anaya 1999).

the continuous occupation of the land and surviving colonialism, as in the Mabo case in Australia (Magallanes 1999). It is worthy to note that governmental and legal recognition of these historical documents has become more noticeable since the 1970s.

### 2.1.3   Local and pan-local self-determination

The term self-determination is widely used by indigenous people and their supporters. It however remains an ambiguous term.  In debates, the term continues to be used loosely to signify an array of options, which vary considerably in scope and complexity.  On the one side, governments seem to gravitate towards systems of self-administration. Sectors of activity such as health services, child protection, economic development, housing, education, etc. are being "transferred" to indigenous organisations with quasi-municipal authority or as service delivery agencies.  The terms of reference for the programs, the Act(s) that define parameters, and terms of accountability may remain largely under Government control.  In this context, self-determination may be limited to measures of self-administration and local participation. On the other side, indigenous authorities argue in favour of land claims, compensation, larger power and control over definitions, funding, jurisdiction and structures.  These aspirations reflect a commitment to continued autonomy that can only be served by differentiated citizenship.

Scott suggests that the Canadian government shifted its position on self-government, from one defined in legislation with constitutional guarantees, to community-based piecemeal self-government arrangements.  In the process, he argues, "First Nations" have been pruned back to "Indian communities" (Scott 1993, p. 319). The shift occurred mainly in relation to implementing self-government. The issue is complex. While most indigenous nations continue to exist with local forms of governments, there is, in all three countries discussed, a substantial number of indigenous peoples who use the collective self-referents Aboriginal (used in Australia and Canada) or Māori to define their identity, but who do not or cannot connect back to a local or tribal identity.  Although cultural connections may be strong, one can assume that some may have severed ties voluntarily for a spectrum of reasons, while others are likely the descendants of children taken into custody for assimilative or compassionate reasons (Australia National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children 1997, Royal Commission on Aboriginal Peoples 1996b). Locating self-determination at a national level will include these people, but will necessarily gloss over cultural and ethnic differences, and generate substantial discomfort with some local nations.  Locating self-determination at individual nations'

level risks excluding urban indigenous peoples altogether, but also placing serious limits on the potential transfer of responsibilities.  As mentioned in the introduction, there are currently 627 different First Nations, with populations from a few dozens to 10,000 members, of which 30 to 40 percent may live off reserve. Keeping this in mind, self-determination necessarily requires addressing both levels, but the division of powers between national and local indigenous governments remains contentious.

In the Canadian context, the Royal Proclamation of 1763 continues to be used as the rationale for First Nation and Inuit to claim compensation for their loss of land, restricted access to natural resources for subsistence activities and economic development, and cultural loss associated with policies of assimilations. As shown in Table 2.1, comprehensive land claim settlements, or modern Treaties as they are sometimes called, are still being signed. The Inuit of Labrador ratified their Agreement-in-Principles on May 24th, 2004. These agreements make provisions for land and financial restitution. They also make provisions for the appropriation and delivery of publicly delivered health, educational and social services. In each case, it is the local or tribal group that has received compensation. There is no movement for similar processes at the national pan-indigenous level.

| Table 2.1, Modern Treaties in the Canadian context (Indian and Northern Affairs Canada 2004a) | | | |
|---|---|---|---|
| Agreement | Year | Population | Provisions |
| The James Bay and Northern Quebec Agreement | 1975 | 19 000 Cree, Inuit and Naskapi of northern Quebec | $230 million in compensation, ownership over 14 000 square kilometres of territory, and exclusive hunting and trapping rights over another 150 000 square kilometres |
| The Inuvialuit Final Agreement | 1984 | 2 500 Inuvialuit in the western Arctic | 91 000 square kilometres of land, $45 million to be paid over 13 years, guaranteed hunting and trapping rights, and equal participation in the management of wildlife, conservation and the environment, a $10 million Economic Enhancement Fund and a $7.5 million Social Development Fund |
| The Nunavut Land Claims Agreement | 1993 | 17 500 Inuit of the eastern Arctic | 350 000 square kilometres of land, financial compensation of $1.17 billion over 14 years, the right to share in resource royalties, hunting rights, and a greater role in the management of land and the environment. The final agreement committed the federal government to a process which divides the Northwest Territories and creates the new territory of Nunavut by 1999 |
| The Sahtu Dene and Metis Agreement | 1994 | Sahtu Dene and Metis | 41 437 square kilometres of land (of which 1 813 square kilometres will include mineral rights), a share of resource royalties from the Mackenzie Valley, guaranteed wildlife harvesting rights, participation in decision-making bodies dealing with renewable resources, land-use planning, environmental impact assessment and review, land and water use regulations, and $75 million over 15 years |
| The Nisga'a Agreement-in-Principle | 1996 | Nisga'a of British Columbia | $190 million cash settlement and the establishment of a Nisga'a Central Government with ownership of and self-government over 1 900 square kilometres of land in the Nass River Valley. It also outlines the Nisga'a ownership of surface and subsurface resources on Nisga'a lands and their entitlements to Nass River salmon stocks and wildlife harvests |

### 2.1.4   Marginalised populations' participation in health

Cultural diversity is now the hallmark of most countries, and poses a challenge to liberal democracies.  Diversity in health needs is simply another expression of this situation, and a concern for policy makers in an age where inequities in health are understood as a human rights issue. Healy and McKee write,

> *The health care system of a country should take account of increasingly diverse populations, particularly since this diversity is growing with greater movements of people between countries in an increasingly globalised world, and where people may have particular needs and expectations with regard to health care (Healy & McKee 2003a).*

Healy and McKee equate cultural diversity with diversity of needs, and argue that health care services need to be both accessible and responsive to diversity. Canada is

now engaged in supporting parallel primary health care services for First Nation and Inuit. This is only one option that countries have pursued to meet the need of marginalised populations. The alternatives they proposed are itemized in Table 2.2.

| Table 2.2, Service delivery models and examples (adapted from Healy & McKee 2003b) | | |
|---|---|---|
| Service delivery models | Principles | Examples |
| Mainstream (collective) | Services available to everyone without specific provisions being made for specific populations. | Multicultural health care in Britain <br> Refugees in Sweden |
| Integrationist | Specific provisions made to ensure that accessibility to mainstream services can be extended to specific populations with recognised greater needs. | The poor in Britain |
| Participatory | Services within mainstream health care system that offer avenues for particular groups to have more say in policy-making and management. | Māori in New Zealand |
| Alternative | Services that exist in addition to mainstream services, providing an alternative that is intended to be more responsive. | ATSI Australians |
| Parallel services | Services that exist as substitute to mainstream services, and that cater exclusively to the need of a defined constituency. | Native Americans <br> Canadian First Nations <br> ATSI Australians <br> Māori in New Zealand |

A gradient is apparent in the Table above. As one moves from mainstream to integrationist, through participatory, alternative and finally parallel services. Accommodating differences may require significant investment. The shift to separate or alternative services may also require some trade-offs. Healy and McKee identify both advantages and disadvantages to separate services. This is summarised in Table 2.3.

| Table 2.3, Advantages and disadvantages of separate services (Healy & McKee 2003b) | |
|---|---|
| Advantages | Disadvantages |
| Self-determination | Undermining of social solidarity |
| More control | Less state responsibility, vulnerability of funding |
| Greater consumer choice | More limited choice of scope and scale |
| Better access for some | Limited availability to whole population group |
| Greater quality in terms of responsiveness | Possibly worse quality in terms of clinical effectiveness |
| Better targeted services | Higher cost to state |
| Higher political profile | Greater stigma |

Participatory, alternative and parallel services provide opportunities for increased participation. For the past thirty years, community participation has played a major role in the international discourse on public health and primary health care. In

May 1973, the World Health Organisation's 26th Assembly in Geneva drew attention to the cost and ineffectiveness of on-going health care intervention, leading WHO/UNICEF to recommend a new strategy, based on primary health care, which entailed:

> *providing the populations with easily accessible health services that are simple and effective as regards to cost, techniques and organization* (Berthet 1979, p. 34).

Community participation constitutes the very core of the primary health care concept. Many have also noted that this commitment is largely based on a number of problematic assumptions. First, it assumes a finite and defined community, imagined as a coherent, harmonious and/or natural whole.[18] Drawing extensively from Cohen (1985), Jewkes and Murcott (1996) suggest that the term is at times defined in *aggregational terms*, as a geographically located entity, and sometimes in *relational terms*, meaning in relation to the "other" or "outsiders". The debates echo concerns raised in the context of self-determination. The boundaries are fuzzy and defined symbolically as well as geographically, linguistically or politically.[19] The Alma-Ata did not include an explicit definition of a community. Implicitly, community was presented as,

> *a locality-bound aggregation of people who share economic, socio-cultural and political characteristics, as well as problems and needs. A community was assumed to be a coherent unit, whose members could operate together for shared purposes, for example expressing their health needs and planning services (Jewkes & Murcott 1996, p. 558).*

The Ottawa Charter further developed this concept to include the hierarchy of individual, family, community and country (World Health Organisation 1986). Their empirical investigation of the concept of community showed a plurality of meanings being juggled simultaneously (Jewkes & Murcott 1996). They noted that "members" tended to define community in relational terms.

Second, governments seek participation for different purposes. Rifkin (1996) identifies that the literature generally cites two frames of reference allegedly used by health planners and managers.

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[18] See Anderson (1991) for a critical analysis of the concept.

[19] For example, who is and who is not indigenous is an interesting question. The terms of inclusion and exclusion are alternatively been defined on the basis of genetic, race, ethnicity or culture. Lately, relational terms have been validated in Australia: an ATSI person is one recognised as such by other ATSI peoples. Māori are able to self-identify. First Nations may also do the same, but the bureaucratic construct of "Indian" to which is attached some individual and Treaty benefits, is closely guarded by the Department of Indian and Northern Affairs Canada's Registry. The "Indian status" is inherited based on the status of parents, and can become diluted and indeed extinguished based on mixed ancestry (Lavoie 2003b). It is not necessarily a fair proxy for cultural affiliation, language use or health care need.

- Target-oriented frame: Health planners may decide on program objectives, and then attempt to convince community people to actively accept these objectives; or

- Empowerment frame: Community people may be encouraged to make decisions about resource allocation and priorities.

She suggests that neither have produced the anticipated *magic bullet* because they construct participation as "linear, causal and contributing to a system which is viewed as the sum of all its parts" (Rifkin 1996, p. 86). Following Uphoff (1992), she proposes a combined frame of reference which implies a continued dialogue between community and planners.

Finally, others have argued that the relationship between community, representation and participation is not well defined. Abelson et al (1995) showed that community members' willingness to take responsibility in health care decisions varied considerably. Community members tended to differ to traditional decision makers such as elected officials, experts and the provincial government on contentious decision, but remained willing to play a consultative role. In a subsequent study reporting four case studies, Abelson (2001) differentiates between styles of participation, friendly and informal as opposed to highly organised and sophisticated, depending on the socio-economic characteristics of the community. She shows that institutions are more receptive to participation that is sought and that operates following a carefully defined script. She also reflects that formal engagement is more likely to occur in communities of higher socio-economic status. Some authors have argued that in fact, the rhetoric of community participation became a pillar of the new strategy because it satisfied political-ideological needs informed by "bourgeois principles of self-reliance and individual responsibility" (Morgan 1990, p. 212). It presumed democracy, while allowing governments to reach out and extend their control over their rural country.

> *The rhetoric of participation can be a convenient way for a government to perpetuate the illusion of democracy, while large segments of the population are systematically denied access to the political process. This is not to say that government elites conspire to deceive their constituents, but the competing agendas of different social classes often result in policies that enhance elites' control* (Morgan 1990, p. 212).

Aside from individual participation through employment, what participation means in the Canadian context is a matter of perspective. First Nations' participation in non-indigenous organisations, whether governmental, private or voluntary, is generally associated with reserved seats on the board of directors or advisory/consumer committees. Appointments to these seats may dovetail with indigenous processes of governance, thereby ensuring that appointees can speak to their constituency's interest. Alternatively, appointments to these seats may come directly from the Minister, and by-pass tribal/community governance structures. In either case, individual

First Nation representatives often find themselves caught in between their commitment to representing their own community, while being asked to participate as an individual in decision-making process where a variety of interests are to be balanced. The tension is between representation of the collective through the individual, versus representation as an individual with specific experience to contribute. This logic appears nebulous to many, leading to frustration that indigenous representatives cannot be found, remain silent at meetings, or retain their allegiances and advocate for their community/tribe rather than as an agent of the Board. The clash is at the level of governance and representation, and is central to perceptions of fairness (Azzi 1993, Azzi & Jost 1997).

The second model of community participation is through the establishment of separate organisations and services. This process implies the establishment or the validation of an organisation that is owned and managed by indigenous people with self-defined governance mechanisms. A core motivation for pursuing separate services is the need to secure control over decision-making processes, and to ensure that culturally appropriate decision-making protocols are observed both in intra-community affairs and in relation to government.

### 2.1.5  Summary

Three main points can be drawn from the above discussion. *First*, indigenous people define their identity in collective terms and claim the right to exist as distinct cultures or nations at the local or tribal level. This position is supported by Treaties and international covenants, but is also promoted for other reasons. Whether at the 2000 Sydney Olympics or a visit by British Royalty of the Māori Queen Dame Te Atairangikaahu Te Arikinui,[20] the importance and distinctiveness of the indigenous populations of Australia and New Zealand are now more than ever recognised and highlighted.

*Second,* the concept of self-determination underlines aspirations for equitable collective processes of participation that go beyond a simple implementation of pre-defined programs and encompasses instead participation at all levels of decision-making. Implementing self-determination however is a complex matter. A localised or tribal-based version of self-determination limits powers and risks further marginalizing indigenous people living in urban areas or those unable to reconnect their indigeneity to a local group or community. National approaches to self-determination will gloss over local cultural differences and perhaps more importantly, local governance

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[20] Dame Te Atairangikaahu Te Arikinui is broadly recognised as Queen of the Tainui tribe. Her legitimacy as the Queen of the collective Māori is contentious.

structures. There is no consensus on how to define self-determination and how to implement it in practice.

*Third*, aspirations for culture-specific participation create discomfort in countries where the provision of health care services is largely seen as a governmental responsibility, and where a dominant liberal ideology collides with the idea of differentiated citizenship. At the governmental and popular levels, the focus on indigenous participation in health can be confused with arguments in favour of indigenous people having preferential, thereby inequitable, access to and control over health resources and decision-making processes. There is no consensus on the appropriate or optimal level of participation required to ensure that marginalized population have access to the services they require.

The tensions explored above are reflected in debates surrounding indigenous health policy formulation. Once policies are formulated, indigenous people largely depend on government's goodwill to oversee and monitor implementation, in order to ensure that the stated goals are being achieved. Canadian and Australian indigenous populations both account for between 2 to 3 per cent of the national population and as such, cannot hope to secure a voice through the democratic process alone. In contrast, Māori constitute nearly 15 per cent of population of New Zealand, and to some extent, can hope to protect their interest through the Parliamentary system.

## 2.2    From policy formulation to practice

The main objective of this thesis is to investigate how governments balance out the ideal of indigenous self-determination with other pressures, such as current trends in public administration and accountability, pressures on the health care system, issues of and sensitivities around minority rights, equity in health and cost-efficiency. The above debates provide a necessary backdrop.

Policy analysis is a well-established field of inquiry. Walt (1988) differentiates between two types of policy. High politics policies, otherwise known as macro or systemic policies, are generated by national or state governments, and include broad-based reforms or regulation of health services. Macro-policy formulation is generally highly influenced by political context. Low politics policies, also known as sectorial or micro-policies, are generated closer to the ground. They may be offsprings of local governments or hospitals, and deal with the implementation of programs. The policies explored in this research are considered macro or systemic policies, mainly because they address issues that remain controversial in all three countries: the relationship between the nation-state and its minority indigenous constituency. This section focuses

largely on the context and process of policy formulation and its relationship to processes of implementation.

The literature on health policy analysis took a turn in the late 1980s, from a focus on the technical content of policies to the investigation of the role of actors in policy development. Many authors have highlighted the importance of key actors in influencing or determining the process of policy formulation and implementation. For example, Grindle & Thomas analysed twelve processes of policy and institutional reforms in developing countries (Grindle & Thomas 1991). Their analysis highlights the role of policy elites in shaping and directing formulation and implementation of macro-policies. Walt (1988) and Walt & Gilson (1994) have argued that actors are at the centre of the policy process influencing the choice of policies and the values they reflect, while reflecting the context of policy formulation (historical, political, economic and sociocultural). They offer the framework shown in Figure 2.2 and suggest that technical considerations may be superseded by political considerations (see also Carlisle 2001, Davis & Howden-Chapman 1996).

**Figure 2.2, Policy implementation, cponceptual framework**

Context

- Actors as individuals
- Actors as members of groups

Content          Process
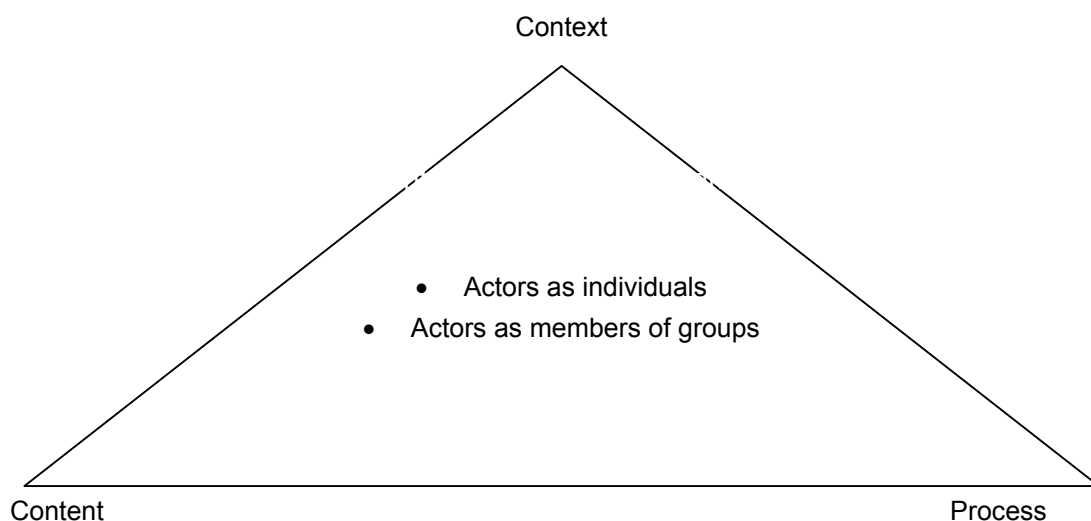
The distinction between policy formulation and policy implementation is highlighted in this thesis. Just as in any text, policy documents are textual constructions imbedded in a historical, political and social context. It is therefore not surprising to find that the language and content of policy documents may be more likely to reflect the need to mediate the political landscape than to truly outline how policy statements and objectives are translated into practice. Apthorpe writes,

> *Policy language… is itself a form and source of policy power. Policy discourse tries more to persuade than describe; genre and style are integral to policy paradigms, not adornments to be dispensed with if they do not please. It is not through its language*

*alone that the general nature (if there is any such thing) of policy or a policy analysis can or ought to be comprehended (1997).*

The formulation of macro-policies and the processes of implementation are likely to involve different actors, and reflect different agenda.

Policy statements and the debates they generate are important areas of inquiry, but it is in the implementation processes that they really take their full meaning. While the content of the policy may not change, the understanding of what this content means in terms of implementation may very well shift across actors and over time. Walt states,

*Policy making is interactive, with formulation and implementation two elements of a continuous loop, and both as political as the other (Walt 1988, p. 156-57).*

Drawing from Hogwood and Gunn (1984), Walt draws a list of ten characteristics of perfect policy implementation:

- The circumstances external to the agency do not impose crippling constraints;

- Adequate time and sufficient resources are available;

- The required combination of resource is available;

- Policy is based on a valid theory of cause and effect;

- The relationship between cause and effect is direct;

- Dependency relationships are minimal;

- There is an understanding of, and agreement on, objectives;

- Tasks are fully specified in correct sequence;

- Communication and coordination must be perfect; and

- Those in authority can demand and obtain perfect compliance.

She cautions that these characteristics are useful mostly as a checklist. Few policy implementation processes meet these requirements. Further, it is unlikely that systemic policies can match these standards, because they typically are broad-based, complex, implemented over a long period of time and involve a large number of stakeholders with varying levels of commitment and understanding.

In their attempt to develop a conceptual framework for policy implementation, Van Meter et al (1975) review three large bodies of literature, spanning organisational theory, the impact of public policy and selected studies on intergovernmental relations. As others have done (Nicholson 1994, Shore & Wright 1997, Walt 1988), they readily challenge the classic Weberian legal-rational model that holds policy implementation to be a linear process where subordinates faithfully implement the decisions of their

superiors (Van Meter & Van Horn 1975). They suggest instead that policy implementation is greatly influenced by the bureaucracy tasked with implementation. They highlight two factors: the amount of change involved and the extent to which there is goal consensus among participants in the implementation process. Atkinson's research on the decentralisation of health system management in northeast Brazil shows that informal constraints such local political culture, management style, commitment and continuity of staff, source of funds, use of information impact the implementation of decentralisation policies. In other words, the context of policy implementation influences a great deal the process, extent and outcome of policy implementation (Atkinson et al 2000, Atkinson 2002). She concludes that formal reforms are invariably renegotiated by the political culture in existence at the implementation level. While policy formulation may include perspectives and accommodate influences situated outside the bureaucracy (Grindle & Thomas 1991), cycles of implementation more closely reflect the context in which policies must integrate themselves. The two processes are not necessarily closely linked.

In summary, and according to the literature, the processes of policy formulation and of implementation are subject to different pressures, some contextual and some related to actors involved. Policy implementation is more likely to align with the original intent of the policy where,

- The policy is evidenced-based and there is consensus on the objectives, and cause and effect;

- The policy requires a limited amount of change;

- External circumstances do not collide with the realisation of the initial intent of the policy;

- Resources remain available; and

- Policy makers retain a great deal of control over the implementation process.

The following section reviews the context and process of First Nation health policy formulation in Canada. As will be shown, the policy formulation process was borne out of divergent perspectives, pressures exercised by First Nations for increased engagement in matters that affect them, and decisions accepted within the Federal government to various degree. The level of consensus was and remains poor. First Nations' interest in the policy has revolved around its potential as an avenue to recover control over policy decisions that affect their every day lives. In contrast, government actors have had to balance this consideration with matters of public administration, health services delivery and personal values, in a manner that remains palatable to the Canadian electorate. As a result, implementation has shifted considerably over time.

### 2.2.1    The Health Transfer Policy

In the Canadian **context**, the *Constitutional Act of 1867* defined health care as a provincial jurisdiction and Indian affairs as a federal jurisdiction, thereby beginning a jurisdictional debate over Indian health that remains current over one hundred years later.  The Canadian health care system is a publicly financed, publicly administered, and at least partially privately delivered national health care system. This has been the case since the early nineteen-seventies.  As shown in Figure 2.3, primary, secondary and tertiary care is entirely funded through progressive income tax garnered at the provincial and federal levels.  Poorer provinces benefit from equalisation payments generated from taxation revenue.



Figure 2.3: Canadian Health Care Financing
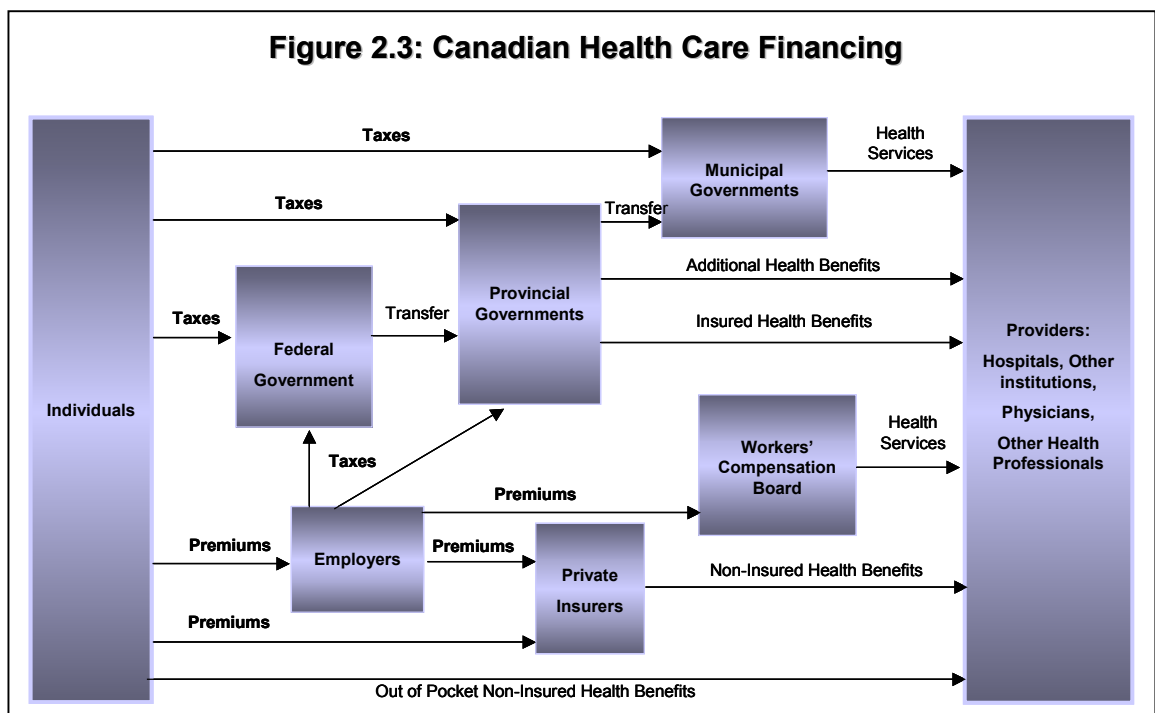
All off-reserve services are the responsibility of the provinces.  Public health, primary, secondary and tertiary health care services can be accessed at no direct cost to the individual,[21] via Medicare, the publicly funded health insurance scheme (Health Canada 1999b).  Further, the *Canada Health Act 1984* guarantees "reasonable access" for all Canadians, including the indigenous population. This promise can be challenging, given the sparse population and geographical spread.

The original impetus for the development of health services for First Nations came from the settlers who arrived at the turn of the century to farm the land.  They found themselves neighbouring Indian reserves where appalling health conditions

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[21] Co-payments and access fees were made illegal in 1984.

prevailed. It was the fear of epidemics, mostly tuberculosis, that led the federal government to invest funding in health services, with the hiring of a General Medical Superintendent in 1904 and a mobile nurse visitor program in 1922 (Maundrell 1942). The first federally funded on-reserve nursing station was set up at Fisher River, Manitoba in 1930. The formation of the Department of National Health and Welfare in 1944 led to the establishment of the Indian Health Branch, and a sustained expansion of health services to First Nations (Waldram et al 1995). Currently, nearly all First Nation reserves have access to services delivered by a health centre located on-reserve.[22] These facilities offer public health and treatment services, delivered by nurse-practitioners and local Community Health Representatives (CHRs). Other services include addiction counselling and transportation. Physicians funded by the province visit these communities on a regular basis. Patients requiring secondary or tertiary care in between visits or in emergency situations are transported to the nearest referral centre, which is under provincial jurisdiction.[23] Thus, on-reserve primary health care services have always been parallel services to off-reserve primary health care services, largely for historical reasons.

The Health Transfer Policy was announced in 1986. Its goal was to allow on-reserve First Nation governance structures to take over the planning and delivery of existing on-reserve services, with funding from the federal government. The emergence of the Health Transfer Policy is linked to a series of events that reshaped relations between First Nations and the nation-state. One of the events that may have acted as a catalyst was the Hawthorn Report (1966), the first comprehensive survey of on-reserve social and economic conditions that emphasised the dismal living conditions on Indian reserves, and recommended a shift from care taking and management to economic development. The Hawthorn Report was followed by a study of health services accessible to Canadian Indians completed by Booz•Allen & Hamilton Canada Ltd (1969). They noted that:

1. The federal-provincial responsibilities in matters of Indian health and health related services had not been fully clarified. It emphasised the need for clarification in the areas of environmental and economic conditions, medical and dental treatment, and public health education;

2. The Indian health programs delivered on reserve were broad in scope, but failed to involve Indians in the planning and evaluation of programs. They also emphasised the need for prevention. And;

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[22] On reserve funding is the exclusive or nearly exclusive domain of the federal government.

[23] See Waldram for a more extensive discussion of the system (1995).

3. The shortage of highly trained health professionals hampered [Health Canada] services.

They recommended the development of programs to address priorities in service delivery, the recognition of Treaty Rights, a clarification of federal-provincial jurisdiction, and increased participation of First Nation in health service delivery with emphasis on public health.

The Trudeau liberal government was elected in 1968, having fought a campaign couched in liberal ideology under the slogan *The Just Society,* which advocated for equality and human rights on an individual basis. The Trudeau government's position on Indian affairs was articulated in what became known as the 1969 "White Paper," calling for the repeal of the Indian Act, the dismantling of the Department of Indian Affairs, the elimination of the Indian reserve system and the inclusion of First Nation people in fabric of Canadian society on an individual basis (Government of Canada 1969). This proposal was met with strong opposition from First Nations, eventually leading to the formation of the National Indian Brotherhood (now the Assembly of First Nations) and the withdrawal of the White Paper (Weaver 1981). Thus the historical jurisdictional divide was retained and later reaffirmed in the Constitutional revisions of 1982.

The mobilisation of the nineteen-sixties and the formation of the National Indian Brotherhood (now the Assembly of First Nations) led to numerous debates over "the Indian problem" between the federal government and First Nations. This eventually resulted in the formulation of the Indian Health Policy, tabled on September 19, 1979 (Crombie 1979). The policy was a two page document that could be best portrayed as a statement of values with one broad based objective:

> *the goal of Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves (Health Canada 2000a).*

The policy, which is still in place today, builds on three pillars:

> *The first, and most significant, is community development, both socio-economic development and cultural and spiritual development, to remove the conditions of poverty and apathy which prevent the members of the community from achieving a state of physical, mental and social well-being.*

> *The second pillar is the traditional relationship of the Indian people to the Federal Government, in which the Federal Government serves as advocate of the interests of Indian communities to the larger Canadian society and its institutions, and promotes the capacity of Indian communities to achieve their aspirations.*

> *The third pillar is the Canadian health system. This system is one of specialized and interrelated elements, which may be the responsibility of Federal, Provincial or Municipal Governments, Indian bands, or the private sector. But these divisions are superficial in the light of the health system as a whole. The most significant federal roles in this interdependent system are in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment.*

*The most significant Provincial and private roles are in the diagnosis and treatment of acute and chronic disease and in the rehabilitation of the sick. Indian communities have a significant role to play in health promotion, and in the adaptation of health services delivery to the specific needs of their community. Of course, this does not exhaust the many complexities of the system. The Federal Government is committed to maintaining an active role in the Canadian health system as it affects Indians. It is committed to promoting the capacity of Indian communities to play an active, more positive role in the health system and in decisions affecting their health (Health Canada 2000a).*

The policy made no distinction between First Nations living on and off-reserve.

**The policy formulation process** The Indian Health Policy did not lead to the formulation of an implementation strategy with short, medium and long term objectives, either under the Conservative or the subsequent Liberal governments. The adoption of the Indian Health Policy was followed three months later by the release of an Indian Health Discussion Paper that presented the results of a study on Indian Health Services conducted by the Indian Health branch of Health Canada (then called the Medical Services Branch or MSB), which made four broad recommendations:

- The achievement of effective communication between Indian people and National Health and Welfare through the development of mutually acceptable communication strategies;

- Sharply increased efforts to reduce environmentally related disease and to promote a health social environment on Indian reserves;

- The achievement of self-determination in the health field by Indian communities; and

- The encouragement of community development through the creation of a National Institute of Indian Health and Social Development.

The paper spoke to a number of issues, notably the transfer of existing health services to Indian communities (National Health and Welfare 1979). By May 1981, the national Health Minister tabled a document exploring the possibility and complexities of transferring existing services to First Nations (Bégin 1981). By 1982, the Community Health Demonstration Program was in place to allow First Nations to experiment with different models of community based service delivery (Garro et al 1986).[24] Thus, implementing the Indian Health Policy became equated with the transfer of on-reserve services to First Nations. As a result, plans to deal with off-reserve services, and services to Métis, virtually disappeared from the national agenda.

Alongside the demonstration program, MSB established two Sub-Committees in March 1985, a first on Community Health and a second on the Transfer of Health Services. The *Sub-Committee on Community Health*'s mandate was

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[24] Only 31 of such projects were funded, and only for two years.  Only seven dealt with issues of governance and local priority setting in health (Garro et al 1986, p. 282).

> *"to formulate preferred options for the implementation of appropriate strategies for supporting Indian/Inuit communities to optimise their health status recognizing the objective of Indian/Inuit control of health services" (Health and Welfare Canada (MSB) 1986a).*

The report supported a shift from MSB being the sole provider of services to MSB becoming a funding and development Branch "that supports Indian Bands in their operation of their own services" (Health and Welfare Canada (MSB) 1986a). The report recommended,

- The need for multi-year agreements;

- The use of aggregated First Nation and Inuit community health plan as the basis for regional and national planning;

- The removal of program-specific restrictions so as to permit the aggregation of resources in the communities; and

- A refocus of the role of MSB in the context of the progressive control of Indian Health Services by the Indian people.

The *Sub-Committee on the Transfer of Health Programs to Indian Control*'s mandate was to propose policy options for the control and provision of health services by Indian people. The report recommended a developmental approach to health transfer. Funding of existing services was expected to come from existing funds. The committee also recommended annual adjustments for price and other relevant cost factors to be included in transfer agreements (Health and Welfare Canada (MSB) 1986b). The vision of the committee was a balance between flexibility in community allocating resources in locally defined priority areas and the respect of nationally defined minimum program requirements in key areas such as immunization, communicable disease control, environmental health and curative services.

The objectives of transfer and administrative intricacies were outlined in the Health Program Transfer Handbook, a first version of which was made public in September 1987 in anticipation for the November 1987 conference (Assembly of First Nations 1987). The transfer process was presented as entirely voluntary and progressive. Under the Health Transfer Policy, First Nations and Inuit were encouraged to apply for funding for the first stage, the Pre-Transfer study, where communities were expected to engage in a community-based needs assessment leading to a community health plan. The second phase was that of negotiations with Health Canada. The third phase was implementation. Here contracts may be signed for three or five years depending on the First Nation's previous experience with program administration. The agreements allowed for the retention of surpluses and budgetary line flexibility in order to promote local priority setting and responsiveness.

It is difficult to estimate to what extent the National Indian Health Transfer Conference helped shape the subsequent submission to the Treasury Board which was required for Health Canada to secure the transfer of authority to enter into contracts with First Nations. The process was already well underway, with 279 Indian communities located in Saskatchewan, Manitoba, British Columbia and Québec engaged in pre-transfer activities as early as 1988 (Health and Welfare Canada 1988). The first agreement was signed in Montreal Lake Saskatchewan in 1988, apparently in anticipation of the Treasury Board's approval. As Bird and Moore relate, the signing of an agreement with the Montreal Lake Band was delayed because of the lack of tools, including formulae for financial allocation and sample contracts (Bird & Moore 1991). Health Canada's submission to Treasury was eventually approved (National Health and Welfare & Treasury Board of Canada 1989), and Regional Directors advised of the transfer initiative's approval in June 1989 (Nicholson 1989).

According to the Treasury Board submission, the Health Transfer Policy had three broad objectives:

> *To enable Indian Bands to design health programs, establish services and allocate funds according to community health priorities.*
>
> *To strengthen and enhance the accountability of Indian Bands to Band members. And,*
>
> *To ensure public health and safety is maintained through adherence to mandatory programs (National Health and Welfare & Treasury Board of Canada 1989).*

The submission also stated that,

> *The Health transfer initiative is consistent with self-government… and serves to reinforced federal policy to increase Indian control of programs for Indian people (National Health and Welfare & Treasury Board of Canada 1989).*

As was the case for the Indian Health Policy, the Health Transfer Policy was and remains defined in a two page document that most closely resembles a statement of intent.

The Health Transfer Policy envisioned the transfer of existing community-based and regional services to a single community/Band or a group mandated by communities/Bands (Health and Welfare Canada 1989). The majority of transfers has occurred in single communities that range from less than 200 to 10,000 residents, with the average being around 500 (Indian and Northern Affairs Canada 2004b). The services targeted for transfer included community-based basis, including nursing, Community Health Representatives and addiction counselling. Communities were also offered to take on zone or regional services on a pro-rated services, including: nutrition, health education, dental services provided by dental therapists (where provinces recognise and license dental therapists), Environmental Health and professional supervision for health professionals. The transfer of these positions meant the attrition

of employment opportunities with the federal government, and the transfer of these opportunities to First Nation employers. The onus was placed on smaller communities to demonstrate that zone and regional services could be provided based on the funding allocated (which at times amounted to as little as 0.014 of a person year) (Lavoie et al 2004).

All services chosen by the community were block funded under a single flexible agreement for a period of three to five years. Although mandatory public health and safety programs (i.e., immunization, communicable disease control, etc.) were to be delivered based on pre-established albeit only loosely defined standards, all other services were to be based on a Community Health Plan targeting local priorities with locally defined programs.

As of December 2000, Health Canada reports that 67 percent of eligible First Nations have taken over the administration of their health services and that another 14 percent are engaged in pre-transfer discussions (Health Canada 1999a, 2000b). Sixteen years after it was first announced, it is obvious that the policy has had some relevance in meeting indigenous communities' aspirations. The implementation of the policy has however shifted over time for a number of reasons.

**Implementing transfer** By 1994, a federal priority shift towards balancing the national budget and debt reduction seriously began to limit access to implementation resources. As shown in Table 2.4, new programs introduced since 1994 have been outside the scope of the health transfer. They are instead funded through yearly contribution agreements. This shows a shift in perspective within the federal government. Many new programs are nation-wide and under the stewardship of Health Canada program officers that work outside the First Nation and Inuit Health Branch. The resistance to move programs within the First Nation-specific branch may show discomfort with the reality of separate services and with the initial commitment to flexible services and its associated loss of government control. Perhaps more importantly, it is apparent that the federal government is increasingly unwilling to allocate significant funding for First Nation health services, and rather prefers or perhaps finds it easier to justify allocating public funding to proposal-driven targeted programs designed to address nationally-defined priorities. It is noteworthy that the funding provided to transferred communities has not keep up with population growth, price increases and inflation (Lavoie et al 2004).

| Table 2.4, Programs and Transferability (Health Canada 2003) | | |
|---|---|---|
| PROGRAM NAME | Created in | Transferable |
| Addictions | | |
| Alcohol and drug - Community-Based Program | 1984 | yes |
| Solvent Abuse Program | 1994 | yes |
| Tobacco Control Strategy | 2001 | |
| Children | | |
| Aboriginal Head Start On-Reserve | 1998 | |
| Canada Prenatal Nutrition Program | 1994 | yes |
| FAS/FAE Initiative | 1999 | |
| Chronic diseases | | |
| Aboriginal Diabetes Initiative | 2000 | |
| Communicable diseases | | |
| Communicable Disease Control | 1979 | yes |
| HIV/AIDS Strategy | 1997 | |
| Tuberculosis Elimination Strategy | 1992 | |
| Community Health Services | | |
| Brighter Futures | 1993 | yes |
| Building Healthy Communities | 1994 | yes |
| Community Health Prevention & Promotion | 1979 | yes |
| Community Health Primary Care | 1979 | yes |
| Community Nutrition | 1979 | yes |
| Dental/Oral Health Strategy | 1997 | |
| Home and Community Care Program | 1999 | Under review |
| Environmental Health | | |
| Environmental Health Program | 1979 | yes |
| Environmental Contaminants Program | 1990 | |

In 1997, a report from the Auditor General of Canada (1997) severely criticised Health Canada's lack of follow up to ensure accountability by First Nations under transfer. This report has also contributed to invalidate the vision of a total transfer of all responsibilities for health services to First Nations (Health Canada (MSB) 1995), and instead promotes a reinvestment in government-based human resources tasked with the close monitoring and auditing of First Nation organisations. As a result, the reporting requirements have multiplied to an extent that is now deemed excessive, expensive and counterproductive by the same Auditor General (Auditor General of Canada 2002). She was quoted in newspapers stating:

> *"There is not much point in first nations [sic] exchanging data for dollars with the federal government when the information is of no real benefit to either party (Auditor General Sheila Fraser, cited in Kruzenga 2002).*

From a national perspective, the reporting burden yields around 20,000 paper-based reports focusing on financial reporting of program-specific expenditures, activity reports, and some limited public health/service delivery indicators. The focus of the reporting system has been on government administrative officers monitoring individual

agreements, rather than on collecting information to ensure an oversight of the overall performance of the system. The system as it stands does not have the resources to collate the information submitted to produce an overall performance report (Lavoie et al 2004).

For the past decade, Health Canada has had to periodically approach Treasury Board to secure additional funding to cover the increased cost of services it continues to provide. These costs are associated with population growth, inflation, additional demands for services associated with improved responsiveness, the increased dependency on costly computerised systems with a short life span, the sharp increase in liability insurance that resulted from 9/11, etc. Requests have not always been successful and communities that have taken transfer have seen their budgets frozen in light of growing costs. This lack of support, political pressures by First Nations, the very public Auditor General of Canada's flip-flop on reporting and accountability, as well as a shift in government, have to some extent eroded the government's commitment to the initial vision. A new policy statement is expected in 2005. While Health Canada is unlikely to go backward and deploy government human resources to provide direct services to communities as it did before the Health Transfer Policy, it is unclear whether the historical commitment to flexibility and local responsiveness may be renewed, or replaced by prescriptive programs that may be evidence-based at a national level.

### 2.2.2   Summary

The Canadian example explored above echoes findings from the literature. The Canadian policy formulation environment bears the mark of the First Nations' advocacy processes of the 1970s. This culminated in the formulation of the broad-based Indian Health Policy, which spoke of improving the responsiveness of the overall health care system. In contrast, the subsequent pruning of this policy to a focus on the less controversial on-reserve services likely reflects provincial reactions to a federal policy encroaching on their jurisdiction. It also shows a shift within the federal government in the manner in which self-government is spoken of.

Further, although the objectives of the Health Transfer Policy remain unchanged on paper, the way in which the policy has been implemented has changed as a result of shifting understanding and outside pressures. To draw from criteria discussed above:

- **Consensus on objectives and theory of cause and effect** The policy was based on a debated theory of cause and effect, where causality between participation and improved health could not be demonstrated. There never was a consensus

between First Nations and Health Canada as to the scope and purpose of the policy.

- **Amount of change** The policy required a substantial amount of change, including the elimination of employment opportunities within the government, and the relocation of these opportunities to First Nation employers.

- **Availability of resources, external pressures and continued commitment** The early 1990s' shift towards cost containment impacted the sustainability of the policy. Public criticisms by First Nations and by the Auditor General as to the management of accountability further eroded the bureaucratic commitment to the policy.

- **Policy makers' control over the implementation process** The implementation of the Health Transfer Policy occurred at the regional level, where employees have a long established and closer relationship with First Nations than Ottawa-based policy writers. Maintaining these relationships, the complexity of the First Nation environment and political pressures cumulated in compromises. Over time and through increased participation in service delivery, First Nations have gained a stronger voice at the national and regional level, leading to some shifts in power. This, coupled with pressures from Cabinet and the Auditor General, have contributed to shifting the objectives of the policy towards vertical strategies to re-establish a higher level of government control.

As a result, the implementation of the policy has diverged from its initial focus on financing on-reserve services in a flexible manner to ensure local responsiveness, to the funding of pre-defined programs designed to address national priorities and accessible mainly through proposal writing. In the Canadian context, the divergence from policy to implementation could have been predicted, at least to some extent, based on the literature.

The above discussion and review of literature suggests that, where macro-policies are concerned, formulation and implementation are subject to different pressures and may diverge, depending on the level of consensus that existed at the time of formulation and competing pressures colliding with the implementation of the policy over time. Tracking changes made to policy in the process of implementation can provide insight on context and levels of commitments. It is however an imprecise reflection of what may be occurring in practice. The next section will explore an analytical avenue to map out policy implementation from the perspective of practice.

## 2.3   Options in health care contracting

Health care systems being complex systems, decision-making is amenable to fragmentation into components to be managed by different levels of authority.  The Health Transfer Policy is simply an example of this. A commitment has first to be made by a government to endorse some measure of indigenous self-determination, and to allow for an expression of this principle in health care. Then, policy makers are left to

make choices as to how, in what context and to what extent will indigenous participation in decision-making and service delivery be implemented.

The options exercised under the Health Transfer Policy are possibilities among a range of other possibilities. This section explores the literature on health care decentralisation, on the role of the third or non-profit sector, and on contracting in health and accountability. The objective of this section is to develop an analytical framework for exploring the opportunities and contingencies generated by the indigenous contractual environment.

### 2.3.1   Decentralisation

Decentralisation is best understood as a movement of responsibilities between different organisations.  As shown in Table 2.5, Mills et al (1990) identifies four types of decentralisation: deconcentration, devolution, delegation and privatisation. Deconcentration refers to the regionalisation of administrative functions without a significant transfer of autonomy. It implies a shift of responsibility within an existing and presumably governmental authority. Devolution involves a transfer of administrative functions coupled with a regionalisation of some decision-making power. Again, devolution is expected to result in a shift of power within an existing and presumably governmental authority. Delegation implies a transfer of responsibilities to an arm-length organisation with some level of autonomy. Privatisation relates to the transfer of responsibilities to independent and politically autonomous organisations.

| Table 2.5, Models of Decentralisation (Mills et al 1990) | | | | |
|---|---|---|---|---|
| | Deconcentration | Devolution | Delegation | Privatisation |
| Operational Definition | Administrative decentralisation | Political decentralisation | Transfer of specific functions to a commission or corporation | Transfer of functions to private and voluntary agencies |
| Potential Advantages | Some local discretion, removal of pressure on the centre | Sensitivity to local issues, greater coordination of services | Greater flexibility in the management of these functions; some political independence | Greater flexibility and political independence |
| Potential Disadvantages | Lack of coordination and of sensitivity to local needs | Central funding necessary in high-cost health services, and hence central control | Lack of coordination with other departments and agencies | Need for regulation and control mechanisms |

This typology reflects ideal types. Many have noted that is focuses on who receives new decision-making authority and does not really provide an analytical tool to explore how decentralisation operates in practice (Mills et al 2002, Fielder & Suazo 2002,

Wang et al 2002, Bossert et al 2003a). In the case of First Nations, indigenous organisations are politically independent organisations that nevertheless depend on public funding. Conceptually, they straddle categories as they generally function as private organisations in terms of processes of decision-making. Their decision-making is nevertheless highly constrained by the conditions related to access to public funding.

The complexity of the First Nation situation is not unique and poses specific methodological challenges mainly because, in this case, decentralisation is implemented through a contractual environment. In the context of this study, it is more useful to look at models of decentralisation from the point of view of how they operate in key sectors of decision-making. Table 2.6 shows a framework developed by Bossert (1998). This framework focuses on the level of decision-making power (space) and autonomy an organisation can exercise in the key areas of financing, service organisation, human resources and governance. These areas relate to the goals for improved performance through health reforms developed by Berman (1995).

The framework is intended to facilitate an analysis of the functions over which local decision-makers can exercise authority. Each criterion is explored from the perspective of the range of choices it provides. Bossert developed his initial framework to analyse the impact of decentralisation, and explores whether the planned reform implies innovations, changes or no changes in key area of health systems in developing countries. He has used this framework to assess the impact of reform on local authorities' increased ability to make choices (before and after), for comparative international studies of intergovernmental health system decentralisation and to advise governments on alternatives (Bossert 2002, Bossert et al 2003a, Bossert et al 2003b).

There are two main limitations to the framework as it stands. First, the measures and the differences in the range of choice are quite subjective. And second, the criteria do not neatly fit the analytical needs of First Nation, indigenous or NGO contractual environments and require validation or adaptations. The literature on the NGO sector, on contracting in health and the Canadian context will be reviewed to identify principles that can be used to adapt the framework developed by Bossert to better fit the purpose of this study. Each will be explored in turn.

| Table 2.6, Decision Space Analysis Bossert (1998). | | | | |
|---|---|---|---|---|
| Function | Indicator | Range of choice | | |
| | | Narrow | moderate | wide |
| Finance | | | | |
| Sources of Revenue | Intergovernmental transfers as % of total local health spending | High % | Mid % | Low % |
| Allocation of expenditures | Intergovernmental transfers as % of local spending that is explicitly earmarked by higher authorities | High % | Mid % | Low % |
| Fees | Range of prices local authorities are allowed to choose | No choice or narrow range | Moderate range | No limits |
| Contracts | Number of models allowed | None or one | Several specified | No limits |
| Service Organisation | | | | |
| Hospital autonomy | Choice of range of autonomy for hospitals | Defined by law or higher authority | Several models for local choice | No limits |
| Insurance plans | Choice of how to design insurance plans | Defined by law or higher authority | Several models for local choice | No limits |
| Payment mechanisms | Choice of how providers will be paid (incentives and non-salaried) | Defined by law or higher authority | Several models for local choice | No limits |
| Required Programmes | Specificity of norms for local programmes | Rigid norms | Flexible norms | Few or no norms |
| Human Resources | | | | |
| Salaries | Choice of salary range | Defined by law or higher authority | Moderate salary range defined | No limits |
| Contract | Contracting non-permanent staff | None or defined by higher authority | Several models for local choice | No limits |
| Civil Service | Hiring and firing of permanent staff | National public service | Local civil service | No civil service |
| Access Rules | | | | |
| Targeting | Defining priority populations | Law or defined by higher authority | Several models for local choice | No limits |
| Governance Rules | | | | |
| Facility Board | Size and composition of boards | Law or defined by higher authority | Several models for local choice | No limits |
| District offices | Size and composition of local offices | Law or defined by higher authority | Several models for local choice | No limits |
| Community participation | Size, number, composition, and role of community participation | Law or defined by higher authority | Several models for local choice | No limits |

### 2.3.2    The non government sector in primary health care delivery

The non-government or third sector is defined as "a body of individuals who associates for any of three purposes:

- to perform public tasks that have been delegated to them by the state;

- to perform public tasks for which there is a demand that neither the state nor for-profit organisations are willing to fulfil; or

- to influence the direction of policy in the state, the for-profit sector, or other non-profit organisations (Dobkin Hall 1987).

These organisations are generally managed by a Board of Directors of elected community members. Salamon et al. have conducted extensive research to create a scholarship of the non-profit sector (Salamon & Anheier 1996b, Salamon 1998). Their review shows that the term NGO applies to an eclectic range of organisations (Salamon & Anheier 1996a, 1997).

The relationship between the government health authority (Ministry of Health, its delegate or technical term, "the purchaser") and the third sector ("the provider") hinges on two key elements: the conduct of the relationship through contract and the separation of service recipient and the provider.[25] These two elements constitute what Stewart (1993) calls "governing by contract." Considerable attention has been paid to the role the non-profit sector can play in meeting the needs of vulnerable populations (Crampton et al 2001, Frank & Salkever 1994, Needleman 2001, Tollman 1991). The non-profit sector is best able to play a positive role if, first, the organisation does have a close relationship with its client population; and if, second, the learning that occurs as a result of this relationship can be shared back with the purchaser (i.e., the government) and incorporated in the contractual relationship to ensure that services are responsive to needs. This is most likely to occur when the contractual relationship is based on trust. These are important qualifications.

Matthias and Green's review of the evidence suggests that assumptions that NGOs are more efficient and effective than their government counterparts, that they are more innovative, and that they are more able to reach the grass roots largely depend on the contractual environment in which they operate (Matthias & Green 2000).

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[25] The terminology adopted here has currency in international health system and economic literature, and defines the system in terms of role and money flow. The purchaser is often the Ministry of Health, but that role can also be delegated to Health Boards if they are fund holders tasked with paying independent service providers like general practitioners. Providers can be a medical practice, an indigenous health organisation, a private hospital, and are contracted by the purchaser to deliver specific services. The terminology remains useful as it separated roles and clearly reflects asymmetries in power. See Fougere in the topic (2001).

They review Gilson et al (1997) study of the practices of church-run health services in Zimbabwe, Ghana and Tanzania, concluding that church hospitals equate or in the case of Zimbabwe can outperform their governmental counterparts. Reviewing the contractual relationship between governments and NGO, they recommend a mix of increased management flexibility, increased specifications of responsibilities in terms of outputs required of the NGO, and tighter control over government financing. Having said that, they also recommend that agreements remain broadly defined to ensure that NGO can retain their flexibility and non-profit motivations, but also minimise administrative burdens. Their conclusion illustrates the tensions that exist between the need of the state to monitor NGO performance in health versus the risk of developing inflexible and administratively cumbersome mechanisms that hamper rather than capitalise on the advantages of an NGO run services. They suggest that more tightly formalised contracts go against a relationship based on trust and flexibility, and undermine the benefit of NGO involvement. This responsiveness may be aided or hampered by the contractual relationship. The work of Gilson et al (1994) suggests that the NGO-client relationship is contingent on a number of issues, including the relationship between the local NGO and its parent organisations, government and funders.

Frank and Salkever write "Government appears to both promote and mistrust non-profit organizations in the health sector" (1994). From the government perspective, the mistrust is based on having limited control over the provider, while remaining accountable for the appropriate expenditure of public funding and the overall quality and effectiveness of the services delivered. From the provider's perspective, the mistrust comes from a limited ability to influence or structure the contractual environment to access resources in a way that better fits the population served and service delivered. This mistrust can undermine working relationships, and limit the funder's willingness to adapt the contract based on the provider's experience.

Most research on NGO engagement in the health sector has been pursued in third world and middle income countries, where limited competition in the health care market and weak public sector capacity leave large services gaps (McPake & Hongoro 1995). Turshen (1999) speaks of health care throughout the African continent, noting that the NGO sector is often promoted as a mechanism to advance civil society, good governance and democracy, thus a mechanism to lessen the grip of government. NGOs are said to fill gaps left open by government services and the private sector. The commitment to NGOs is associated with the ideal of depoliticising civil society. She notes that international pressures in favour of a growing NGO sector carry the interesting paradox of side stepping the very mechanism of democracy. At the national

level, NGOs are not immune to national politics, may align themselves with local or national governments to further their own interests, and/or may align themselves to specific ethnic groups in order to further their interests within the country. Turshen, who argues that accountability is generally weak in countries where democracy is weak, also questions the ideal that NGOs are intrinsically more accountable to the constituency they serve.

The Canadian First Nation "sector" exhibits similarities and differences with the NGO sector. The sector plays a counter hegemonic role that is more akin to the role the NGO sector plays in developing countries. As with the NGO sector, the government relations with the First Nation sector show a balancing act between stewardship, risk management and autonomy. Although not immune to politics or poor management, First Nation organisations are necessarily closer to their constituency: by virtue of being local cultural organisations, they operate with intricate knowledge of their constituency's history, culture, language and community dynamics. In this context, the relationship is one of trust and linked with identification (Gilson 2003). The purchaser-provider' mistrust highlighted by Frank and Salkever (1994), and its predicted impact, is also apparent in that environment.

This section suggests that in the indigenous contractual environment, access rules and targeting should be aligned with the provider's constituency. The principles also suggest that contract provisions should be negotiable to ensure that the provider's knowledge of their constituency's needs is reflected in the contracts they sign. Finally, these principles validate Bossert's criterion regarding flexibility in programming.

### 2.3.3   Contracting in Health

Contracts define the relationship between the purchasing authority and providers. The neoclassical economic literature frames the contract as the purchasing of discrete, well-defined transactions in a market-like environment, where both parties enter into an agreement freely, and in which the purchaser controls the power to define, and the provider competes for the mandate to provide. Its main contribution has been to study the role of competition and markets. This focus has generally side-stepped the context in which purchasers and providers operate and assumed transactions to be costless. Deakin and Michie note that this approach has led to the development of an extensive and formal theory of exchange, but that a corresponding theory of contract has yet to emerge (Deakin & Michie 1997).

In the context of this study, contracts between the Crown and indigenous health organisations build on either a long-term relationship between a single or primary purchaser and a single provider in a non-competitive environment, or at the least a

quasi-market like-environment that is constrained by the legal framework that informs the relationship between the state and indigenous nations. In this context, contracting in health is used not as a mechanism to promote competition, choice and effectiveness, but rather to promote participation and responsiveness.

In that context, it is not possible or particularly productive to isolate the contractual environment from its larger context of production. Here, Williamson's New Institutional Economics provides valuable insights (Williamson 2000). Institutional economics is interested in the larger context in which economic activities occur. This requires broadening the theoretical base drawing from legal and organisational theories. Williamson describes four layers of social analysis that provide the larger context in which contracts occur, including,

- Embeddedness: the context in which informal institutions, customs, traditions, norms and religion;

- Institutional environment: formal rules in which institutions operate, including the legal framework;

- Governance: the regulatory context of transactions, especially the contract; and

- Resource allocation and employment (Williamson 2000).

He suggests that the fourth level is where neoclassical analysis is most relevant. In contrast to neoclassical contract theory, Williamson defines the contractual environment as being constrained by bounded rationality, being the expression of limited cognitive competence and access to information,; with a resulting incompleteness, and governed by opportunism. The "human factor" is thus central.

Building on Williamson's work, Macneil formulated a theory of relational contracts that reframes the contract as "*relations* in which exchanges occur" (Macneil 2000, p. 878).[26] This approach is gaining support in health contracting research as a framework for analysis (Allen 2002, Palmer & Mills 2003). What Macneil acknowledges is that contracts do not occur in a social and relational vacuum. Rather, contractual relationships are best understood as extensions of social relationships. In this context, the contract becomes a microcosm of the overall relationship between the funder and the provider. This relationship is generally articulated through contractual provisions for accountability.  Accountability is about visibility in public administration.  But it is also about power and the discharging of responsibility *between* stakeholders, in this case the state and indigenous organisations.

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[26] See Eisenberg (2000), Feinman (2000), Gudel (1998), Lees (2001), Macaulay (2000), Macneil (1985, 2000) and Speidel (2000) for a comprehensive overview:.

*Recent developments show that funding arrangements are not simply administrative means for transferring federal moneys to First Nations and related organizations; they are a centrally important forum through which the policy, administrative and financial roles and relationships of the Canadian parliament government, DIAND[27] and First Nations are being worked out* (Indian Affairs and Northern Development 1993, p. 14).

Mills and Broomberg provide an extensive review of the literature on contracting options in health. Table 2.7 summarises options. Eligible contract bidders may be selected through tendering or as is the case in Canadian First Nation environment, the contracting may be between a single funder and a single provider. The contract specifications may be outcome-based or method-based, with each method shifting the risk between funder and provider. The alternative, which is more prevalent in health care contracting, is a contract that is more broadly defined to accommodate shifting needs and unforeseen situations. Price specification options include block payment or capitation as fixed payment options that shift the risk to the provider, or cost/volume and fee-for-service payment that shift financing risks on the funder. Non-performance may be met with sanctions, usually a financial penalty, or remedied cooperative. The latter is most evident in environments where alternative providers are unlikely.

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[27] The Canadian Department of Indian Affairs and Northern Development.

| Table 2.7, Options in contracting (Mills & Broomberg 1998) | | |
|---|---|---|
| Category | Options | Characteristics |
| Eligible bidders | Bidders determined by tendering (open or close) | • Encourages new entrants, increases competition and reduces prices<br>• Potentially high administrative and monitoring costs |
| | Contracting without competition | • Appropriate where a close contractual relationship can be of mutual benefits<br>• More prevalent with the non-profit sector |
| Contract specification | Outcome-based contracting | • Higher risk for the contractor and higher priced as a result. |
| | Method-based contracting | • Less risk for the contractor |
| | Extent of specification | • Depends on the services, generally health services contracts are broadly defined (relational contracts) |
| Price specification | Block payment contracts | • Access to a defined range of services is paid through a flat annual fee. Places financial risks on the contractor as unanticipated demand may increase costs. |
| | Cost and volume contracts | • The provision of a defined number of treatments or cases at an agreed price. Provisions exist for additional cases. The open-endedness places risks on the funder. |
| | Capitation payment | • Common for primary health care services, but carry financial risk for the contractor that may be addressed through the selection of clients with less onerous needs (cream-skimming) |
| | Fee-for-service payment | • Less desirable as it carries an incentive to provide care to maximise gain. |
| | Fix bid contracts | • Attractive to budget-limited organisations as it ensure that contractors will bid to deliver the maximum standard they can afford. Tends to promote low quality providers. |
| Sanctions for non-performance | Punishment-based | • Generally applies to simpler services and where entry in service provisions is easier. |
| | Co-operative approaches | • Generally apply to more complex services because monitoring non-performance is complex and contractor replacement difficult |

The literature identifies two broad categories of contracts: classic and relational. The vocabulary varies considerably depending on authors. Classic contracts are often called short term (Lane 2001), explicit and transparent (Cumming & Scott 1998), or complete (Allen 2002). Relational contracts are at times described as complex, cooperative or trust-based contracts (Goddard & Mannion 1998). Table 2.8 summarises the possible characteristics of each model.

| Table 2.8, Contract characteristics (adapted from Goddard & Mannion 1998, Lane 2001) | | |
|---|---|---|
| | Classic contracts | Relational contracts |
| Description | Based on a single funder engaging multiple providers in competing for contracts. | Based on a single funder and a single provider engaged in a long term cooperative contractual relationship |
| Transaction costs | Contract drafting requires careful definitions of requirements and outputs, as well as contingencies | Contract drafting broader and more flexible |
| | Higher transaction costs associated with contract drafting and renewal | Reduced transaction costs (drafting and negotiating) |
| Priority setting | No incentive for the provider to invest in long term interventions | Promote long term planning and intervention |
| | Tends to focus interventions on individuals | Promotes population approaches |
| | In the case of vertical strategies, allows for the testing of new approaches across many providers | Possibility of improved responsiveness |
| Efficiency | Promotes competition between providers and potentially efficiency | May result in organisational inefficiency and substandard performance |
| Organisational issues | May create instability in organisations as a result of lack of commitment for continuous funding | Stable funding facilitating recruitment and retention of staff |
| | Promotes the deployment of resources based on contractual obligations | Facilitates the strategic deployment of human resources as needed |
| Monitoring | Explicit output requirements facilitate contract monitoring | Contract monitoring more challenging and costs may offset transaction cost savings. |
| | Provider performance assessed through contract outputs | Possibility of provider performance assessed through outcomes |
| Risk | For purchaser, mediated through choice of provider | Considerable for purchaser, may be mediated if purchaser can choose between providers (tendering process) |
| | For provider, mediated by focusing on short term strategies | For provider, minimal for the length of the contract, but considerable at the time of renewal |
| Dispute resolution | Short term contract may act as a disincentive for the purchaser to settle dispute | Mutual interest in settling disputes amicably |

Based on these authors, it appears that both models carry advantages and challenges. Classic contracts require extensive drafting and negotiation. The resulting specificity however facilitates their monitoring. They tend to promote and therefore are more appropriate for individual-focused and short-term interventions (Howden Chapman & Ashton 1994). As a result, they are useful for testing the effectiveness of varied or competing approaches. The lack of continued funding can create recruitment and

retention challenges for organisations. Because of their short lifespan, they lack incentives to settle dispute, and purchaser-provider conflicts may be addressed by changing provider.

Relational contracts generally broadly define service provisions, making them easier to draft, flexible and more appropriate for funding continued services. They have the potential to improve responsiveness to local priorities. Long-term contracts promote population-based, longer term strategies that can be evaluated on the basis of their impact on health. Stable funding may facilitate the recruitment and retention of more qualified staff. The security attached to the funding may also lead to complaisance and the delivery of substandard services. The lack of specificity in service description may also cause monitoring challenges. According to Lane, long term contracts inherently carry "massive moral hazard" for the purchaser (Lane 2001, p. 35), as they hinge on long term purchaser-provider relationships. Considerable risk also exists for the provider, who may feel compelled to accept contractual provisions or risk losing the contract and a substantial part of its budget. As a result, both the funder and the provider may feel compelled to seek an amicable resolution in times of dispute.

Evidence suggests that the above classic-relational dichotomy is to some extent an over-simplification of the reality. For example, Goddard et al (1998) note that even in the context of yearly contracts, purchaser and providers invest in the development of long term trust-based relationships as a way to minimise risk. Thus, the potential anti-competitive aspect of long term contracting is not absolute. They however note that from the purchaser's perspective, trust can only occur where there is a choice of provider. Without choice, long term contracts between a single potential purchaser and a single potential provider are instead based on dependency and hope (Goddard & Mannion 1998).

Well-defined contracts with clear role, responsibilities and deliverables have the advantage of clarifying stakeholders' roles. Holding both parties to their specified role will be more evident. Classic contracts however have many limitations: neatly defined deliverables are inherently inflexible. Creating a seamless health care system through highly specific contractual agreement will necessarily require lengthy and complex contract writing processes. Dividing the responsibility for the health care system between competing providers will also require extensive performance monitoring. Transaction costs will necessarily rise (Ashton 1998, Goddard & Mannion 1998). The choice thus seems to be between designing and managing a complex single contract, or designing and managing complex contractual environments resulting from a collection of simple contracts.

Lane (2001) contextualises the 1990 shift from long to short term contracting in the United Kingdom, Scandinavia, Australia, New Zealand and Canada to the pursuit of increased efficiency in public administration. According to Lane, long-term contracts have historically been used for the provision of tax-financed "soft" social goods, such as health care, education and social care. In contrast, short-term contracts have been used for services may be partially financed through taxation and partially through user fees. The literature suggests that this trend is now being reversed (Goddard & Mannion 1998). Koperski et al (1999) suggest that factors such as fragmentation, increased administrative costs and inequitable distribution of providers are leading the NHS back to adopting a collaborative system based on long term contacting partnerships.

While helpful, the literature does not entirely meet the theoretical needs of this study, mainly because authors tend to focus their discussions on purchaser-provider relations in the context of a single contract. This study instead focuses on the contractual environment for a single provider, whether simple or complex. The contractual environment is likely to vary depending on the types of contract(s) preferred by the purchaser(s), whether comprehensive and flexible or discrete and tightly defined. In the Canadian context, the contractual environment has shifted from a single long term contract in 1989, to 60 percent of income being derived from the single long term transfer agreement and a residual 40 percent of funding derived from short term program-specific and inflexible contracts. The fragmentation of the contractual environment has increased transaction costs and failed to yield the increased accountability promised (Auditor General of Canada 2002, Lavoie et al 2004). To date, no other study has focused on the contractual environment from the provider's perspective.

Evidence from the literature shows that flexible, comprehensive, long-term contracts carry significant advantages for providers. This suggests that one of Bossert's indicator, which focuses on the type of contract the provider is allowed to engage in, should be refocused to document the number and type of contracts in place. Second, the payment structure is an important feature of the contractual relationship. A fee-for-service or volume-based funding provides the most flexibility, and thus the greatest range of choice for providers.

### 2.3.4  Stewardship and Accountability

Accountability is about social relations, and in the indigenous context, about social relations inscribed and informed by a legal framework, macro-policy statements, history and localised understanding. Hughes Tuohy (2003) suggests that accountability requires three things: the identification of responsibility, the provision of information,

and the availability of sanction. She discusses how through much of the twentieth century, the role of the state has been that of a "principal" in a trust-based principal-agent relationship. Decisions over the provision of care by non-government providers, mainly physicians, were based on trust and the delegation of authority. The shift to contract-defined relationships has reshaped the role of the state from a trust-based delegation to that of contract monitoring first focused on deliverables (outputs) and increasingly on the reporting of a variety of performance indicators (results and outcomes) that can be audited to ensure quality in care provision. In the process, the state is increasingly defining how care should be provided.

This shift is associated with a number of changes, including, first, growing expectation in the role of the state in ensuring that the health care system produces equitable health. Stewardship has been defined as "a function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by citizenry" (Saltman & Ferroussier-Davis 2000). The 2000 World Health Report (World Health Organisation 2000) squarely placed the responsibility for the performance of the national health care system onto the shoulders of national governments. In the context of a contracted out system, the stewardship over the performance of that system rests with the government.

Second, the growth of government in the funding of health services has increased over the past thirty years. In systems where taxation funds providers, oversight of the use of public resources requires a formalised accountability framework.

Third, Hughes Tuohy (2003) argues that globalisation has led to a change from a trust-based management of service delivery, where norms were assumed to be shared, to a system of written and enforceable norms. The development of formal contractual relationships has raised the question of monitoring in terms of performance, quality, outputs and outcomes. The ideal of provider monitoring, especially for outcomes and quality, has been made possible, or at least imaginable, by advances in information technologies.

Table 2.9 highlights four dimensions of accountability. The purchaser requires accountability for the use of public funding. The purchaser also requires performance accountability. An aggregation of providers' performance may be used to inform government on the performance of the overall system, assuming that the performance data available to or produced by providers is standardised and can be aggregated in a

cost effective manner.[28] Clients are also interested in provider accountability. Measures of reciprocal accountability ensure that both parties can be held to the terms of the contract. Finally, political accountability is related to the broader context of credibility and trust, carries intangible indicators and is more closely related to the culture, context, history and tensions influencing decision-making in health care.

| Table 2.9, Dimensions of accountability (adapted from Cumming & Scott 1998, Hughes Tuohy 2003) | | |
|---|---|---|
| | Definition | Dimensions |
| Political accountability | Related to the broader context of credibility and trust, and carries intangible indicators | Purchaser to Government Provider to purchaser Provider to clients |
| Reciprocal accountability | Ensured through an appropriate dispute resolution process and third party monitoring | Between purchaser and provider |
| Performance accountability | Monitoring of contracted output based on established standards where stated, and resulting impact on outcomes | Purchaser to Government Provider to purchaser Provider to clients |
| Financial accountability | Appropriate and prudent use of public funding | Provider to purchaser |

Reporting requirements are pragmatic extensions of accountability, and generally defined in contracts. Reporting is required to ensure that the purchaser can continue to have oversight over single contracts. The link between accountability and reporting is poorly articulated in the literature. Only three analyses of accountability frameworks have surfaced. Crough (1997) provided a comparative analysis of the diversity of contractual arrangements available to Canadian First Nations and Australian ATSI through central indigenous-specific government agencies (all sectors except health). The analysis focused mainly on political accountability, in that possible contractual arrangements were analysed to shed some light on policy positions in each country. His analysis provided no information on the link between accountability and reporting, or on indicators. Kaufman Thomas and Associates (2001) compared First Nations' to the accountability framework of other Canadian quasi-governmental institutions, such as Regional Health Authorities, municipalities and schools. There, the accountability framework was typically governmental in nature, with clear legislative and policy frameworks. They noted that quasi-government institutions generally receive broad authority and control. The performance of layers of government is not relevant to the analysis being pursued here, as governments generally report on their performance

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[28] Electronic submissions are more amenable to cost-effective manipulation than paper-based reports, but the option to submit reports electronically is expensive and not necessarily available to all providers.

in programming as a unique entity. The third study was performed from the Auditor of Canada (1996), and aimed at investigating accountability practices from a First Nation perspective. This is the only report that considers accountability in the context of reciprocity, discusses the importance of transparency for both parties, and looks at obligations as a mechanism to foster better understanding and trust. The report highlights the distinction between performance and financial reporting to serve government's needs and the same to service community needs, noting that the format, if not the message, is necessarily different. It also suggests that responsibility in reporting should be aligned with capacity, but does not define the relationship between governments' needs for accountability and reporting requirements. The report was exploratory in nature and did not attempt to make pragmatic conclusions.

Current trends in accountability seem to require the elaboration of information systems that can inform on the performance of individual providers and, once performance indicators are aggregated, on the overall performance of the system. The realisation of this objective is however complex and costly (Light 2001). To date, it appears that little work has been done on developing meaningful and theoretically informed provider performance indicators, which can also inform on the performance of the overall system once aggregated. Crampton et al write,

> *We contend that a theoretical foundation is absolutely necessary in the formulation of performance indicators. A theoretical framework provides answers to questions such as: why do we need indicators? What should they measure? How should they be constructed? In the absence of clear answers to these questions, performance indicators can be used variously as a means to unjustifiably punishing primary care providers, or as a tool for shifting funding in response to political or lobby group pressures (Crampton et al 2004).*

The slim but growing literature on quality in health care purchasing appears to support the development of provider-driven and therefore provider-appropriate standards of quality in service delivery (Buetow 2004, Crampton et al 2004, Gross 2004, Ovretveit 2003). This is recommended as a cost-effective and appropriate answer to purchasers' concerns that also protects the need for services to remain responsive to local needs in service delivery. Provider-specific standards may not resolve the need for the funder to monitor the performance of the overall system.

Gilson's (2003) extensive review of the role of trust in health care suggests that classic contracts are costly to implement and monitor, and reflects that trust can assist in reducing transaction costs and enhance the possibility of managing complexity. This, she suggests, requires the development of relational contracts that contain effective sanctions.

The information reviewed in this section suggests that reporting requirements focus on indicators that are evidence-based and meet the accountability needs of the

purchaser. Failing this, the reporting requirements should be streamlined. In this case, contractual provisions should include effective measures of reciprocal accountability to ensure that both parties can be held accountable for their responsibilities.

## 2.3.5 Exploring Bossert's framework in light of the Canadian experience and the literature

This section explores each of Bossert's criteria in light of the Canadian experience and the literature discussed above to assess relevance, identify gaps, formulate new indicators and criteria reflecting range of choices.

**Finance** Bossert focuses on sources of revenue, allocation of expenditures, fees and contracts. Bossert assumes that a dependency on government funding, as opposed to the opportunity to raise funds from fees and through other means, leads to a reduction in the range of choices for providers. In the case of First Nations, 100 percent of funding comes from public funding allocated to the Band, either through the transfer agreement or through a collection of optional program-specific yearly contribution agreements (see Table 2.4, shown earlier). Some First Nations secure funding through agreements with their respective provincial or regional health authority (for diabetes or urban services), but this is still public funding, and minor in terms of total revenue. Contrary to Bossert's assumption, reliance on government funding provides stability to First Nation providers. The situation is somewhat complex.

Transfer affords First Nations some flexibility in programming that is however matched only to a limited extent with flexible resourcing. The initial financing formula was based on historical expenditures that were to some extent workload and population related, with an additional allocation for administration. For zone and regional positions, funding was allocated on a per capita basis. The community could choose between hiring the services of a health professional from an outside agency or to purchase back services from Health Canada (Health and Welfare Canada 1989). Concerns over the level of financing have been repeatedly expressed. No baseline existed at the onset to ensure some level of equity. A recent analysis shows that inequities have cumulated over time (Lavoie et al 2004). First Nations have argued that the current allocation formulae challenges the long term sustainability of on-reserve services (Assembly of First Nations 2002). The transfer agreements include a 3 percent indexation per year. But it also includes a non-enrichment clause, whereby First Nations signing a five-year agreement fail to receive any adjustment for increased on-reserve population whether due to population increase or a movement back to the reserve as a result of improved infrastructure. The on-reserve First Nation population continues to grow at a rate ranging from 2.8 to 3.5 per year (Indian and Northern Affairs

Canada 2000). Thus, First Nations are seeing their health resources spread thinner year after year. The contractual environment has also become progressively atomised over the past decade. Until 1995, First Nations had budgetary line flexibility over 100 percent of their health program budgets, which was block funded. Surpluses could be retained. New programs are now being introduced through yearly contribution agreements outside of transfer, accounting for 30-40 percent of First Nations health budget. These agreements are standardised and their provisions non-negotiable. Each new program is generally funded for short-term initiatives with specific targets for expenditures and no budgetary line flexibility. Surpluses cannot be retained.

This analysis suggests that a 100 percent dependency on government funding, which is a feature of the indigenous health environment is not necessarily problematic, provided that the funding is commensurate with the cost of providing care and that budgetary line flexibility is permitted. Payment structure thus needs to be added to the framework. As discussed above, a fee-for-service or volume-based funding minimises the risk to providers. The analysis also justifies the validity of allocation of expenditures as an indicator. The issue of fee is not relevant, as First Nation, and indeed indigenous providers, were set up to ensure access to services and do not charge fees.

The literature also validates the need for new indicators. In terms of contract, the focus should not be on the number of models First Nation organisations are allowed to engage in, but rather on the level of fragmentation existing in the contractual environment and on the type of contract preferred by the provider. Length of contracts also correlates with stability in funding. Finally, fair negotiation in contracting would require the ability for all parties to access information to ensure that contractual obligations and the funding provided is evidence-based.

The literature emphasises the importance of capitalising on providers' knowledge of their constituency, where a close relationship exists, to ensure responsiveness. This can be best reflected in a number of indicators. First, providers' ability to negotiate contractual provisions should be documented to ensure that their knowledge of their constituency's needs is reflected in the contractual obligations. In the Canadian context, agreement provisions are standard and non-negotiable. Second, flexibility in programming is also validated as important indicators, which Bossert located under the category **Service organisation**. Bossert's focus on hospital autonomy, insurance plans, payment mechanisms for providers as indicators under the same category are however not relevant to the First Nation or indigenous provider environment. Third, **access rules** should align with the indigenous provider's constituency to ensure that the benefit of this relationship can be reflected in service delivery. Service provision, funding and access rules should align. This is not the case

in the Canadian context, where First Nations may provide services to a broader constituency if they so desire, but must provide services to and are funded exclusively for First Nations living on-reserve. In reality, the First Nation population is highly mobile and may periodically leave the reserve as a result of housing pressures, education or employment opportunities, or health care needs. The permanent on-reserve population does not take into account First Nations that live periodically on and off-reserve. The funding also fails to recognise that First Nation health organisations may also be providing services to non-indigenous populations living off-reserve because of the unavailability of alternative providers, especially in rural or remote environment.

**Human resources** Bossert's framework was developed to meet the needs of health systems decentralisation from one layer of government to another. His criteria include salaries, contract payment for non-permanent staff and responsibility over the hiring and firing of staff. These criteria are not relevant to a situation where governmental responsibilities are being contracted out, since limits on management of human resources would interfere with the employer-employee relationship. These criteria were deleted.

**Governance** Bossert's framework speaks to the size and composition of facility boards and local offices as well as the role of community participation. As in the case of human resources, these criteria are not relevant in a contractual environment. They instead speak more readily to the context of decentralisation between layers of government.

One important gap in Bossert's framework in the context of this thesis is that it does not include a criterion for **accountability**. This is an important issue in the First Nation-Health Canada relationship. The literature remains vague on the relationship between accountability and reporting. It does however suggest that until evidence-based indicators are available, monitoring relations should be streamlined and trust-based. Another theme emerging from the literature is that of the need for contracts to reflect provider's experience and circumstances. This suggests that contracts should include a dispute resolution mechanism. In the Canadian context, although a dispute resolution mechanism exists on paper, any decision emerging from that process is not binding on Health Canada and has led to frustrations, especially when issues challenge provider sustainability (Adams & Brown 1999).

Table 2.10 shows the final framework. Indicators have been regrouped under three rather than the original five categories: finance, governance and service organisation, and accountability. The range of choices for each category is derived from the above discussion. This framework allows for mapping out what policies, and the compromises associated with implementation, actually mean in practice.

| Table 2.10, Decision Space Analysis (adapted from Bossert 1998) | | | | |
|---|---|---|---|---|
| Function | Indicator | Range of choice | | |
| | | Narrow | Moderate | High |
| **Finance** | | | | |
| Sources of Revenue | Public funding as % of total local health spending | Substantial funding raising expected to cover the cost of health services | Public funding represents a substantial portion of the budget for health services | The budget for health services comes from public funding |
| Allocation of expenditures | Intergovernmental transfers as % of local spending that is explicitly earmarked by higher authorities | High percentage | Moderate percentage | Low percentage |
| Contracts | Number, type and level of fragmentation | High degree of fragmentation (many classic contracts) | Moderate degree of fragmentation (a complement of larger and somewhat flexible contracts) | One more comprehensive contract. |
| Length of contracts | Short versus long term | Short term contracts | Short and longer term contracts | 3 to 5 year contracts |
| Payment structure | Block, volume, fee-for-service, partial funding | Partial funding, Outcome-based funding | Block, flexible funding | Volume or fee-for-services Method-based funding |
| Fair negotiations | Disclosure on all parties of financial basis for funding. Equal access to information. | No negotiation | Some opportunities for discussions and contractual amendments led by the provider | Full negotiations |
| **Governance and Service Organisation** | | | | |
| Access Rules and Targeting | Defining priority populations | Access rules do not match the indigenous provider's constituency | Some level of compromise between access rule and indigenous constituency | Access rules match constituency |
| Required Programmes | Specificity of norms for local programmes | Programs rigidly defined | Some flexibility in priority setting and programming, and some define programs | Flexibility in priority setting and programming |
| **Accountability** | | | | |
| Measures of reciprocal accountability | Provision for dispute resolution | Purchaser-driven sanctions No effective dispute resolution mechanism | A somewhat effective dispute resolution mechanism, possibly based on mutual goodwill | Cooperate dispute resolution process An effective and mutually binding dispute resolution mechanism exists |
| Reporting | Reporting required of the provider | Reporting requirement elaborate Activity reporting | Moderate reporting requirement | Streamlined reporting requirement Evidence-based indicators |

## 2.4    Linking policy, implementation and practice

Implementation and practice necessarily require compromises on the ideals expressed in policy objectives. When applied to the Canadian Health Transfer Policy, the framework outlined in Table 2.10 highlights key areas where the policy, as implemented, has resulted in compromises. This is explored in Table 2.11. First, although all funding comes from government, a significant proportion of this funding is now earmarked. The funding provided under the comprehensive transfer agreement was based on historical expenditures rather than evidence and has not kept up with population growth and increased costs. Inequities have grown. The system does not provide a mechanism to address this issue. Contracts are renewed without negotiations and an effective dispute resolution mechanism does not exist to address important issues. Another key compromise relates to providers' ability to meet the health service needs of their First Nation constituency. Services are block funded, taking loosely into consideration the population living on reserve. Block funding does not take into account service volume associated with diversity of needs from one community to the next, the high mobility associated with First Nations leading individuals from remote or rural communities to relocate to semi-urban reserves to improve access to care, education or employment. Program-specific funding does not take into account diversity of needs and poorly matches the first objective of the policy, which was to enable Indian Bands to design health programs, establish services and allocate funds according to community health priorities (National Health and Welfare & Treasury Board of Canada 1989).

Whether the compromises shown here are the logical consequences of contingencies associated with practice, as opposed to policy pressures associated with other interests, may be a matter of debates. This is a very difficult question to answer without a basis for comparison. This approach developed here will be used in chapter 6 to explore the decision-making autonomy provided to indigenous providers in Australia and New Zealand. This will be compared to indigenous polices discussed in chapter 4, to produce an analysis similar to the one undertaken in this chapter.

This chapter began with three questions:

- What is the larger context and debates influencing indigenous health policies;

- What is the link between and the factors that influence the relationship between, policy formulation and policy implementation; and

- What options exist in contracting in health, and how do there options relate to the needs of public administration and accountability, health care system management and local priority setting, and cost-efficiency.

| Table 2.11, Decision Space Analysis as it applies to the Health Transfer Policy (adapted from Bossert 1998) | | | |
|---|---|---|---|
| Function | Indicator | Range of choice, Canadian Health Transfer Policy | |
| | | Range | Rationale |
| **Finance** | | | |
| Sources of Revenue | Public funding as % of total local health spending | Moderate | The budget for health services comes from public funding, which may however be insufficient and has built-in inequities. |
| Allocation of expenditures | Intergovernmental transfers as % of local spending that is explicitly earmarked by higher authorities | Moderate | 40% of First Nations' health budget comes from separate program-specific contribution agreements that are inflexible, and 60% comes from a single flexible contract. |
| Contracts | Number, type and level of fragmentation | Moderate | |
| Length of contracts | Short versus long term | Moderate to high | Mix of short term and one longer term contract |
| Payment structure | Block, volume, fee-for-service, partial funding | Moderate | Block, flexible funding |
| Fair negotiations | Disclosure on all parties of financial basis for funding. Equal access to information. | Narrow to moderate | No negotiation, services being transferred are those previously offered by Health Canada. |
| **Governance and Service Organisation** | | | |
| Access Rules and Targeting | Defining priority populations | Moderate | Access rules match constituency as long as they live on reserve. |
| Required Programmes | Specificity of norms for local programmes | Moderate | New programs are inflexible, and attached to specific health gains. The single comprehensive agreement is flexible, but funding provided under this agreement is not sufficient to ensure sustainability. |
| **Accountability** | | | |
| Measures of reciprocal accountability | Provision for dispute resolution | Narrow to moderate | A somewhat effective dispute resolution mechanism based on mutual goodwill exists to deal with minor issues. Major issues such as equity in financing and sustainability have remained unaddressed. |
| Reporting | Reporting required of the provider | Narrow | Extensive reporting requirements focusing largely on activity reporting. |

The literature and Canadian experience suggest that implementation is more likely to align with policy where policies are based on a recognised theory, where the level of consensus is high, and where the change required by the policy is limited. Clearly assessing the impact implementation may be best pursued through the framework developed in section 2.3.

The objective of this study is represented in the conceptual framework, shown below. This framework identifies eight questions that will be the focus the analysis:

1. What are the historical factors that impacted the development of indigenous health policies?

2. What values are apparent in policies?

3. Do policies more readily reflect indigenous aspirations, indigenous-state's historical relationship or other interests?

4. What are the apparent compromises made in the process of implementation?

5. What factors led to compromises?

6. Are indigenous providers able to exercise some control over key areas of decision-making?

7. What are the constraints on operations? And,

8. Is the contractual environment an accurate reflection of indigenous health policies or of the state practices in health contracting? Are compromises made to respect indigenous aspirations?

The first five questions are explored in chapter 4. Questions 6 to 8 are the focus of chapter 6. Chapter 7 is a synthesis of all questions.

## 2.5    Conclusions

A number of forces have converged to inform indigenous health policy in Canada. These forces include international covenants and national historical documents. Other forces include current debates over health inequalities, ideology that defines the role of the private sector in health care, indigenous aspirations for self-determination, stewardship, accountability and risk management. These forces may be weighted somewhat differently in Australia and New Zealand. The Canadian case study and literature presented above sets the stage for chapters 4, 5 and 6, looking at the relationship between policy, implementation and practice.

# Figure 2.4, Conceptual Framework with Research Questions

National Health Indicators

| COMPONENTS | OBJECTIVES | RESEARCH QUESTIONS |
|---|---|---|

**Central Government (Regional Governments)**

**Context** — To describe the historical and political context of state-indigenous relations, as they relate to questions of access to and delivery of health care services

1. What are the historical factors that impacted the development of indigenous health policies?

Government Department responsible for Indigenous health

**Policy formulation** — To analyse indigenous health policies, including the values they convey and mechanisms and processes they identify to implement their stated objectives

2. What values are apparent in policies?
3. Do policies more readily reflect indigenous aspirations, indigenous-state's historical relationship or other interests?

Government Departments responsible to implement indigenous health policies

**Policy Implementation** — To track changes and compromises made in the process of implementing indigenous health policies over time

4. What are apparent compromises, if any, made in the process of implementation?
5. What factors led to compromises?

Community-based Indigenous PHC Organisations

**Practice** — To document the level of decision-making authority being transferred to Indigenous PHC services, including opportunities and contingencies

6. Are indigenous providers able to exercise some control over key areas of decision-making?
7. What are the constraints on operations?
8. Is the contractual environment an accurate reflection of indigenous health policies or of the state practices in health contracting? Are compromises made to respect indigenous aspirations?

**Health care consumers**

Health Inequalities

# CHAPTER 3, METHODOLOGY

Policy formulation and implementation are not linear processes, but rather processes that are shaped by social relations reflecting larger debates. The information presented on the Canadian experience was largely based on the literature. Similar analyses will be pursued in Australia and New Zealand. This chapter describes the approaches, strategies and methods used to conduct these analyses. The aims of this chapter are to explore the strategy developed to answer the questions raised in chapter 2, explain why a case study methodology was adopted, and provide an understanding of how results were generated.

The chapter is divided into five main sections. A first section outlines the methodological framework adopted for this study and describes its scope. Section two discusses issues associated with accessing the field. Section three describes the process adopted to select the study sites. The fourth section describes the process of data collection and analysis. A final section explores the relevance of this study and its generalisability. As stated in the introduction, the objectives of this study are,

1. To describe the historical and political context of state-indigenous relations as they relate to questions of access to and delivery of health care services;

2. To analyse indigenous health policies, including the values they convey and mechanisms and processes they identify to implement their stated objectives;

3. To document the level of decision-making authority being transferred to Indigenous PHC services, including opportunities and contingencies; and

4. To assess the level of convergence and congruence existing between policy objectives and implementation mechanisms.

This research does not take a position on the superiority or effectiveness of indigenous controlled health services. It rather wants to contextualise their existence and how they operate within their larger historical, policy, relational and administrative context.

## 3.1    Methodological choices

An exploratory multiple case study design was adopted for this study. Case study methodology has been used by a broad spectrum of researchers and in many different ways. The methodology spans the single, anthropological, in-depth case study approach founded by the Chicago School at the turn of the century (Hamel et al 1993, Stoecker 1991, Dyer & Wilkins 1991) to a positivistic multiple case study approach that focuses on testable propositions and sampling strategies (Dyer & Wilkins 1991). Lately, case study methodology has effectively been used to explore the connection between policy and health services (Bentley 1989, Jacobson et al 1989, Yin 1999). Although the methodology has been criticised for its limited generalisability, the criticisms generally

apply to single case study design (Eisenhardt 1989). Critiques of multiple case study designs argue that the approach necessarily sacrifices depth for breath, generally as a result of time and resource constraints (Dyer & Wilkins 1991).

Undertaking multiple case studies in two different countries presents methodological and logistical challenges.  Havemann (1999d) provides a detailed comparative analysis of indigenous rights in Canada, Australia and New Zealand. He suggests that international comparative analyses are fraught with difficulties and must consider:

- The need to justify all choices of units and themes, and to be explicit about the focus of comparison and the standpoint of the writer;

- The historically contingent nature of events, processes, and practices, which take place in linked but unique historical eras, of which they are both a product and a cause;

- The salience of contextual specificity: the significance of unique historical, political, economic, and sociological factors, which combine to structure action and reaction - of which indigenous rights jurisprudence, for example, is an outcome and an agency;

- The interdependence of internationalised discourses about indigenous peoples - concerning human rights, for example, or the fiduciary obligations owed by the settler Crown;

- The phenomenon in which apparently similar concepts may have different meanings and significance in different jurisdictions - for example, indigenous rights (Havemann 1999d, p. 3-4).

He suggests that any analysis must be appropriately contextualised.

In the context of this study, detailed case studies of indigenous health organisations were undertaken. Health policies are necessarily informed by the historical relationship existing between indigenous people and the state, and the legal framework that informs indigenous rights within each country. Case studies were therefore contextualised within their policy, historical and political milieu.  A great deal of energy and time was spent reviewing the historical context of health policies and primary health care development in each country. This process required the development of a detailed chronology of key events (Treaties and other legal documents, legislations, history of state-indigenous reflections, shifts in political ideology, etc.); and a comparative spreadsheet of policies with their time of implementation, stated objectives and mechanisms.  Policy and related documents on indigenous health were collected for a period of 20 years and contextualised through a review of the literature and interviews.

The exploratory approach developed by Yin was found particularly well suited to accommodate the complexity of this study. Yin defines a case study approach as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (Yin 1994, p. 13). To Yin, each individual case study is in fact a distinct experiment, in which a theory is to be tested (Yin 1994). If supported by two or more case studies, replication has occurred. Each case study must generalise to theory, not across case studies. Multiple case studies are selected to ensure that either they produce the same results for the same reasons, or produce different results for predictable reasons. Herriot et al argue that the intent of multisite qualitative policy research is to optimise generalisability and description, while recognising the tension that exists between the two (Herriot & Firestone 1983). They argue that the balance between generalisability and description can be achieved if the study design is mindful of four key issues: structured data collection, number of case studies, length of time spent at each site for data collection, and site-specific as opposed to issue-specific reporting (Herriot & Firestone 1983). Each will be explored in turn.

**1. Structured data collection**: Each case study was conducted by a single investigator. The data gathering was structured along indicators outlined in the decision-space analysis framework developed in chapter 2. The methods utilised are explored in section 3.4.1.

**2. Number of case studies and length of stay:** Decisions on the number of case studies and the length of stay at each were constrained by delays in ethical approval and trust (see section 3.2). Given the historical relationship between researchers and indigenous organisations, it was felt that a smaller number of case studies and longer time for data gathering would foster the development of relationships leading to improved access to documentation, and improved accuracy in interpretation. Four case studies were conducted, two in Australia and two in New Zealand. The Australian sites were Katherine West and Danila Dilba. The New Zealand sites were Te Raukawa O Raukawa and Te Roopu Huihuinga Hauora Inc.

**3. Site-specific versus issue-specific reporting:** Each participating organisation was guaranteed that a case study report would be provided to senior staff and to Board members for their review. Each organisation was assured that the information collected would not be considered data until approval of the case study report had been granted by the Board. In all cases, the case study report was discussed with senior administrators to ensure validation. The results of the case studies are presented in chapter 6. The reports cannot be reproduced in this thesis because of space constraints. They were reproduced as approved for publication by

the Board of their respective organization, in a report on indigenous primary health care financing (Lavoie 2003a).[29]

As shown in Table 3.1, Yin has developed a number of criteria to ensure that a research design maintains validity and reliability (Yin 1994). Construct validity is assured when the correct operational measures are used to study the concepts under study. In the context of this study, multiple sources of evidence were used to ensure triangulation. In the case of policy analysis, a primary document analysis was supplemented with interviews and a review of literature. In the case of organisational case studies, senior staff and board members were given the opportunity to read over the case study report and comment.

Reliability is assured through transparency of research process. In the case of this study, the sources of information, whether contracts, minutes, correspondence or interviews, are referenced in the case study reports. Finally, external validity involves ensuring that the study's findings are commensurate to the study conducted, and are generalised within a like-context. In the case of this study, the conceptual and methodological frameworks borrow from the literature on policy implementation, health services decentralisation and third sector engagement. The findings of this study compare to other studies looking at third sector engagement in health service delivery explored in chapter 2. Issues related to generalisability are explored briefly in section 3.4. A comparison between the findings of this study and others appears in chapter 7.

Documents on history, policy, institutional arrangements and analysis were collected in both Australia and New Zealand. These documents provided the broader context. Data collection focused on policy themes, funding arrangements for indigenous primary health care organisations, and relationships between indigenous providers and the government. Interviews were conducted whenever the information collected left important gaps. The next section explores how this methodological framework was implemented.

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[29] Available at http://www.umanitoba.ca/centres/centre_aboriginal_health_research/cahr-research/research_publications_reports.html

| Table 3.1, Ensuring quality in research design (Yin 1994, p. 33) | | | |
|---|---|---|---|
| | Construct validity: Establishing correct operational measures for the concepts being studied | Reliability: Demonstrating that the operations of a study – such as the data collection procedures can be repeated, with the same results. | External validity: establishing the domain to which a study's findings can be generalised |
| Context and actors | • A broad and comprehensive review of literature was conducted on the history of indigenous–state relations; the health care system over the past 30 years; the history of health services to the indigenous population; national and indigenous positions on Indigenous and Treaty rights; and salient events.<br>• Actors were conceptualised as the national and regional governments, indigenous groups and organisations, and key stakeholders in the health care system.<br>• Sources were diversified to ensure validity. | • This component is largely drawn from the literature, and contextualised with interviews only when gaps in knowledge or understanding occurred. All written sources are disclosed.<br>• Evidence of international debates: a review of international covenants and their influence on indigenous health was conducted and is provided in Appendix I. | • The broader context documented in this study, that of indigenous state relations in three relatively wealthy countries, and how this context has informed policy and implementation cannot be generalised broadly. This research draws on the published literature on cross-national comparative analyses of indigenous policies (Armitage 1995, Dyck 1989, Fleras & Elliot 1992, Havemann 1999c, Scrimgeour 1995). This work has generally been pursued to explore alternatives to national options. |
| Policy formulation and implementation | • Test: Senior administrative staff and board members reviewed the draft case study report, made comments, asked questions. The final report was approved for publication by the Board. | • Detailed analysis of current policies is provided in Appendix II. | • Findings on the convergence and congruence of policy versus implementation inform and add to these debates. |
| Workings of the policy | • Test: Senior administrative staff and board members reviewed the draft case study report, made comments, asked questions. The final report was approved for publication by the Board. | • The decision-space analysis framework was used to structure data gathering. It created categories and themes around which the data was structured for cross-case study analysis.<br>• The source of information was disclosed in case study reports, whether from interview, correspondence, internal communications or reports.<br>• Quotes were cleared with each participants and permission secured.<br>• Triangulation between sources was done to ensure that single source biases were balanced out by other sources. | • Findings on contracting may provide insights to health care contracting in general. |

## 3.2    Access to the Field and Ethical Considerations

As McDonnell et al (2000) point out, methodological theory and carefully laid out plans often collide with the reality of fieldwork. Internationally, access to indigenous study sites has been repeatedly portrayed as difficult for a number of reasons (Kowalsky et al 1996, Tuhiwai Smith 1999). Indigenous peoples and communities have increasingly defined protocols to limit access and constrain the use and publication of information (Hopi Cultural Preservation Office n.d., Indigenous Peoples Council on Biocolonialism 2000). A main goal is to prevent research that either produces no useful information for the community, or results in dissemination strategies that side-step the community altogether. Another goal is to ensure that communication protocols are respected and that sensitive information is treated as such (Australian National University 1993, Collins & Poulson 1991, Ford n.d., Health Research Council of New Zealand n.d., Humphery 2000, Johnstone 1991, Todd et al 2000).  Active participation by the community, which may include capacity building, is also emphasised. Collective and individual consent is required, and collective and individual protection is demanded (Wyatt 1991). Here, the idea of protection goes beyond confidentiality and extends to the concept of cultural protection (Tuhiwai Smith 1999). Although some researchers have been concerned that this may introduce biases in research, or serve to prevent "useful" research from taking place, the potential for validation of interpretation should not be overlooked.

Community-based protocols and local indigenous ethics committees have emerged to help researchers adopt culturally appropriate processes. At the same time, no mechanism has yet emerged to facilitate pan-indigenous international research (Kaufert & Lavoie 2003). This gap, as well as local concerns, were raised and negotiated both at the ethical committee and organisational levels, following a process similar to the one documented by Kaufert et al (1999) for Canada.

This study secured ethical approval from the London School of Hygiene and Tropical Medicine in May 2001. This approval was conditional to local approval. Ethical approval in Australia caused some delays and much confusion. Early consultation appeared to suggest that ethical approval from the Australian National University Aboriginal Ethics Committee may be sufficient. The national guidelines do indicate that single university studies require approval from a single university-based committee (available at http://www.health.gov.au/nhmrc/issues/index.htm). Ethical approval from the Australian National University was secured in September 2001.

This process however appeared unacceptable to ATSI providers and to ATSI Ethics Committees geographically located where the research was to take place. Upon

arrival in the Northern Territory, the Top End Ethical Committee made it clear that ethical approval was required from them. This was pursued and secured by the end of November 2001. A submission was also made to the Central Australian Human Ethics Committee for a possible case study in Central Australia. As a result of delays in response, the possibility of undertaking a case study in Central Australia was dropped. By that time, two sites in the northern part of the Territory had already consented to participate in the study, and it was clear that the delays incurred made it impossible to line up a third case study in Australia.

In contrast, the New Zealand process was much clearer, with a national process dividing the country into 13 regions, all relying on a single form and coordinated process.  An application was submitted in October 2001 to all thirteen committees. The choice to submit to all committees was motivated by the fact that sites remained to be selected, and historical players may need to be interviewed in different parts of the country. Approval was secured in September 2002. However, one committee suggested that the timing for this type of study was less than ideal for political reasons. Sites from this region were not selected. Massey University, which housed the researcher for the length of fieldwork in New Zealand, did not require a separate process.

Securing ethical approval required evidence of prior support from indigenous organisations in both countries. Ethical approval was secured on the strength of letters of support in both Australia (from two study sites and an Aboriginal MLA) and New Zealand (from Professor Mason Durie, a prominent Māori health researcher).

### 3.3    Selecting sites

Site selection was highly constrained by three main factors:

• The complexity and lack of documentation of the field;

• Ethical approval; and

• Fortuitous contacts within key organisations, trust, local priorities and acceptability.

These will be explored in turn.

#### 3.3.1   The scope of the phenomena

Although both Australia and New Zealand support the development of indigenous health providers, the scope and profile of the indigenous health sector has not been documented. This led to some challenges early in the field, as there was really no mechanism to identify,

• The number of existing indigenous health organisations;

- The different funding models in place;

- The scope of services being delivered by indigenous health providers; and

- The number and type of organisations that may be potential sites for the study.

A first task was to develop two databases, one for each country, to help define the scope of the phenomena and what was known about it. These tools were set up:

- To identify the prevalence and geographical distribution of the phenomena;

- To explore issues and definitions of governance, community control, financing models for sampling, set up analytical categories; and

- To geographically locate sites in both countries to facilitate conversations and data gathering.

A listing of financing models emerged including:

1. Competitive access to funding: This is the most prevalent contractual arrangement both in Australia and New Zealand. It refers to funding provided by multiple or consolidated relatively small grants with the Central government (Australia Commonwealth Department of Health or the New Zealand Ministry of Health) and/or regional governmental authorities (the Australian State/Territory governments or the New Zealand District Health Boards).

2. Regionally-based comprehensive primary health care. In Australia, this refers to the Primary Health Care Access Program (PHCAP). This model is comparable to the Canadian Health Transfer Policy. Although a "Whole-of-Health" model is under discussion in New Zealand, no site has yet been implemented.

3. A Grant-in-Aid model existed in the Northern Territory of Australia. This model was used to set up a service contracts between the Northern Territory Health and an Aboriginal Council, to deliver health services at a local clinic. It included no funding for administrative skill development, recruitment, capacity building, or administration. The grant covered only service delivery. Most Grant-in-Aid communities have now terminated these agreements, and the model is being phased out. It has been severely criticised (Scrimgeour 1997).

4. The New Zealand Māori Purchaser Organisations (MAPO) are funded to purchase services from providers and may opt to purchase from Māori providers only. These organisations were created as a result of the implementation of the purchaser/provider split in the early 1990s. This policy is now being abandoned by New Zealand. Only three MAPOs exist, all located in the north of the North Island, and no new MAPO is being set up. The future of the MAPO model was somewhat uncertain at the time of fieldwork.

5. The Māori Development Organisations (MDOs) emerged as an alternative to MAPOs around 1998. They are funded umbrella organisations tasked with supporting existing small Māori providers with contract negotiations, organisational and service development. Although limited in numbers, the MDO movement is growing.

6. Finally, the "Whole-of-Government" model is currently under discussion in New Zealand, and a few agreements have been signed. These are cross-sectorial funding contracts all brought under the umbrella of an iwi (Māori political unit, serves as administrative body) which receives all funding (health, economic

development, education, etc.) under one single contract.  This model comes closer to the Canadian "self-government" model. Although interesting, these models are too young and thinly deployed to be included in this study.

This process helped narrow the site selection process. Since the grant-in-aid model is no longer being pursued, it was eliminated from the list. So was the whole-of-government approach, which was just being developed. At the time of fieldwork, the future of the MAPO model was also uncertain. The following models were therefore selected (Table 3.2).

| Table 3.2, Number of Cases per Category[30] | | | |
|---|---|---|---|
| | Competitive access to funding | Regionally based comprehensive primary health care | Alternative models |
| Australia | 1 | 1 | Not available |
| New Zealand | 1 | This remains under discussion or early implementation | 1 |

A second process required the development of key selection criteria for site selection. These are shown in Table 3.3.

[30] Australian database (Australia Commonwealth Department of Health and Aged Care Office of Aboriginal and Torres Strait Islanders Health Services 1998, 2001, National Aboriginal Community Controlled Health Organisation 1998, Office of the Registrar of Aboriginal Corporations 2001). New Zealand database (Crengle 1999, Health Care Aotearoa 2001, Malcolm et al 1999, New Zealand Health Funding Authority n.d., 1998b, 1999, New Zealand Ministry of Health Maori Health Department 2000, Tuhi Tuhi Communications 2001).

| Table 3.3, Selection criteria | |
|---|---|
| Criteria | Rationale |
| 1. Must be in operation for more than 2 years with the primary funding structure/arrangement being studied;<br><br>2. Must have some (historically) stable funding (no pilot projects); | Many organisations spring out as for the length of one contract, and then disappear. Since this study relies on organisational documentation produced over time, including contracts, minutes and correspondence, it was thought preferable to focus on organisations with a track record. |
| 3. Must be an indigenous health care organisation (as opposed to a state or private organisation with an indigenous component, or an indigenous organisation operating a short term, small health project); | This criterion reflects policy commitment to "indigenous controlled organisations". As explored below, identifying such an organisation can be a challenge. |
| 4. Must offer at least primary health care services at the community level or itinerant services; | Primary health care was defined as curative, rehabilitative, promotive and preventive services. The first two are individual-based, the last two are population based. The criterion was meant to differentiate between addiction counselling and treatment services, health training organisations, hospitals, etc. Although the expression "primary health care" is often associated with services delivered by general practitioners, the presence of a general practitioner on staff was thought unnecessary, as many indigenous organisations use referral processes. |
| 5. Must want to participate; and<br><br>6. Must accept my ownership of data. | For obvious reasons. |

Despite a successful narrowing of the potential sites, the above approach left too many choices to assumptions rather than facts. It was obvious early in the process that a more subjective approach was to be the only alternative for the final site selection.

### 3.3.2   Access to Study Sites

All study sites were recommended by indigenous health researchers who understood the research and agreed to provide introductions, or at least to allow the use of their name in initiating contact with the organisations. All indigenous organisations contacted approved access, following the same process. An initial meeting occurred with senior administrative staff. A formal request was subsequently conveyed to the Board of Director by either myself (three organisations) or by the Chief Executive Officer (one organisation).  The processes varied in length, from a six week to six months turn-around from initial contact to approval.

In all cases, the same protocol was followed. Information about the study was provided in writing and a commitment was made that: (1) the senior staff and Board members would be given the opportunity to review and comment on the draft case study report to ensure accuracy and ascertain that sensitive information was not being unduly disclosed; and (2) that a technical report summarising all findings would be produced in a timely manner and distributed to them. Some sites requested that copies of any publications be made available for their information.

### 3.3.3   The selected sites

For Australia, both case studies were located in the Northern Territory. This is a possible limitation of this study. The choice was made as a result of delays and complexities in dealing with ethical approval. Having said that, the issue of geography is not seen as a major limitation because the main source of funding and the government department having responsibility for funding ATSI health providers is the Commonwealth Department of Health. In New Zealand, each case study was conducted in a separate region.

### 3.4   Data collection and analysis

Most data were collected from July 2001 to June 2002 in Australia and July 2002 to April 2003 in New Zealand.  Funding for fieldwork was provided by the Canadian Fondation Ricard (http://www.fondationricard.com/boursiers.html).[31]  In both countries, the process for data gathering followed a similar path. The collection and analysis of policy document was conducted first. This was done to provide some context for the case studies. It also ensured an efficient use of fieldwork time, while awaiting approval for ethics and participation in case studies.

For each case study site, data collection occurred during a period of six weeks to two months spent on site. Sources of data included the minutes of every Board meeting since incorporation, minutes of health committees, participation in meetings (where possible), and the review of all funding contracts for a sample fiscal year, from July 2001 to June 2002 (the fiscal year in both Australia and New Zealand). Interviews and informal discussions provided additional context.

In general, and depending on the availability of the files to be reviewed (which may be used by others at the case study site), the process began with a detailed

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[31] La Fondation Ricard provides funding for secondary and tertiary education to French Canadians living in a minority situation. Although it favours recipients whose project is supported by the/a community, it was not engaged in defining the project, and had no vested interest in the results.

review of Board meeting minutes and detailed note taking. The purpose was two fold: first, minutes of meeting provided a detailed history and helped provide an orientation to the organisation, names of historical players and current Board and staff members, as well as developmental milestones. Since negotiating access to contract information and interviews are generally somewhat more sensitive, the process of reviewing minutes gave time for the researcher to get known which generally facilitated the process of trust building. Contractual information was generally reviewed second. Once a clear picture of the organisation emerged, gaps were identified and explored in interviews. Interviews were also used to explore themes that may have emerged in the policy review, and to identify their significance for the organisation.

A list of documents reviewed for the policy analysis and the case studies is provided in Appendix IV.

### 3.4.1   Data Gathering Plan

This research relies on a number of data sources. The relevance of each source, their selection and the process for analysing, are shown in Table 3.4, and explored in the following sub-sections. How the data sources related to the conceptual framework explored in chapter 2 is shown in Figure 3.1.

| | Questions | Methods | Data Source |
|---|---|---|---|
| | | | |

Table 3.4, Research Plan

| | Questions | Methods | Data Source |
|---|---|---|---|
| Context | 1. What are the historical factors that impacted the development of indigenous health policies? | Chronologies of key events (Treaties and other legal documents, legislations, history of state-indigenous reflections, shifts in political ideology) | Literature<br>Interviews |
| Policy formulation | 2. What values are apparent in policies?<br>3. Do policies more readily reflect indigenous aspirations, indigenous-state's historical relationship or other interests? | Policy analysis | Policy documents<br>Interviews |
| Policy implementation | 4. What are the apparent compromises made in the process of implementation?<br>5. What factors led to compromises? | Policy analysis over time | Policy documents<br>Interviews<br>Indigenous providers' minutes of board meetings |
| Practice | 6. Are indigenous providers able to exercise some control over key areas of decision-making?<br>7. What are the constraints on operations?<br>8. Is the contractual environment an accurate reflection of indigenous health policies or of the state practices in health contracting? Are compromises made to respect indigenous aspirations? | Decision-space analysis | Review of contracts for a sample of one year<br>Review of correspondence, minutes of meetings, and internal documents from time of incorporation<br>Interviews |

# Figure 3.1, Conceptual Framework

National Health Indicators

| COMPONENTS | OBJECTIVES | FOCUS OF INQUIRY | METHODS |
|---|---|---|---|

Central Government
(Regional Governments)

**Context**

To describe the historical and political context of state-indigenous relations, as they relate to questions of access to and delivery of health care services

History of relations
Societal values
Health Care System

Review of literature
Interviews

Government Department responsible for Indigenous health

**Policy formulation**

To analyse indigenous health policies, including the values they convey and mechanisms and processes they identify to implement their stated objectives

Indigenous Health Policy Analysis

Document analysis
Interviews

Government Departments responsible to implement indigenous health policies

**Policy Implementation**

To track changes and compromises made in the process of implementing indigenous health policies over time

Indigenous Health Policy Analysis
Administration over time

Document analysis
Interviews
Case studies

Community-based Indigenous PHC Organisations

**Practice**

To document the level of decision-making authority being transferred to Indigenous PHC services, including opportunities and contingencies

Contractual environment for Indigenous PHC Services

Framework adapted from Bssert

Health care consumers

Health Inequalities

94

### 3.4.2   Interviews

A total of twenty-seven unstructured interviews were conducted with key stakeholders in indigenous health and policy development, including government officials, senior administrators, Directors of the Board and historical players. The exact breakdown is provided in Table 3.5.

| Table 3.5, Interview conducted | | | | |
|---|---|---|---|---|
| Category | **OZ** | | **NZ** | |
| | # of interviews | Reference number in text | # of interviews | Reference number in text |
| Government officials | 4 | AU09, AU10, AU18, AU26 | 4 | NZ07, NZ23, NZ27, NZ28 |
| Senior administrators and directors of the Board | 7 | AU02, AU12, AU13, AU14, AU20, AU21, AU29 | 6 | NZ01, NZ03, NZ06, NZ08, NZ11, NZ16, |
| Historical players | 3 | AU05, AU15, AU22, | 3 | NZ24, NZ25, NZ30 |

The selection process for interviewees was somewhat opportunistic. In most cases, interviews were conducted towards the end of the document/contract review process. Requests were made in person, and a suitable time was scheduled. In the case of senior administrators in particular, time constraints limited the length and scope of interviews and interruptions occurred repeatedly. For individual case studies, all senior administrative staff was interviewed. In the case of government employees, access was limited by a number of factors including political caution, time constraints, and a limited opportunity for the interviewer to explain the purpose of the research and establish a relationship. In some cases, government employees contacted the researcher to consent to a meeting, after months of attempts at establishing contact. In a few cases, only a casual conversation was agreed to. These are not included in the above Table as a formal consent process and interview was not agreed to.

Key themes explored in interviews included:

- Key factors or events that led the government to begin to support community-based indigenous PHC initiatives, obstacles and debates;

- Role and vision of person being interviewed;

- Goal of government, vision, scope of responsibilities being transferred, opportunities in terms of service delivery and contingencies;

- How is the financing structured, how sustainable is this within the political landscape; and

- Can the services meet the needs of the indigenous population, what are opportunities, contingencies, how does this match indigenous aspirations for self-determination.

Interview guides are provided in Appendix III. These were used with flexibility. In some cases, the documentation analysed had already provided ample evidence on some themes, but other questions had arisen. In other cases, it was clear that the question was not appropriate for the person being interviewed, or that they had their own topic they planned to discuss. The interviews complement the documentation and analyses. They provide context and were sometimes used as a stepping stone for pursuing another line of inquiry.

The interviews were conducted to supplement and give context and meaning to key issues and fill gaps in the literature. They were analysed using NVIVO. All interview transcripts were anonymised. An attribute grid was created reflecting the country where the interview was conducted, the ethnicity, role and organisational attachment of the interviewee. Transcripts were thematically coded with a total of 343 free codes. Some of these were later merged as the concept they reflected dovetailed too much to justify separate codes. The majority of free codes were then classified under fourteen broad categories, including,

- Community and tribal issues;
- Participation;
- Government;
- Issues of community control;
- Funding and budget;
- Contract;
- History.

- Indigenous place – legal issues;
- Relational contract;
- Health services;
- Administrative issues;
- Health needs;
- Theoretical concepts; and

NVIVO allows for reports to be generated on specific or clustered codes that can then be analysed for patterns and prevalence. Coding reports were generated and analysed along themes.

### 3.4.3   Contract analysis

Funding contracts were read and notes were taken on a variety of issues, including purpose; type of funding (core, recurrent, project, one of); funding levels and terms; payment schedule and process; length of contract and scope; provisions for renewal, dispute resolution and amendments; standards and flexibility; reporting requirements and accountability framework; intellectual property rights; and any other particularities of relevance, such as mentions of a particular policy, obligation, legislation, treaty, etc. These specific provisions relate to those defined in the decision-space analysis adapted for this study (see Table 2.10). The information was entered into an Excel spreadsheet for comparison of provisions between contracts for a single organisation and a comparison of the contractual environment between organisations.

### 3.4.4   Minutes and other documents

For each case study, minutes of meetings from the time of incorporation, correspondence, internally produced documents and annual reports were reviewed. Detailed verbatim notes were taken on selected themes including:

- Relationship with government and funding agencies;

- Impact of health reform;

- Impact of system's changes;

- Issues related to funding;

- Relationship with union where applicable; and

- Issues related to governance.

A detailed reading of the material was done to identify recurring key themes. This information was integrated into the text of the case study reports and a reference quoted.

### 3.4.5   Synthesis: Analysing policy and implementation over time

Key portions of policy documents were analysed for objectives, recurrent themes in their justification and anticipated results. In each country, the most recent policy documents were secured. Previous policy statements as well as foundation documents were identified from recent policies and analyses of these documents, and copies were secured.

The retrievability of these documents was excellent. In Australia, a visit to the national library provided most relevant documents. The Commonwealth Aged and Health Care web site (http://www.health.gov.au/) was also helpful, as most policy documents are available electronically. Finally, a health policy timeline posted on the healthinfonet web site completed the list (http://www.healthinfonet.ecu.edu.au/). In New Zealand, the health librarian of the New Zealand Ministry of Health was extremely helpful in providing a crash course on New Zealand health policy development, locating original copies of all relevant documents and suggesting the name of key historical players.

Implementation was tracked through mapping out successive policy development, discussions and critiques appearing in the literature (more extensively developed in New Zealand) and through interviews with key historical players, current government employees and indigenous health providers. Indigenous providers' minutes of Board of directors meeting were very helpful in highlighting emerging issues, such as political pressures, in identifying how these were dealt with by

government and how these decisions impacted policy implementation and the indigenous provider.

### 3.4.6  Synthesis: Evaluating decision-making space

As discussed in chapter 2, the framework adapted from Bossert's decision-space analysis was used to evaluate the level of and constraints on providers' autonomy in meeting the needs of their culturally-defined constituency.

### 3.4.7  Strengths and limitations of sources of information

Each source of evidence collected for this study carries strengths and limitations. Overall, the case study-specific documentation accessed for this study was fairly comprehensive. All sites opened their files for consultation and extensive note taking. The investigator was able to freely access files and documents and select items for review. Retrievability was lower for one site only, and only with regards to its first year of operation. This was not seen as a significant problem. Selectivity bias remains a potential issue, because:

- Some pertinent information may not be written; or

- The information filed may not contain the full spectrum of information related to specific contracts.

However, any significant factor affecting the organisation or specific contracts is likely to be raised in Board meeting minutes or show in contract reporting and correspondence between the purchaser and the provider. Likewise, the retrievability of policy documents was high. However, the context of policy document production could only be partially reconstructed, mainly from the literature. While not crucial to the study, context may have helped predict sustainability.

| Table 3.6, Potential Strengths and Weaknesses of Sources of Evidence (adapted from Yin 1994) | | |
|---|---|---|
| | Strengths | Weaknesses |
| Case Study Specific Documentation | • Stable-was reviewed repeatedly;<br>• Unobstructive;<br>• Reliable: created independently from the study to communicate information to informed participants;<br>• Exact and extensive: include dates, names, details of events;<br>• Broad coverage: long life span, many events, | • Retrievability can be low;<br>• Potential biased selectivity;<br>• Reporting biases reflect biases of author;<br>• Access may be deliberately blocked. |
| Policy documents | • Stable-was reviewed repeatedly;<br>• Unobstructive;<br>• Reliable: created independently from the study;<br>• Broad coverage: long life span, many events, | • Retrievability can be low;<br>• Potential biased selectivity;<br>• Reporting biases reflect biases of author;<br>• The full context of production is not disclosed;<br>• Access may be deliberately blocked |
| Interviews | • Targeted: focuses on case study topic;<br>• Insightful: provides perceived causal inferences. | • Biases due to poorly constructed questions;<br>• Response bias;<br>• Inaccuracies due to poor recall;<br>• Reflexivity: interviewee gives what the interviewer wants to hear, or withhold information. |

### 3.4.8  Triangulation

Triangulation was conducted to ensure reliability. McDonnell et al discuss how using different accounts from different participants, and analysing multiple types of documents including minutes, policy documents, minutes of meetings, etc., generates "a multidimensional picture… created by an amalgam of perspectives" (McDonnell et al 2000, p. 387). A number of strategies were used for this study. Themes raised in correspondence or minutes were explored through interviews. Policy documents were explored through interviews, the literature discussing them, a review of the media where possible, and through the case studies in term of implementation. Some themes raised only in interviews were explored in other interviews. The case study reports, which contain some policy analysis as these relate to the experience of the indigenous health organisations, were reviewed by senior health administrators and Board members, some of whom were historical players involved in policy debates.

### 3.5  Relevance and Generalisability

This research project focuses on the place occupied by indigenous health organisations within the health care system of Canada, Australia and New Zealand. As

discussed in chapter 2, there remain significant gaps in the literature with regards to the link between policy and the performance of complex contractual environments. This research helps address some of these gaps. The research however has broader relevance, as it explores issues related to the organisation of primary health care services for vulnerable populations and contracting with non-government organisations.

Writing for this thesis occurred over a four and one half year period. Although all the material presented in this thesis was produced for this thesis, a number of publications drawing from this material have been published elsewhere. Lavoie (2003b) explores the value and challenges of separate health services through a discussion of the health transfer policy (discussed in chapter 2). Two publications explore some of the preliminary results of the cross-national analysis of the policy and contractual environments discussed in more depth in chapters 4, 5 and 6 (Lavoie 2003a, 2004). Kaufert and Lavoie (2003) explore issues related to the development of ethics guidelines in Australia and summarise the experience related with negotiating ethical approval in three countries.

The author's current work commitments include acting as the principal investigator in the national evaluation of the Canadian Health Transfer Policy. This commitment began in July 2003. All research presented in chapter 2 was completed before the beginning of this contract. This thesis has informed the national evaluation. The reverse is true only to a limited extent as the final report of the national evaluation is likely to remain under ministerial embargo until mid 2005.

At a time when indigenous people world-wide are advocating for some measure of self-determination (Ewen & The Native American Council of New York City 1994), and working towards the creation of an international network on indigenous health knowledge and development, international applied comparative analyses are of particular relevance. As of December 2004, eight seminars on this material have been delivered to policy makers in all three countries, by invitation.

# CHAPTER 4, INDIGENOUS HEALTH POLICIES IN AUSTRALIA AND NEW ZEALAND

This Chapter provides a cross-national analysis of indigenous health policies, as formulated in Canada, Australia and New Zealand. It attempts to answer three key questions:

1. What are the historical factors that impacted the development of indigenous health policies?
2. What values are apparent in policies?
3. Do policies more readily reflect indigenous aspirations, indigenous-state's historical relationship or other interests?
4. What are the apparent compromises made in the process of implementation?
5. What factors led to compromises?

Havemann suggests that international comparative analyses must be appropriately contextualised, taking into consideration the interdependence of internationalised discourses on indigenous rights, the history of indigenous-state relations and contextual specific phenomena (Havemann 1999d). The pursuit is nevertheless worthwhile. Havemann (1999d) and Armitage (1995) point out that international comparative analyses can be of use to first, provide some perspective on existing policies, and second, explore possible alternatives.

This chapter explores the processes of policy formulation and implementation in Australia and New Zealand, and contrasts these to Canada. The first two sections look at the emergence of Aboriginal Medical Services (hereafter referred to as ACCHS)[32] and of Māori providers respectively, and the policy development that ensued. The third section analyses the policies currently in place, paying particular attention to the analytical questions outlined above. The final section summarises the findings.

## 4.1 Australia: Background

In Australia, the origin of "by indigenous for indigenous" health policies appears to have been grounded in two national historical processes. The first was the election of a Labour Government in 1972 and its adoption of a policy of self-determination. This led to the Commonwealth Government taking over the responsibility for Aboriginal

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[32] Aboriginal Medical Services was the expression used at the time. Although still widely used, the current terminology is Aboriginal Community Controlled Health Services or ACCHS. ACCHS is used throughout the text for clarity.

Affairs, including ATSI health from the states. The visibility of ATSI issues increased tremendously as a result.

The second, which coincided with the first, was the emergence of community controlled ACCHS in the early seventies. This was the result of ATSI communities' mobilisation to ensure that some level of health services was accessible to an impoverished, marginalised and underserved Aboriginal and Torres Strait (hereafter ATSI)[33] population. The number of ACCHS grew over the next decade and now counts over 100. Eventually supported by policy and some core funding, it is clear from the onset that ACCHS were seen as complementary to existing state/territorial services. Their funding was and remains largely limited to project funding from vertical strategies. The ATSI community however uses ACCHS as the mechanism designed to make primary health care services accessible to them. Indeed, alternatives are lacking in many communities (Deeble et al 1998).

This perspective has now shifted as a result of research linking issues of equity and ATSI health care financing (Deeble et al 1998). The Primary Health Care Access Program (PHCAP) was endorsed in policy in 2003 (National Aboriginal and Torres Strait Islander Health Council & Australian Health Ministers' Conference 2003). It is now being rolled out. For the first time, Australia is promoting the implementation of a national comprehensive process to ensure that all ATSI people, whether urban, rural or remote, have equitable access to primary health care. This section will first explore the emergence of ACCHS in Australia. This will be contextualised with a discussion of the Australian health care system and followed by chronological review of ATSI health policy development.

### 4.1.1   ACCHS in the Australian Health Care System

The financing of the Australian health care system is anything but simple. As shown in Figure 4.1 (adapted from Organisation for Economic Co-operation and Development 1994), the system involves an interplay between public subsidies and market forces (Connelly & Doessel 2000, Donato & Scotton 1998). The Commonwealth Government funds the Health Insurance Commission whose role is to: a) administer Medicare, the national health insurance system; b) administer the Pharmaceutical Benefits Scheme; and c) provide grants to non-governmental organisations for health related projects. Medicare and the Pharmaceutical Benefit Schemes are financed through a combination of federal income tax (63%) and an

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[33] In Australia, the term indigenous applies to both the collective "Aboriginal people" and Torres Strait Islanders. The abbreviation ATSI has been adopted throughout the text.

earmarked (hypothecated tax) of 1.5% on income (27%) (Commonwealth Department of Health and Aged Care 2000).  Features of the Australian system include:

Figure 4.1: Australian Health Care Financing
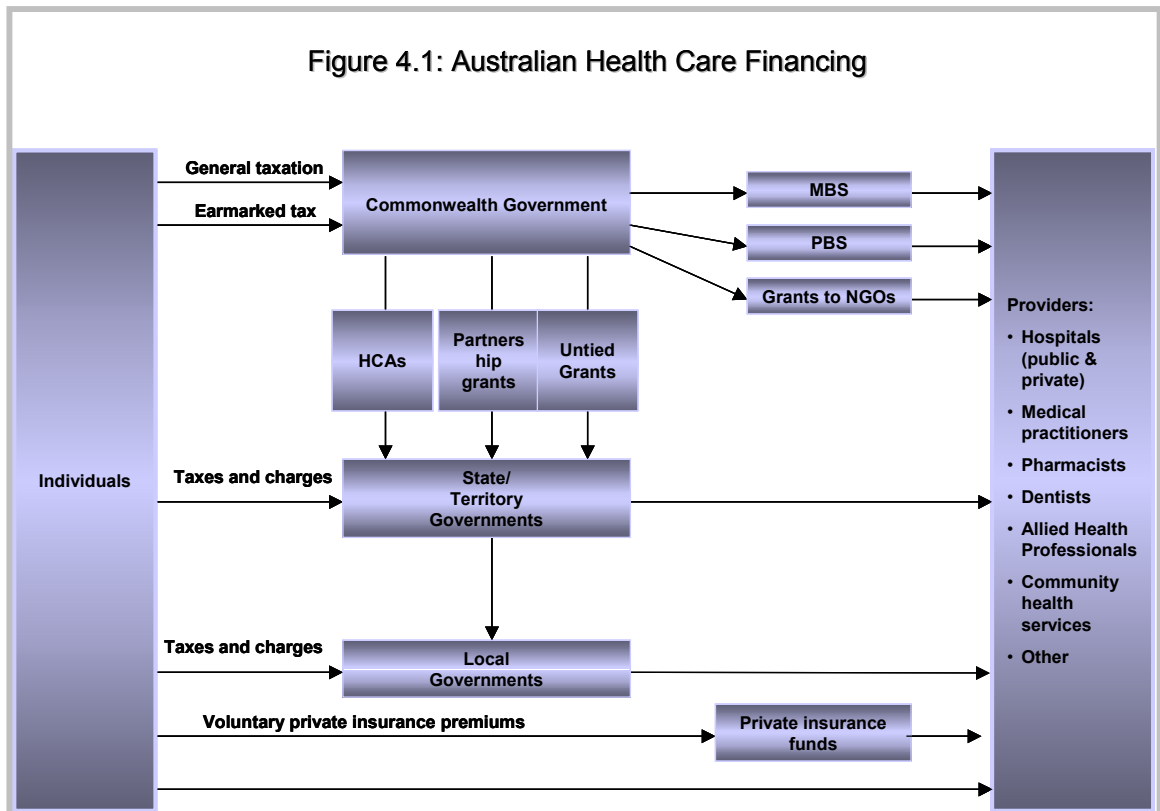


- Doctors are generally self-employed, especially in ambulatory care services. Hospital physicians may be salaried, although some opt to contract their services rather than being employed.

- In theory, Medicare covers 85% of the schedule fee for physicians.  Since the schedule fees are not compulsory, some doctors may only charge 85% of the schedule fee, leaving no out-of-pocket cost for the patient.  Alternatively, if physicians opt to charge above the schedule fee, patients must cover the difference either through direct payment or private insurance.

- Under Medicare, hospital care provided by a public hospital (or a hospital administered by a non-profit, non-governmental organisation but funded by the government) and pharmaceutical supplies dispensed in hospital are free.  Medicare refunds care obtained in private hospitals are the rate of 75% of the total cost.

- The Pharmaceutical Benefits Scheme subsidises the cost of medications by capping the cost to the patient.  The cap is a means-adjusted threshold and based on family income.

Two systems exist to access Medicare funding: patients may be required to pay 100% of the physician fee, and apply for a Medicare refund which is unlikely to cover 100% of the initial cost; or alternatively, some physicians have the option of "bulk billing" Medicare directly to the Commonwealth government.  Under this second option, physicians are prohibited from charging over the Medicare refunded fee.  Voluntary private insurance is available, its utilisation vigorously encouraged, and generally used

to top up services covered under Medicare, such as access to private hospitals. Purchasers of private insurance receive a 30 percent subsidy (Commonwealth Department of Health and Aged Care 2000, Organisation for Economic Co-operation and Development 1994).

At the state/territorial level, the Australian Health Care Agreements (hereafter HCAs) provide the mechanisms to finance the delivery of hospital services (Galbally 2000). Public health programming has historically been the realm of states and territories, with strategies funded out of the Base Health Care Grants. Each state and territory has its own public health legislation, although the Communicable Diseases Network Australia New Zealand (CDNANZ) has been coordinating the National Notifiable Diseases Surveillance System (NNDSS) since 1990. Historically, the states and territories have tended to favour vertical strategies for health promotion and prevention, rather than providing broader-based funding to NGOs and local organisations to develop comprehensive strategies (Galbally 2000).

The private sector has always been a part of the Australian health care system and has grown since the implementation of Medicare. Like the UK and New Zealand, Australia enthusiastically adopted the ideology of *economic rationalism* in the late 1980s. Evidence of this ideological commitment can be seen in the adoption of the funder-purchaser-provider split as the principle of health care resource allocation and delivery (Somjen 2000).

Given the largely decentralised constitutional model in place in Australia, each state and territory have been free to develop their own medical system following local ideology. In New South Wales and Queensland, the state governments have established a regional health care system with centralised purchasing and providing roles. In South Australia and Victoria, a purchaser/provider split model with output-based funding has been implemented (Somjen 2000). Access to private hospitals has remained an option subsidised under Medicare. The public interest in private hospitals has been looked upon as an opportunity by the state governments to harness private capital in health care delivery. Private hospital admissions now account for nearly one third of all acute admissions (Foley 2000). A number of public hospitals have been privatised since 1994.

The Northern Territory health care system has to-date been challenged with a scarcity of providers, and seriously underserved populations. Three recent studies by Bartlett et al (Bartlett et al 1997, Bartlett & Duncan 2000) and Wakerman et al (1997)

have shown that the system has been far from seamless.[34] The Northern Territory also experimented with the purchaser-provider split from 1999 onward (Australia Territory Health Services 1999). It now appears that this has been abandoned altogether under the leadership of the NT Labour government elected in October 2001.

Theoretically, all Australians can access care through the Medicare financed system. Despite documented higher health care needs, Deeble et al (1998) reported a much lower Medicare and Pharmaceutical Benefits utilisation rate by ATSI people and a higher utilisation of state-funded services. This is shown in Table 4.1. This implies a higher secondary and tertiary care utilisation rate over primary health care. The reasons for this are numerous. First, general practitioners play a gate-keeping role in the Australian health care system. In remote environments, where general practitioners are unlikely to be found, access to Medicare is simply nil. Second, accessing doctor services may simply not have been prioritised early in the onset of illness. Third, Medicare can only be accessed with a unique, personal Medicare number. This is secured through a process of enrolment, which was developed largely on the assumption that new registrants are immigrants. Many ATSI people however have historically relied on services offered to them by the state or territorial governments, and have never required registration. Others have faced obstacles linked to transience or problems with identification (Young 1997).[35] In areas where there is no general practitioner, state and territorial governments have opted to set up clinics staffed by nurses, thus financing activities that are generally paid for by the Commonwealth government for the general population (Bartlett et al 1997, Bartlett & Duncan 2000). The Northern Territory Public Accounts Committee documented the situation in 1995, showing that this model of health care financing has been particularly inadequate for the Northern Territory (Australia Legislative Assembly of the Northern Territory Public Accounts Committee 1996).

The Australian health care system was designed to serve the needs of the Australian majority. It was never designed to address the sparsely populated, highly marginalised ATSI communities (Deeble, 2001).[36] It is in this context that the ACCHS emerged in the early 1970s, capturing the imagination of many academics,

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[34] The 2000 study identified 3,690 people living in the top end of the NT, representing 8.6 percent of the population, as having no access to primary health care delivered by either a general practitioner, a nurse or an Aboriginal Health Worker.

[35] The requirement for identification is generally served by a birth certificate. This document is however not a given for Aboriginal people from more remote communities.

[36] This was a public statement was made by Professor Deeble in October 2001, at the office of the National Centre for Epidemiology and Population Health. Professor Deeble is acknowledged as the creator of the Australian Medicare system.

professionals, and community activists, ATSI and non-ATSI alike. ACCHSs created much hope that community-based decision-making was the solution to improving ATSI health. Stories of their emergence revolved around themes of resistance against adversity, lack of collaboration and governmental funding, success in implementing innovative strategies, hard work and dedication (Briscoe 1974, Campbell & Ellis 1995, Carter et al 1987, Crawshaw & Thomas 1992, Fagan 1991, Foley 1982, Fulton 1985, Saggers & Gray 1991, Waterford 1982). The growth of the sector marked a shift in power between state/territorial health departments and the ACCHS (Scrimgeour 1997). Passion continues to permeate discussions over their value, yet the area has remained remarkably unscrutinised with the notable exception of Nathan (1980) who provides the only empirical case study of an ACCHS.

| Table 4.1, Gross expenditures per person, ATSI and non-ATSI people, through publicly subsidised programs 1995-96, by program (Deeble et al 1998) | | | |
|---|---|---|---|
| | Abor. | Non-Abor. | Ratio Abor/ Other |
| Delivery | $ | $ | |
| Through state and local government | 1,763 | 806 | 2.20:1 |
| Through Medicare/PBS | 128 | 535 | 0.24:1 |
| Through ATSI health organisations & other Commonwealth programs | 344 | 213 | 1.62:1 |
| Total | 2,235 | 1,554 | 1.44:1 |

The first ACCHS was set up in the urban centre of Redfern (a suburb of Sydney, NSW) in 1971, Fitzroy (near Melbourne, VIC) followed in 1973, and Perth (WA) in 1974. In the NT, the Central Australia Aboriginal Congress was set up in 1973 and began to offer health services in 1975. These services operated under the direction of an ATSI Board of Directors, offered primary health care and functioned with volunteer staff (including physicians, nurses and community staff) securing rent and other necessities with in-kind donations. Commonwealth funding came later. Their goal was to provide accessible and appropriate health services. Some have expanded over the years, while others have retained their original clinical care focus. Recognising the need for a common voice, ACCHS supported the creation of the National Aboriginal and Islander Health Organisation (NAIHO) in the mid 1970s (Scrimgeour 1997). Following some factionalism and reported administrative difficulties, NAIHO was replaced by the National Aboriginal Community Controlled Health Organisation (hereafter NACCHO) in 1992. State and territorial "peak bodies" (state and territorial ATSI health organisations) emerged thereafter. The movement has grown remarkably since it first emerged in 1971 with ACCHSs in each state and

territory, operating in both urban and remote environments. New member organisations have been added every year.

In effect, the ACCHS movement has provided "patches" in a health care system that was far from seamless for ATSI people. Although the number of ACCHS has increased over time, counting over 100, there remain areas where these services are not offered. Further, ACCHS are able to offer the services for which they can secure funding. Although they play an important role, they have historically remained peripheral to the overall health care system.

### 4.1.2 Chronology of ATSI health policy development

The Australian distribution of powers between the state, territorial and Commonwealth governments has followed a distinct path to that of Canada creating other opportunities and challenges alike. The creation of Australia was really a coming together of separate colonies who wished to retain considerable autonomy. ATSI affairs thus remained the realm of the states, rather than the Commonwealth. In theory, each state had its own approach to ATSI health. In effect however, the practices ranged from benign neglect to coercive public health measures (Briscoe 1996, Harrison 1997, Hetzel 2000, Hunter 1993, Jebb 1984, MacLeod & Denoon 1991, Maguire 1991, May 1991, Reid 1990, Reynolds 1982, Ring & Elston 1999, Saggers & Gray 1991). By the 1960s, attitudes were shifting at all levels of the Australian society, leading to legislative changes to end discriminatory practices. Voluntary voting was extended to Aborigines in 1962. Constitutional changes in 1967 gave the Commonwealth government the authority to make laws in relation to all ATSI people. By the same token, the Commonwealth government was given the authority to enumerate Aborigines in the yearly national census, a power that had been constitutionally denied since 1901 (Thomson 1984).

ATSI health first became a national priority in 1968 with the establishment of the Commonwealth Office of Aboriginal Affairs. From 1968 onward, government's responsibility for ATSI health shifted six times before finally landing with the Commonwealth Department of Health & Aged Care in 1995. In the Northern Territory, the Commonwealth government was theoretically exclusively responsible for Aboriginal health from 1911 until 1978. In the states, ATSI health program delivery initially remained a state responsibility with funding from the Commonwealth. At that time, ATSI access to health care services was limited by a number of factors. Services were available in some mission settlements, but for a majority of Aborigines living in remote environments, access to treatment was sporadic and linked to the Royal Flying Doctor Service. Elsewhere, economic limitations made access impossible because of a lack

of transportation (Kamien 1975). When transportation was available, direct charges for hospital and physician care added difficulties. Prior to Medicare, health financing schemes had been linked to employment, and therefore disadvantaged the poor and the unemployed. Applying for the exemption to secure access to free health care apparently proved a complex bureaucratic undertaking (Saggers & Gray 1991).

By 1972, the Labour Party was elected to office and self-determination became the official policy. Aboriginal Affairs had been part of the Labour Party election platform and following the election, Commonwealth expenditures on Aboriginal Affairs doubled. The Office of Aboriginal Affairs was replaced by the Department of Aboriginal Affairs (DAA). DAA continued with the State grants, but also initiated direct grants to the emerging ACCHS. Initially, self-determination was portrayed as creating opportunities for ATSI communities to decide the pace and direction of their future development. Eventually, self-determination crystallised as self-management of governmental schemes and projects for Aborigines with possibilities for input in planning, development and implementation.

In 1973, the Commonwealth Government offered State Ministers to assume full responsibility for ATSI affairs policy and planning. All accepted with the initial exception of Queensland. The Department of Aboriginal Affairs was thus finally given the central authority over ATSI policy. Self-determination in matters of health care came to mean the transfer of funds from the Commonwealth Government to ACCHS. This was identified in *The Ten Year Plan for Aboriginal Health,* which had as an objective to "raise the standard of health of the Aboriginals of Australia to the level enjoyed by their fellow Australians" (cited in Saggers & Gray 1991). A House of Representatives Committee on Aboriginal Affairs (with no ATSI representation) was established shortly after, reporting mostly on the status of Aborigines but making no comment on the effectiveness or accessibility of health services. It did however criticise the states, who since 1972 had received increased funding for ATSI health initiatives. According to Saggers & Gray:

> *While the states asserted their* constitutional *responsibility for Aboriginal health, they had not accepted* financial *responsibility for the provision of Aboriginal health programs (1991, original emphasis).*

Meanwhile the Commonwealth Government was actively pursuing the consolidation of its role in ATSI health. By 1984, the responsibility for all Commonwealth ATSI health programs, including the Department of Health's role in the funding of some ACCHS, was established within the Department of Aboriginal Affairs. It is in this context that, in 1987, an attempt was made to develop a national Aboriginal health strategy with the formation of the National Aboriginal Health Strategy Working Party, chaired by Naomi

Myers, of the National Aboriginal and Islander Health Organisation and Director of the pioneer Redfern-based ACCHS.[37]  The National Aboriginal Health Strategy (hereafter NAHS) report was released in 1989 making recommendations in three broad areas:

- Improving ATSI services by establishing minimum standards of delivery, promoting the transfer of state/territorial services to ATSI control and ensuring adequate funding;

- Improving essential services and community infrastructure; and

- Improving education, training and employment opportunities for ATSI people in ATSI health.

The strategy also recommended the development of,

- A Council of Aboriginal Health, set up as a standing committee to both the Australian Ministers' Conference and the Australian Aboriginal Affairs Council, consisting of community representatives and officials;

- Tripartite Forums in each state and territory with representation from the Commonwealth, state/territorial and ATSI community; and

- An Office of Aboriginal Health within the Commonwealth Aboriginal Affairs portfolio.

The purpose of these bodies was to ensure meaningful ATSI participation in policy and program development.  Anderson (1997b) provides a detailed review of the NAHS implementation.  In essence, the NAHS' commitment to what Anderson calls *tripartism* (Commonwealth, state/territory and the ATSI health sector) in ATSI health, with its lack of a clear jurisdiction and accountability, was responsible for the initial claim of failure (Anderson 1997b, Evaluation Committee 1994).  By 1994, the Council of Aboriginal Health had yet to truly function. The Aboriginal and Torres Strait Islander Commission (ATSIC),[38] established in 1990 to replace the Department of Aboriginal Affairs, and tasked with securing matching grants from the State and Territorial Governments, was stalling.  The 1994 evaluation of the NAHS simply recognised that the strategy was never effectively implemented.  It again called for improved access to funding for the ACCHS sector and increased intersectorial collaboration (Evaluation Committee 1994).

One of the main issues being debated around that time was ATSIC's ability to manage ATSI health.  Funded for ATSI health, ATSIC's funding could but provide project-based funding and ACCHS were expected to apply for funding yearly, on a

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[37] This service was the first Aboriginal controlled health service to open its doors in 1971.

[38] ATSIC is a statutory authority of the Commonwealth government, and continued to deliver the programs of the former Department of Aboriginal Affairs.  The Commission functions under the guidance of an Aboriginal elected body who designs policies and direct resource allocation.

competitive basis.  Although the debate took some unfortunate turns,[39] one core issue was that funding for ACCHS was limited and remained disconnected from Medicare and other health care funding allocated to the Commonwealth Department of Community Services and Health, and by extension, to state governments.   The campaign to move funds from ATSIC to the Commonwealth Department of Health was orchestrated by the ACCHS sector, which saw this move as the only option available to access appropriate health funding through ATSI and other sources, namely the Medical Benefits Scheme (MBS).   The issue was particularly critical in remote communities, because the absence of general practitioners meant that Medicare funding was inaccessible (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1994c, Interview 0020)

The transfer of responsibility for ATSI health from ATSIC to the Commonwealth Health Department was completed in 1995, under the Office for Aboriginal and Torres Strait Islander Health Services (OATSIHS).[40]   With it came a shift in focus, from funding ACCHS for projects, to incorporating ACCHS into the overall Australian health care delivery system.  ACCHS began to receive some core funding. Recommendations made in the 1989 NAHS were revisited. In 1995, each Australian Health Ministers negotiated a Framework Agreement state/territorial ACCHS peak bodies, State/Territorial ATSIC representatives and the Commonwealth Department of Health. The Framework Agreements required the establishment of Health Forums in each jurisdiction with representatives from each of the signatory bodies, namely the representatives from the Commonwealth Department of Health (OATSIH), the state or territorial Department of Health, ATSIC and the state or territorial ACCHS peak body. The forums were designed to act as regional joint planning processes tasked with the identification of gaps in service provision and defining priorities (Australia National Health and Medical Research Council 1996). By the end of the year, Framework Agreements had been signed in all with the exception of Tasmania and the Northern Territory, who signed in 1998 (HealthInfoNet 1999).

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[39] Personal attacks were prevalent. See for example the Koori Mail of March 23, 1994 (1994a).

[40] It appears that ATSIC may have retained some responsibilities some responsibilities over Aboriginal health. In 2001, ATSIC released an Aboriginal Health Policy, speaking to the need to address health inequalities and promoting community controlled health services (Aboriginal and Torres Strait Islander Commission 2001). The policy was remarkably silent on a number of key developments, including PHCAP (discussed below). The policy appears to have remained largely unnoticed, and is not referred to in OATSIH Aboriginal Health Frameworks (Aboriginal and Torres Strait Islander Commission 2001, National Aboriginal and Torres Strait Islander Health Council 2001, National Aboriginal and Torres Strait Islander Health Council & Australian Health Ministers' Conference 2003). ATSIC was dismantled in 2004.

In 1996, the Commonwealth Minister for Health announced the establishment of the Aboriginal and Torres Strait Islander Health Council, a national health advisory forum complementing the state/territorial forums. In addition, a national level Joint NACCHO/Departmental Working Group was established in 1997 to review current arrangements for ATSI access to Commonwealth health program funding. These processes had first been proposed in the 1989 National Aboriginal Health Strategy (Australia National Aboriginal Health Strategy Working Party 1989).

The Primary Health Care Access Program (PHCAP) was announced in the 1999-2000 Commonwealth budget. Its origin will be explored in more detail in the Katherine West case study in chapter 5. The implementation of PHCAP requires the carving of Australia into regions where an ATSI regional health board would be funded with pooled Commonwealth and state/territorial primary health care funding to provide services following local priorities and in a manner deemed as appropriate by the Board. The level of funding provided by the Commonwealth is based on the average Australian Medicare expenditure multiplied by two in acknowledgement of higher ATSI needs and by another factor of two if remote. As a model, PHCAP is a potentially remarkable change and stands to have significant repercussions for ATSI Australia. PHCAP has three objectives:

- Increase the availability of appropriate primary health care services where they are currently inadequate;

- Reform the local health care system to better meet the needs of ATSI people; and

- Empowering individuals and communities to take greater responsibility for their own health (Bartlett et al 1997).

What is innovative is the pooling of funding from state/territorial and federal health sources, including Medicare dollars that have historically not been accessible to ATSI people, for reasons previously mentioned. The Board may opt to remain a purchaser of services, or to carry both the functions of purchaser and provider.

Implementing PHCAP is however a complex process (Interviews AU02, AU05, AU10, AU18, AU20, AU26). In the Northern Territory, a total of 21 zones were defined based on two studies, one for Central Australia (Bartlett et al 1997) and one for the Top End (Bartlett & Duncan 2000).[41] The primary health care resources and needs were mapped out, and priority zones for PHCAP development were selected. In Central Australia, five zones were selected as priorities for PHCAP implementation, based on

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[41] These two studies are really an environmental scan of (lack of) services availability in the NT. They make for remarkable reading, with some communities as late as the mid nineties receiving visits from a flying medical officer once or twice a year, and no other forms of health care services (Bartlett et al 1997, Bartlett & Duncan 2000).

highest needs and the scarcity of available services. This task was completed in 1998. At the time of writing, the development of zone strategic plans for primary health care are in their infancy, and PHCAP fatigue is prevalent.

As shown in Figure 4.2, the structure and process adopted for the implementation of PHCAP is remarkably complex, involving three layers in the decision-making process. Each layer brings together the four main stakeholders and members of the Health Forum: the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT, the territorial ACCHS peak body), the Aboriginal and Torres Strait Islander Commission (ATSIC), the Territorial Health Services (THS) and the Commonwealth Department of Health & Aged Care (DHAC). While each layer may very well be essential to the successful implementation of PHCAP, there are some sticking features to this structure. First, it is remarkably complex when one considers that an organisation like AMSANT is relatively small, and that the total NT ATSI population to be served in the 21 zones identified is around 50,000. Thus, the multiplicity of roles adds a considerable workload to relatively few staff within this organisation.

Second, the program literature on PHCAP speaks to the role of each individual partner (THS, OATSIH, AMSANT and ATSIC). Two main issues remain unclear:

- The roles and responsibilities of each layer represented in the structure are not defined; and

- The timelines and output expected from each layer are also not defined (Aboriginal and Torres Strait Islander Health Forum 2001a, 2001b, 2001c).

Third, there are concerns that the discussions to date have been spent in meetings dealing with higher issues, and that zone issues, including capacity building, have been left to be dealt with later (Interviews AU05, AU20, also raised in many informal discussions). According to the PHCAP literature, consultants hired by OATSIH were allocated 3 to 6 months to come up with zone plans. What seemed to have occupied the planners could perhaps be qualified as consensus building. This of course is necessary. But a concern that recurred in interviews was that community members who were to be helped by this "community controlled" initiative had not been integrated into the process. Another concern is that PHCAP is now absorbing all energies. Although it is progressively being rolled out, a full implementation will take some time. Fifteen years after it was announced, the Health Transfer Policy, a PHCAP-like model, has been successfully rolled out to 67 percent of eligible communities (Health Canada 2001). Medium term solutions may be required. Because it is seen as the solution, reflections on immediate and intermediate solutions for low priority PHCAP zones have not been discussed.

Australia's most recent health policy position is the 2003 *Aboriginal Health Strategic Framework*, a product of the National Aboriginal and Torres Strait Council. The document has reasserted the 1989 *National Aboriginal Health Strategy*'s commitment to ATSI community controlled primary health care services, naming the new Primary Health Care Access Program and making a commitment to supporting the development of ATSI Health Boards. It notably goes beyond primary health care and identifies the need for the whole health care system to become more responsive to ATSI health. The document was signed by all state and territorial Health Ministers (National Aboriginal and Torres Strait Islander Health Council & Australian Health Ministers' Conference 2003).



**Figure 4.2: Primary Health Care Access Program - NT Implementation Structure**
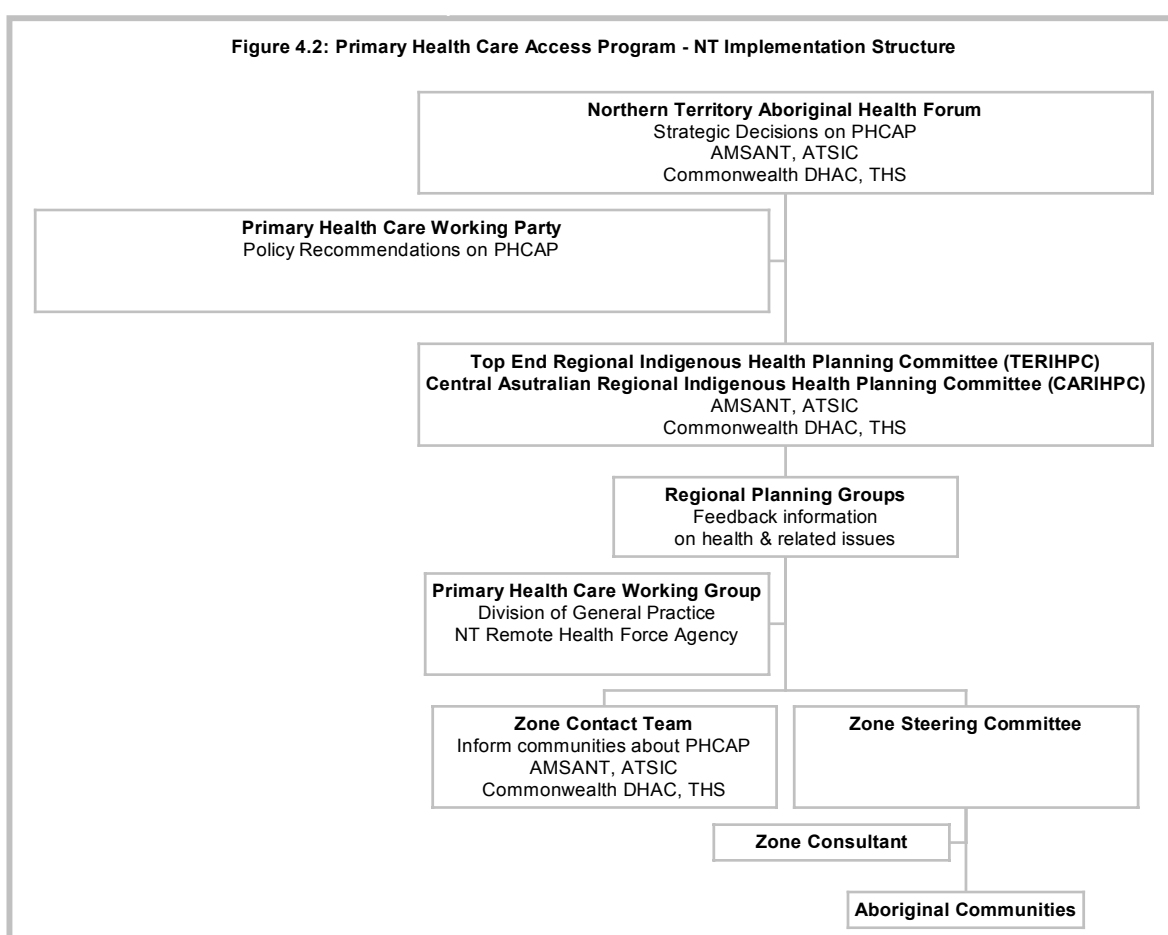
This was followed on April 1st, 2004, by Parliament announcing the demise of ATSIC. As a result, ATSIC's portfolio, which included all ATSI-specific programs with the exception of health, has been distributed across thirteen Commonwealth Government Departments. An Office of Indigenous Policy Coordination will be located

within the Department of Multiculturalism and Aboriginal Affairs.[42]   While the mainstreaming of ATSI programs may be construed as a step backward, it also removes ATSI services from the realm of projects, and places them within existing program frameworks that are usually better funded. The shift from ATSIC-managed ATSI health projects to the Commonwealth Department of Health in 1995 has yielded positive policy commitments. The engagement of 13 separate Commonwealth Departments and their state/territorial counterparts is however likely to create coordination and consensus building challenges.

### 4.1.3   Summary

In summary, Australia has progressively moved from mainly state-delivered policies of either benign neglect or control, to the promotion of ACCHS as a mechanism to provide more appropriate health services. The process has evolved largely in answer to ATSI pressures. ACCHS emerged in the early 1970s. The National Aboriginal Health Strategy (NAHS) was adopted in the late 1980s. Since, ACCHS have been endorsed and promoted in official policies as a key solution to improve ATSI health. The implementation of the NAHS was largely delayed until the Commonwealth Department of Health took over the responsibility for ATSI health in 1995.

PHCAP is emerging as the new strategy to improve ATSI health and access to health care. It is an ambitious policy shift. If implemented as planned, ATSI controlled health services will change from playing a role of patch in the system, to that of being an integral part of the system, with stable funding. This policy appears to be supported by the Commonwealth, state and territorial Health Ministers, and has been well received in the ATSI community. This may reflect nearly thirty years of ATSI advocacy and consensus building. While support now exists at the political level, implementing PHCAP will require yet more localised consensus building, creating other challenges.

### 4.2    New Zealand

Like Australia and Canada, New Zealand has opted to promote the development of indigenous-led primary health care. In contrast to Australia and Canada however, New Zealand has resisted pressures by Māori to set up a separate funding avenue for Māori services. Māori providers emerged in the 1990s following the implementation of the purchaser-provider split. Thereafter, they began to compete for funding alongside other providers. The Ministry of Health reports that the sector grew from 23 providers in 1993 to 240 in 1998 (New Zealand Te Puni Kökiri 2000). The rapid

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[42] This information can be read on the ATSIC website, at http://www.atsic.gov.au/ATSIC_ATSIS_Closure/Default.asp.

growth of the Māori health sector has created challenges, many of which can be linked to a revolving reform process that has taken New Zealanders through four major health care reforms in a period of twelve years.

The most recent reform is shifting the focus of the system from competition to a more systematic deployment of primary health care funding, associated with regionalisation and the consolidation of primary health care providers under the umbrella of Primary Health Organisations (PHOs). Despite a policy that continues to support the development of Māori providers, some have expressed some fear that the emerging PHOs may in fact challenge their existence (Interviews NZ11, NZ16). This section focuses on the emergence of Māori health providers and the development of Māori health policy.

### 4.2.1   Historical context

The settlement of New Zealand followed a different path from that of Australia and Canada. As the last colony to be settled, the colonial government was committed to avoid the violence documented in Australia, and the complexities of the reserve system established in Canada and the United States. Integration rather than marginalisation became the objective. The Treaty of Waitangi was signed in 1840 between the Crown, the Governor and around 500 Māori Chiefs.  The need for a Treaty had been discussed by the Crown for a few years prior to signature.  Moon contends that from the Crown's perspective, the impetus for the Treaty was the need to regulate and protect its British citizens living in New Zealand and to exert territorial sovereignty (Moon 1999).  Discussions leading up to the Treaty made no mention of extending the protection of British common law to Māori.

From 1840, the imperial government adopted a policy of "racial amalgamation", conferring certain legal and civil rights to Māori while selectively incorporating them into European institutions.  It appears that the goal was to ensure the achievement of colonial ends peacefully and to avoid the costs of military interventions, while appeasing philanthropic interests in London.  Hospitals were set up using colonial funds in Auckland, Wellington, Wanganui and New Plymouth.  These were non-segregated and accessible to both Māori and Europeans, a phenomenon Nicolson believes was unique in the history of British colonial administration (Nicolson 1988). The overall goal of the policy of racial amalgamation was to integrate Māori, while buying up land and ensuring the peaceful settlement of New Zealand. The education of Māori in European ways was prioritised. The anticipated result was that of a monocultural European country. Still, the strategy yielded some benefits, including four

seats reserved for Māori to ensure representation[43] in Parliament, some forums for Māori participation in health care and better educational attainment. These provisions have no real equivalent in Australia or Canada (Dow 1995, 1999, Durie 1998a, 1998b), but nevertheless fell short of Māori aspirations for a parallel government. The Treaty of Waitangi remained largely ignored for many years.

The seventies proved a time of rapid changes. The Treaty of Waitangi Act 1975 was passed by parliament, thereby removing the implementation of the Treaty from the realm of policy and providing a mechanism to resolve disputes. Māori were increasingly more vocal about the need to link culture and health. This led to Māori conferences, health promotion campaigns and community health initiatives, including the 1984 *Hui Whakaoranga* that recommended increased Māori participation (New Zealand Ministry of Health 1984). While Māori argued that health could be described as *taonga* [cultural assets], and therefore protected under article two of the Treaty, this interpretation was rejected by the New Zealand government, which argued that its responsibility in matters of health care was the same for all citizens. Although the debate did not lead to separate services, it has provided a solid base for Māori to argue for "a fair share of society's benefits" (Durie 1998b) including health.

The 1988 policy statement *Te Urupare Rangapū* (Wetere 1988) made an unprecedented and never repeated commitment for the Crown to enter into partnerships with *iwi*, which, under the policy, would be tasked and funded to deliver services on the Crown's behalf. *Iwi* were to be formalised as legal corporations under the short lived *Runanga Iwi Act 1990*. The Act was a response to increasing demands for the recognition of a Māori's system of governance in New Zealand politics, reflecting Māori aspiration for *tino rangatiratanga* [self-determination]. Although the Act was repealed the same year it was passed,[44] its influence on policy remains.

A Board of Health Standing Committee on Māori Health had been set up in 1984 to advise on policy. It was replaced by a Ministerial Advisory Committee on Māori Health in 1989. Both initiatives were short lived and had limited success, but eventually led to the current structure of the Māori Health Directorate located within the Ministry of Health, in place since 1993 (Durie 1998b). The commitment to a partnership between the Crown and Māori had been diluted considerably. The Crown has now adopted a fairly narrow view of the Treaty of Waitangi, with a fluctuating recognition of the *iwi* as

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[43] Albeit at a lower level that demographics might allow.

[44] By focusing on the *iwi,* the Runanga Act had failed to provide a mechanism to represent the interests of Maori unaffiliated with an *iwi,* and/or living in urban environments. The tension between *iwi*-based governance structures and the pan-*iwi* reality of urban Māori is not new. A satisfactory solution remains to be found.

the centre of Māori participation. The Treaty-based health policy advocated for by Māori has yet to emerge.

### 4.2.2   Background to the Development of Māori Providers

New Zealand's national health care system was first set up in 1938 through the Social Security Act, providing free and universal access to general practitioners, hospitals, pharmaceutical and maternity services.  The health care system hinges on the government acting as the single public payer for health services.  At the same time, the provision of services remained largely in the hands of the private sector, with 261 private hospitals and medical, pharmacy and laboratory services.  While the number of private hospital beds would initially diminish following the implementation of the Social Security Act[45] from 22 percent in 1938 to 15 percent in 1949, it was recognised that private hospitals drew less on the public purse.  The 1957 Hospitals Act was to support higher subsidy to private hospitals, thereby entrenching a dual hospital system (Dow 1995).  From the time the Act was implemented, the New Zealand government recognised that cost control would be an issue.

By the early 1980s, state funding was mostly for the young, old and heavy adult users.  Out of pocket payments and private insurance reimbursement were the main source of payment for services for the majority of New Zealanders (Borren & Maynard 1993). An economic downturn coupled with rising cost led to the introduction of more cost cutting measures in the 1980s. From then on, New Zealand embarked on a series of reforms, each leading to a shift in the authority responsible for purchasing primary health care services, namely the Area Health Boards (1983-1993), the Regional Health Authorities (1993-1998), the Health Funding Authority (1998-2000) and the District Health Boards (current).  This is detailed in Table 4.2.

The decentralisation to 17 Area Health Boards (AHB) was intended to provide local co-ordination of public health and hospital care. The idea was first introduced by the Labour government following the 1972 election. Implementation was however stalled by an overwhelming lack of support from the medical profession, small hospital boards, voluntary agencies and the private sector. Implementation was completed in 1983. Physicians were left to operate on a fee-for-service basis (Gauld 2001). The AHBs marked the beginning of community participation in health care planning.  The Labour Party was re-elected in 1984 and continued with the implementation plan, albeit with a closer look at integration. It took another 6 years to bring all hospitals under the

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[45] One reason for this decline was that public hospitals offered unfair competition.

umbrella of the AHBs (Clark 1989) and for the government to fully define the relationship between the Ministry and the AHBs (New Zealand Ministry of Health 1989).

Figure 4.3: New Zealand Health Care Financing
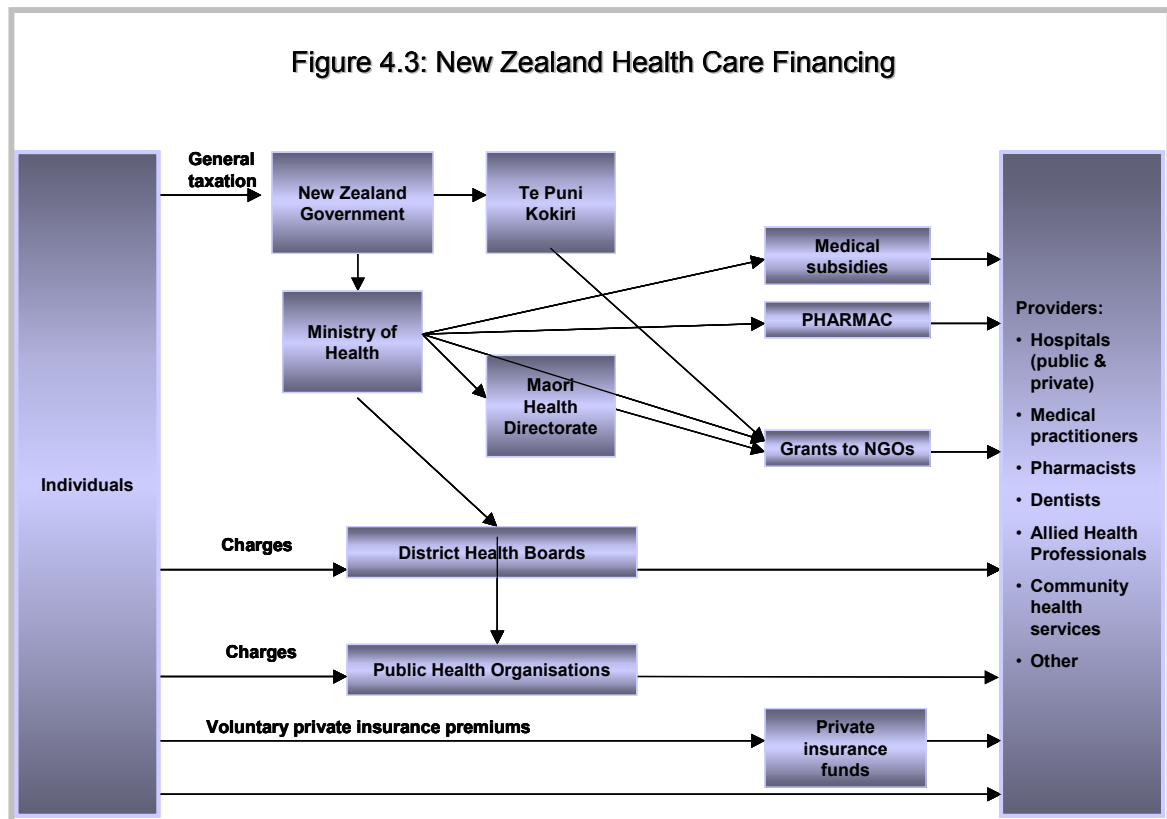


By 1983, the Department of Health began to subsidise Māori community health centres.  These centres were expected to be community-based, community-staffed and community-controlled. Implementation required a substantial training component for staff (van Meijl 1993).  As will be discussed in chapter 5, Te Runanga O Raukawa (TROR)'s health services emerged as a result of this initiative. The services provided were limited to the hiring of Māori Health Workers to act as liaison in the system (Interview NZ16, Te Runanga O Raukawa Inc. 1994). Funding was available on a yearly basis and provided limited capacity building and administration. This marked the beginning of Māori organisations' participation in health care delivery (Durie 1987).

| Table 4.2, Health funding bodies through the reforms (Gauld 2001) | | | | | |
|---|---|---|---|---|---|
| Era | Party in power | Leading Ideology | Authority | Number nationally | Billing |
| 1972-1975 | Labour Government | Regionalisation Rationalisation | Area Health Boards under planning | | |
| 1975-1983 | National Government | Regionalisation Rationalisation | Area Health Boards under planning | | |
| 1983-1993 | Labour Government (1984) | Regionalisation Rationalisation | Area Health Boards | 17 | Regional authority |
| 1993-1997 | National Government (1990) | Privatisation Competition | Regional Health Authorities | 4 | Regional authority |
| 1997-1998 | New Zealand First-National Coalition (1996) | Public Administration Status quo | Transitional Health Authority | 1 | National office |
| 1998-2000 | New Zealand First-National Coalition (1996) | Public Administration Competition | Health Funding Authority | 1 | Regional authority |
| 2001-current | Labour Party (1999) | Public Administration Coordination | District Health Boards | 21 | National office |

### 4.2.3   The consolidation of Māori Health Providers

The engagement of self-governing *iwi* in public policy is relatively recent. Historically, New Zealand has preferred to engage Māori in public policy and public health by promoting individual Māori participation in public bodies. For example, the passage of the Māori Council Act in 1900 gave nineteen elected Māori Councils a vehicle for community input into local affairs and public health. The formation of the Department of Health in 1901 reaffirmed the role of the Councils in public health (Durie 2000). These structures were revived in 1945, with Māori Councils at the village level and regional Māori District Councils, each being given responsibilities in the areas of welfare, housing and economic development. The Council's historical role in promoting Māori development has been important. However, these structures were never independent agents of Māori self-determination (Ward 1999). The focus rather echoed the historical decision of promoting integration (Interview NZ23).

Following the refocused attention to the Treaty of Waitangi, the 1988 Royal Commission on Social Policy recommended that three Treaty based principles become the basis of all social policy dealing with Māori:

- Partnership: working together with *iwi, hapū, whānau* and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.

- Participation: Involving Māori at all levels of the sector in planning, development and delivery of health and disability services.

- Protection: Ensuring Māori enjoy at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices (New Zealand National Health Committee on Health and Disability 2002).

What these principles mean in practice has shifted over time (Interviews NZ16, NZ24, NZ30).

The return to power of the right-leaning and market oriented National Party in 1990 led to the demise of the AHBs, despite campaign claims to the contrary (Gauld 2001). The 1991 Green and White paper called for,

- the introduction of the purchaser-provider split;

- the establishment of four Regional Health Authorities (RHAs) bulk-funded and tasked with the purchasing of services from public, private and non-government organisations;

- alternative Health Care Plans from which New Zealanders could chose to purchase care and to ensure competition with the RHAs;

- 23 for-profit Crown Health Enterprises, mostly hospitals, also competing for health dollars and the provision of services;

- an independent Public Health Commission to provide advice, and a Public Health Agency to monitor and provide services; and

- a shift to managing health services via contractual relationships with independent providers (Upton 1991).

These changes were proposed in the name of fairness, efficiency, increased personal choice and self-reliance. This has become known as the 'big bang' approach to health care reform. While ideologically-driven, the new National Government was also motivated to address the financial crisis New Zealand was heading towards, with health services accounting for 61 percent of the overall budget. The controversial market-oriented RHA system was implemented in 1993.

General Practitioners anticipated the implementation of competition with some concerns and began to organise themselves as Independent Practitioners Associations (IPAs), owned and governed by General Practitioners. Malcolm and Mays (1999) reported that thirty IPAs were in operation in 1999. Over time, they have gained access to development and research funding, and provide a spectrum of services including some health promotion and prevention.

Māori also received the announcement of the purchaser-provider split with a mixture of apprehension and hope. Māori organisations anticipated that opportunities

may develop for greater involvement in service delivery.  But at the same time, such participation would imply a support for the commercial overtone of the reform:

> *"Tino rangatiratanga and its promise of greater Māori autonomy could be construed as offering implicit support for privatization or at least for reduced State provision of services" (Durie 1998b).*

The RHAs were instructed to follow the recommendations of the joint Department of Health and Te Puni Kokiri [Ministry of Māori Development] policy document *Whaia te ora mo te iwi*,[46] promoting the development of by Māori for Māori health services and the adoption of a developmental approach to Māori providers (New Zealand Ministry of Health & New Zealand Te Puni Kokiri 1993). As a result, a number of Māori organisations signed contracts with the RHAs, resulting in an increased number of Māori organisations providing primary health care.  Under the RHA model, specific Māori policy guidelines were issued yearly (New Zealand Ministry of Health 1994, 1995a, 1996a). These documents granted considerable latitude to the RHAs as to the exact direction of their purchasing strategy (Cunningham & Durie 1999), resulting in different approaches:

- The North Regional Health Authority adopted a population-based approach to purchasing and promoted the development of Māori Purchasing Organisations (MAPOs) (Ashton 1995, Kiro 2001). Three MAPO were set up, linked to a total of 20 by Māori for Māori providers (1997 figures, New Zealand Transitional Health Authority Maori Health Groups 1997).

- The Midland Regional Health Authority set up four regionally-based pan-*iwi* joint-ventures, tasked to advise on Māori health service purchasing (Hartley & Mules 1996, New Zealand Transitional Health Authority Maori Health Groups 1997).

- The Central Regional Health Authority opted to adopt a "community development" approach and established direct relationships with the 15 *iwi* in the region. This approach led to consultations as to how Māori themselves preferred to see the direction of Māori provider development (New Zealand Transitional Health Authority Maori Health Groups 1997).

- The Southern Regional Authority promoted a "community-driven" approach, where Māori played an advisory role in the purchase of health and disability services (New Zealand Transitional Health Authority Maori Health Groups 1997).

Both the Central and Midland Regional Health Authorities endorsed a more aggressive approach to contracting to encourage competition (Howden Chapman & Ashton 1994).

The shift towards privatisation and the purchaser-provider split created opportunities and the number of Māori providers expanded quickly. The era was one of experimentation with different models.

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[46] Strive for the Good Health of the People.

- Co-ordinated care was introduced in 1995 to described the MAPO, population-based approaches and initiatives that blended primary and secondary care (New Zealand Ministry of Health 1995b).

- Managed care by Māori was introduced by *Te Puni Kokiri* at a *hui* held at the Whangarae Marae in December 1994. It involved the establishment of Māori organisations as purchaser and provider of health services for a registered population (New Zealand Te Puni Kokiri 1995).

- The Midland Regional Health Authority encouraged the development of Integrated Care Organisations as fund holders and tasked to provide a range of services for a defined population. Māori joint-venture Boards were encouraged to develop new structures in view of setting up a Māori Integrated Care Organisation (MICO). The 1996/97 policy guidelines to RHAs explicitly supported these initiatives (New Zealand Ministry of Health 1996b).

According to Durie (1998b), the opportunities opened up by the RHAs however fell short of Māori aspirations, because,

- The burden of administration, stringency and level of details of the contracts led some participating Māori organisations to compromise on Māori values;

- In the process, *tino rangatiratanga* was reconstrued by the New Zealand government as self-management;

- The off-loading of state obligations on *iwi* authorities and the resulting contract monitoring increased the State's involvement in *iwi* administration; and

- In the name of efficiency, *iwi* were placed in a situation of competition with one another as service providers, a situation that created tensions and divisions, instead of collaboration.[47]

He sums up the impact of the reform, stating that, "Privatization masqueraded as *tino rangatiratanga*...; biculturalism was confused with partnership; and devolution merely created the illusion of self-determination" (Durie 1998b).

The RHA model of competitive contracting proved expensive and labour intensive to maintain. The Transitional Health Authority (THA) was established in 1997 to replace the Regional Health Authorities. The move was an attempt by the Minister of Health to shift the focus from a regionalised and competitive development to the implementation of national standards in purpose, contracting and pricing (Gauld 2001). In terms of Māori development, the THA proposed to make strategic investments at two levels. First, it opted to create a fund to support Māori provider development in terms of infrastructure and workforce development. As a result, the Māori Provider Development Fund (MPDF) was set in place. Second, it opted to support the MICO model as

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[47] Under the HFA, the development of Maori providers was strongly encouraged. In practice however, observers recall that issues of sustainability were not necessarily considered, resulting in a multiplicity of small Maori providers competing for limited opportunities (Inrerviews NZ06, NZ10, NZ23, NZ25; Te Roopu Huihuinga Hauora Incorporated 2000c).

developed by the Midland Regional Health Authority (New Zealand Transitional Health Authority Maori Health Groups 1997, Interviews NZ24, NZ30). The Health Funding Authority (HFA), set up in 1998 in replacement for the THA, issued an internal and brief Māori Health Policy to guide its purchasing practices (New Zealand Health Funding Authority 1998a). The HFA continued to work towards standardisation in priorities, pricing and process. The policy made it explicit that Māori health gains could not be achieved solely through the development of Māori health providers. Thus, every contract saw the inclusion of a Māori Health Clause, requiring all providers to,

> *"establish and implement a Māori Health Policy that reflects that fact. In developing this policy the provider will take into account the Purchaser's strategic direction for Māori health in terms of minimum requirements for Māori health based on the Treaty of Waitangi, Crown objectives for Māori health and specific requirements negotiated from time to time with the Purchaser" (King 2000).*

Following the election of the Labour Party in November 1999, the Ministry of Health and the HFA found themselves increasingly at odds. Observers recall the HFA coming out in the media with statements contradicting the Labour government (Interviews NZ24, NZ30). In particular, the HFA actively promoted the American HMO-inspired Integrated Care Organisations (ICO) and Māori Integrated Care Organisations (MICO) models that aimed at merging primary and secondary care funding under single organisation for a registered population. This model was not supported by the new Minister, who was perhaps echoing concerns from general practitioners (Central Region Maori/Iwi Integrated Care Organisations 1998). Many Māori organisations were engaged in developing proposals in 1997 and 1998. By December 1999, all MICO development was stopped. Māori organisations were instead instructed to develop proposals for the establishment of Māori Development Organisations (MDO) (Te Roopu Huihuinga Hauora Incorporated 2000b, Te Runanga O Raukawa Inc. 1999c). The focus of this emerging model was to act as coordinating and capacity development organisations to support the multiplicity of small Māori providers that had emerged under the previous reforms.

The June 2000 *New Zealand Health Strategy* signified the intent of the government to return to decentralisation (King 2000) by announcing the creation of 21 District Health Boards (DHBs). This strategy, which remains current, promotes the formation of Primary Health Organisations (PHOs) to consolidate general practices and other primary care providers, including Māori providers and IPAs, under a single coordinating organisation offering services to a registered population. The PHOs have been tasked to develop service plans targeting priority health gains and improving access for Māori, Pacific Islanders and economically deprived New Zealanders (New Zealand Ministry of Health 2004). Organisational membership into PHOs is optional.

However, providers and IPA who decide not to join a PHO will be expected to secure their primary health care funding via one or perhaps a number of PHOs (New Zealand Ministry of Health 2002a, NGO\MOH Health and Disability Forum 2004). As of March 2004, the Ministry reported that 49 mostly IPA-driven PHOs had been formed (NGO\MOH Health and Disability Forum 2004).

The *New Zealand Health Strategy* and associated literature make an explicit commitment to Māori providers and to MDOs (New Zealand Ministry of Health 2001d). *He Korowai Oranga*, the Māori health strategy, reaffirms the Treaty-based core values of partnership, participation and protection. The strategy recognises three key threads: *rangatiratanga,* building on the gains and reducing inequalities. It is notable that the strategy speaks of *rangatiratanga,* but not of *tino rangatiratanga.* *Rangatira* is the Māori word for chief. The suffix *tanga* refers to attributes or qualities of chieftainship. In acknowledging *rangatiratanga,*[48] the strategy speaks to Māori's right to exercise leadership in health. The word *tino* in the context of *tino rangatiratanga* refers to 'absolute/unqualified chieftainship'. The commitment to *rangatiratanga* may be best explained by the strategy emphasising Māori participation within existing structures and processes, rather than the development of parallel Māori-specific structures and processes. The strategy reiterates the commitment to Māori provider development, Māori Development Organisations (MDO) and Māori Purchasing Organisations (MAPO). It repeats the thirteen priority health gains identified in the *New Zealand Health Strategy* (New Zealand Ministry of Health 2002c). The document *Whakatātaka,*[49] *Māori Health Action Plan 2002-2005* provides a blue print to the District Health Boards for implementation (New Zealand Ministry of Health 2002c). It highlights the role of the DHB, *iwi* and Māori communities in the regional planning process. With regard to Māori provider development, the action plan situates the process as a partnership between the Ministry of Health, existing Māori providers, Māori communities and DHBs. With regards to the emerging PHOs, the action plan speaks to Māori provider participation in PHOs but does not take a position on governance.

The DHBs have been tasked with the development of PHOs. How this development will impact existing Māori providers remains unclear. As in the past, regional differences are anticipated. In Auckland, the development of a consortium of previously independent Māori providers has led to the formation of two Māori-driven PHOs. In other regions, Māori providers anticipate having to affiliate themselves with

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[48] Williams translates the word as "evidence of breeding and greatness" (Williams 2002).

[49] The weaving of strands.

PHOs that are managed by consortiums of Māori and non-Māori specific organisations, or driven by IPAs.

### 4.2.4   Summary

Since 1988, health policies have reiterated the principles of partnership, participation and protection. What these principles have meant shifted over time depending on the focus of the reform. During the Area Health Board era (1983-1993), some Māori providers were able to secure contracts to employ Māori Health Workers as liaisons in the system. The implementation of the RHAs (1993-1997) and its focus on privatisation created opportunities for Māori providers to multiply and experiment with different models of service delivery. Competition was finally abandoned under the HFA (1997-2000). It was during the era that a policy was adopted requiring all providers to demonstrate how their services helped meet the Government Māori health gain priorities, thus ensuring that all services would become responsive to Māori needs. The recent DHB-PHO development requires Māori to link with IPAs and consolidate primary health care interventions.

Although a commitment to Māori providers exists in writing since 1993, what that commitment has meant has shifted over time.   Māori advocacy for *tino rangatiratanga,* or parallel services governed by Māori, has been met with opportunities to participate in existing structures. All policy documentation nevertheless cites the Treaty of Waitangi and requires a Treaty-based partnership with *iwi*. It is obvious that a consensus on what this Treaty actually means in terms of Māori's place within New Zealand has yet to emerge.

### 4.3   Indigenous health policies in Canada, Australia and New Zealand

The last two sections reviewed the emergence of indigenous health care policies in Australia and New Zealand. This section provides a cross-national analysis guided by the questions developed in chapter 2, namely,

1. What are the historical factors that impacted the development of indigenous health policies?
2. What values are apparent in policies?
3. Do policies more readily reflect indigenous aspirations, indigenous-state's historical relationship or other interests?
4. What are the apparent compromises made in the process of implementation?
5. What factors led to compromises?

The literature suggests that the relationship between policy formulation and implementation is impacted by five factors:

- A consensus on objectives based on a clear theory of cause and effect;

- The amount of change required for full implementation;

- The availability of resources;

- External pressures and continued commitment; and

- Policy makers' control over the implementation process (Van Meter & Van Horn 1975, Walt 1988).

Australian and New Zealand policies will now be revisited in light of these criteria and Canadian experience. Findings are summarised in Table 4.3.

**Australia** The implementation of the 1989 National Aboriginal Health Strategy (NAHS) followed rather than preceded the ACCHS movement. The NAHS shows evidence of ATSI and of the ACCHS movement's advocacy. While there may have been broad consensus within the ATSI community over the objectives of the NAHS, there were significant delays in implementing the strategy. These delays were related to,

- The moving of ATSI health funding from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Commonwealth Department of Health, achieved in 1995; and

- The consensus building required for the formation of ATSI Health Forums in each state and territory, with representatives from the Commonwealth Department of Health (OATSIH), the state or territorial health department, NACCHO and ATSIC. The forums are tasked with states/territories setting ATSI health priorities and defining strategies.

Until the adoption of PHCAP, the amount of change required was important, but gradual.

The values reflected in the 2003 Aboriginal Health Strategy reiterate those first included in the 1989 National Aboriginal Health Strategy, namely,

- Health equity;

- Participation by ATSI people in national and state/territorial priority setting;

- Community control of primary health care services as a preferred method of service delivery with a focus on localised decision-making; and

- Improved responsiveness of the whole system.

| Table 4.3, Health Policy Frameworks in Australia and New Zealand (see Appendix II for more details). | | |
|---|---|---|
| | Australia | New Zealand |
| Policy/ strategy Foundation | The 1989 National Aboriginal Health Strategy and 2003 Aboriginal Health Strategy | The 2000 New Zealand Health Strategy acknowledges that the Crown is a Treaty partner with Māori; the Treaty guarantees cultural protection for Māori, meaning that that Maori will have an important role in implementing health strategies for Māori. |
| Policy objectives | To ensure that Aboriginal and Torres Strait Islander peoples enjoy a long and healthy life enriched by a strong living culture, dignity and justice. | People will be part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups. |
| Values apparent in policy | Cultural security; Addressing inequalities; ATSI participation in planning forums and at the national level; Community controlled health services; Responsiveness of the whole system; Commitment to PHCAP (since 2000) reflecting an interest in providing Aboriginal health Boards with substantial funding to provide comprehensive primary health care services. | Integrative rather than parallel systems; Building on the gains, highlights improvements in Māori and *whanau ora* outcomes, service uptake and Māori participation throughout the health and disability sector. Reducing inequalities in health care. |
| Authority for policy formulation | Central government | Central government |
| Authority for policy implementation | Pre-PHCAP: central government Post PHCAP: central and state/territorial governments | DHB and PHOs |
| Level of consensus | Although slow in emerging, there appears to be broad consensus surrounding the objectives of the 2003 Aboriginal Health Strategy. | For the past 12 years, health care reforms have succeeded each other too quickly to have time to build consensus and ensure political sustainability. There is no broad-based consensus for the current PHO development process. |
| Amount of change required | Until recently, moderate and gradual. Implementing PHCAP and ensuring the responsiveness of the overall system will require a considerable amount of change. | Considerable: The current focus on PHO requires IPA and independent providers such as Māori providers to merge, thus shifting power relations and potentially impacting Māori governance of Māori organisations. |
| Availability of resources | Until PHCAP, implementing the NAHS did not require a substantial investment of ATSI-specific resources. PHCAP will however require an unprecedented investment. | As a result of integration, the implementation of Māori health policies does not require the ring fencing of significant resources to be allocated to Māori organisations. |
| External pressures and continued commitment | International and national focus on health inequalities. | The sustainability of the current reform and of its associated institutions may be challenged by a change in government. |
| Policy makers' control over the implementation process | The Commonwealth Depart of Health has little control over the overall implementation process, since this engages state and territorial government and ATSI forums, and the ACCHS sector. | The policy writers (Ministry of Health and Māori Health Directorate) have indirect control over implementation. The DHBs and PHOs will platy a large role. Past experience shows that organisations have in the past benefited in a great deal of latitude in interpretation. |

Implementing PHCAP will require a considerable investment in terms of time and resources by the Commonwealth and state/territorial government. Although the 2003 Strategy was signed by all state and territorial Health Ministers, suggesting a high level consensus, it is at the implementation level that compromises may be required. PHCAP will necessitate the engagement of a number of players not directly under the control of the Commonwealth government, namely state and territorial government for financial contributions and ATSI peak bodies and communities. The substantial financial investment in ATSI-specific organisations will increase the visibility of ATSI health services to the Australian public. PHCAP may also impact existing providers in less isolated regions. Current debates over the deployment of PHCAP have focused on whether ATSI people have the capacity to shoulder the level of responsibility required of them. There is already some evidence that implementing PHCAP will be contentious, and may, as in Canada, lead to compromises in implementation. This will be explored in more details in Chapters 5 and 6.

**New Zealand** Since 1988, New Zealand social policies have spoken of the principles of partnership, participation and protection. The way in which these principles have been reflected in the health sector has shifted depending on ideology. The process of reform has led to the multiplication of small providers. Reforms succeeded each other too quickly for consensus building, full implementation or evaluation.

Historically, guidelines citing Treaty obligations were released by the purchasing body of the day to ensure responsiveness to Māori. This approach now appears to be waning. The recent reform saw the release of a broader-based policy requiring the engagement of Māori providers, Māori communities, the DHBs and the Ministry of Health in regional planning. The DHBs and emerging PHOs are also required to ensure Māori involvement in program planning and on the Board. The Boards have been tasked with developing a Treaty partnership with all *iwi* located within their boundaries. The partnership requires the engagement of the local *iwi* on the Health Board and decision-making committee. The partnership is however not a one-to-one, DHB-*iwi* relationship. Although *iwi* designates may speak to the interests of their *iwi*, they hold a single vote and can be overruled by the Board or Committee.

The tread that runs through the past fifteen years is that Māori providers have emerged, and gained credibility. They are now mentioned in policy, albeit in somewhat ambiguous ways. While there is a commitment to Māori providers and MDOs, there is a higher commitment to consolidating small primary health care providers and IPAs into PHOs. The ambiguity of the current policy documents speaks to the need to balance the coordination of primary health care resources and Māori aspirations for *tino rangatiratanga*. This ambiguity will however need to be settled in implementation. Here,

pressures from stakeholders are likely to play an important role and may lead to different solutions. In the Auckland area, larger Māori providers have joined with IPAs to develop two Māori controlled PHOs. In other areas, Māori anticipate that PHOs may be dominated by IPAs and/or non-Māori, and that the principles of partnership, participation and protection may be interpreted in a variety of ways. Preliminary reports suggest that these assumptions are correct (NGO\MOH Health and Disability Forum 2004).

The current policy is consistent with a past commitment towards integrated rather than parallel systems. The Māori Health Strategy emphasises the role of Māori providers in addressing health inequalities, and requires DHBs to establish a Treaty-based relationship with *iwi* located in their respective boundaries. It also focuses on improving the responsiveness of the overall health care system. Although addressing health inequalities is prioritised, the focus here is on addressing health gain priorities identified nationally rather than on local priority setting.

The situation documented in Australia and New Zealand contrasts with that of Canada. Of all three countries, Health Transfer Policy is by far the most narrowly focused. It vows to work towards improving health outcomes in First Nation communities. The mechanism chosen is that of community-based primary health organisations integrated with First Nation governance structures. The federal government department tasked with policy formulation, FNIHB, is also the funder-purchaser. The federal government has never attempted to extend its influence to ensure that provincial services are responsive to First Nations. The responsiveness of secondary and tertiary care remains unaddressed.

Consensus building does play an important role in the Canadian context, in that transfer uptake by First Nation is voluntary. Local buy-in is therefore crucial to the success of the policy. At the national level, the Assembly of First Nations has established a relationship with Health Canada, and sits on planning meetings advising on the development of initiatives. Their contribution is important and influential, but also limited to the political sphere. For the past 20 years or so, the Canadian approach has been to promote the transfer of responsibility for community-based services to First Nation authorities. Thus, the focus has been largely one of local engagement.

In many ways, the distinctions that exist between the Canadian, Australian and New Zealand approaches to indigenous health policy reflect the debates shaping indigenous health policies explored in Chapter 2. While all three countries recognise indigenous identity as collective identity and accommodate for participation in services delivery, the policies that emerged reflect a different understanding or willingness to accommodate the concept of self-determination. For example, Canadian policies

clearly favour a localised concept that relies on tribe-specific governments delivering government-designed programs with varying levels of specificity. In New Zealand, DHBs are expected to develop *iwi*-specific, Treaty-based partnerships that ensure local *iwi* a voice in decision-making. Although Māori expect this approach to also extend to service delivery, the Ministry of Health has resisted the development of parallel services for Māori. In Australia, ATSI provider development has been left largely to community-based mobilisations. Australia's former practices of ATSI displacement and relocation have largely destroyed traditional governance practices. Most communities are blends of many ATSI language groups. The ATSI community has focused its energies on securing better access to services delivered by ATSI communities themselves, and on participating in decision-making on ATSI issues at all levels. It is noteworthy that both New Zealand and Australia speak to the need to improve the responsiveness of the overall system, whereas Canada focuses on local service delivery alone. It thus appears that a localised concept of self-determination leads to a much narrower approach to the pursuit of health gains. The choice of approach is not evidence-based, but is rather rooted in history and in political debates as they evolved over time.

## 4.4   Conclusions

Although by indigenous for indigenous policies emerged from different processes and in different contexts, the policies also bear the marks of international debates on indigenous rights. The text of the policies would suggest that policy statements take positions that are likely broadly supported to ensure political sustainability. The policies reflect commitments made in the distant past, for example, integration in New Zealand. They also reflect the value of equity in health, and implicitly embody debates over indigenous rights.

# CHAPTER 5, INTRODUCTION TO CASE STUDIES

This chapter introduces the case studies conducted in indigenous-controlled health services. It is divided into two broad sections. The first section introduces the four organisations studied, focusing on the circumstances that led to their emergence, and the policy or model of contracting that defines the services they provide. The intent of the section is to provide context for further discussions. As a result, it remains largely descriptive. Section two explores organisations' commonalties and differences and provides the context for the discussion provided in chapter 6.

## 5.1    The Selected Case Studies

As noted in the chapter 3, the case study sites were not selected based on representativity. The selection process was constrained by a number of factors including time, financial resources and acceptability of the project to providers. The four case study sites are diverse. This diversity is nevertheless useful in exploring the strengths and weaknesses of different contracting models.

### 5.1.1   Danila Dilba

Danila Dilba Biluru Butji Binnilutnum Health Service Aboriginal Corporation (hereafter Danila Dilba)[50] is an Aboriginal controlled health organisation based in Darwin, Northern Territory. The corporation's name was given by the Larrakia people, the traditional landowners. In Larrakia language, *"danila dilba"* means the dilly bag used to collect bush medicines. *"Biluru butji binnilutnum"* means "blackfella" getting better (Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation 2002). The corporation was established in 1991. The organisation provides services to Aboriginal people living in Darwin and Palmerston and in the

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[50] The organisation's logo was designed by Walter Fejo, a member of the Larrakia nation. The Danila Dilba website provides the following explanation:

*The fish being in a school are excited when jumping around and convey to us our exciting, healthy life. A full life that takes in play, laughing and enjoying, a part of your well being of tucker [food]. The turtle represents the people going back to lay her eggs. The stick represents a hunting tool on how to find her eggs (Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation 2002).*

Aboriginal town camps of Kulaluk, Minmarama Park, One Mile Dam, Knuckey's Lagoon and Fifteen Mile. It also serves the homeless Aboriginal population living in temporary camps around Darwin (Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation 2002).

Darwin is the capital of the Northern Territory and is located in the Top End. The Aboriginal Traditional Owners of Darwin are the Larrakia people, also known as the "saltwater people." Unlike other parts of the Territory, the Larrakia people came into contact with Europeans early on, as a result of the 1869 NT Survey Expedition. By 1874, settlers were asking Aboriginal people to move out of the area because of the noisiness of corroborees. The emerging settlement was destroyed by a cyclone in 1897, but re-emerged to become a small government settlement by 1911. It was partially destroyed by a cyclone in 1937, by Japanese bombers in 1942 and nearly levelled by cyclone Tracy in 1974. Today, Darwin is the home of 68,802 people, one third of the overall Northern Territory population, and is remarkably cosmopolitan. The 1996 census showed a total of 5,723 Aboriginal people in Darwin (8.5 percent) distributed throughout the suburbs of the town with some concentration in Karama, Malak, Tiwi, Millner and Anula. Palmerston is located 25 km south east of Darwin and has a total population of 13,121 people of which 1,645 are of Aboriginal descent (12.5 percent) (McLennan 1996). According to the Larrakia Nation Aboriginal Corporation, there are currently 1500 Larrakia people living in the Darwin area (Larrakia Nation Aboriginal Corporation 2001).

Before Danila Dilba, health services in Darwin were delivered by the outpatient service of the Darwin Hospital and the use of private physicians. The Northern Territory Department of Health and Community Services also operated a clinic in the Bagot community (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1993a).[51] Cyclone Tracy devastated the city of Darwin on December 25th 1974. Large segments of the community were simply levelled. The wide scale evacuation of survivors that followed led some Aboriginal people to come into contact with Aboriginal Community Controlled Health Services (ACCHS) in Alice Springs (Central Australian Aboriginal Congress, established in 1973) and Redfern (Aboriginal Medical Services, established in 1971) and created an interest in opening a similar facility in Darwin (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1996c).

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[51] This is an Aboriginal community located within the boundaries of Darwin.
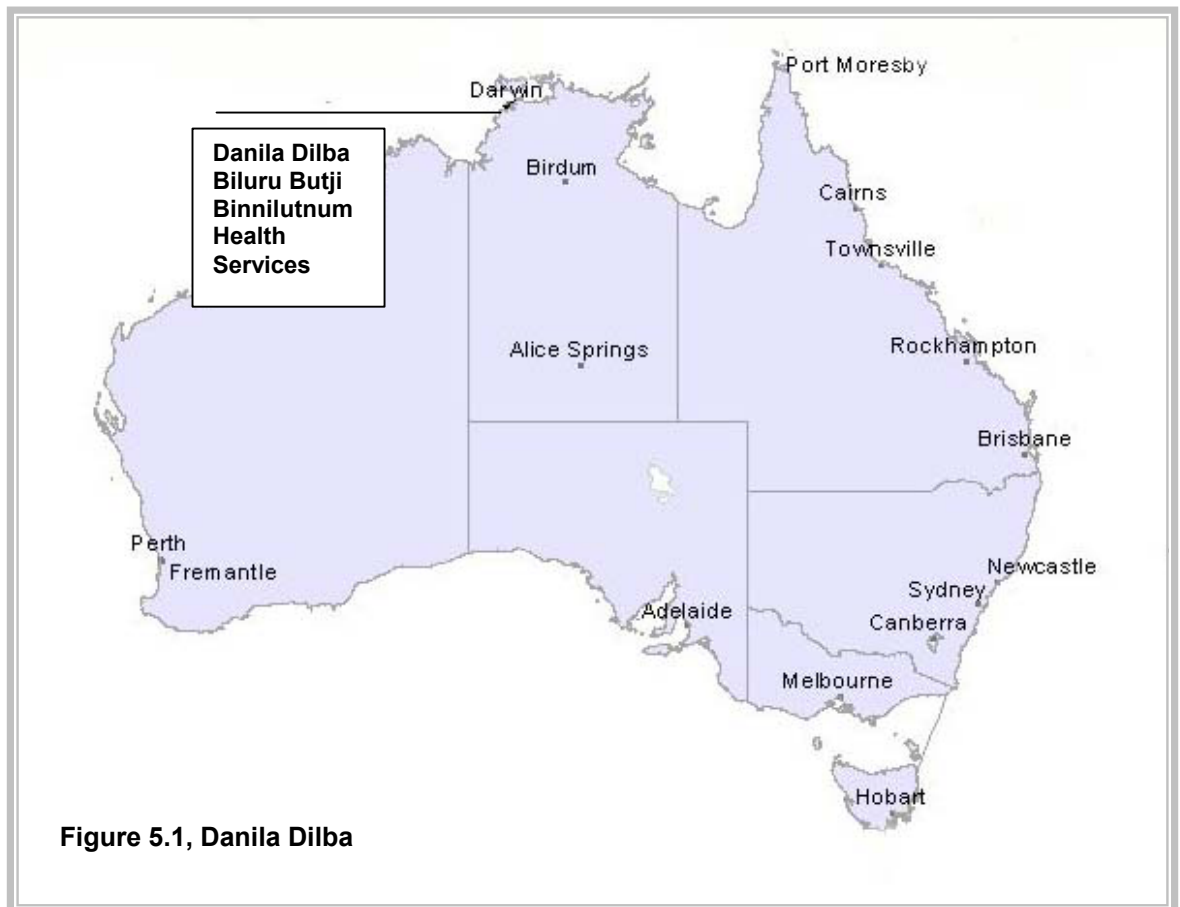
**Figure 5.1, Danila Dilba**

Initial calls for the establishment of an Aboriginal controlled health service were met with resistance.

> *Towards the end of the 1970s, there were demonstrations and a sit-in at the Department of Aboriginal Affairs (DAA) area office about Aboriginal health conditions and there were calls for an Aboriginal community controlled health service in Darwin. This led to discussions and negotiation with the Health Department. However, we were told of considerable obstruction by the NT health bureaucrats of the day (Crawshaw & Thomas 1992).*

This resulted in the establishment of the Aboriginal and Islander Medical Service (AIMS), an organisation funded by the Northern Territory government whose mandate and funding was limited to medical transportation (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1996b). This "solution" fell short of aspirations and the Department was met with vocal dissatisfaction. The Bagot clinic continued to operate but remained out of reach for most of the Darwin-based Aboriginal population. In

addition, the facility at Bagot caused concerns.  It was deemed too old to serve its original purpose.  A proposal was submitted to the Northern Territory government to include a new clinic as part of the proposed Bagot Council office complex.  This proposal was however removed from the capital works list for 1990-91 without explanation provoking angry responses from workers and the Aboriginal community (Interview AU20).  A meeting with the NT Minister of Health was held in June 1990, where the Minister promised that a Health Centre would be reinstated on the capital works program.  Apparently this never happened, but it may have acted as a catalyst.  Concerned Aboriginal residents met at Bagot and a working party was formed, including Aboriginal community organisation representatives, health centre staff and Aboriginal employees of NT Health Department.  The working party's mandate was to see the establishment of an Aboriginal controlled health service in Darwin, separate from the Bagot clinic.  Its role was to write the proposals, to lobby and network.  In February 1991, the interim committee of the Darwin Aboriginal and Islander Medical Service submitted an expression of interest to Aboriginal and Torres Strait Islander Commission (ATSIC) for National Aboriginal Health Strategy Funding for the establishment of a medical service.  The submission was accepted, the organisation was incorporated in June 1991,[52] and the first patient was seen in October 1991.  The original clinic was set up in facilities leased from the Northern Territory government.  This site was later handed over by the Minister of Health as a lease in perpetuity (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1991, Interview AU20, fieldnotes, Dunham 1994a, see also 1994b, Chandler 2005and , 1994c).

The first five years of Danila Dilba's life were a constant struggle for funding (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1993a, 1993b, 1994a, 1994b, 1995, 1996a).[53]  The original submission to ATSIC for seed money to employ a person to coordinate the initial setting up of the organisation was apparently accepted as the basis for on-going funding.  This caused problems thereafter, as the organisation remained underfunded for core funding and forced to rely on a spectrum of smaller funding opportunities to remain afloat.

*Danila Dilba has lurched from one financial crisis to another over this last year.  The Service took these difficulties to whoever would listen and this included the large public*

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[52] Under the Aboriginal Council and Association Act, 1976.

[53] Annual Report s do not provide financial statements for the organisation. The 1990-91 and 1991-92 Audited Financial Statements show a total income of less than $300,000AU for all expenditures. By 1994, Danila Dilba recorded 6,700 active files (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1994b).

*rally held earlier this year. The Service came under considerable political pressure as we struggled to maintain a medical service for the Aboriginal and Torres Strait peoples of Darwin.*

*Visitors during the year included the former Minister for Health, Graham Richardson, Dr Brendan Nelson, Federal President of the Australian Medical Association, Senator Stephen Looseley and the Human Rights Parliamentary Sub-Committee, the World Council of Churches, Senator Christobel Chamarette of the Greens and Dr Carmen Lawrence, the current Federal Minister of Health.*

*We spoke to them all and explained our Service and our difficulties (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1994a).*

The issue was picked up in the media. The NT Times of April 5th, 1994 shows the headline, *Health protest call* (1994b). Although Danila Dilba was fighting to secure its own stable funding, the issue was tied with health funding being managed by ATSIC.



March 24 – Public rally outside ATSIC's Casuarina offices by Danila Dilba staff and supporters in response to funding crisis. ATSIC provides emergency funding to keep the service operating.

*[The] debate on a national level about the funding of Aboriginal health has been hard but the facts are:*

*The National Aboriginal Health Strategy came down in 1989 and was strongly supported by the federal and state/territory governments. What did not happen (or maybe the Minister was not advised correctly or successful in) was a Cabinet decision to increase the amount of funds for the implementation of the strategy. It would have cost several billions of dollars but in my view it was the responsibility of the federal Minister for Aboriginal and Torres Strait Islander Affairs and/or the Minister of Health to approach Cabinet for the funds.*

*What did happen was that ATSIC set aside -$50million in their budget for 'top-up' funding but actually fully funded some of the 96 Aboriginal Health Services across the country. They came under attack because of the frustrations that services like ours have in trying to get the funds that they do not have…*

*The federal health budget is already more than $33billion dollars and rationalisation will occur within his overall budget to either set up a Division of Aboriginal Health or make funds more accessible to community organisations on a triennal based funding level.*

*I think that it is good that this debate is happening and when the smoke clears, hopefully, resources will be made available to organisations such as ours to get on with the work (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1994b).*

ATSIC's underfunding meant that funding to ACCHS was allocated yearly through a submission-driven process. The need to compete for funding created tensions with other ATSI health organisations (Crough & Cronin 1996) and instability.

*The past year has been another extremely hard year as the organisation continued to battle for its very survival. This has put tremendous strain on all the staff which needs to be acknowledged...*

*Direct funding, as you will recall, is a Recommendation of the Royal Commission into Aboriginal Deaths in Custody.[54] Most of my time since I took up the job as Director and*

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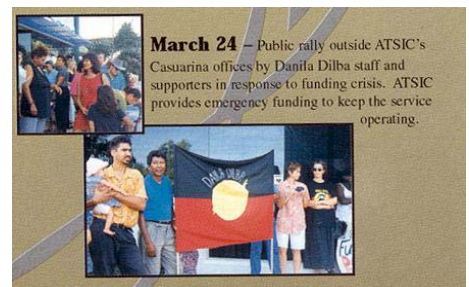
[54] The Royal Commission on Aboriginal Deaths in Custody described the ATSIC funding cycle as follows:

*the time of all previous Directors, has been spent chasing funds in order for our Service to exist and to survive. Hopefully, now this cycle is drawing to a close and myself and future Directors will be free to devote our time, experience and expertise to our community and to have an even better health service catering to the needs of our community now and as these needs change…*

*Direct funding will allow us to maintain our self respect (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1995).*

Funding under ATSIC was neither formulae-based nor based on needs. For example, the minutes of a Management Committee meeting in January of 1994 reports the following:

*Data reflecting staffing levels and funding from other major Aboriginal Health Organisations within the NT indicate that we are grossly underfunded in Darwin ie.*

*Congress Alice Springs, 3000 active files, 100 employees;*

*Auluginya Tennant Creek, 928 active files, 69 employees;*

*Wurli Wurlinjang Katherine, 1500-2000 active files, 24 employees;*

*Danila Dilba, 6700 active files, 22 employees (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1994b).*

Once funding was transferred from ATSIC to the Commonwealth Department of Health in 1995, Danila Dilba's attention shifted to another debate, that of securing an effective voice in Aboriginal health policy and planning in the Northern Territory (Interview AU20). This meant the creation of the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), which was formed in October 1994. Although an independent organisation, AMSANT was initially set up under the Danila Dilba umbrella until it acquired its own funding and structure. It now counts 13 members. One of the core issues for AMSANT and Danila Dilba was the signature of the Framework Agreement.

*…As you are aware, the NT is the only State [sic] which has not signed a Framework Agreement. It is unlikely that the NT government will. This meeting was called by [the Secretary, Territory Health Services] to discuss if we could have an arrangement and still work collaboratively together. There was no agenda except this loose discussion.*

*We talked about the content of the Framework Agreement which is very open and loose. It really is a "gentleman's agreement" and could only work if all parties agreed to actively participate. The main stakeholders to the Agreement are NT government, ATSIC, Commonwealth government and AMSANT. We expressed disappointment that even at this bare minimum level the NT was not prepared to cooperate. AMSANT said that it was difficult for us to have a collaborative arrangement with the Department when [it was] making public statements denigrating AMSANT...*

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*At the moment, Aboriginal communities are invited to 'bid' for funds for their general needs or else to apply for grants under particular programs. In either case the Aboriginal request is considered in the context of existing programs, and if the 'bid' or request fits within the funding category and if funds are available and, further, if the community is deemed eligible on a 'needs' basis then funding is approved, usually for a year (Australian Council for Aboriginal Reconciliation 1998).*

Recommendations 190 and 191 emphasised the need for Aboriginal organisations to be funded with a system of block funding from a single source on a triennal basis.

*The discussion went backwards and forwards and culminated with [THS] putting on the table the possibility of them funding AMSANT Secretariat. He suggested a figure of $100,000.00. We said this wasn't enough, we had a prepared submission into OATSIHS for $195,000.00. [OATSIH] countered by saying perhaps the Commonwealth could pick up the shortfall as a one off. We were not happy with this proposal (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1997).*

The Framework Agreement was finally signed in 1998, leading to the formation of the Northern Territory Health Forum, where ATSIC, THS, OATSIH and AMSANT meet as equal partners (although with unequal access to resources).[55]

The 1995 transfer of Aboriginal health funds to the Commonwealth Department of Health provided an opportunity for improved access to funding, but did not entirely resolve the issue (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1996b). The core funding provided was administrative and not linked to primary health care programming which needed to be secured through proposal writing (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1996a), an issue acknowledged in the media as problematic by the Federal Health Minister in 1994 (Cridland 1994). The Commonwealth Department of Health extended approval for Aboriginal controlled health services to bulk-bill Medicare in July 1996. By 1998, Aboriginal controlled health services were also allowed to bill for longer consultation periods. Danila Dilba began to use Medicare monies somewhat reluctantly on May 31st, 1999. The reluctance was grounded in the General Practitioner-focused Medicare, which means that consultations managed by Aboriginal Health Workers were not billable to Medicare, this despite being a more efficient use of resources (Thomas et al 1998).

Securing access to Medicare funding has been a major gain. Nevertheless, a review of the organisation's contractual environment shows that the funding on which the organisation depends remains fragmented. A substantial portion comes from time-limited and proposal-driven projects. This case study shows to what extend current and past debates in Aboriginal health have impacted Danila Dilba's ability to provide health services to its constituency. The sector developed from the bottom up and has had to gradually negotiate its place as a service delivery organisation. The 1989 National Aboriginal Health Strategy's commitment to support ACCHS to alleviate inequalities resulted in ACCHS being able to access some core funding in 1995. However, access to funding remained fragmented. The environment over which Danila Dilba has control is largely defined at national and territorial levels, and can only be challenged through lobbying.

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[55] Although the issue lies outside the scope of this particular research, state and territorial peak organisations are called to play a very important role under the Framework Agreements, and one wonders the extent to which resources match expectations.

*Nothing has been given, a lot of passive verbs if you listen to people when they speak about Aboriginal people, a lot of passive verbs like the lost language, like someone just dropped a tissue somewhere and just walked away… Not a single thing has been given, it is through a lot of hard work and lobbying, a lot of sacrifice, a lot of late community meetings. It has been like that ever since non-Aboriginal people have been here. So, we get irritated by all these passive verbs surrounding Aboriginal people because it is just not true, nothing has been given. I mean, accessing better primary health care and finding a sound and qualified place, that has come from us, not from the state government system (Danila Dilba staff, 2002).*

### 5.1.2   Katherine West Health Board (KWHB)

Based on the information reviewed, it appears that the story of the Katherine West Health Board Aboriginal Corporation (hereafter KWHB) should be told from at least three different perspectives. There is the story of Aboriginal people in the region who suffered for one hundred years at the hands of government policies and the pastoral industry, opting for passive resistance in order to avoid more massacres (Interview AU14)[56] and the possibility of extermination, until the Daguragu strike
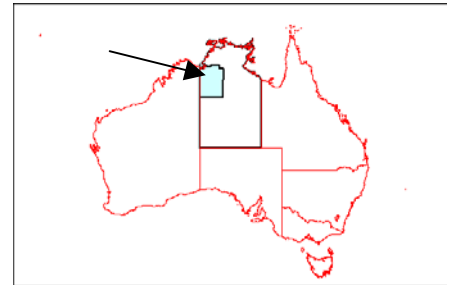


Figure 5.2.  Katherine West Health Board (KWHB) Coordinated Care Trials Service

Cattle Stations and Aboriginal Communities and Out Stations
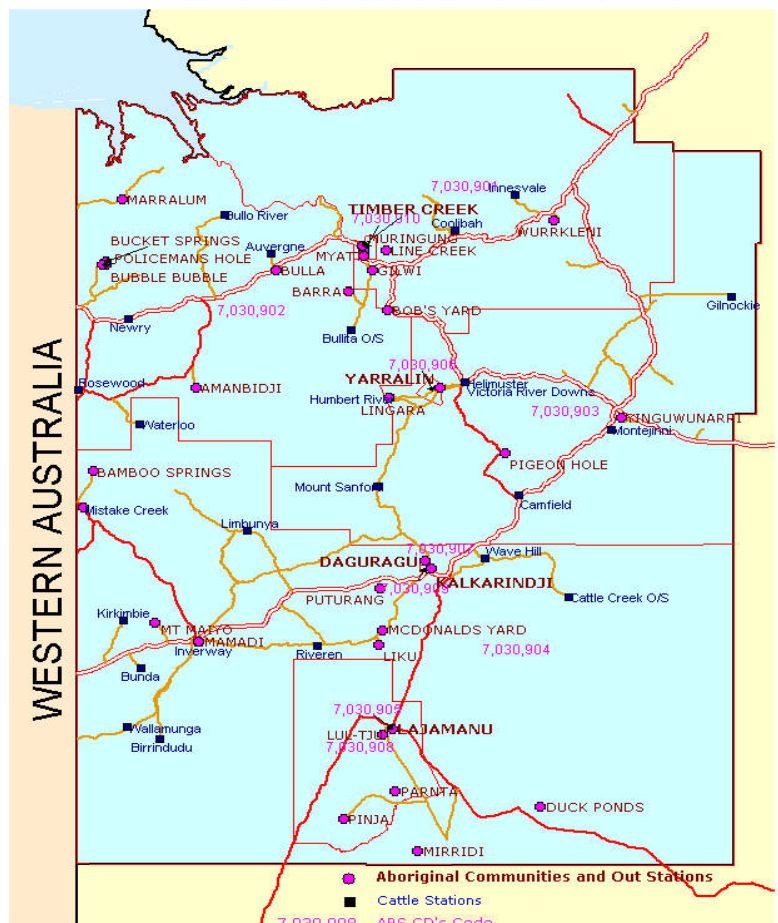
[56] The extent and details of this story has been document by Bird Rose (Rose 1991) and remained unchecked until the second world war, after which employment in the cattle industry guaranted access to grossly insufficient rations and wages (Berndt & Berndt 1987, Katherine West Health Board 2003).

of 1966.  This story has been told by Creswell (2001) and is central to the creation and success of KWHB:

> *Just like Daguragu strike and things like that, they had a bit of power too and someone been helping them to get to that state.  And now, this Katherine West been putting something in our heart to make our own strike to build that up (Jack Little, KWHB Board Member and former chairperson, cited in Creswell 2001).*

The origin of KWHB is also rooted in the ACCHS movement explored in chapter 4 and through the Danila Dilba case study, with in its continued lobbying for better access to primary health care and stable funding.  The third perspective relates to the opportunity that was taken by a group of people, including the District Medical Officer for the Top End and the District Medical Officer for the Katherine region, to submit a proposal to undertake two Aboriginal Coordinated Care Trials (CCT) involving the pooling of financial resources from the Commonwealth and THS (interviews AU02 and AU10).[57]

The KWHB region is a heterogeneous collection of culturally and linguistically diverse people, albeit with strong historical and cultural ties.  It is an administrative creation that emerged for the purpose of the Coordinated Care Trial with the Board of Directors having input into the inclusion of communities and outstations (the region was created as a result of the Bartlett study, Bartlett & Duncan 2000).  The town of Katherine is not part of the service delivery area, although the Board's offices are located in town.  The region is 162,000 square km in size with an estimated population of 2800, of which 84 percent is of Aboriginal ancestry (Katherine West Coordinated Care Trial Local Evaluation Team 2000).

The region includes the town of Daguragu, which was born as a result of protest by Gurindji people over the poor living and working conditions on cattle stations.  On August 22, 1966, Gurindji leader Vincent Lingiari headed a walk off of workers and set up camp at Wattie Creek, a place called Daguragu.  This camp became the strikers' headquarters where sympathisers and strikers could organise in the struggle for better wages, conditions and land rights.  The strike had a ripple effect among Aboriginal people working in the cattle industry in the Victoria River district and Daguragu became the home of workers laid off during the wet season.  In 1972, workers of Moolooloo, Pigeon Hole and Mt Sanford also "walked off" and moved in Daguragu. Their example was followed by workers from Humbert River.  In 1975, the strikers were able to secure title to 2,500 square km from the nearby Wave Hill station.  This land became Aboriginal land in 1981.  Kalkarinji, formerly known as Wave Hill, was shaped by the

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[57] A more detailed description and evaluation of the process can be obtained from the Menzies School of Health Research's evaluation reports (d'Abbs 1998a, 1998b, d'Abbs et al 1998, 2002, Katherine West Coordinated Care Trial Local Evaluation Team 1998a, 1998b, 1999a, 1999b, 2000, Katherine West Health Board Aboriginal Corporation 2001).

events outlined above. After the walk off, Government officials and the Wave Hill station government regarded the Wave Hill community as a legitimate community, whereas Daguragu was regarded at an illegitimate community, a striker's camp. Whereas police, welfare entitlement, health and postal services were delivered to Wave Hill, Daguragu received nothing (fieldnotes from visit to Daguragu and Kalkarindgi). The 1981 Gurindji land claim included Kalkarinji (d'Abbs et al 1998, Katherine West Coordinated Care Trial Local Evaluation Team 2000).

Aboriginal people in more southern stations supported the land right strike, but were unwilling to join the camp at Daguragu. Going to Daguragu would have meant leaving their own country and facing the possibility of never being allowed to return. Instead, they organised their own strike in 1972 to press for land. In November 1973, an agreement in principle was signed securing the transfer of 240 square km to be used as a cattle station, including the derelict Gordon Creek station, now renamed Yarralin. This was not a first choice for location, and the size of the land allocation was deemed insufficient, but the conditions were nevertheless accepted as a gesture of goodwill. Additional land was secured in 1984 (d'Abbs et al 1998, Katherine West Health Board 2003). These events remain highly significant. The Daguragu land claim was the first successful land recovery process in the history of Australia and is a source of great pride. A picture of the hand-over ceremony hangs in the local pub and new comers are told the story of the strike without prompting (fieldnotes from visit to Daguragu and Kalkarindgi). The event has been made the theme of popular Australian songs.

Jack Little was the first Chairperson of the KWHB Board and remains a Board Member today. Now in his mid-eighties, he had a long involvement in health and was the head of the Katherine Institute for Health, an organisation created in the early 1980s to deliver the Health Worker Training Program
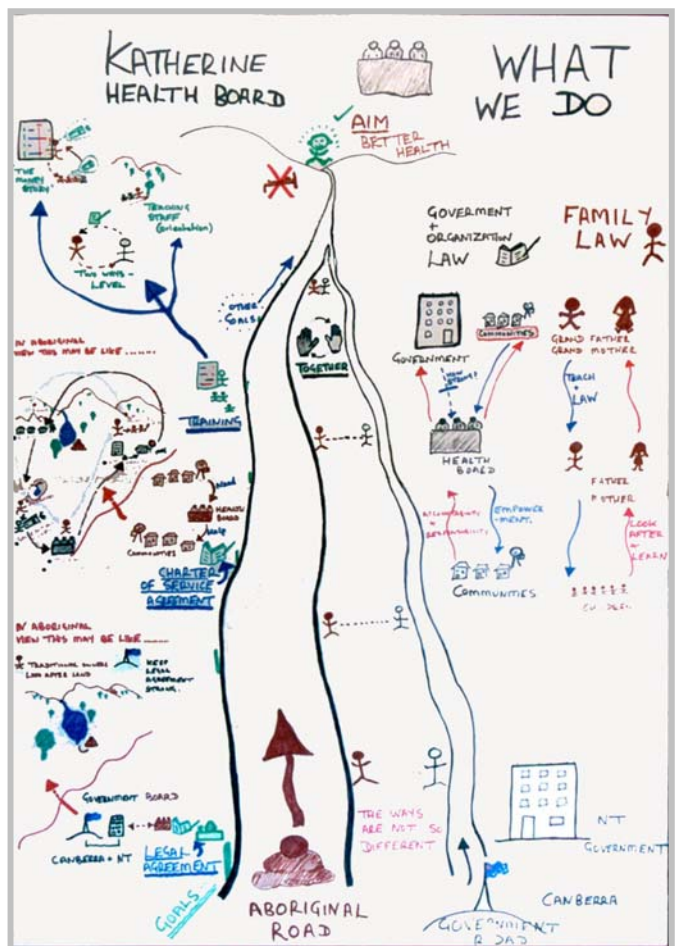
(Fleming & Devanesen 1985). Jack Little was involved from the beginning. It was he who drew a poster to represent the vision of the Board, explained as follows:

*Why I did that [poster] because, what brought that really, we want better health. I think Europeans and Aboriginal people should work together. That's why there's two roads, the narrow road for European people and that broad, wide road that's for Aboriginal people. But there're all in it for health.*

*When I thought about it, why every European people always have to be in charge, why can't Europeans come to the Aboriginal road? Both get an idea from each, whiteman get ideas from blackfella, and blackfella get ideas from whiteman, so they can work together.*

*And not only that too, our dreamtime and things like that, that's very important, our culture and our dreamtime, that's our health. We lose that, we sick, not physical, spiritual, sick inside cause we lost everything. You know what I mean? And that's really why we had to put that up.*

*It wasn't easy, trying to run this Katherine West trial, we had hard trouble to get there. We had to be present, to come to every meeting, we had to commit ourselves and show that we can do it, we are capable of doing it! (Jack Little, KWHB Board Member and first Chairperson, 2002; Katherine West Health Board 2003)*

KWHB was initially set up in 1998 to implement the Katherine West Co-ordinated Care Trial. It was one of four Aboriginal Coordinated Care Trials to be conducted across Australia. This was part of a larger national process motivated by a changing demographic profile and the need to explore strategies for cost containment. In February 1994, the Council of Australian Governments (COAG, head of each State/Territory and Prime Minister) appointed a national Task Force who recommended the restructuring of the health care system into three streams corresponding to three categories of individual needs:

- The general care stream, corresponding to people's needs for occasional and uncomplicated care;

- The acute care stream, corresponding to people's need for acute and specialised care; and

- The coordinated care stream, corresponding to people's need for a mix of services for a long period of time (Council of Australian Government's Task Force on Health and Community Services 1995a).

Neither the 1995 Task Force report, nor the update issued in December of the same year made any reference to Aboriginal needs (Council of Australian Government's Task Force on Health and Community Services 1995a, 1995b). In September 1995, the Commonwealth Department of Human Services and Health called for expressions of interest from the public and private health sectors. Nine "mainstream"[58] and four Aboriginal and Torres Strait Islanders CCTs were undertaken. All mainstream CCTs

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[58] The idea that indigenous life occurs at the margin of a "mainstream" is prevalent in Australia. The terminology is maintained because it is local and historical, but may be uncomfortable to certain readers.

were located in areas where services were readily accessible (Commonwealth Department of Health and Aged Care & University of Adelaide (GISCA) 1999). The Aboriginal CCTs were located in remote or very remote environments. Mainstream and Aboriginal trials were evaluated both locally and nationally.

Mainstream CCTs focused on the coordination of care plans for clients with multiple and complex needs. The trial required the establishment of a coordination process to avoid duplication, and to ensure an effective, high quality intervention (Australia Commonwealth Department of Health and Community Services 1995, 2001). In contrast, the Aboriginal CCTs involved setting up a capitation model involving the pooling of financial resources previously allocated for Aboriginal health, but administered separately, and the transfer of that pool to an Aboriginal authority thereafter charged with the task of purchasing services for a population located in a designated geographical area (Interviews AU02, AU10, AU18, AU26).

Aboriginal health had not been identified as a fertile ground for coordinated care trials. The 1995 call for a proposal by the Commonwealth Department of Health and Community Services did not specifically target Aboriginal health services. In the Northern Territory, the Territorial Government initiated the proposal that led to the Katherine West and Tiwi trials.[59] Key players at the Territorial Health Services (hereafter THS) saw this as an opportunity to access Medicare and pharmaceutical benefit dollars not available to the Northern Territory because of its thinly distributed population and its lack of general practitioners (Interviews AU02, AU10, AU18, AU26). This situation had been discussed extensively in the Aboriginal health sector for many years. The Aboriginal CCT proposal submitted by THS to the Commonwealth Government proposed the establishment of two regional Aboriginal Health Boards to act as fundholders,[60] with funding pooled from THS and the Commonwealth government, including Medicare. It was seen as the solution to bring Medicare funding into the Northern Territory. Although there were probably as many perspectives as protagonists on what the CCT would look like once implemented, some THS employees saw the Aboriginal Health Boards as a mechanism that would allow THS to continue to offer services directly to the communities, while having access to Medicare through the fund-holders (Interviews AU02, AU10, AU15, AU29).

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[59] One in Tiwi and one in Katherine West. It is unclear whether the same occurred for the two other Aboriginal trials, Perth (WA) and Wilcannia (NSW).

[60] According to both authors of the proposal, the role of the Aboriginal Health Board as a provider was not defined in the proposal. But the proposal did not exclude this possibility,

The planning of the CCT required a complex process of consensus building at three levels. First, within the KWHB region, community members and leaders had long been used to *whitefella* promises.

> *When the government people come they promise on thing. When they go home, something that's very important that the community people been ask for, well nothing happen (Jack Little, KWHB Board Member and former first chairperson, cited in Creswell 2001).*

The ACCHS sector initially opposed the CCT, because of concerns over the idea that KWHB's role might be limited to that of a fund-holder and merely a mechanism for THS to secure access to Commonwealth funding (Interviews AU02, AU15, fieldnotes on KWHB). A contributing factor may have been that there were limited Aboriginal community and authority involvement in the initial proposal. Time constraints appear to have been a major factor: the initial response to the call for a proposal was drafted in 48 hours to meet a deadline (Interview AU10). Discussions with the ACCHS sector began after that and support was eventually gained.

The most time-consuming and complex process involved OATSIH, THS and KWHB's negotiations for appropriate resourcing, process and fund pooling (See minutes of the following meetings for discussion: Katherine West Health Board et al 1999, 2001c, 2001a, Katherine West Coordinated Care Trial Local Evaluation Team 2000, d'Abbs et al 2002, see also 2001b for a detailed discussion). As shown in Table 5.1, the planning phase lasted one and a half years. The CCT Live Phase began on July 1st 1998, meaning that KWHB became a fund-holding body mandated to purchase health services on behalf of the CCT population located in the KWHB region. At that time, KWHB continued to purchase services from THS for the clinics located at Kalkarindji, Daguragu, Yarralin and Pigeon Hole. There was however some discomfort with that arrangement:

> *How is community control going about though, because the clinics belong to Territory Health, how is the community going to have control of co-ordinated care? (Helen Morris, Board Member, Daguragu, cited in Katherine West Health Board Aboriginal Corporation 1998).*

| Table 5.1, The Development of KWHB (d'Abbs et al 2002) | |
|---|---|
| Coordinated Care Trial Phase Planning | January 1997 to June 30th, 1998 |
| Coordinated Care Trial Live Phase | July 1st, 1998 to March 31st, 2000 |
| Transition Year | April 1st 2000 to December 31st, 2001 |
| Primary Health Care Access Program | January 1st, 2002 |

KWHB took over the clinics at Daguragu/Kalkarindji, Yarralin and Pigeon Hole on November 1st, 1999. This was followed by the clinic at Lajamanu in September 2000, and the clinics at Timber Creek, Bulla and Mialuni in June 2001 (Katherine West Health

Board et al 1998a, 1998b).  KWHB signed a three- year contract on December 19th, 2001, funded under the Primary Health Care Access Program (PHCAP). This is the first organisation in Australia to be funded under the new.

Under the KWHB-PHCAP model, access to Medicare shifted from a demand-driven process to a capitation model, facilitating the adoption of a primary health care model of service delivery.  This is something the ACCHS movement lobbied for many years (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1998, This was evident in Danila Dilba's board minutes, 2000a, 2000b).  It is therefore not surprising that KWHB is now considered a remarkable success story that is having repercussions for all ATSI people.  This is THE example provided every time PHCAP is mentioned.  Much of the enthusiasm expressed towards KWHB comes from the fact that this is a tremendous improvement over the former level of service delivery.

KWHB now operate eight community clinics, and oversee 72 staff.  Its governance model is that of a regional organisation, with the benefits and challenges that it poses.  While it is governed by an Aboriginal Board, the space the Board exercises control over is carefully defined by legislation, finances, performance indicators, geography, recruitment and retention, and a spectrum of other factors as well.  The organisation nevertheless greatly benefits and draws considerable flexibility from having access to predictable, substantial and comprehensive funding.

### 5.1.3   The *iwi*-based Te Runanga O Raukawa

Te Runanga O Raukawa Inc. (hereafter TROR) is an *iwi*-based organisation, located in Otaki, with offices in Levin, Palmerston North and Feilding. It was incorporated in February of 1988. The organisation delivers services in the areas of health, social services, education, employment readiness and justice. Although its mission is primarily to serve the development needs of Ngati Raukawa and affiliated *hapu/iwi* [sub-tribe/tribe], services are delivered to those who seek them, including the larger Māori population living in the area as well as all other cultural groups (discussions, Otaki fieldnotes). According to the 2001 Census, Ngati Raukawa (Horowhenua/Manawatu) counts 11,088 members, totalling 2.4 percent of the overall Māori population of New Zealand (Statistics New Zealand 2001). A third of Ngati Raukawa members live in the Manawatu-Wanganui region.
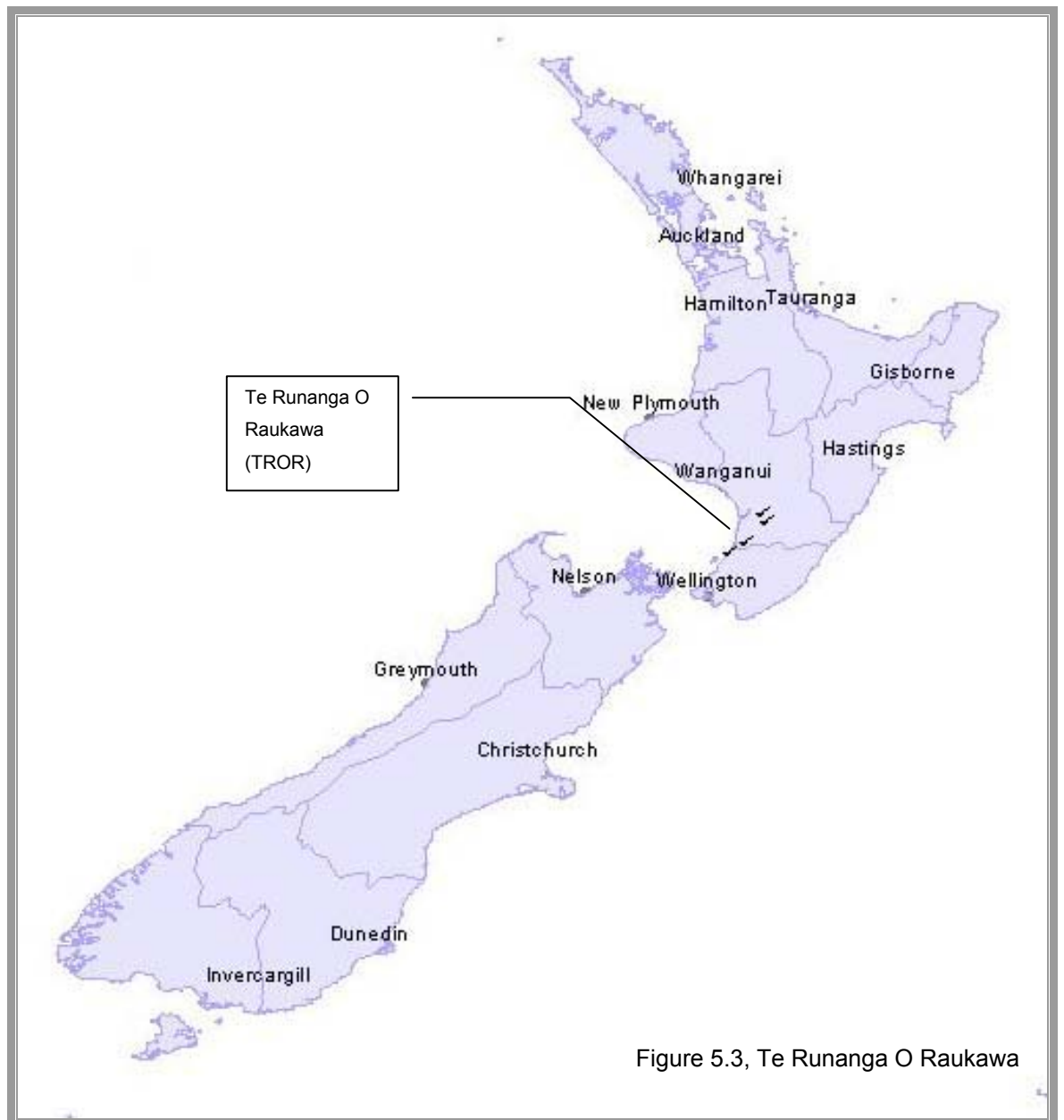
Figure 5.3, Te Runanga O Raukawa

Ngati Raukawa's involvement in service delivery is linked to the history of Māori Councils. The Raukawa District Māori Council was founded in the early eighties to administer a government economic development loan scheme (MANA Enterprise). Involvement in health care followed in 1982 with the successful establishment of a health promotion initiative with the Palmerston North Hospital Board. The goal of the service was to raise health awareness. Five Māori Health Workers were hired in the early eighties (Interviews NZ08, NZ16, Minutes of meeting from April 23, 1986).

In 1984, the fourth Labour government embarked on a reform of Māori affairs that culminated with the document *Te Urupare Ranapu/Partnership Response* (Wetere 1988), promoting the development of *iwi* as an operational base for Māori development. This position echoed Māori demands for greater participation and autonomy in Māori affairs. The Runanga *Iwi* Act adopted in 1990, enabled *iwi* to

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register as the authorised voice of that *iwi*, and to be recognised as such by the Crown and all public authorities (Bennion & Melvin 2002). This was the first attempt in New Zealand to recognise and integrate traditional Māori tribal and governance structures in public policy and service delivery. Although the Act was repealed in 1991 following the election of the National Party, it has left an important imprint on Māori development and shaped the development of TROR.

*Te Runanga O Raukawa was formed in 1989, in response to the devolution policies of the Labour Government, which in 1986, in a move to promote Māori development, established the MANA LOANS and MAORI ACCESS schemes and authorised Te Komiti Whakatinana O Raukawa, a joint committee of the Raukawa District Māori Council and the Raukawa Trustees to manage these schemes. Prior to "devolution" these programmes would have been administered by the Department of Māori Affairs and Department of Labour respectively.*

*The Komiti Whakatinana [Governance Committee] O Raukawa, a non incorporated body, had limited powers and a body with wider powers was needed to give full effect to Government policy. In 1989, the Department of Māori Affairs was dis-established and the Iwi Transition Agency (ITA) was set up to manage the transition of MANA, MACCESS and other programmes to iwi control. Following the approval of its Constitution, Te Runanga O Raukawa Inc. replaced the Komiti Whakatinana O Raukawa as an Interim Iwi Authority and took over the management of the programmes and associated funds and iwi development generally.*

*The Runanga/Iwi Act 1990, gave statutory recognition to Runanga/Iwi and opened the way for all iwi to express their rangatiratanga [sovereignty]. This encouraged the break up of previously stable multi iwi groupings as individual iwi moved to express their own identities. Te Runanga O Raukawa was not immune and as iwi indicated their desire for autonomy, so too did the hapu of Ngati Raukawa.*

*In September 1990, a number of hapu voiced a desire for amendments to the Constitution which would give Ngati Raukawa hapu a greater say in their affairs. Three subsequent hui held in June and July 1991 gave overwhelming support for this view. Amendments have shifted the decision making powers to the hapu of Ngati Raukawa but do not exclude the participation of all iwi who were included in the original Constitution (Te Runanga O Raukawa Inc. 1991b).*

The overall goal of the organisation was to integrate all services defined by public policy under a single organisation and single contract, and deliver *kaupapa* Māori services [services founded on principles reflecting Māori culture] to *whanau* [family] and *hapu* [clan]:

*Our vision was that health would be part of the broader field of Māori development. So that the health programmes would be linked into our employment programmes and to our education programmes and to our justice programme. We had this idea that… social policy might be under one umbrella and… every hapu would develop in a holistic way. Now we tried that and but because in about 1991 or '92 we had a number of contracts with the different sectors, we called all the sectors together. Health, justice, social welfare, education and their subdivisions like probation services and early childhood and said to them you know it's great we've got a contract with each of you, [but] we would like to work together so that we don't have to repeat for every sector what we think is common to you all. So we called this meeting. We had two meetings actually, and to our surprise of course because we were naïve, it was the first time that most of these different sectors had actually met each other although they all operated in the same region. And after the second meeting it was pretty evident that any notion that they might work together to produce a single contract that would enable us to pursue this holistic vision was probably before its time. So that's where opportunism I*

*think took over… This is how the contracts are being shaped, that's what we'll do.  But there is still that notion that… really the runanga's mission is not about health or about education, it's about development at another level.  And we would like it to be able to reflect all those things in some combination that we don't yet have (Interview NZ16).*

TROR has lived through four (4) major health care reforms since it first became active as a health service provider in 1992, from the Area Health Boards (1983-1993) to the Regional Health Authorities (1993-1998), the Health Funding Authority (1998-2000) and the District Health Boards (current). As shown in Figure 5.4, TROR has thrived through the reforms, continuously expanding its access to funding.[61] But the reforms have brought many challenges to the organisation.[62] For example, the transition from the Manawatu/Whanganui Area Health Board (1983-1993) to the MidCentral Regional Health Authority (1993-1998) created some disruption. As noted by Ran Jacobs, CEO at the time, in his report to the *Whaiti*,



**Figure 5.4, Access to Health Contracts through the Reforms**
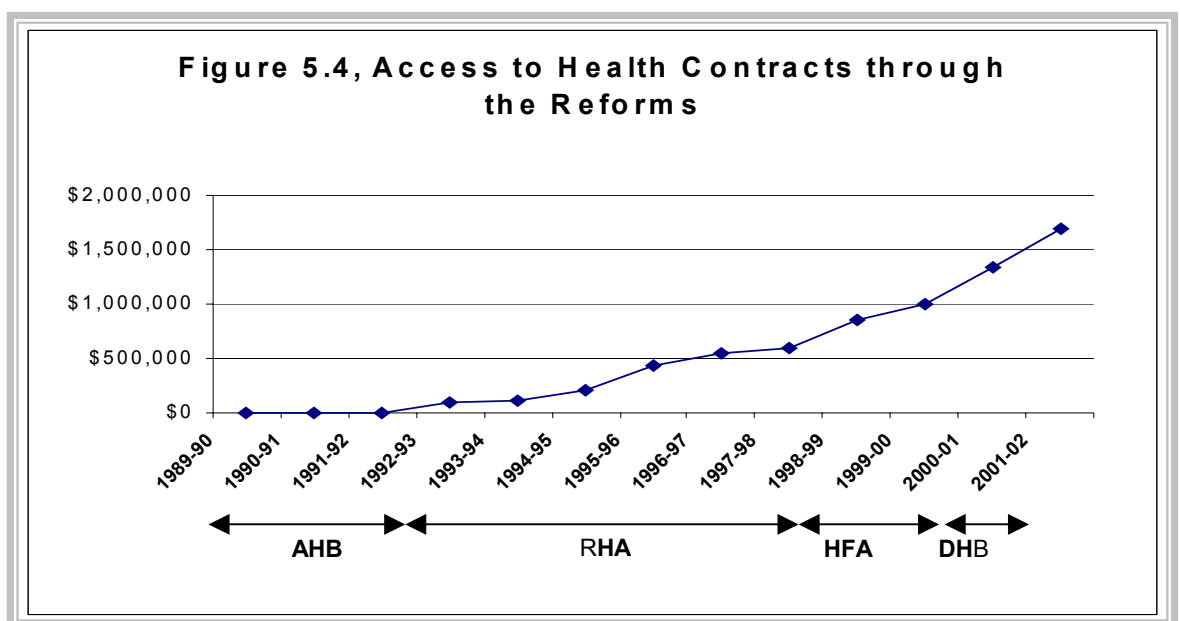
*The new health system is confusing. New structures and new terminology make it difficult for the general public to fully understand it. The Runanga Health Committee has spent a lot of time adapting to the changes and renewing contracts with the new organisation.*

*Changes in the Health system took effect on 1 July 1993. The Manawatu/Wanganui Area Health Board was replaced by the Mid Crown Health Enterprise. The 1992-93 contract to provide a community health programme that the Runanga had with the MWAHB was transferred to the Mid CHE on 1 July. The contract will continue (in quarterly segments) until the Central Regional Health Authority (Central RHA), the funding agency for all health providers, becomes fully operational, at which point we hope to contract with the Central RHA to deliver the Whanau Ora Health Plan.*

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[61] Based on audited financial statements from annual reports.

[62] Challenges are repeatedly expressed in minutes of meetings and reports, related to how TROR relates to new structures, and with continuity of programs and funding (Te Runanga O Raukawa Inc. 1993, 1998a, 1999a, 2000a, 2000b, 2002).

*It is probably that the Whanau Ora Health Plan or a modified version of it, will be in place by the commencement of the new year (Te Runanga O Raukawa 1993).*

The *Whanau Ora* [family health & wellbeing] programme had already been in the planning since October 1992. Discussions with the Manawatu/Whanganui Area Health Board had to be halted to accommodate the reform. Funding for the programme was finally secured in September 1994 with a much reduced budget (Te Runanga O Raukawa 1994).

The transition from the MidCentral Regional Health Authority (1993-1998) to the Health Funding Authority (1998-2000) led to a roll-over of contracts without an opportunity to review volume in light of needs (Te Runanga O Raukawa Inc. 1997). The transition to the HFA gave TROR the opportunity to explore the possibility of a different model of development. Nationally, the Regional Health Authorities had led to an interesting development for Māori health providers. Each of the four authorities had developed a different model to engage local Māori, whether as *iwi* or pan-*iwi* organisations. In the north of the country, Māori Purchasing Organisations (MAPO) had emerged to act as advisers in health funding allocation and to support independent Māori providers. The Midland Regional Health Authority opted for joint ventures governed by RHA and Māori *iwi* representatives. In contrast, the MidCentral Regional Health Authority had largely maintained the practice of purchasing services from small *iwi*-based providers (Cunningham & Durie 1999).

The HFA supported the development of Māori Integrated Care Organisation (MICO) proposals. The model was seen by TROR as an opportunity to move forward to implement its vision. The development of a MICO proposal was first brought up at the *Whaiti* meeting of March 31, 1998 [Board meeting] (Te Runanga O Raukawa Inc. 1998b). By the mid November 1998 *Whaiti* meeting, funding had been secured and a consultant hired to develop a proposal. The HFA abandoned the MICO model in June 1999, at the request of the Health Minister (Te Runanga O Raukawa Inc. 1999b, 1999c). As expressed in the Health Strategic Planning Committee's Report at the 1999 Annual General Meeting,

*By June 1999, and contrary to local information, the HFA had reversed its policies on MICO and all MICO development was terminated. Although there was no financial loss to the runanga (the HFA eventually agreed to meet all expenses) a great deal with time had been spent and the outcome was disappointing. Reasons for the change in HFA policy are not clear but it appears to be linked to the Authority's intention to establish… partnerships with iwi (Health Strategic Planning Committee 1999).*

The most recent reform, the transition from the Health Funding Authority to District Health Boards, was anticipated with some discomfort.

*It has been widely reported in the media that the new Government intended to dismantle the Health Funding Authority - HFA and return to [District] Health Boards.*

*Consequently, Iwi Māori Health Providers have expressed major concern about the effect that this will have on Iwi Māori around the motu [island]. Ngati Raukawa has been quoted, particularly as a "preferred provider"[63] of health services as likely to be disadvantaged by the proposed changes. Meetings have been held at Parliament with the Associate Ministers of Health and Employment and correspondence has been sent directly to the Minister of Health about those concerns (Te Runanga O Raukawa Inc. 2000b).*

Hopes that *iwi*-based health providers may be funded directly by Central Government, rather than the District Health Board, did not materialise either (Te Runanga O Raukawa Inc. 1999a). At this time, most of TROR's funding comes from the MidCentral District Health Board.[64]

This reform is still in the process of being implemented. More specifically, the implementation of the Primary Health Care Strategy (New Zealand Ministry of Health 2001d) requires the DHBs to promote the development of Primary Health Organisations (PHO), which will be funded on a per capita basis and tasked to provide (or purchase and provide) primary health care services to an enrolled population. TROR, through its participation in the pan-*iwi* consortium Manawhenua Hauora, has produced a position paper to guide the MidCentral District Health Board with minimum specifications to be required of a pilot PHO (Durie 2002). This is an attempt to ensure that Māori needs will be considered and provided for. Depending on the direction taken in the development of the PHO in the region, TROR may see its funding coming from yet another authority, this time a PHO of which it may or may not be a stakeholder. It is yet unclear whether the organisation will continue to exist as an independent provider (Interviews NZ08, NZ16).

In summary, the contractual environment that emerged as a result of a New Zealand's shift towards competition in the early 1990s has created opportunities for Māori participation in service delivery. TROR has thrived on these opportunities. The initial vision of the organisation was to funnel all primary health care funding through a single contact facilitating the breakdown on jurisdictional barriers and western categorisation in service delivery. This has been reshaped by the contractual environment (Interviews NZ08, NZ16, also evident in minutes of meetings and

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[63] This means that the organisation can hope to have its contracts renewed without having to submit a proposal or compete through a standard tendering process. It is unclear whether the Preferred Provider status is linked to an official policy of the funder, or whether this is simply a practice established by the HFA. It is further unclear whether this practice will have currency under the present reform. The Preferred Provider status prized by Te Runanga O Raukawa is not mentioned in contracts. No contract contains an explicit provision for contract renewal. This means that theoretically and legally, good performance does not guarantee renewal. As the system stands, the funder holds no obligation to the provider once the contract has ended.

[64] The Runanga O Raukawa service "map" overlaps neatly with that of the MidCentral Health Board. This is a fortunate coincidence.

discussions). The organisation is now delivering services defined narrowly by highly defined health contracts. It is not that the vision has been abandoned, but rather that the requirements of continued service provision and the limitations of a health care system continuously involved in reforms have limited TROR's opportunity to pursue its vision.

The Crown has repeated its commitment to partnership, participation and protection (New Zealand Ministry of Health 2001a). How are these values to be reflected in practice may well remain a matter of debate. Contracts continue to be designed as patches to the current health system delivery. The organisation remains vulnerable to shifts in political ideology and health care reforms. How this relates to a "Treaty partnership" is unclear.

### 5.1.4   Te Roopu Huihuinga Hauora Inc.

Te Roopu Huihuinga Hauora Incorporated (hereafter TRHHI) is a Māori organisation based in  Whataku, near Hastings. It coordinates contracts and health provider services in the Hawke's Bay region. The organisation was incorporated in May 1997.

In its role as a Māori Development Organisation, TRHHI provides support services to nine independent Māori health provider member organisations. TRHHI's philosophy statement reflects the current Crown interpretation of the *Tiriti O Waitangi* [Treaty of Waitangi] framework, which includes participation, partnership and protection (Te Roopu Huihuinga Hauora Incorporated 2003).
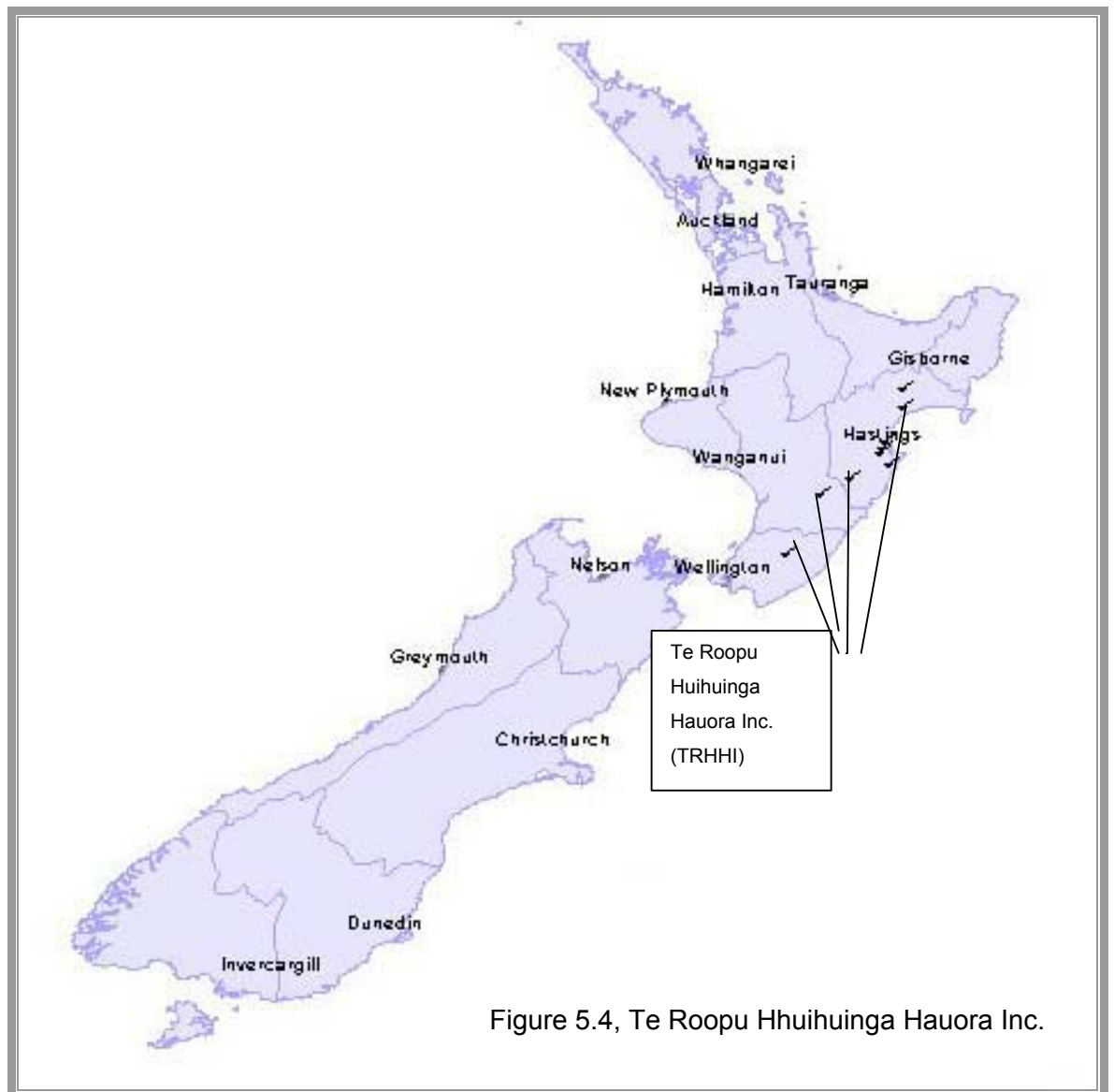
Figure 5.4, Te Roopu Hhuihuinga Hauora Inc.

Ngati Kahungunu is the largest and fastest growing *iwi* in the country, with 51,552 members claiming *whakapapa* [genealogy, lineage] back to the tribe (New Zealand Transitional Health Authority Maori Health Groups 1997). The organisation covers a wide region reflecting the Ngati Kahungunu *rohe* [area, tribal boundaries]. It crosses administrative and district health board boundaries, compounding governance and administrative complexity (Interviews NZ11, NZ27).

TRHHI was incorporated under the Incorporated Societies Act 1908 in May 1997. It was a coming together of sixteen Māori providers existing in the region and wishing to create an umbrella organisation to advance their interest with the funding authority of the day. Interim trustees selected from member Māori providers were appointed in February 1999 and a proposal was submitted (March) to the Health Funding Authority (Interviews NZ06, Te Roopu Huihuinga Hauora Incorporated 1999b).

The development of the Māori Development Organisation is linked to changes brought by health reforms. As shown in Table 5.2, TRHHI's beginnings overlapped with a succession of health care reforms. This has meant a shift in government priorities, funding authorities and funding officers.

| Table 5.2, Timelines | |
|---|---|
| May 1997 | TRHHI is incorporated |
| June 1997 | Reform 1: Regional Health Authorities replaced by the Transitional Health Authority |
| June 1998 | Reform 2: Transitional Health Authority replaced by the Health Funding Authority |
| March 1999 | TRHHI submits a MICO proposal to the Health Funding Authority |
| October 1999 | TRHHI is informed that its MICO proposal was rejected |
| November 1999 | TRHHI is informed that it will be funded as an MDO |
| December 2000 | Reform 3: The Health Funding Authority is replaced by the District Health Boards |

TRHHI's initial plan was to secure funding as a Māori Integrated Health Organisation (MICO) (New Zealand Transitional Health Authority Maori Health Groups 1997, Te Roopu Huihuinga Hauora Incorporated 1999a, 2000b). The opportunity was however short-lived. As was the case for TROR, the Board was advised that its MICO proposal would not be funded. Instead, the organisation was offered funding under the new Māori Development Organisation model (MDO).

> *Te Roopu Huihuinga Hauora Inc structure has not been exempt from change as you will all be aware, having its beginnings as a Māori Integrated Care Organisation in May 1997 and emerging as a Māori Development Organisation in December 1999.*
>
> *Even the original intent has changed from the provision of high quality, accessible comprehensive health services to Māori by Māori to one that reflects the type of work that the organisation is now engaged in, being the purchase and provision of an integrated continuum of services through a kaupapa Māori approach to health to people residing within the region; and to promote tino rangatiratanga me te hauora of the individual, whanau, hapu and iwi (Te Roopu Huihuinga Hauora Incorporated 2000a).*

Initially, MDOs were expected to be funded on a capitation basis[65] for a registered population. This has however not occurred. The main reason can be linked to a decision-maker within the HFA.

> *I refused to have any contracts written for Māori that were capitated… I hired a statistician demographer who had done all the funding formula for the Treasury and she explained to me that there was no way, there was absolutely no way unless we had an excessively funded capitation contract that this was going to be any good to Māori organisations.  So we kept them all on what we call a nominal population basis which*

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[65] The basis for capitation was never defined. While it is clear that funding for secondary care would not be included, it is not clear at all whether the planned capitation formulae was expected to include all primary health care funding or only a portion of it (health promotion and prevention for example).

*related to their tribal populations and tribal districts. And this provided them with quite some flexibility really in the application of the funding (Interview NZ30).*

The MDO model reflected a new governmental commitment to fund developmental organisations to assist existing Māori providers. This was a significant scaling down from the MICO model. If funded on a capitation basis, MDOs may have been able to develop services in all or at least many priority areas (New Zealand Health Funding Authority 2000, Interview NZ06). Since this was never implemented, the focus of the MDO contract eventually shifted to provider support and coordination (New Zealand Ministry of Health 2001c).

> *The health funding authority decided to move down something called a Māori Development Organisation, basically as a mechanism for building capacity amongst providers. That's really what it was on about. The second thing it was on about was to somehow deal with the proliferation of small providers that were starting to crop up in the Māori field and it made sense that if they could devolve some of that responsibility for looking after those small providers... So the Māori, the managed care type stuff went out the window and in the window came the idea of a capacity building organisation and also an organisation that relieved some of the monitoring and control problems that a proliferation of small providers actually introduced (Interview NZ06).*

Funding to address Māori health priorities was to be secured through separate contracts, thus perpetuating rather than addressing the fragmentation experienced by TROR. The MDO model's focus was two prong:

- To support existing providers in their development, by focusing on Māori provider and service development; providing a professional and efficient infrastructure within which that expansion could occur; creating an administrative umbrella with more service and bargaining strength; and addressing Māori workforce development issues (New Zealand Ministry of Health 2001c). And,

- To promote policy-defined Māori Health Gain Priority Areas. The HFA initially defined 8 such priorities. This has now been extended to 13 (see Table 5.3) (New Zealand Health Funding Authority 2000).

| Table 5.3, Service Priority Area for the MDO (New Zealand Health Funding Authority 2000) | |
|---|---|
| Former HFA Māori Health Gain Priority Areas | New NZHS Population Health Objectives |
| Immunisation | Ensure access to appropriate child health care services including all child and family health care immunisation. |
| Smoking | Reduce smoking |
| Diabetes | Reduce the incidence and impact of diabetes |
| Oral health | Improve oral health |
| Mental health | Improve the health of people with severe mental illness |
| | Reduce violence in interpersonal relationships, families, schools and communities |
| Injury prevention | Minimise harm caused by alcohol and illicit and other drug use to both individuals and the community |
| | Reduce the rate of suicide and suicide attempts |
| | Reduce obesity |
| | Increase the level of physical activity |
| | Reduce the incidence and impact of cancer |
| | Reduce the incidence and impact of cardiovascular disease |
| Hearing | |
| Asthma | |
| | Improve nutrition |

What is clear is that the MDO model, as described in the MDO contract, reflected tendencies in stream-lining the health care system (Interviews NZ06, NZ24). The MDOs were to focus on national priorities, in effect providing additional services and support to Māori in areas where health inequalities were most apparent. This was a departure from earlier approaches focusing on integrated care, capitated funding, and promoting Māori provider participation in all aspects of Māori health services delivery. The approach to priority setting had shifted from local to national.

The end of the HFA was announced in December 1998 and with it, came the end of centralised purchasing. This was replaced by a regional and population-based approach to primary, secondary and tertiary care planning and delivery. The implementation of this strategy led to the formation of twenty-one district health boards (King 2000). Unlike TROR, whose boundaries fits into the territory of a single health board, Te Roopu Huihuinga Hauora's boundaries straddle three. This situation multiplies the number of players to establish relationships with, and administrative complexities. For reasons yet unclear, TRHHI has been made to carry the full responsibility of the success of these relationships (evident in Interview NZ27).

The Primary Health Care strategy has specifically mentioned the role of MDOs in the overall system, placing them on equal footing with Primary Health Organisations

(New Zealand Ministry of Health 2001d). This suggests that existing MDOs may find themselves a preferred mechanism for PHO development. This may well be happening in other regions, but it was not apparent in the Hawke's Bay region. The Hawke's Bay District Health Board has stated that it will support the development of a Māori PHO, leaving to Māori organisations and IPAs the responsibility to sort out ownership and governance issues. Discussions are on-going (Interviews NZ06, NZ11, NZ27).

In summary, TRHHI has been caught in the process of health care reforms. It was a shift in policy that led TRHHI to shift its vision and mandate, from that of an Integrated Māori Health Organisation to that of a Māori Development Organisation. With the recent reform, TRHHI has seen its *iwi rohe* and territory fragmented into three District Health Boards, creating a myriad of administrative difficulties. Despite the policy commitment made to MDO, the future of this particular MDO is unclear.

## 5.2    Commonalties and differences

The organisations discussed above emerged out of different processes. Table 5.4 summarises commonalties and differences. Danila Dilba is the only largely urban organisation. In contrast, KWHB, TROR and TRHHI have central offices located in small towns and serve populations located in a number of small rural or remote communities. Both KWHB and TRHHI are single care providers in their areas, whereas Danila Dilba and TROR provide complementary services. KWHB offers comprehensive primary health care services to a fixed population. In contrast, Danila Dilba serves a variable and highly mobile population. Access to care is to some extent demand-driven, and to some extent population-based, depending on program specifications and funding.

TROR provides contract-defined services to a variety of narrowly defined populations identified in nationally priority areas as having higher needs. These population pockets may or may not be Māori. There is no consistency on the population to be served from one community to the next, or from one contract to the next. The population served by TRHHI's providers is more consistent with its commitment to Ngati Kahungunu. The communities served by these providers are for the most part isolated and providers are the only organisation providing services in the community.

| Table 5.4, Case studies' commonalties and differences | | | | |
|---|---|---|---|---|
| | Danila Dilba (DD) | Katherine West (KWHB) | TROR (RH) | Te Roopu Huihuinga Hauora (TRHHI) |
| Began operation | 1991 | 1998 | 1988 | 1997 |
| Location | Darwin, population 68,802 | SW of Katherine NT, Population 2,800 | Levin, with offices in Otaki, Palmerston North and Feildings | Otaki based, total catchment population (Manawatu-Wanganui) 142,827 |
| Category | ACCHS | PHCAP | Māori organisation that also provides health services | MDO |
| Characteristics | Urban | Katherine based office serving remote and rural communities | Levin-based office serving small offices in rural communities | Otaki-based office serving small offices in rural communities |
| Focus | Health and some education | Health | Cross-sectorial (health, social services, education, economic development, etc.) | Health and provider development |
| Population served | ATSI estimated 7,000 | 14 separate language families 2,350 | 11,008 members in the area | 32,601 Māori in catchment area. Organisation services over 11,000 clients. |
| Services | Comprehensive primary health care, with some prevention/ promotion activities constrained by access to proposal-driven funding | Comprehensive primary health care. Proposal-driven funding supplementary. | Services depend on funding secured yearly, mostly health prevention and promotion | Services depend on funding secured yearly, mostly provider support and health prevention and promotion |
| Alternative access to PHC services | Yes, if sought and responsive. Access fee required | Single care provider in communities | Yes, if sought and responsive. Access fee required | Member organisations are single care provider in communities |
| Emerged out of | Community mobilisation, protest and resistance | Proposal that led to broad based mobilisation and policy shift | Competitive access to funding | Proposal-driven and shift in policy |

Both KWHB and TRHHI are funded on the basis of a model created as a result of policy. In contrast, Danila Dilba and TROR collect funding contracts for an eclectic variety of health services. The difference is grounded in history: both Danila Dilba and TROR emerged out of indigenous processes that connected service delivery with indigenous political aspirations. Although both KWHB and TRHHI could claim the same, their emergence coincided and was largely shaped by the introduction of a

government-driven model of service delivery, the CCT-PHCAP and the MDO. Their access to resources was less gradual and the services they provide are defined by the model of financing they participate in, rather than a collection of contracts gleaned over time. There existence is also linked to indigenous aspiration linking service delivery to self-determination. This is reflected in the contractual environment they have access to: in both case, organisations that emerged through the adopted of a government-drive process benefit from a larger proportion of their funding coming from a relational contract than their community-driven counterpart.

## 5.3    Conclusions

The objective of this chapter was to provide an overview of the four case studies. This chapter provides the backdrop for chapter 6. The Australian case studies reflect the policy development process outlined in chapter 4.

A detailed analysis of the evolution of providers in fact provides insights into policy implementation, its impact on the ground, and on the distance between policy and implementation. This is indeed a postulate of this thesis and will be explored in more details in chapter 7.

# CHAPTER 6, DECISION-SPACE ANALYSIS ACROSS CONTRACTUAL ENVIRONMENTS

This chapter explores the models of financing that emerged to support the development of indigenous health providers in Australia and New Zealand. It presents the results of four in-depth case studies conducted in indigenous-controlled health services. As described in chapter 3, each case study is meant to explore how indigenous health policy shaped the indigenous-controlled health sector. Specifically, this chapter will explore the following questions:

1. Are indigenous providers able to exercise some control over key areas of decision-making?
2. What are the constraints on operations?
3. Is the contractual environment an accurate reflection of indigenous health policies or of the state practices in health contracting? Are compromises made to respect indigenous aspirations?

This chapter is divided into three broad sections. The first section explores all four organisations' experiences using the framework adapted from Bossert. Section two revisits Bossert and offers a critical analysis of contractual environments, in light of the international literature. Section three explores the lessons emerging from the analysis presented in this chapter, and discusses the usefulness of the adopted framework as a methodological tool for exploring contractual environments.

## 6.1    Decision-space analysis

As discussed in chapter 4, the emergence of Māori and ATSI providers has been legitimised in policy. A theme that recurs in policies is that local priority setting and responsiveness are key to improving health inequalities. As discussed in the literature review, the framework adapted from Bossert (1998) provides a useful framework to explore the level of decision-making available to indigenous health organisations in three key areas:

- finance,

- governance and service organisations, and

- accountability.

These areas will be explored in detail in turn. A final section will summarise findings.

### 6.1.1  Finance

As seen in Table 6.1, all organisations receive their funding from a spectrum of contracts. **Danila Dilba**'s budget draws from 18 contracts with eight government sources.[66]  Core funding, nearly half of Danila Dilba's current funding, is the most stable source.  Recurrent funding strategies, nearly thirty percent of the total, are also fairly stable, but are linked to specific medium term vertical strategies tied to performance indicators.  Danila Dilba currently accesses less than two percent of its funding from a strategy that requires Danila Dilba to contribute either in kind or financially from its budget.  Generally, the last two categories (nearly twenty percent of funding) are accessed on a competitive basis.  These are funds from vertical strategies that are usually short lived.

Only the core funding component offers the organisation some flexibility in allocation (Interviews AU12 and AU13).  This includes funds from Medicare.  All other sources of funding are "siloed", in that contractual obligations curtail the movements of fund from one project to another and within the project's budget, from capital to salaries to operation.  Funding comes with pre-drafted contracts, performance indicators and limited budgets. The Commonwealth Health and Aged Care (including OATSIH) actually requires the organisation to set up separate bank accounts for each new project (Interview AU13).[67]

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[66] This review is based on an analysis of the contracts listed in Appendix 5. A nineteenth contract remains under negotiation and may be added if an agreement is achieved.  The organisation administered 19 contracts in 1997-98, 22 in 1998-99, and 17 in 1999-00, 27 in 2000-01.  The same detailed analysis was not pursued for previous years.

[67] Funding authorities appear not be satisfied with audited financial statements and accounting conventions.

Table 6.1: Percentage allocation of funding per category for all case studies, sample year 2001-02[68]

| Category | Definition | Danila Dilba | | KWHB | | TROR | | TRHHI | |
|---|---|---|---|---|---|---|---|---|---|
| | | # of contracts | %of budget | # of contracts | %of budget | # of contracts | %of budget | # of contracts | %of budget |
| Annual budget in GBP, 2001/02 | | £1,814,531 | | £3,255,517 | | £510,717 | | £188,888 | |
| Core | Recurrent operational funding that is not tied to specific programs | 2 | 48.5% | 1[69] | 67.7% | 0 | 0% | 1 | 29.9% |
| Strategies Recurrent Funded 100%[70] | Relatively stable funding sources tied to specific initiatives | 5 | 29.9% | 4 | 7.8% | 11 | 79.6% | 3 | 44.7% |
| Strategies Recurrent, Requiring Employer Financial Contribution | Relatively stable funding source tied to specific initiatives and requiring a sizeable organisation contribution (partial funding) | 1 | 2.0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Multiyear projects | Funding for multiyear innovative project | 4 | 11.4% | 3 | 20.3% | 2 | 9.6% | 2 | 12.9% |
| One of | Single year or shorter term project | 6 | 8.3% | 3 | 4.2% | 2 | 10.8% | 2 | 12.5% |
| | | 18 | 100.0% | 11 | 100.0% | 15 | 100.0% | 8 | 100.0% |

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[68] This information was derived from a review of the organisation's funding contracts for one year. The percentage distribution of funding between categories is provided as a rough indicator, to be used in comparisons with other funding models.

[69] During the transitional phase, core funding was divided under 6 contracts. These were combined under one master contract in December 2001.

[70] May be annually or multi-year.

*To have a harmonious working relationship, you have to break down those silos and kind of get this whole holistic-type of health going. We keep on saying that you can't just do the body part stuff and in not having that you try to break down those silos and try to point out that you can't run nutrition unless you have a good babies health program. You can't run it, you know, how it all flows in together, you can't have a happy, healthy family unless you have emotional, social well being issues addressed…*

*[W]e try to say to staff, we're all part of one big team, all going together. However, that is not the case because as an organisation we're split up into 4 units which is basically education and training, clinical services, emotion and social well being, the special projects and admin. So, there's those 4 big areas. However, even with those 4 big areas you then break it down because this is when you get those silos. So, as a manager of a team, you encourage this team bonding, there's team building, there's team effort. As an administrator of the programs you then have to pull everyone back and put them back in their silo so that you can do the financial reporting of them, and so, you have to say, look you're part of this, for instance, you're part of this emotional and social well-being team, which is fine, but then you have got to say, but however, I need you to isolate your expenditure on that program so it accurately reflects exactly what you're doing. So, part of this, we are obliged to fill this silo idea back in and it's very difficult, because in some aspects, we want people to put themselves in isolation, others of course, we don't (Interview AU13).*

It is apparent from discussions with indigenous administrative staff that submission-driven funding demands a significant time investment and the expertise of more technically proficient staff or consultants (Interviews AU12, NZ03, NZ08, NZ11).[71] Their implementation requires more administrative energy in terms of pursuing the initiative, securing the funding, providing the service and documenting the required performance indicators. Typically this type of funding is accessible only for short-term projects (months to 3 year), and is a drain on administrative energies: this is apparent in all organisations. Danila Dilba still submits proposals to access this funding, mainly because once the organisation has made representations to the community or government agencies that an important health problem requires attention, it finds itself obligated to develop a program to deal with it when funding becomes available. Because of the competitive nature of these strategies, the actual funding approved may represent only a fraction of what was requested (this is especially true for multi-year and one off projects). In such cases, Danila Dilba may feel morally or politically obligated to provide the services, despite administrative concerns.

Danila Dilba is expected to house new initiatives and provide services while maintaining standards expected of all health care delivery facilities, this despite the fact that few sources of funding provide for capital expenditures.[72] Some submission-driven

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[71] This concern was raised in all organisations, except KWHB.

[72] The original facility currently occupied by Danila Dilba was the property of the NT government, and was provided to Danila Dilba through an extended lease at no cost. Other capital costs have been shouldered by Danila Dilba through a variety of sources including donations and fund raising (fieldwork notes).

capital funding is available from THS and the Commonwealth on a competitive basis, but it is only disbursed in association with acceptable project-based services, if at all (Interviews AU09, AU13, fieldnotes from the THS visit).

**KWHB**'s budget draws from 11 contracts with the Commonwealth and Northern Territorial offices of OATSIH. One contract is a tripartite agreement that also includes the Northern Territory Department of Health. As shown in Table 6.1, core funding, over two thirds of KWHB's current funding, comes from a single contract and is both stable and flexible. The pooling of funding does not prevent KWHB from applying for additional funding from other sources (33.3 per cent, Interview AU02). Recurrent funding strategies, nearly eight percent of the total, are also fairly stable, but are linked to specific medium term strategies tied to medium term national priorities (mental health services, for example). Generally, the last two categories (nearly twenty five percent of funding) are accessed on a competitive basis, rather than on needs. These are funds from vertical strategies that are usually short lived (a few months to three years). Unlike other providers in this study, KWHB does not depend on project funding for its own survival as an organisation, or to maintain the provision of comprehensive health care services. Instead, this funding provides KWHB an opportunity to experiment in service delivery and health promotion with the goal of adjusting its service delivery if experiments prove effective (Interview AU02, field notes). This is the most appropriate use of vertical strategies.[73]

The pooling of funding has replaced the previously fragmented flow of health funding to communities (Interview AU02, AU10, AU18, AU29). This is best shown in Figure 6.1.[74] Prior to the Coordinated Care Trial, funding trickled from multiple pots of funding from the Commonwealth and Territorial Government. Under this model, community clinics remained funded and managed by THS. Although opportunities existed for communities to access additional health funding from other strategies, such as nutrition or sexual health, communities themselves may have lacked the capacity and human resources to do that. Thus, the multiplicity of funding sources shown on the left may have been mostly theoretical.

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[73] See contract listing in Appendix 5.

[74] These diagrams were produced by THS as part of the initial community consultations for the Coordinated Care Trial. They are here reproduced with KWHB's permission.

Figure 6.1, Pooling of funding
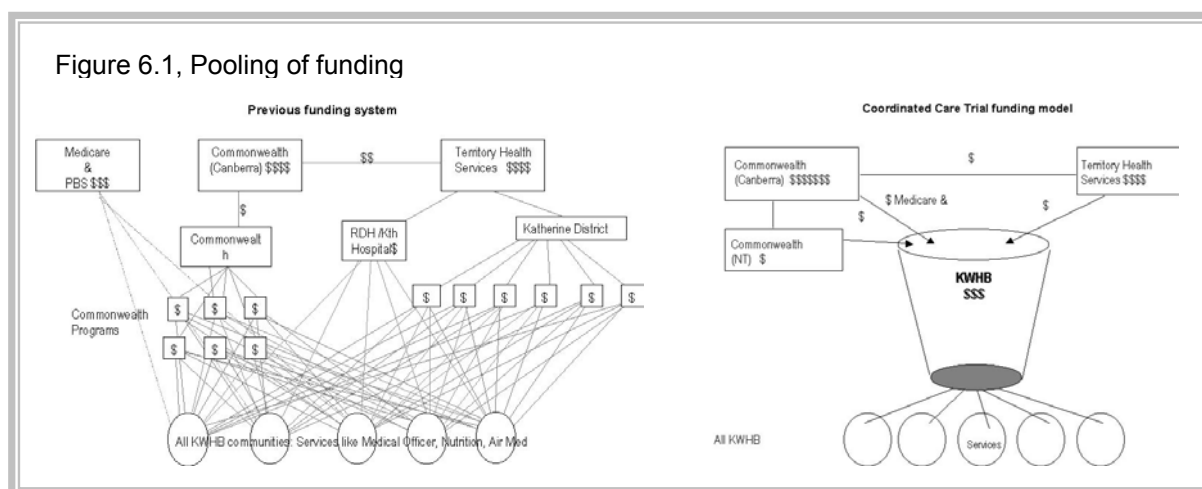


KWHB is currently receiving $1,700/per capita (three times the average Australian utilisation rate) and can bill Medicare for additional activity without penalty. The targeted Medicare pooling of $2,000/per capita (four times the average Australian utilisation rate) will be reached in the near future, at which time KWHB will be given the choice between two options:

- To either receive the full Medicare amount of $2,000/per capita and end any HIC billing. Under this option, services received by KWHB residents outside of the region would be billed back to KWHB by HIC; or

- To receive $1,800/per capita and to continue to bill the Health Insurance Commission (HIC) for Medicare activities. Under this option, services received by KWHB residents outside of the region would not be billed back to KWHB. This scenario is the preferred one at this time.

The current pool does not provide for capital development and facility maintenance. Under PHCAP, health clinics remain the property and responsibility of THS, thus minimising KWHB's financial risk.

The current agreement also provides for KWHB to be refunded for any savings THS may experience as a result of a drop in KWHB population hospitalisation rate (KWHB fieldnotes, d'Abbs et al 2002). This is a meaningful provision. A THS report dated May 2001 suggests that indeed the hospitalisation rate for KWHB dropped slightly between 1996 and 2000 (Foley 2001). What the exact payment will look like remains to be negotiated with THS. This is an example of an economic incentive to promote a more efficient use of health resources and the move from a medical to a primary health care model.

For KWHB, negotiations have been lengthy and complex, involving both the territorial and Commonwealth governments, with each side monitoring the other to ensure that cost-shifting was not occurring. The tension existing between the two governments has helped KWHB's access to information. This was evident in the minutes of most Monitoring Group Meetings (21 sets reviewed).

**TROR** was administrating 15 contracts in the 2001-02 year. The Māori Provider Development Scheme is the only contract funded by the Ministry of Health. All other contracts are funded by the MidCentral District Health Board. The organisation has delivered a majority of these contracts for the past five or six years, which makes up nearly 80 percent of its health funding. As previously mentioned, access to funding has not only been stable, but has also constantly grown.

As an organisation, TROR assumes a substantial amount of financial risks. First, the organisation receives no core funding. The two one-off contracts are for service development. A first is from the Māori Provider Development Scheme.[75] The second is for the development of a primary health care service. All other contracts are for service delivery only.

Second, although increased contracts usually mean capital funding requirements to provide for office and clinic space, funding for capital expenditure has not historically been and is still not provided by the Ministry or its funding bodies (Interview NZ08). An exception to this rule is the primary health care development contract that includes provisions for capital expenditure for renovation, but conversely provides limited opportunity for service development. Given the historical practice of renewing contracts on a yearly basis (see Table 6.2), TROR has had to shoulder all risks associated with capital expansion with limited express guarantee of continued funding.

Finally, the administrative costs associated with the contractual environment are substantial. For example, each contract is negotiated separately and contains contract-specific delivery objectives. All are volume-based with specified minimum levels of services.  Contracts secured in the early 1990s were generally paid quarterly. In contrast, each contract now specifies provisions for monthly billing on a cost recovery basis. It is under the Health Funding Authority that a monthly cost-recovery payment mentality was entrenched in the non-profit sector.[76]  New service contracts generally

[75] Provider support is accessible through the Māori Provider Development Scheme, a fund initiated in 1997 (New Zealand Ministry of Health 1997), that provides some short term proposal-driven development funding.

[76] The rationale for the shift is unclear, and is not Māori-specific.

provide for an upfront payment termed an establishment fee that allows the organisation to accommodate up front expenditures. The first payment reflects 15 percent of the total yearly budget.

| Table 6.2, TROR's Contract Renewal through the Reforms | | |
|---|---|---|
| Era | Date of Meeting | Issue |
| AHB | 01-Jul-92 | • Māori Health Workers contract signed for 12 months. |
| RHA | 01-Jul-93 | • Māori Health Workers contract transferred from the Manawatu/Wanganui Area Health Board to the Central Regional Health Authority. The contract is renewed for 3 months at a time, until the RHA structure develops.<br>• Discussion on the Whanau Ora contract that began with the Manawatu/Wanganui Area Health Board continues with the Central Regional Health Authority. |
| | 12-Apr-94 | • Māori Health Workers contract signed, with an ending date of June 30, 1994. |
| | 01-Jul-94 | • Māori Health Workers extended for a year.<br>• Whanau Ora contract still being negotiated. |
| | 06-Sep-94 | • The Health Committee notes that there is no funding available to accommodate for capital expenditure needs associated with increased staffing for health service delivery. |
| | 01-Oct-94 | • Whanau Ora contract signed, with end date of June 30 1995. |
| | 11-Oct-94 | • Note that contracts do not allow for more than a 5% margin for contingency (including capital expenditures). |
| | 01-Jul-95 | • Whanau Ora and Māori Health Workers contracts rolled over for 12 months.<br>• Mental Health contract signed. Timeline not minuted. |
| | 01-Jul-96 | • Contracts rolled over to August 31, 1996, because of delays in the renewal process. They are eventually renewed for 12 months.<br>• Contract for disability support services signed.<br>• Note that the Health Committee will be endeavouring to increase contractual outputs (fee for services funding formula) to accommodate for increased service utilisation. |
| | 01-Jul-97 | • Whakapiki Hauora topped with a 10% increase in funding. Note that this increase is unlikely to make any meaningful impression in meeting the needs of hapu/iwi members.<br>• Other contracts renewed for one year.<br>• Mental Health contract downgraded by the HFA, who no longer sees the needs for a qualified mental health nurse in this service. TROR is not prepared to simply lay off the employee, and continues to employ her in service delivery, leading to allegations of non-compliance with the contract by the HFA. |
| HFA | 14-Jul-98 | • All contracts rolled over for 12 months with the exception of Mental Health. Delays in renewing the Mental Health contract are related to issues of non-compliance below. |
| | 15-Jun-99 | • TROR requests that contracts be renewed for 2 years. |
| | 13-Jul-99 | • All contracts renewed for 3 years, i.e. until June 30, 2002. |
| | 01-Jul-00 | • New Mobile Nursing contract signed for 2 years. |
| | 18-Sep-00 | • Letter sent to the HFA to request meeting to discuss price increase. |
| DHB | 12-Jun-01 | • Auaki Kore (smoking) contract signed for three years. |
| | 16-Sep-02 | • All contracts are renewed for 12 months. |

It is noteworthy that the New Zealand Treasury Guidelines for contracting with non-government organisations acknowledges the high cost of short term, multiple

contracts and multiple invoicing, and recommends longer term contracts for recurrent services (New Zealand Treasury 2001, p. 26-27). In contrast to these guidelines, TROR must send 14 invoices monthly to recover the cost of providing health services. The invoices are sent to a Dunedin's office of the Ministry of Health, the Health Payments, Agreements and Compliance office (Health PAC, formerly the Shared Support Service Group). Reports, when due, are also sent along. There, it is assumed that invoices are matched against contract requirements. Once reconciled, payment is issued. Reports are not verified for completeness or accuracy by Health PAC, but are rather forwarded to the relevant Health Board for that purpose. Should a report fail to meet the required standard, the Health Board notifies Health PAC and payment may be suspended until the situation is rectified. The lag time is generally a minimum of three months. The centralisation of payment under a single authority was established to minimise opportunities for financial mismanagement (fieldnotes, visit to the MidCentral District Health Board, Interviews NZ07, NZ27). From the outside, the system nevertheless appears cumbersome, inefficient, and unlikely to ensure a level of accountability commensurate with the costs it carries for both the funder and the provider.

TROR administrators report having been able to renegotiate minimum volumes of services on which their contract payments are based at the time of renewal, to accommodate for new circumstances and increased costs (Interviews NZ01, NZ03, NZ08). The level of negotiation cannot be compared to that of KWHB. Senior staff report limited influence in creating a contractual environment that better reflects the organisation's vision (Interviews NZ03, NZ16). The stated objectives of the Crown to favour Māori provider development and to promote Māori models of health (New Zealand Ministry of Health 2002b) are poorly reflected in the contractual environment currently in place, especially when compared to other models reviewed.

**TRHHI** receives some core funding through its Māori Development Organisation (MDO) contract. It also receives some funding from the Māori Provider Development Scheme. These contracts were originally signed with the Ministry of Health. At this time, only the Māori Provider Development Scheme contract remains with the Ministry of Health. This provides infrastructure and capacity development funding, accessed through a proposal-driven process (Interview NZ11).

TRHHI had originally envisioned to be funded on a capitation basis. It would then sub-contract services to its independent Māori member-providers. Five years after it first began to receive funding, the organisation has remained simply a channel for a

few pre-determined contracts with narrowly defined targets and activities (Interviews NZ06, NZ11).

The MDO contract is the only secure funding for TRHHI at this time, and represents less than thirty percent of its total funding. All other funding is from the Hawke's Bay District Health Board and is passed on to member-providers for service delivery. Figure 6.2 below shows that TRHHI's member-providers were previously funded by the same organisation, the Health Funding Authority. Since the reform, one member receives its funding from the MidCentral District Health Board, one from the Wairarapa District Health Board's and all others from the Hawke's Bay District Health Board. This has complicated TRHHI's communications considerably (Interview NZ11).

Figure 6.2, Reform's Impact on TRHHI Governance and Contracts

HFA, Dec. 1999 to Dec. 2000

Ministry of Health — $ Contracts

Health Funding Authority — TRHHI

$ Contracts — Maori Member-Providers

DHBs, since Dec. 2000

Ministry of Health

Wairarapa DHB — Hawke's Bay DHB — MidCentral DHB — DISTRICT HEALTH BOARDS

Maori Health Committee Ngati Rangitane Ngati Kahungunu — Maori Provider Council MDO Ngati Kahungunu Four large Maori providers — Manawhenua Hauora 4 iwi in the region — TREATY PARTNERSHIPS

Contract $ — Contract $ — Contract $ — Contract $ — Contract $ — TRHHI — MDO

1 Provider — 7 Providers — 1 Provider — PROVIDERS

In summary, all organisations discussed above derive nearly 100 percent of their funding from government via a number of contracts. Although all experience a fragmented contractual environment, this fragmentation does not impact organisations in the same way. The impact of this fragmentation is most felt by TRHHI and TROR, and, albeit of somewhat of a lesser extent by Danila Dilba. In contrast, KWHB administers more contracts than TROR or TRHHI. It however benefits from one large, stable and flexible contract and therefore does not depend on collecting a variety of

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small contracts for sustainability or to provide the services its constituency requires. KWHB is the only organisation whose budget (main contract) is linked to needs and population. It is also the only organisation that has been able to negotiate its contractual terms.

| Table 6.3, Estimated number of transactions (payments) for each provider | | | | | |
|---|---|---|---|---|---|
| | Type of contract | Number of contract | Payment | # of payments/ year | Average payment per transaction[77] |
| DD (AUS) | Core | 1 | Quarterly | 4 | |
| | Multiyear | 5 | Quarterly | 20 | |
| | Project | 1 | Performance (payment number varies, min 1) | 1 | |
| | Project | 1 | Bi-annual | 2 | |
| | Project | 1 | Quarterly | 4 | |
| | Project | 1 | Monthly | 12 | |
| | Project | 2 | Single | 2 | |
| | Recurrent 100% | 1 | Bi-annual | 2 | |
| | Recurrent 100% | 2 | Performance (payment number varies, min 1) | 2 | |
| | Recurrent 100% | 1 | Other | 1 | |
| | Recurrent 100% | 1 | Quarterly | 4 | |
| | Recurrent partial | 1 | Unknown | 1 | |
| | | 18 | | 55 | £32,991 |
| KWHB (AUS) | Core | 1 | Quarterly | 4 | |
| | Multiyear | 2 | Monthly | 24 | |
| | Multiyear | 1 | Bi-annual | 2 | |
| | Multiyear | 1 | Quarterly | 4 | |
| | Project | 1 | Quarterly | 4 | |
| | Project | 1 | Single | 1 | |
| | Recurrent 100% | 2 | Quarterly | 8 | |
| | Recurrent 100% | 1 | Unknown | 1 | |
| | Recurrent partial | 1 | Single | 1 | |
| | | 11 | | 49 | £66,439 |
| TROR (NZ) | Multiyear | 7 | Monthly | 84 | |
| | Project | 1 | Bi-annual | 2 | |
| | Project | 1 | Monthly | 12 | |
| | | 9 | | 98 | £5,211 |
| TRHHI (NZ) | Multiyear | 3 | Monthly | 36 | |
| | Project | 2 | Bi-annual | 4 | |
| | Recurrent 100% | 2 | Monthly | 24 | |
| | Unknown | 1 | Monthly | 12 | |
| | | 8 | | 76 | £2,485 |

Each contractual environment includes administrative costs for the funder and the provider. Table 6.3 highlights the number of transactions associated exclusively with the payment of contracts. In Australia, the better resourced KWHB is able to secure more funding per transaction. In fact, KWHB is able to secure 67.7 percent of its funding in four (4) transactions. In contrast, Danila Dilba relies on a number of relatively small contracts and larger number of transactions for relatively small payments, largely for historical reasons. TRHHI and TROR, the least resourced organisations, shoulder

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[77] Calculated by dividing the annual funding received by the number of transactions.

the highest number of transactions. This reflects the contractual environment that emerged as a result of purchaser-provider split, and that appears to have survived since, despite Treasury Board guidelines (New Zealand Treasury 2001).

### 6.1.2    Governance and service organisation

All organisations studied tie service delivery to their constituency, to the ideal of self-determination (Interviews AU15, AU20, NZ08, NZ11, NZ16). The goal is to improve the health of a population to which the organisation is attached politically and to respond to needs with culturally appropriate services. Their ability to do so is constrained by contractual obligations and access to funding. In the context of the KWHB, aspirations are not explicitly tied to national and international indigenous political discourses, but to ATSI people in the Katherine West region having the opportunity to exercise control in a key area of their lives (Interviews AU02, AU14, AU29,). The focus is more regional than national. This is here a slight but important nuance.

As shown in Table 6.4, providers are funded for a variety of services. Of all organisations, KWHB is the only organisation able to sustain its operations and offer comprehensive health care services on its core funding alone. As mentioned above, the funding it accesses from vertical strategies is used to explore the effectiveness of different strategies (Interview AU02). As a result, KWHB is able to ensure that its services continue to improve and adapt to local needs (evident in conversations with staff, also Interviews AU02, AU15). In contrast, Danila Dilba, TROR and TRHHI depend heavily on project-based funding for sustainability. All organisations nevertheless appear able to weave disparate contractual obligations into coherent service delivery plan, albeit to a varying degree. This is explored in the following discussion.

**Danila Dilba** is incorporated under the *Aboriginal Councils and Associations Act 1976* (ACA Act hereafter), a Commonwealth Act administered by the Office of the Registrar of Associations and Councils.  The ACA Act is the only legislation that allows ATSI organisations to limit membership to ATSI people and their spouse, and has been preferred by ATSI organisations for that reason.  The Board of Danila Dilba has been clear that, although it delivers services to non-ATSI spouses, its membership should be limited to ATSI people.  The ACA Act thus is at odds with the Board's wishes.  Other incorporation options exist for organisations, including organising as a public company or as an association under NT legislation.   These options however do not limit

membership to ATSI ancestry.  Thus, no other incorporation mechanism exists that would better meet the Board's wishes.

| Table 6.4, Services for which organisations are funded for (based on contract review) | | | | |
|---|---|---|---|---|
| | DD | KWHB | TROR | TRHHI |
| Organisational administrative funding | | | | Core |
| Facility-based Primary Health Care | Core (incl admin funding) | Core (incl admin funding) | Recurrent | |
| Mobile Primary Health Care | Core (incl admin funding) | Core (incl admin funding) | Recurrent | Recurrent |
| Traditional healing | | | | Recurrent |
| Chronic disease control and prevention | Multi-year project | Multi-year project | | Recurrent |
| Asthma | | | | Recurrent |
| Sexual health | Multi-year project | Short term project | | |
| Eye health | Short term project | | | |
| Renal health | Short term project | | | |
| Nutrition | Multi-year project | Multi-year project | | |
| Tobacco | | | Multi-year project | |
| Addiction (Alcohol & Drugs) | Multi-year project | | Recurrent | |
| Mental Health | Multi-year project | Multi-year project | | |
| Training for staff | Recurrent | Recurrent | | |
| Training (open to non-staff) | Recurrent | | | |
| Youth engagement | Short term project | | | |
| Capital | Short term project | Short term project | | |
| Organisational Development Funding | | | Short term project | |
| Other | Capital project to help another ACCHS | Management contract to help another ATSI region | | |

The Clinic provides medical services free of charge. A men's clinic operates on Tuesdays and a women's clinic on Tuesdays and Thursdays.[78] A mobile clinic operates on a daily basis, providing home care. The organisation reported over 11,000 client contacts in 1999-2000, with peak utilisation rates from March until June. The clinic also offers specialist services, such as audiology, ENT (ear, nose and throat), paediatry, diabetes and asthma.

At the onset, the organisation adopted a policy of Aboriginal Health Workers First.[79] This means that,

> *Patients usually see an AHW first, thereby ensuring Aboriginal control and familiarity 'on the ground'. It also means that as the organisation grows so too does its **empowerment** for AHWs in terms of career profile and structure. As political agents of change (by the very nature of having a political role in Aboriginal health), AHWs have had to and continue to fight for conditions and rights taken for granted in other professions (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1994a).*

This makes clinical activities AHW-focused as opposed to general practitioners focused as in territorial services. In a 1996 study of consultations at Danila Dilba, Thomas et al (1998) reported 42.6 percent of consultations managed by AHWs alone, 53.5 percent managed by both an AHW and a General Practitioner, and 3.9 percent managed by a General Practitioner alone (from a sample of 583 consultations).

The Education and Training Centre is a Registered Training Organisation under the *Northern Territory Employment and Training Authority Act* 2001 and provides training for Aboriginal Health Workers, an essential component to ensure that Danila Dilba has access to a trained workforce. It began to offer the National Aboriginal Health Worker and Torres Strait Islander Health Worker Competency Standards in 1999-2000. The Centre offers First Aid, Vaccinations, Workplace Assessor Training, Training Small Groups and the Well Women's Check course. The Centre also runs community and school-based health education campaigns and an illicit drug use project. The Emotional and Social Wellbeing Centre provides one to one and family

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[78] It is customary for many Aboriginal people to separate genders, especially in matters related to intimate information or ceremonies. This extends to health matters. Thus the staff of the men's clinic is male, whereas the staff of the women's clinic is female. At the time of fieldwork, the oganisation could afford to maintain separate clinics only three days a week. A preferred alternative would be to hold women and men's clinic in separate facilities altogether. The establishment of a men's clinic has been caught in limbo for some time, as funding for capital expenditure and services has yet to be secured. This is a very significant problem. The lack of a facility means that Danila Dilba shoulders the risk of community criticism and of underserving its constituency. Should it find itself able to fundraise to provide the facility, insecure funding means shouldering substantial financial risks.

[79] Danila Dilba does not employ nurses.

counselling services. It also houses a spectrum of support groups (Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation 2001).

Danila Dilba's policy is to deliver health services free of charge to whoever comes through the door. This has however led to some difficulties. The minutes of a Committee Meeting dated December 1999 show that Territorial Health Services were promoting Danila Dilba's services to ATSI and non-ATSI people unable to pay.[80] Serving a non-ATSI population causes some difficulties as most of Danila Dilba's funding is ATSI-specific. The organisation was able to argue the case with Territorial clinics and stop the practice (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1999). It however remains committed to serve anyone requiring care. Refusing access could also lead to a complaint to the Anti Discrimination Commissioner and negative publicity.

Danila Dilba employs 69 people, of which 45 are on a full time basis, for a total of 51 full time equivalent. Of these, over 70 percent are of ATSI ancestry. The organisation has grown considerably since its first year of operation, from a staff of 27 in 1992-93 (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1993a) to 69 in 2002. This represents 45 full time positions, for a total of 51 full time equivalent positions. The size of the staff is defined by the level of funding secured each year. A review of the organisation's Service Activity Reporting[81] for the past three years shows that the number of full-time equivalent has remained mostly stable, from 53.2 in 1998-99 to 50.5 in 1999-00 and 51 in 2000-01.

Like Danila Dilba, **KWHB** became incorporated under the Commonwealth *Aboriginal Councils and Associations Act 1976* on February 3, 1998 (Katherine West Coordinated Care Trial Local Evaluation Team 2000). The choice of incorporating under this act limits Board members to people of ATSI ancestry and their spouses. While 84 percent of the region population is ATSI, the remaining 16 percent are generally associated with the cattle industry that was historically responsible for the massacres and dispossession of ATSI people in the region (Bird Rose 1991). The cattlemen interests have historically been well represented by the Country Liberal Party that was in power in the Northern Territory for the past 25 years. It was defeated by the Labour Party in October 2001. Some have expressed discomfort with their lack of

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[80] This can be interpreted as a humanitarian gesture, since the Territorial clinics charge a consultation fee. It could also be interpreted as cream-skimming of easier cases and the referral of more demanding cases elsewhere.

[81] The Service Activity Reporting is a mandatory yearly reporting attached to funding from the Office of Aboriginal and Torres Strait Islander Health.

formal representation.  The Board has responded by setting up a Sub-Committee of the Executive to represent members of the pastoral industry.  It appears that this solution has not entirely satisfied their aspirations for representation (AU02, AU15, AU21). There is however significant support for the mobile clinic service established by KWHB to serve the cattle stations (d'Abbs et al 2002).

KWHB is governed by a volunteer Board of Directors elected for a term of two years (the election is not staggered, therefore all terms end on the same year).  It includes members from each of the KWHB communities.

| | |
|---|---|
| Lajamanu and outstations: 3 members; | Kalkaringi/Daguragu: 3 members; |
| Yarralin and outstations: 3 members; | Yingawunarri outstation: 1 member; |
| Pigeon Hole: 1 member; | Timber Creek: 3 member; and |
| Bulla: 2 members; | Mialuni: 1 member. |
| Doojun: 1 member; | |

The Board is distinct yet integrated with other ATSI governance structures, namely the traditional owners, the Northern Land Council and the Central Land Council.  KWHB has made a point of seeking permission from the traditional owners to ensure that they approve of KWHB's presence on their land and of the intended activities.  This is a departure from former government practices.

The Board has made it very clear that they see their collective role as that of supporting community-based decision-making.  There have been discussions of setting up Health Committees at the community level (Katherine West Remote Health Board Aboriginal Corporation 1999). These would provide a local voice to support Health Board members in their role and advise in the development of local health and community development strategies (Interview AU21).  By the end of the transition phase, the Health Committee in Kalkarindgi/Daguragu was in place (d'Abbs et al 2002). The precise carving out of the roles and responsibilities of the Health Committees, and how these will relate to the Board, is still in the drafting stage.

Both the Board and staff carry a great deal of pride about their success in having the Board be more than a figurehead, rubberstamping a staff-driven decision-making process.  It was a strategic decision of the previous and current CEO to design policies that carefully limited their own authority especially with regards to the financial management of the organisation, in order to ensure that the decision-making authority remained with the Board.  The Independent Evaluation of the Live Phase of the CCT concluded,

*The establishment of KWHB as a fund-holding body has indeed led to Aboriginal control, both as an objective reality (eg in the take-over of clinic management) and as defined by the subjective experiences of Board members and staff involved. We also believe that three factors have played a particularly significant part in achieving this outcome:*

*The continuing emphasis, which has lasted throughout the Live Phase, on training and educating Board members in matters to do with the Trial, especially financial management;*

*The diligence of Health Board staff in not attempting to usurp the Board's decision-making powers, as so often happens in organisations ostensibly under Aboriginal control; and*

*The continuing high level of involvement displayed by Board members, and reflected in the high level of attendances at Board meetings (Katherine West Coordinated Care Trial Local Evaluation Team 2000).*

One of the key features of the Board's development has been the use of Panagaea Inc.'s Money Story, a software accounting package that provides a pictorial representation of financial statements (see Figure 6.3). With appropriate support, this allows Board members with limited English literacy and numeracy to understand and exercise control over the organisation's budget.[82]

Early in the live phase of the trial, the Board's mandate shifted from that of a fund holder and purchaser of services to that of a community controlled health services provider. The shift from purchaser to community controlled health organisation manifested itself in:

- The take over of four health centres previously managed by THS at Kalkarindji, Daguragu, Yarralin and Pigeon Hole;

- The hiring of three general practitioners to work in the Lajamanu, Kalkarindji/Daguragu and Timber Creek regions;

- The establishment of mobile



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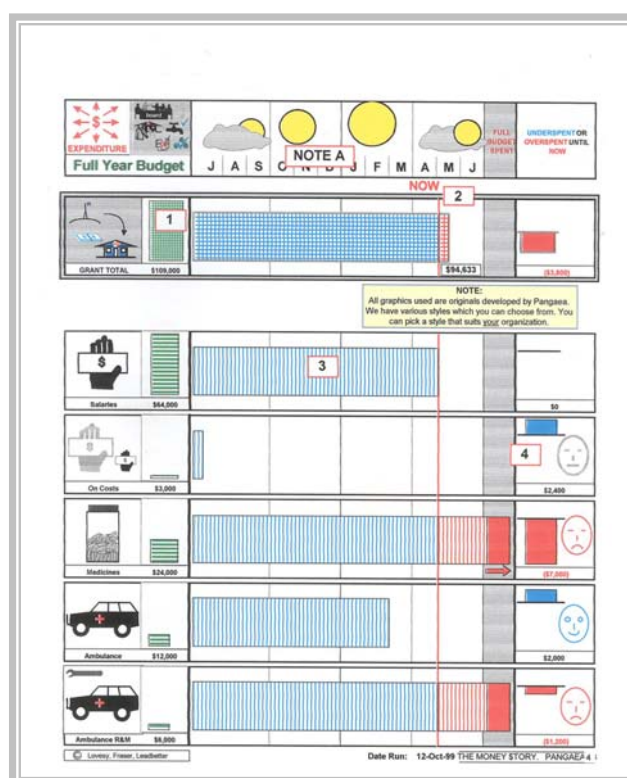
[82] I attended the Annual General Meeting of the Board in November 2001, where the Chairperson and the Vice-Chairperson reviewed of the yearly financial statement using large Money Story posters. I have attended many Board meetings over the years, in the Arctic and the Subarctic, where most Board members have virtually no involvement in the financial management of the organisation. The level of interaction generated at the KWHB meeting was refreshing.

clinics to serve cattle stations; and

- An investment in local human resources that resulted in a shift in service utilisation from secondary and tertiary to primary health care (Foley 2001, Katherine West Health Board Aboriginal Corporation 2001).

Staffing in 2000/01 included 40 staff, of which 57.5 percent were of ATSI ancestry. Clinical staff included 4 doctors, 10 nursing positions and 9 Aboriginal Health Workers recruited locally. This is an expansion of services from pre-trial time. But perhaps more important in the context of this study, the flexibility of the pool has allowed KWHB to make strategic staffing decisions to better meet community needs. The Health Centres now operate under the direction of a community member with training as an AHW. This is a recent change. It is noteworthy that at the beginning of the CCT, several Aboriginal Health Worker positions (in managed THS clinics) were unfilled. Throughout the trial, KWHB encouraged a number of senior AHWs to return to work. Although the final evaluation report noted a high attrition rate especially in Lajamanu, this appears to have stabilised. Administrative Officers were added to the clinic contingent early in the trial to deal with answering the phone, handling the mail, filing pathology reports, etc. A nurse previously handled these tasks. The Administrative Officer is now the first point of contact for patients.

**TROR** became incorporated as a Non-Profit Society under the Societies Act 1908, in February of 1988. The governance structure represents the 23 *hapu* in the region. The overall organisation is governed by Te Runanga *Whaiti*, composed of the *Tumuaki* [chairperson] of the Runanga and one person elected by each *hapu*. Members may hold office for a maximum of three years. The organisation's bylaws provide for a *kaumatua* [elder], whether *kuia* [woman] or *koroua* [man], to be present at each meeting to provide guidance (Te Runanga O Raukawa Inc. 1991a). The Runanga *Whaiti* meets monthly. The day-to-day operations of the organisation are overseen by the Chief Executive Officer. The Health Programme is under the direction of the Health Manager. The overall health workforce has 23 employees, of which 21 are Māori. The Health Reference Committee provides support to the CEO and Health Manager in health related matters, networks with other organisations and makes recommendations to the *Whaiti* on strategic decisions related to health. The Health Reference Committee meets monthly.

| Table 6.5, TROR contractual profile and service coverage | | Rangitikei | Horowhenua | Manawatu | Kapiti | Town specific |
|---|---|---|---|---|---|---|
| Contract | Volume and specifications | | | | | |
| Free contraception | Māori and Pacific Islander women under 25 years of age | | √ | | | |
| Support services for mothers and their pepe | 79 women | √ | √ | √ | √ | |
| Tamariki support/well child | 300 tamariki | √ | √ | √ | √ | All between Bulls and Otaki |
| Tamariki support/well child | 0 to 5 years old, 300 tamariki | √ | √ | √ | √ | |
| Tamariki ora/facilitation | 0 to 5 years old, 150 tamariki/*whanau* | √ | √ | √ | | |
| Tamariki Ora/*whanau*/family support services | 0 to 5 years old, 150 tamariki/*whanau* | √ | √ | √ | | |
| Additional Tamariki ora/well child services | 75 tamariki | | √ | √ | √ | √ |
| Māori Primary Health | Comprehensive primary health and dental care service development | | √ | √ | √ | √ |
| Māori mobile nursing disease state management services | 120 clients | √ | √ | √ | | |
| Māori disability support | Māori with disabilities, 0 to 65 years +, no volume or boundaries specified. | | | | | |
| *Kaupapa* Māori Mental health | None specified | | | | | |

Most contracts require the delivery of services to a narrowly defined and not necessarily Māori population.[83] This is documented in Table 6.5. In a way, this leaves the organisation in a bind, since it is funded for a particular set of activities, but remains accountable to all of Ngati Raukawa.

*And so our contracts are very fragmented. That one in particular, contraception, because its Horowhenua and Otaki only. And I bend the rules because our contracts*

---

[83] The standards for contracts were lifted from pre-existing program standards for out-patient hospital services. The HFA adopted these standards for Maori providers because it was flet that creating Maori-specific standards would be politically contentious. The same standarss remain today (Interviews NZ06, NZ30).

*also talk about within the rohe of Ngati Raukawa ki te Tonga and for me, so the contract delivery states Horowhenua Otaki, but for me the tribal boundary is beyond that.*

*And so I go as appropriate. Yeah our health education promotion, we still do that even though it's not specifically something we have to do (Interview NZ03).*

*The funders at first had a much more generic approach to health, now the contracts are much, much more specific which is a mixed blessing. On the one hand you know what your outputs are going to be. On the other hand it sort of creates a silo effect so that you've got contracts working in parallel with each other, sometimes slightly competitive with each other and its producing – well the good thing it's producing is a strong health workforce. The problem with it is it's a bit of a fragmented workforce as well and not only fragmented between sectors but fragmented within the sector, within health. So although we've got a health team, what is missing I think is an overall health contract to deliver a range of services. One contract which might have a much more holistic approach. So we've bought into a system of fragmented delivery (Interview NZ16).*

The organisation is exploring alternatives in contracting to facilitate the development of a more integrated approach to health and other services.

**TRHHI** serves primarily Ngati Kahungunu Māori. Unlike TROR, TRHHI is not a service arm of the Ngati Kahungunu *iwi*. TRHHI maintains positive on-going discussions with the political organisation, but its governance has always been and remains independent from tribal governance (Interview NZ11, Te Roopu Huihuinga Hauora Incorporated 2002c). As a result of the recent reform, the DHBs have been instructed to develop Treaty-based partnerships with *iwi* and Māori communities (Ngati Kahungunu Iwi Inc. 2003). This requirement, while understandable, has added complexity to the MDO-*iwi* relationship, as was shown in Figure 6.2. The Hawke's Bay District Health Board has entered into a Memorandum of Understanding with the Ngati Kahungunu *iwi*, thus creating a Treaty-based partnership with the tribal administration. This is a potential improvement in ensuring that Ngati Kahungunu interests are represented in regional planning. TRHHI sees the role of the Ngati Kahungunu as being two fold:

*One is to be very knowledgeable about the need of the community that they're responsible for and the second one is that they are very clearly a strong monitor of whether or not what is agreed to from a strategic point of view, is in fact implemented (Interview NZ11).*

The document *Māori Health Plan for Hawke's Bay, Healing our Spirits 2003-2005* (Ngati Kahungunu Iwi Inc. 2003), reflects Ngati Kahungunu priorities for Māori health development in the Hawke's Bay region. Ngati Kahungunu has requested access to $467,000 to set up its infrastructure and deliver on the Treaty partnership. As such, its role would be to analyse information using the DHB health databases, monitor the performance of Māori and for Māori service delivery, and provide support to the DHB in developing effective Māori health strategies. It has been careful not to define itself as a service provider.

Both Ngati Kahungunu and TRHHI's visions of the Treaty partnership show congruence (Te Roopu Huihuinga Hauora Incorporated 2001c, 2002a). However, the Treaty-based relationship with Ngati Kahungunu and Ngati Kahungunu arm's length relationship with TRHHI appears to have created some confusion at the Hawke's Bay District Health Board (apparent in Interview NZ27). This confusion currently threatens TRHHI's access to funding and limits its future developments. The Wairarapa District Health Board has set up a Māori Health Committee consisting of Ngati Rangitane and Ngati Kahungunu. It has also signed individual Treaty-based Memoranda of Understanding with each Tribe. TRHHI has a positive relationship with that Board. The MidCentral District Health Board has signed a Treaty-based Memorandum of Understanding with an pan-*iwi* organisation, Manawhenua Hauora, representing the four *iwi* located in the region. TRHHI has representation in this organisation. The relationship between Manawhenua Hauora and the MidCentral District Health Board is positive. However, the relationship between the MDO and the MidCentral District Health Board, its main funding body, is somewhat tense.

TRHHI's governing body is composed of representatives from its membership and external members nominated by its member organisations. TRHHI's Constitution defines the criteria for members as being a provider of Māori health services within the region (meaning the geographical area from Mahia in the north to Wairarapa in the south) holding a service contract with a Government owned funding agency for a period of not less than 12 months (Te Roopu Huihuinga Hauora Incorporated 2001a). All member-providers are Ngati Kahungunu.

At the time of incorporation, the Board of Directors was formed exclusively by member-provider representatives. The organisation had 16 members, of which three were large and well-established providers. In many ways, the needs of the three large providers differed considerably from that of smaller providers. It was at the request of smaller providers that the organisation restructured its governance to allow for the nomination of three non-provider Board members. This was meant to create a more level playing field among member-providers and reaffirm the need for impartiality in contract allocation. This change led to the departure of the three large providers from the membership (fieldnotes, staff discussions). Table 6.6 shows the existing membership at the time of fieldwork. It is noteworthy that the policy climate of the time supported the idea of large Māori providers taking over smaller ones (New Zealand Transitional Health Authority Maori Health Groups 1997). This was a departure from the former MidCentral Regional Health Authority, which promoted a community development approach.

| Table 6.6, Te Roopu Huihuinga Existing Membership (Te Roopu Huihuinga Hauora Incorporated 2001b) | | | |
|---|---|---|---|
| **Name** | **Location** | **In operation since** | **Number of clients** |
| Kahungunu Health Services "Choices" | Hastings | 1995 | 4500 registered clients, of which a majority is Māori. |
| Mangaroa Marae Health | Hastings | 1997 | 533 registered clients, 522 are Māori. |
| Nga Kaitiaki O Waikaremoana | Tuai | 1996 | 469 registered clients, 362 are Māori. |
| Ngati Pahauwera Hauora | Raupunga | 1996 | 460 registered clients, 396 are Māori. |
| Tamaki Health | Dannevirke | 1994 | 850 clients of which 800 are Māori |
| Tamatea Youth Consultants | Waipukurau | 1994 | 289 clients, of which 269 are Māori. |
| Te *Whanau* Awhina O Waimarama | Waimarama | 1997 | 440 registered clients, of which 410 are Māori. |
| Whaiora Whanui Trust | Masterton | 1997 | 3,410 registered clients, of which the majority is Māori. |
| Hine Kotau Ariki | Napier | 1989, funded in 1991 | 600 Māori clients with 800 consultation annually. |

TRHHI has developed an assignation policy that allows for the transfer of all DHB provider contracts to TRHHI. Once assigned, TRHHI would assume the responsibility for negotiating, signing and administrating these contracts, while subcontracting service delivery directly to its member-providers. This had been encouraged for a number of anticipated benefits, including, a) improving the consistency of quality across the membership; b) increasing the MDO flexibility to place resources where they will provide the best return; and c) encouraging and supporting better planning and service delivery (Fleming 2002). In effect, providers delegate the responsibility for their negotiations and communications with the District Health Board to TRHHI.

| Table 6.7, TRHHI Membership and Contract Assignation as of January 2003 | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Service contracts | | | | | | | | | | | | | | |
| **Name of Member-provider** | **Location** | District Health Board | Assignment policy signed | *Whanau* Ora/Health care plans | Community asthma | Primary health/GP services | Disease state management | Māori rongoa | Mental health, community and residential | Maternity services | Tamariki Ora – Well-child | Immunisation | Sexual health | Cervical smear | Smoking cessation | Integrated diabetes | Breast screening | Māori liaison disability |
| Hine Ko Tou Ariki | Napier | HB | No | | | | | | HB | | | | | | | | | |
| Kahungunu Health Services "Choices" | Hastings | HB | No | HB | | HB | | | | HB | HB | | HB | HB | HB | HB | | |
| Mangaroa Marae Health | Hastings | HB | 08/02 | HB | TR | | | | | | | | | | | | | |
| Nga Kaitiaki O Waikaremoana | Tuai | HB | No | HB | TR | HB | | | | | | | | | | | | |
| Ngati Pahauwera Hauora | Raupunga | HB | No | HB | | | Delivered by TR | | | | | | | | | | | |
| Tamaki Health | Dannevirke | MC | 09/02 | MC | TR | | | | | | | | | | | | | |
| Tamatea Youth Consultants | Waipukurau | HB | 07/02 | HB | | | | | | | | | | | | | | HB |
| Te *Whanau* Awhina O Waimarama | Waimarama | HB | 07/02 | HB | TR | | | | | | | | | | | | HB | |
| Whaiora Whanui Trust | Masterton | W | No | W | TR | W | TR | | | | W | | | W | | | | |

MC: MidCentral District Health Board    HB: Hawkes Bay District Health Board

W: Wairarapa District Health Board    TR: Te Roopu Huihuinga Hauora Inc.

It is noteworthy that some members have opted to retain their direct linkages with the funder. According to a draft audit report of TRHHI commissioned by the Hawke's Bay District Health Board, larger providers appear to both want TRHHI's administrative and clinical support, while also wanting to retain their autonomy and resenting the financial contribution made to TRHHI (Te Roopu Huihuinga Hauora Incorporated 2002b, Thompson & Fakahau 2003). This is reflected in Table 6.7.

The reality of the system as it stands is that TRHHI's role is limited to that of Māori provider support and vulnerable to shift in DHB policy and priority in funding allocation (including deficit management). While this is an essential role, and one that was never fulfilled by government funders, the opportunity for TRHHI to capitalise on Māori culture and provider experiences to develop more responsive *kaupapa* Māori contracts with its providers is very limited. At this time, TRHHI can at best reallocate the limited contractual terms it secures.

The MDO is currently revising its Constitution to allow for a broadening of its mandate. Assuming that the proposed revisions are accepted by the Board, the MDO will be in a position of extending its membership and services to Māori organisations providing services in other areas. This is a step towards inter-sectorial innovations, which to some extent is being prompted by the current climate in the health sector.

> *One of the reasons why I'm insisting…that we diversify [is] because if we rely on the health service with the shortage of money, there's very little chance of it actually being subsidised to the extent that it can grow in the way all believe it should grow because there's no more money. I mean the government have made it very, very clear that…the Māori people have got to come up the, the wellness scale in some way or other. That's all very well but that automatically means some form of repriorisation if you're going to succeed because there isn't the money there to do it (Interview NZ06)*

As of April 2003, the organisation's membership has been increased to twelve providers (Notes, Constitution meeting, Te Roopu Huihuinga Hauora Incorporated 2002d).

In summary, Danila Dilba's vision and obligation to its constituency is aligned with the services it offers. It serves primarily ATSI people. It is however not able to serve the primary health care needs of all ATSI people requiring its services in the Darwin region. The services it offers are constrained by contractual limitations and funding. In contrast, KWHB is mandated and funded to provide the full complement of primary health care services to its constituency. TROR and TRHHI offer the services they can secure funds for. As shown in Table 6.5, TROR is particularly disadvantaged with a patchwork of contracts with narrowly defined populations. TRHHI's contract more closely reflects its commitment to Ngati Kahungunu Māori, but is limited by an amazingly complex administrative structure, spanning three District Health Boards.

Although both TROR and TRHHI report being able to adapt programs to meet their constituency's needs, their situations cannot be compared to KWHB or to lesser extent Danila Dilba in terms of flexibility.

Nevertheless, all organisations engage their community in decision-making to ensure responsiveness, either through their Board (all of them), local Health Committees (KWHB), consultations (TRHHI or TROR) or other means. Danila Dilba's commitment to its policy of Aboriginal Health Workers first has diminished its dependency on general practitioners and creates a cost-effective and cultural appropriate alternative. KWHB's commitment to local engagement and hiring, coupled with significant increases in service delivery, has led to a modest decrease in secondary and tertiary care utilisation. Innovations are less evident for TROR and TRHHI, partly because the contracts they sign are highly prescriptive and fragmented. There is less room for innovation and evidence of improved outcomes will be more difficult to track. While all organisations are obligated to balance responsiveness with contractual obligations, TROR and TRHHI have significantly less room to do so.

### 6.1.3  Accountability

Table 6.8 summarises at the reporting burden for each organisation. It appears that the reporting burden is least for the best resourced organisation, KWHB. The reporting burden is remarkably high in New Zealand.

| Table 6.8, Number of report for the 2001-02 sample year, as prescribed in contracts | | | |
|---|---|---|---|
| | Sample year budget | Number of reports | Average funding per report |
| Danila Dilba | £1,814,531 | 46 | £39,446 |
| KWHB | £3,255,517 | 25 | £130,221 |
| TROR | £510,717 | 30 | £17,024 |
| TRHHI | £188,888 | 36 | £5,247 |

**Danila Dilba**'s current reporting framework is fragmented and defined by the funding agencies whose programs are accessed every year.  Core funding reporting requirements are mostly limited to participation in annual national Service Activity Reporting (SAR) and the submission of financial statements (Danila Dilba SAR file).  All other funding sources have stringent performance indicators and reporting requirements.  OATSIH requires the organisation to participate in the SAR, plus includes specific program performance indicators in each contract.  Only one contract from the Northern Territory government harmonised reporting with OATSIH to ease

administrative burden. Commonwealth health funding strategies that are not OATSIH-based have their own reporting requirements.

Funding from the Northern Territory Education, Training Authority is tied to retaining Quality Endorsed Training Organisation (QETO) status and in the submission of performance indicators on training and completion meeting Territorial requirements. Funding for multiyear projects is tied to the submission of bi-yearly progress reports addressing performance indicators.

All contracts reviewed provided provisions for termination in the case of non-performance by the organisation. Contracts from the Commonwealth Health and Aged Care, including OATSIH, make a provision for dispute resolution with the help of a mediator that can be called by either party. However, contracts do not provide for a readjustment of funding or performance indicators if circumstances change. This is a problem especially for multiyear project funding, which is designed to foster the development of innovative approaches to service delivery (Interviews AU12 and AU13). Innovation necessarily means that unanticipated opportunities and strategies may emerge as more productive than what was originally anticipated as the project develops. The contract framework cannot, at this point, accommodate a readjustment.

The reporting requirements under **KWHB's** new tripartite agreement are extensive, covering 64 distinct indicators. KWHB submitted its first report in March 2002. In a letter dated March 21, 2002, the CEO made the following remarks:

> *"Whilst this has been an exceptionally tedious process, it has been worthwhile for a number of reasons.*
>
> *In the first instance, it has enabled us to look more closely at the information we gather and its relevance to the Katherine West Health Board. Currently we gather information for three reporting formats (SAR, Sch 5 and Monthly clinic reports). Where we can we will adapt and modify information requirements so the process can be streamlined. In the main this will mean changing the monthly clinic reports which are a legacy from THS days and which have not been modified since the handover to community control.*
>
> *The reporting process also revealed the inadequacies of training on [a new health information system] it has been charged with providing and the alarming under reporting in some clinics. This problem has now been resolved and the KWHB… provide all training. Improved training we believe will rectify the under reporting problem.*
>
> *One final issue which became apparent during the compiling of this report was the shortcomings of many of the questions and the difficulty of obtaining information to fit questions that were vague, incomplete, proscriptive or unobtainable due to legislation changes (Whelan 2002).*

Each other contract includes specific reporting requirements, namely,

- Quarterly activity reporting,

- Bi-annual narrative report, addressing eligibility criteria for the program, and

- Annual financial reports.

The Monitoring Group emerged to meet the needs of the CCT and remained when the KWHB moved into the current arrangements, at the request of the Board. It brings together representatives from the Commonwealth Department of Health & Ageing, Northern Territory Community and Health Services and KWHB. Its purpose for the CCT was to work as a forum for communication and coordination. A review of the Monitoring Group minutes since its inception in 1997 shows that this mechanism has played a vital role in the success of the CCT, since it brought together the key stakeholders to problem solve. They also show a dynamic where one government can put pressure on the other in order to bring about a resolution on contentious issues (Monitoring Group, 2001). This is best reflected in the dispute resolution clause provided for in the PHCAP contract. It can be invoked by any of the three parties, requires the involvement of a mediator agreeable to all three parties and whose decision is final and binding on all parties. The clause has been tested twice and has proven cost-effective in settling disputes.

**TROR**'s contracts target a different population, including at times, all poor women in the area, or mainly Māori residents in the *rohe*, or Māori and Pacific Islanders in a given community, etc. (New Zealand Ministry of Health 2001b). The quarterly reports are limited to outputs. As the system currently stands, it is difficult to see how the multiplicity of reports on outputs (activity reports, number of workshop held, number of clients seen) can contribute useful information on health outcomes (changes in health status as a result of activities and improved health). Indeed, the high level of fragmentation in the contractual environment makes it difficult to establish whether this provider's, or any other provider, interventions produce better outcomes. Conversely, the funder cannot have its funding strategy evaluated in light of its obligation to produce better outcomes.

In the case of **TRHHI**, the MDO contract reporting requirements include,

- The yearly production of a business plan;

- A three year strategic plan; and

- An annual report covering the organisational structure and governance, outputs and performance against strategic and business plan targets and milestones; a list of MDO stakeholders; policies and procedures; a report on Māori Health Gain service provision; a comprehensive disease prevention and health promotion analysis report; a report on quality plan activities, including practitioner/provider/consumer satisfaction summary; and report on MDO issues and areas for improvement.

The organisation is also expected to report quarterly on,

- MDO Health Services – being the key MDO establishment and Operational activities, including human resources and organisational system development;

- MDO Stakeholder relationships; and

- Service & Client Co-ordination improving managed access, utilisation, choice and service.

This reporting is for the MDO contract only. Any other service contracts have their own reporting requirements above and beyond those mentioned. The level of reporting required here is daunting and it is unclear what purpose it actually serves.

Contracts originally written under the HFA required the MDO to provide invoices and reports within 20 days of the end of the month. TRHHI, by virtue of its mandate, must first secure reports from its contract holders and consolidate them to abide by its contractual reporting requirements. It is interesting that the current contracts make no allowances for a more appropriate time frame for this coordination. Hence, TRHHI has allotted 10 days to its members for submitting reports and allotted itself 10 days for consolidation and report submission. This may be somewhat unrealistic and may explain why mentions of late reports recur in correspondence with the funder (reporting file review).

All New Zealand (whether for TROR and TRHHI) contracts make a provision for audit requirements giving the funder the authority to appoint an auditor of its choice. The provision does not require that this choice be by mutual agreement. The current process focuses on governance, policy and procedures, administration, quality assurance and consumer satisfaction. TRHHI has just undergone an audit, commissioned by the Hawke's Bay District Health Board. It duplicates the reporting process outlined above. It is not clear whether the auditors actually accessed TRHHI's reports prior to the audit, since these were not mentioned in the audit (Thompson & Fakahau 2003).

All contracts contain standard provisions of accountability in the areas of:
- Financial management,

- Quality assurance in service delivery, and

- Required outputs.

The contract gives the funder the authority to monitor the provider and to suspend funding if accountability standards are not met. A dispute resolution clause is present in all contracts, with the exception of the Māori Provider Development Scheme contract. However, the clause is weak as the process can only be activated by mutual consent. Thus a provider cannot activate the process without the consent of the funder. Of

course, litigation is an alternative, but given the disparity in funding, this option is not as readily available to small providers as it is to the District Health Board.

To summarise, of all organisations, only KWHB's core contract has an effective dispute resolution mechanism. This anomaly may be attributed to the fact that this is a tripartite contract signed with both the territorial and Commonwealth government. Both levels of government have shown a keen interest in ensuring that their counterpart is contributing adequate funding to avoid cost-shifting. Although other organisations have dispute resolution mechanisms in their contracts, these provisions have not been tested.

At this point, each contract has contract-specific reporting requirements that focus on outputs rather than outcomes. Collectively, they are onerous and of little use to the organisation or the funder in assessing the effectiveness of programs.

### 6.1.4  Synthesis

Table 6.9 summarises the findings discussed above. Boundaries around provider's decision-making result from a number of factors, including limited stable funding, prescriptive programs and outputs associated with specified populations. Less visible constraints are associated with the administrative costs of managing a fragmented contractual environment with extensive reporting and large number of transactions.

For example, although all organisations derive their funding from government contracts, the percentage of that funding that is earmarked for specific programs or expenditures varies considerably. KWHB's funding is the most flexible with 32.3 percent of its funding earmarked, followed by Danila Dilba at 51.6 percent, TRHHI at 70.1 percent, and finally TROR at 100 percent. Although all experienced a contractual environment that is fragmented, the impact of this fragmentation can be amortised by having some flexibility over a higher percentage of expenditures. In general, core or relational contracts tend to be longer-term contracts, and block funded. With the exception of the KWHB core funding contract, block funded contracts did not correlate the funding provided with some assessment of needs or expected expenditures. When proposal-driven, the allocation generally amounted to a percentage of what had been requested. Volume-based contracts (TROR or TRHHI) specified a minimum level of service to be provided for payment. They favoured individual intervention over population-based approaches. TROR reported being able to negotiate the volume of service required at the time of contract renewal. Of all organisations, KHWB is the only one that was able to engage both the territorial and Commonwealth governments in

meaningful negotiations at the time of signing its first tripartite agreement and also at the time of its renewal.

In terms of access rules, both KWHB and Danila Dilba are funded to serve the health care needs of the ATSI population in their area. KWHB's funding is calculated based on the population it is mandated to provide primary health care services to. The situation is different for Danila Dilba, who's mandate is to offer primary health care services to the Darwin and Palmerston-based ATSI community, but is constrained by the level of funding it can secure. Its approach is therefore a blend of providing services on demand, with some outreach, population-based strategies (illicit drug use or nutrition programs, for example). By virtue of serving communities that are somewhat isolated and mainly Māori, the service contracts TRHHI signs on behalf of its member-providers are closely aligned with its mandate to serve the needs of its Ngati Kahungunu. TROR, for reasons that remain unclear but that may be largely historical, is asked to serve the needs of a variety of populations, narrowly defined in contracts in terms of ethnicity, socio-economic status, gender and geographical location.

Both KWHB and Danila Dilba have a great deal of flexibility in designing their programs. Core funding is entirely flexible. Targeted funding is generally accessed through proposal writing, thus the organisation can define its own approach to addressing the health issue being targeted. TROR and TRHHI face a different situation. The contracts they sign are highly specific, describing with precision the activities to be undertaken. The only exception is the MDO contract.

The fragmentation of the contractual environment impacts mostly on reporting requirements. Here, Danila Dilba, TROR and TRHHI face a considerable burden as reporting requirements are contract-specific. KWHB is also burdened with contract-specific reporting requirements. The reporting under the large PHCAP contract is however streamlined. KWHB administrative staff can absorb the burden associated with the other contracts. TROR and TRHHI, which are in comparison relatively small organisations, are more impacted by the administrative burden they shoulder. Of all organisations, only KWHB benefits from an effective dispute resolution mechanism, which was specifically designed for the tripartite contract. In contrast, TROR and TRHHI depend on a provision that requires the DHB to agree that there is a dispute. The case arose during fieldwork where TRHHI and the MidCentral Health Board found themselves at odds over an issue related to funding. TRHHI made representations to have this item identified for resolution under the dispute resolution provision. At a meeting held between TRHHI and the DHB, which was attended by the researcher, the

MidCentral Health Board however disagreed that there was a dispute, ruled that the matter had been settled and left TRHHI with no recourse.

Table 6.9 synthesises the information provided in the case studies following the framework adapted from Bossert. The information as presented gives some indications as to the level of decision-making available to each provider. The following section will re-evaluate this information in light of the range of choice criteria developed in chapter 2.

## 6.2    Decision-space analysis applied to contractual environments

This chapter began with three questions. This section focuses on the first two:

1.  Are indigenous providers able to exercise some control over key areas of decision-making?
2.  What are the constraints on operations?

The answer to these questions depends largely on the contractual environment in place. The above analysis shows that contractual environments are complex and operate in manners somewhat similar and somewhat different from what is discussed in the contracting in health literature. To date, the literature on contracting has focused on the characteristics of single contracts. The framework adapted from Bossert has been used in this chapter to map out the characteristics of four contractual environments. When reviewed against the range of choice criteria adapted from Bossert, the case studies sum up to the analysis presented in Table 6.10. Here, the four contractual environments explored in this chapter and the contractual environment experienced by First Nations have been ranked based on their range of choice. Based on this analysis, it appears that contractual environments that hinge on a multiplicity of classic contracts offer the least opportunities for choices. This is the case for TROR and TRHHI. This limits opportunities for significant innovations. The presence of a relational contract increases flexibility and opportunities for innovations. The administrative burden is also greatly reduced. In the case studies reviewed, administrative burden was inversely proportional to the proportion of the organisation's budget that is derived from the relational contract. In both Australia and New Zealand, it appears that administrative costs are highest for the least resourced organisation. This is reflected in the number of transactions for payment and in reporting requirements.

| Table 6.9, Case Study Summary | | | | | |
|---|---|---|---|---|---|
| Function | Indicator | Danila Dilba | KWHB | TROR | TRHHI |
| **Finance** | | | | | |
| Sources of Revenue | Intergovernmental transfers as % of total local health spending | Nearly 100 percent | Nearly 100 percent | Nearly 100 percent for health services | Nearly 100 percent |
| Allocation of expenditures | Intergovernmental transfers as % of local spending that is explicitly earmarked by higher authorities | 51.6 percent | 32.3 percent | 100 percent | 70.1 percent |
| Contracts | Number, type and level of fragmentation | 18, mostly classic, moderate to high fragmentation | 11, one main relational contract | 9, classic, high fragmentation | 8, high fragmentation |
| Length of contracts | Short versus long term | Yearly except for multi-year projects (N=4) | Core funding is 2.5 years, other depends | Yearly, some renewed more or less automatically, some time limited vertical strategies | Yearly, some renewed more or less automatically, some time limited vertical strategies |
| Payment structure | Block, volume, fee for services or partial funding | Core funding and vertical strategies are block payments Quarterly payments up front | Core funding is a mix of block payment and fee-for-service. Others are block payments Quarterly payments up front | Mainly cost and volume contracts Monthly payments on a cost recovery basis | Core funding is block funded. Service funding is through cost and volume contracts Monthly payments on a cost recovery basis |
| Fair negotiations | Disclosure on all parties of financial basis for funding. Equal access to information. | No negotiations | Extensive negotiations throughout the study phase, more limited thereafter | Some negotiations on deliverables | No negotiations |
| **Governance and Service Organisation** | | | | | |
| Access Rules and Targeting | Defining priority populations | ATSI, largely demand-driven | ATSI, defined by geography | Largely TROR, although includes other Māori, Pacific Islanders and some underserved populations, defined by contract | Largely TRHHI, although includes other Māori and Pacific Islanders |
| Required Programmes | Specificity of norms for local programmes | Flexibility for core funding Remaining contracts are proposal-driven | Flexibility for core funding Remaining contracts are proposal-driven | Limited flexibility in program design | Limited flexibility in program design |
| **Accountability** | | | | | |
| Reporting | Reporting required | Reporting defined in each contract, onerous | Reporting consolidated for the PHCAP model | Reporting defined in each contract, onerous | Reporting defined in each contract, onerous |
| Measures of reciprocal accountability | Provision for dispute resolution | Dispute resolution clause in 72% of contracts | Main contract has effective clause Dispute resolution clause in 45% of other contracts | Dispute resolution clause in all contracts, both parties must agree that a dispute exists | Dispute resolution clause in all contracts, both parties must agree that a dispute exists |

The classic-relational dichotomy apparent in the literature does not adequately reflect how contractual environments, both those that rely on a number of classic contracts, or those that blend both classic and relational contracts, operate. The following discussion provides examples of such differences.

| Table 6.10, Decision Space Analysis as an analytical tool for contractual environments | | | | | | |
|---|---|---|---|---|---|---|
| | | Range of choice (increasing from left to right) | | | | |
| Function | Indicator | TROR (NZ) | TRHHI (NZ) | DD (AUS) | HTP (CAN) | KWHB (AUS) |
| Year of incorporation | | 1988 | 1997 | 1991 | 1989 | 1998 |
| **Finance** | | | | | | |
| Sources of Revenue | Public funding as % of total local health spending | Narrow to Moderate | Narrow to Moderate | Moderate | Moderate | High |
| Allocation of expenditures | Intergovernmental transfers as % of local spending that is explicitly earmarked by higher authorities | Narrow | Narrow | Narrow to Moderate | Moderate | High |
| Contracts | Number, type and level of fragmentation | Narrow | Narrow | Narrow to Moderate | Moderate | High |
| Length of contracts | Short versus long term | Narrow | Narrow | Narrow | Moderate to high | High |
| Payment structure | Block, volume, fee-for-service, partial funding | Narrow to Moderate | Narrow to Moderate | Narrow to Moderate | Moderate | Moderate to high |
| Fair negotiations | Disclosure on all parties of financial basis for funding. Equal access to information. | Narrow | Narrow | Narrow | Narrow to Moderate | Moderate to high |
| **Governance and Service Organisation** | | | | | | |
| Access Rules and Targeting | Defining priority populations | Narrow to Moderate | Moderate | Moderate | Moderate | Moderate to high |
| Required Programmes | Specificity of norms for local programmes | Narrow | Narrow | Moderate | Moderate | High |
| **Accountability** | | | | | | |
| Measures of reciprocal accountability | Provision for dispute resolution | Narrow | Narrow | Narrow | Narrow to Moderate | Moderate to high |
| Reporting | Reporting required of the provider | Narrow | Narrow | Narrow | Narrow | Moderate to high |

**On classic contract, and the pursuit of efficiency through competition** In the context of the providers studied, the funder's fragmentation of the contractual environment does not aim to increase provider efficiency through competition. Although contracts do not contain provisions for automatic renewal, providers such as Danila Dilba, TROR and TRHHI reported that between 75 to 80 percent of their funding was relatively stable from year to year. The goal is rather to direct providers to deliver services on health priorities defined nationally. This raises the issue of local responsiveness. It also raises the issue of purpose: is there an advantage to the New Zealand model of small distinct contracts? At this time, the contractual environment appears to be a remnant of the first part of the 1990s. It remains to be seen whether

the current (DHBs) and future (PHOs) purchasers may be willing to let go of the control classic contracts provide them.

Competition is further hampered by the provider's legitimacy and access to its indigenous client constituency. The Ngati Kahungunu TRHHI organisation can call on its *iwi* affiliation to legitimise its access to Ngati Kahungunu clients. The same can be said of TROR. Danila Dilba's status as an ACCHS legitimises its access to its clientele. The same can be said of First Nations. These organisations may not be the only providers from which services are accessed, but their indigenous status provides them with increased legitimacy, which is re-enforced by health policies. The client-governance relation can be understood as a form of asset specificity that prevents other providers from being able to compete for the same contracts. The concept of *political/cultural affiliation* as a variation of asset specificity does not appear in the literature. It is however a useful distinction.

**Multiple simple contacts create complex contractual environments** Providers accessing a number of "classic" contracts with highly defined specific outputs shoulder a complex contractual environment, which involves higher transaction costs, higher levels of fragmentation potentially creating gaps in services shouldered by the providers at a cost to themselves, and an overall higher cost of coordination of the system, which may or may not be recognised or shouldered by the purchaser. This is most evident in New Zealand. This raises questions as to assumptions with regard to the monitoring costs of classic over relational contracts. While it is clear that a single classic contract may be easier to monitor than a single relational contract, it is also clear that monitoring a multiplicity of classic contracts can become onerous for the funder. For example, TROR and TRHHI are required to provide 30 and 36 reports annually to fulfil their reporting requirements. This workload is for a single provider. The funder is tasked with assessing the performance of programs for all of its providers. Although there are likely some variations, the number of reports required of TROR or TRHHI are likely reflective of reporting requirements with other providers. This brings into question the likelihood that a large number of small contracts can be monitored to ensure accountability. This was investigated in New Zealand, where a single purchaser system exists. Government interviewees suggested that both historical and contemporary funding agencies lack the human resources to ensure an appropriate oversight. This suggests that in health care, a classic contractual environment can lead to the multiplication of contracts leading to high transaction and monitoring costs. These findings echo concerns expressed by Howden-Chapman and Ashton (Ashton 1998, Howden Chapman & Ashton 1994). The same was documented in Canada (Auditor General of Canada 2002, Lavoie et al 2004). In other words, multiple simple

contracts generate a complex contractual environment that is also difficult to monitor, not for a lack of specific contractual provisions, but rather because of multiple specific contractual provisions. In the context of the case studies pursued, the costs have been born by both the purchaser and the providers. In the case of First Nations, the multiplicity of report does not add up to a coherent information mechanism for FNIHB (Auditor General of Canada 2002). It appears that the same issue is being raised in New Zealand (Crampton et al 2004). Cost effectiveness analysis does not appear to be part of the design of accountability systems.

**Balancing contractual and community obligations** Theoretically, providers funded through multiple classic contracts offer a patchwork of services that is defined by the contracts secured. In reality, services were reportedly offered beyond the scope of contractual agreements as theoretical boundaries clashed with common sense and community expectations.[84] This however means that providers on the classic side of the contractual spectrum assume a larger part of the risk associated with their moral-cultural-political obligation to align services with local expectations (*kaupara Māori* services for example): the wider the gap between local expectation and contractual specifications, the higher the risk for the provider. The literature calls this the harnessing of community goodwill, defined as a provider's willingness to go beyond contractual obligations to ensure that appropriate services are available (Lane 2001). Providers who benefit from some flexible funding are able to use this flexibility to amortise risks. It would follow that the higher the percentage of flexible funding, the lesser the potentially gap between expectations and service obligations. There is obviously a threshold beyond which limitations associated with targeted contracts are easily absorbed by the organisation: this is the case for KWHB and is related to the fact that core funding alone assures sustainability.

**Relational contracts carry substantial risks for both the funder and the provider** Providers funded with contracts of a more relational nature benefit largely from a single purchaser - single provider relationship with streamlined contracting and reporting requirements. Contracts are longer terms, three to five years, meaning lower negotiation costs for the purchaser and provider. They are broadly defined, outlining the responsibility of the provider to offer comprehensive primary health care, and leaving the provider the responsibility to allocate services, human and financial resources accordingly. Reliable, population based funding opens the door to long term

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[84] The distance between contractual expectations and service provision by Māori providers is the subject of Ms. Amohia Boulton PhD thesis. I am grateful for her insights (Boulton, 2004, personal communication).

planning and strategising. It also draws on the cultural expertise of providers, a key theme for indigenous providers. The literature suggests that this situation creates a shared responsibility on the part of the purchaser and the provider to ensure that the relationship is protected, and that disagreements are addressed (Goddard & Mannion 1998, Stewart 1993). During the implementation of the KWHB model (the CCT phase), KWHB could count on the Monitoring Group, which included membership from both government funding bodies, to work through issues (Monitoring Group 2001). Recent communications (email dated February 2004) suggests that OATSIH is now making unilateral decisions regarding the funding pool. KWHB, having no alternative funding for its core functions, is left with the choice of ending its own existence and the services provided to its mainly ATSI constituency, or signing on.  First Nations have reported the same situation. In fact, at least in the indigenous environment, the single funding-single provider relationship carries significant risk for the provider, as unilateral decisions cannot be side-stepped. Indigenous organisations' moral-cultural-political obligation to provide services simply compounds the situation.

**The trust in trust-based contracts** Relational contracts are also termed trust-based contracts. In these case studies reviewed, TROR had no trust-based contract. TRHHI had a small trust-based MDO contract with fairly flexible provisions. This contract provided mostly for administrative expenditures associated with the provider capacity building mandate of the MDO. Danila Dilba had access to a trust-based contract accounting for nearly half of its funding. KWHB held the largest trust-based contract accounting for to thirds of its yearly budget, over £2M. As shown in Table 6.10, KWHB is the youngest of the organisations studied and had no track record in service delivery prior to the CCT. A majority of members on the Board of Directors at the time of fieldwork had limited literacy and numeracy capacity. It initially benefited from a large relational contract with funding pooled from the Commonwealth and Territorial governments. More recent developments indicate some erosion in the governmental commitment to pooling funding and interest in fragmenting the funding under separate contracts (Whelan, 2004, personal communications). In contrast, Danila Dilba had been delivering services since 1991 and had a successful track record. Likewise in New Zealand, TROR was established in 1988, is acknowledged at least verbally by the MidCentral Health Board as a preferred provider,[85] and counts Dr Mason Durie, one of the most respected Māori health researcher, as a member of its Board. TRHHI is ten

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[85] This unofficial designation emerged under the HFA to mean that providers who successfully delivered a program can expect that contract to be renewed without the contract having to go through a tendering process.

years younger. It experienced some difficulties with three of its founder member-providers and some credibility issues with the Hawkes Bay District Health Board. In the Canadian environment, the trust-based, single relational contractual environment has been eroded in favour of a blend on trust-based and classic contracts.

In the indigenous environment, trust-based contracts do not replace classic contracts once providers are established and have secured some credibility. Instead, trust-based contracts are used to introduce new approaches or models of service delivery promoted by policy (PHCAP, the MDO or the community-based model emerging from the Health Transfer Policy). The commitment to funding these models through relational contracts however appears to eventually wane in favour of more explicit or classic contracts. The reasons are likely varied. *First,* new models are usually designed and implemented by a central agency that is distant from the day-to-day challenges of contract monitoring. Indigenous buy-in is important since uptake is generally voluntary, and poor uptake may reflect poorly on the government agency and carry political risks. Relational contracts, because they are flexible and can promote local approaches to service delivery, are more appealing. *Second*, new models necessarily mean that all possible future contingencies could not be known at the time of their deployment. As a result, relational contracts may be used until sufficient experience has been gained to make the drafting of more specific contracts practical. *Third*, once the model is established, the funder's initial enthusiasm may be replaced with a pragmatic need to anticipate challenges related to service delivery and performance monitoring, and to limit them. The advantages of classic over relational contracts may be weighted differently when implementation is left to mid-level administrators working in regional organisations and tasked with the monitoring of contracts. *Fourth*, in the indigenous environment, trust between the funder and indigenous providers is vested with the collective as well as with the individual provider. Non-performance of some indigenous providers may lead to shifts in risk management practices affecting all. For example, the failure of the Tiwi Island CCT brought the issue of risk to the forefront of PHCAP discussions in 2002-03. The success of KWHB could not outweigh the concerns raised, and led to some rethinking on the pooling of funding. Other factors, such as administrative difficulties experienced by the Canadian federal government[86] in the mid 1990s, also lead to unilateral changes in the way contracting was perceived and pursued, whether with new or well established organisations.

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[86] Scandals emerged in the mid 1990s in the administration of Human Resources Canada and Health Canada, with allegations of embezzlement and fraud.

The analysis outlined above shows that contractual environment exhibits some similarities and some important differences when compared to the literature on classic and relational contracts. In the indigenous environment, classic contracts are used not to promote competition and the associated efficiency it may promote, but rather to ensure that national priorities in health gains are reflected in service delivery. While the aim is justifiable, the means multiplies administrative costs. The siloed approach to contracting can also leave important service delivery gaps that may be overlooked, or addressed by indigenous providers. Signatories of relational contracts also face some risks is that the funder exercises considerable control over the terms and conditions contained in single substantial contracts. In the context of single funder, single provider relationships, the funder benefits from a quasi-monopoly over access to funding and the indigenous provider's commitment to meet the needs of its constituency. As a result, some of the benefits reported in the literature, such as the resolving of dispute amicably, may or may not occur. The basis of the relational contract appears to have less to do with trust, and more to do with the need to secure indigenous buy-in in government initiatives. Once the buy-in has occurred, there seems to be less interest in maintaining the commitment to relational contracts.

## 6.3    Conclusions

Overall, the framework derived from Bossert is a useful tool to assess the responsiveness of diverse contractual environments and their alignment with the literature on contracting in health. It facilitates the analysis of contractual environments that blend classic and relational contracts and allows to explore the experience of organisations that operate with multiple and diverse contracts. In the context of this study, the framework clearly indicates the limitations of a reliance on a number of small and fragmented classic contracts. This model poorly reflects indigenous aspirations for self-determination and appears to carry more limitations and advantages. The limitations of classic contracts, higher transactions costs, are compounded once contracts multiply and their advantages, cost-effective monitoring, eroded. This brings up the last question raised at the beginning of this chapter: Is the contractual environment an accurate reflection of indigenous health policies or of the state practices in health contracting? Are compromises made to respect indigenous aspirations?

# CHAPTER 7, PATCHES FOR EQUITY?

Previous chapters explored the emergence of "by indigenous for indigenous" policies and their impact on the delivery of primary health care services in Australia and New Zealand.  The historical context in which these policies emerged was discussed at length. Despite similarities, all three countries have developed somewhat different relationships with their indigenous health sector reflecting differences in history, health care system, jurisdiction over health and indigenous affairs. The contractual environment that emerged in each country was also explored at length.

The objective of this thesis was to explore how governments balance the ideal of indigenous self-determination with other pressures, such as current trends in public administration and accountability, pressures on the health care system, issues of and sensitivities around minority rights, equity in health and cost-efficiency. This chapter will review the findings discussed in chapters 4 to 6, in light of the study's original questions developed in chapter 2, and the international literature.

This chapter is organised in five sections. The first section explores the relationship between policy, implementation and the contractual environment in which indigenous providers operate. This section concludes by revisiting the findings in light of the study questions. Section two explores the lessons specific to contractual environments. Section three situates these findings within the larger context of international indigenous debates and policies directions in Canada, Australia and New Zealand. Section four discusses areas in which findings may be generalised and explore directions for further research.  A final section revisits the objective of this study, and summarises the broad conclusions to be derived from this thesis.

## 7.1    Linking indigenous health policies to the contractual environment

This section provides a synopsis of the comparative analyses of indigenous health policies, the inevitable compromises associated with implementation, and of the resulting contractual environments. The research reported in this thesis was guided by eight questions:

1.  What are the historical factors that impacted the development of indigenous health policies?
2.  What values are apparent in policies?
3.  Do policies more readily reflect indigenous aspirations, indigenous-state's historical relationship or other interests?
4.  What are the apparent compromises made in the process of implementation?
5.  What factors led to compromises?

6. Are indigenous providers able to exercise some control over key areas of decision-making?

7. What are the constraints on operations? And,

8. Is the contractual environment an accurate reflection of indigenous health policies or of the state practices in health contracting? Are compromises made to respect indigenous aspirations?

Each question was explored in chapters 4 and 6 on a country per country basis. The purpose of this section is to re-explore these findings in light of the literature, in order to draw generalisable conclusions on the connection between policy, implementation and the contractual environment.

Table 7.1 summarises the key findings. Overall, all policies exhibit characteristics stemming for the historical relationship between the state and their indigenous constituency (questions 1 to 3). In all three countries, policies have endorsed indigenous-specific forms of collective representation and promoted service responsiveness through indigenous participation. There are however important differences. New Zealand's approach is to design national policies that identify priorities. All providers are then tasked to address these priority areas, which include improving Māori access to services and outcomes in key areas. These policies, although "Treaty-based", continue to reflect New Zealand's commitment to integrated rather than parallel systems.

Canada and Australia have instead preferred to endorse the development of parallel services. The reasons for these differences are largely historical. In Canada, parallel systems emerged as a result of the historical Constitutional divide. The current policy focuses on a transfer of responsibility from the federal government to First Nations for on-reserve services. As such, it simply perpetuates an arrangement that has existed for some time. It also side-steps the engagement of the provincial health care systems that operate autonomously from one another, and to a large extent, from the federal government. In the Canadian context, First Nations understand themselves as distinct nations. This policy focus on local responsiveness may echo First Nation governance structures and aspirations, but leaves a major part of the system, namely all off-reserve primary health services, as well and second and tertiary care services, with no obligation to demonstrate responsiveness.

| Table 7.1 Indigenous health policies | | | |
|---|---|---|---|
| Focus of policies | Local priority setting and overall responsiveness to address inequalities: Australia | National priority setting in addressing health inequalities: New Zealand | Local engagement in primary health care to ensure responsiveness: Canada |
| Factors impacting development | | | |
| Relationship with the Crown (health) | • No legislative framework recognised | • Treaty of Waitangi<br>• Partnership | • Royal Proclamation<br>• Self-government provision in the Constitution<br>• Not Treaty-based |
| History of Indigenous-state relation | • Focus on segregation and oppression.<br>• Recently, creation of parallel primary health care systems | • *Rangatiratanga*<br>• Integration | • Focus on segregation and creation of parallel systems |
| Policy mentions indigenous/ Treaty rights or self-determination | • Recognition of pre-conquest ATSI rights in the area of land rights not extended to other area.<br>• Policy recognises self-determination, not tied to traditional community-based governance structures | • Policy cites the Treaty of Waitangi<br>• Policy situates Māori participation in health structures and processes, instead of the establishment of parallel structures and processes. | • Active resistance to pressure from First Nations to acknowledge a Treaty obligation in policies<br>• Health Transfer Policy integrated with national policy of self-government |
| Policy | | | |
| Source of policy | • Central government since 1995 | • Historically, guidelines from central government issued to public service providers.<br>• Recent shift in 2002 Māori specific strategy and action plan drafted by Central government | • Aboriginal health policies issued by central government |
| Responsibility for implementation | • Central government, with consensus from state/territorial governments | • Regional authorities (DHBs, PHOs) | • Central government |
| Values | • Equity in health;<br>• ATSI participation in planning forums and at the national level;<br>• Community controlled health services;<br>• Responsiveness of the whole system;<br>• Substantial resource investment. | • Māori participation within existing structures but at all levels<br>• Māori development as a people.<br>• Building on improved Māori outcomes<br>• Increase service uptake<br>• Māori participation throughout the health and disability sector.<br>• Reducing inequalities in health care. | • Concentrates on primary health care interventions only<br>• Focuses action solely on on-reserve services<br>• Supports community development as mechanism to improve health |
| Results | | | |

| Table 7.1 Indigenous health policies | | | |
|---|---|---|---|
| Focus of policies | Local priority setting and overall responsiveness to address inequalities: Australia | National priority setting in addressing health inequalities: New Zealand | Local engagement in primary health care to ensure responsiveness: Canada |
| Contractual environments | • Pre-PHCAP : classic contractual environment<br>• PHCAP: Relational contractual environment | • Classic contractual environment | • From relational (1989) to a mix of classic and relational contracts (1994). |
| Indigenous aspirations | • Pre-PHCAP : policy expressed aspiration, but contractual environment was underfunded and limited ATSI participation in service delivery<br>• PHCAP: policy and contractual environments now aligned. | • Aspirations for high level participation reflected in policies, albeit reflecting integration rather than parallel systems.<br>• The contractual environment is a poor reflection of aspirations and f the language of the policy. | • Indian Health Policy better reflects aspiration.<br>• The Health Transfer Policy as implemented in 1989 addressed local aspirations at the expense of broader processes of engagement<br>• The shift towards a classic contractual environment is seen as an erosion of FNIHB commitment to First Nations' rights to health. |

In Australia, parallel systems emerged out of ATSI advocacy. The historical failure of the states and territories in addressing ATSI health needs also played an important role. The Commonwealth Government was able to gain control over ATSI affairs in the early 1970s. Coincidentally, ACCHS also emerged in the early 1970s as a result of community mobilisations. The Commonwealth government's endorsement of parallel services was the logical next step. In contrast to Canada however, Australia is now looking at going beyond the ACCHS movement to address ATSI health inequalities. The current Aboriginal Health Strategy highlights the need to improve the responsiveness of the whole health care system. It was signed by all Health Ministers.

It appears that the contractual environment in which providers operate bears a highly nuanced resemblance to the official policy put in place by their respective governments (questions 4 and 5). Indigenous providers who operate in an environment where the funder is an indigenous-specific government authority (as in the case of First Nations, and in Australia under the new PHCAP program) have access to a more favourable contractual environment administratively, financially and in terms of comprehensiveness of services. In contrast, services that operate in a competitive environment are more likely to access funding via a multiplicity of fragmented contracts, which increases administrative costs for both the funder and the provider; generates operational costs for the provider; leads to increased and duplication in reporting requirements that do not necessarily contribute to the overall goals of health status monitoring or accountability; and creates coordination costs with other providers, to ensure that the overall services provided are as seamless as possible. As well, a fragmented contractual environment is less likely to facilitate the provision of comprehensive primary health care services for a defined population. This may result in a patchwork approach to service delivery, which may be less conducive to achieving the health gains sought.

Preferences in terms of contractual environments have also emerged. In New Zealand, and in the case of ACCHS, providers must compete for funding with other services providers. This results in a classic contractual environment, where each contract contains narrowly defined program specifications. In the case of the Canadian HTP, as originally implemented in 1989 and under the new PHCAP program, providers are understood as the sole legitimate provider to serve a geographically and culturally-defined population. Contracts are flexible and obligations broadly-defined (questions 6 to 8).

The contractual environment in all three countries shows tensions related to competing values existing between indigenous demands for collective recognition and processes of engagement, and the purchaser's broader concerns. The differences in

focus are shown in Table 7.2. The responsibility for indigenous health is vested in central governments who will necessarily place more importance on national priority health gains, and on standardised approaches to facilitate evaluations and reporting on effectiveness.  The focus of indigenous provider is local in both priority setting and in the design of interventions.

| Table 7.2, Competing values | |
| --- | --- |
| Purchaser (government) | Indigenous Organisations |
| National priority setting | Local responsiveness |
| The role's government as the steward responsible for ensuring appropriate expenditures and effectiveness | Indigenous provider's independence, responsiveness to their indigenous constituency |
| Need to show results.<br>Requires harmonised approaches to facilitate evaluations | The need to provide appropriate care that requires flexibility and responsiveness |

Overall, the evidence collected in this thesis suggests that the contractual environment better reflects the tensions at play in indigenous-state relations, whereas policy statements embody national and international debates for indigenous rights and recognition. This finding echoes comments made by Apthorpe (1997). Indigenous advocacy has been successful in ensuring that policy statements and objectives reflect their aspirations.  Implementation is subject to different forces, including divergent interests within the health care system, public perceptions of unfair advantages awarded to culturally-specific services, and values and practices entrenched in public administration.

## 7.2    Lessons from Contractual Environments

The four case studies, and the Canadian experience, are reflective of different contractual environments. These generally fall into two categories:

- **Classic contractual environment**: Providers rely on a majority of contracts that are closer to the "classic" model described in the literature. As a result, providers must compete for funding with other service providers. If core funding is provided, it is not sufficient to sustain the organisation's core activities. Included in this category are TROR, TRHHI and Danila Dilba.

- **Relational contractual environment**: Providers rely on a single or collection of contracts that are closer to the "relational" model described in the literature. Providers are understood by their government as the sole legitimate provider to serve a geographically and culturally defined population. This is the case for KWHB in Australia and for First Nations in Canada.

Each environment exhibits characteristics that emulate single classic and relational contracts. The multiplication of contracts, and the specificity of the indigenous

environment, however create some important differences.   These are reviewed in Tables 7.3 and 7.4.

Table 7.3 compares the characteristics of classic contracts as defined in the literature, to contractual environments based on a collection of classic contracts. Contractual environments that rely on multiple classic contracts to fund on-going services face a number of challenges, including high transaction costs associated with contract drafting. In the indigenous environment, classic contracts may be used to promote interventions in nationally-defined priority areas, to stimulate innovation or to fund on-going services. The objective is not one of competition, but rather of ensuring that the purchaser retains substantial control over priority definition, funding and intervention. There is a risk that a collection of highly specific contracts, which may be easily monitored on a contract per contract basis, creates a patchwork approach to service delivery with significant gaps that may be difficult to track. From the provider's perspective, it may not be possible to let gaps in funding lead to gaps in services. The closer relationship with the indigenous constituency creates opportunity to ensure responsiveness, which may in turn leave the provider caught in between contractual and community obligations.

The short-term and focused nature of the contracts facilitates single contract monitoring, but may complicate the performance monitoring of the overall contractual environment. Further, output-oriented monitoring provides little information on the overall value of the services provided in improving outcomes.  Because of the short-term nature of the contract, there is limited incentive for the funder to settle dispute. Instability in funding can create risks associated with securing and maintaining facilities, and in recruitment and retention.

In the context of this research, no provider operates under a single relational contract. Both KWHB and First Nations operate in mixed environments characterised by a single relational contract that accounts for over half of their funding, complemented with some classic contracts. In these environments, the relational contract funds the on-going primary health portion of services for a defined population. Classic contracts play a more limited role in focusing some interventions on national health priorities or providing an opportunity for experimentation. The flexibility apparent in this environment can promote community engagement in priority setting and intervention, as was the case for KWHB and First Nations. Characteristics are summarised in Table 7.4. Overall, this model ensures access to more stable funding.

The literature suggests that long term contracting carries a "massive moral hazard" because of the difficulty to monitor less defined contracts (Lane 2001). This study suggests that, at least in the indigenous environment, the moral hazard

associated with monitoring contracts is shared between classic and relational contractual environments. Providers that are receiving their funding through a spectrum of small classic contracts require close monitoring to ensure that contractual requirements are met. Providers that access the majority of their funding through a single relational contract depend on the renewal of this contract for their continued existence. Further, the single purchaser-provider relationship that exists spreads the moral hazard to both parties, promoting an amicable resolution of disputes.

In summary, the results of this research do not necessarily reproduce the classic-relational dichotomy reported by other authors (Goddard & Mannion 1998, Lane 2001). Two main reasons are at play. First, the indigenous environment has particularities that are not necessarily reflected in other environments. Indigenous providers have a political-cultural connection with their constituency. As a result of the legal framework in that informs indigenous-state relations, many indigenous providers benefit from a single purchaser-provider relationship. Second, and perhaps more importantly, all research encountered focused on analysing single contracts, rather than the contractual environment, or looking at contracting from the purchaser's perspective. More research is required in contractually fragmented areas to identify whether the conclusions presented here are unique to the indigenous environment, or reflect the context of multiple contracts. In that context, contractual environments show a continuum from classic to relational.

| Table 7.3, Strengths and weaknesses of single classic contracts and contractual environments built on a collection of classic contracts | | |
|---|---|---|
| Criteria | Single contract (Goddard & Mannion 1998, Lane 2001) | Contractual environments: Danila Dilba, TROR, TRHHI |
| | Based on a single funder engaging multiple providers in competing for contracts. | Based on a single organisation accessing funding for program through a number of separate classic contracts to fund on-going services |
| Transaction costs | • Contract drafting requires careful definitions of requirements and outputs, as well as contingencies<br>• Higher transaction costs associated with contract drafting and renewal | • High administrative costs associated with a single contract is compounded with multiple contracts |
| Priority setting | • No incentive for the provider to invest in long term interventions<br>• Tends to focus interventions on individuals<br>• In the case of vertical strategies, allows for the testing of new approaches across many providers | • If proposal-driven, allows providers to experiment with specific interventions. Closer alignment between funding and output allows the funder to report on the performance of targeted strategies.<br>• Tends to focus interventions on nationally-defined rather than local priorities<br>• Over-reliance on vertical strategies for on-going funding |
| Efficiency | • Promotes competition between providers and potentially efficiency | • Not used to promote competition, but rather to ensure that the purchaser retains substantial control. |
| Organisational issues | • Promotes the deployment of resources based on contractual obligations<br>• May create instability in organisations as a result of lack of commitment to continuous funding | • Contract specifications may not match community needs and expectations, leading to political instability for the providers or to providers over-extending the resources they have to ensure responsiveness<br>• Patchwork of funding creates patchwork of services with higher coordination costs<br>• May create instability in organisations as a result of lack of commitment for continuous funding |
| Monitoring | • Explicit output requirements facilitate contract monitoring<br>• Provider performance assessed through contract outputs | • Single contract monitoring is relatively easy.<br>• Monitoring of the overall contractual environment onerous and complex<br>• Output-based monitoring provides little information of the performance of the overall contractual environment in achieving health gains. |

| Table 7.3, Strengths and weaknesses of single classic contracts and contractual environments built on a collection of classic contracts | | |
|---|---|---|
| Criteria | Single contract (Goddard & Mannion 1998, Lane 2001) | Contractual environments: Danila Dilba, TROR, TRHHI |
| | Based on a single funder engaging multiple providers in competing for contracts. | Based on a single organisation accessing funding for program through a number of separate classic contracts to fund on-going services |
| Risk | • Lower risk for government-funder as contracts are short term and can be easily terminated with limited consequences for the funder<br>• Higher risk for the provider who must provide facilities and recruit professionals, while relying on funding commitment that are short term only. | • Higher risk for the provider who must provide facilities and recruit professionals, while relying on funding commitment that are short term only.<br>• Higher risk for the provider who bears the responsibility for accessing funding. |
| Settlement of dispute | • Short term contract may act as a disincentive for the purchaser to settle dispute | • Short term contracts my act as a disincentive for the purchaser to settle dispute |

| Table 7.4, Strengths and weaknesses of relational contracts and relational contractual environments | | |
|---|---|---|
| | Single contract (Goddard & Mannion 1998, Lane 2001) | Blended contractual environments where a relational contract dominates KWHB, HTP |
| Description | Based on a single funder and a single provider engaged in a long term cooperative contractual relationship | Based on a single funding engaging with a single provider in a substantial relational contract that may be complemented with some classic contracts |
| Transaction costs | • Contract drafting broader and more flexible<br>• Reduced transaction costs (drafting and negotiating) | • Relational contract carries lower transaction costs for both the funder and provider |
| Priority setting | • Promote long term planning and intervention<br>• Promote population approaches<br>• Possibility of improved responsiveness | • Flexibility promotes community goodwill and creativity<br>• Promotes improved responsiveness<br>• Reliance on vertical strategies for experimentation only |
| Efficiency | • May result in organisational inefficiency and substandard performance | • Promotes PHC, population-based approaches that are flexible to meet local priorities, and focus strategies to meet the need of national priorities |
| Organisational issues | • Stable funding facilitating recruitment and retention of staff<br>• Facilitates the strategic deployment of human resources as needed | • Relational contract provides stable funding<br>• Recruitment & retention may be facilitated by long term funding guarantees. |
| Monitoring | • Contract monitoring more challenging and costs may offset transaction cost savings.<br>• Possibility of provider performance assessed through outcomes | • Non-performance by organisation leads to higher risk for the funder<br>• Possible provider complaisance related to secure continuous funding (may be mediated by community expectations) |
| Risks | • Moral hazard: non-performance by providers is difficult to track and severing contractual relations may be costly. | • Neither the funder nor the provider can (readily) establish a contractual relationship with another contractual partner.<br>• The provider's viability may be tied to its acceptance of the contract. |
| Dispute Resolution | • Mutual interest in settling disputes amicably | • Mutual interest in settling disputes amicably. |

Relational contracts have intuitive appeal and have been promoted by theorists (Allen 2002, Gilson et al 1997, Palmer & Mills 2003). Governments appear to see them in a different light. Trust-based contracting was first implemented in Canada, with the signature of a single, flexible 3 or 5 year contract. This has now been eroded, and a significant proportion of providers' funding (30-40 percent) is secured through classic contracts reflecting national health priorities. This situation reflects that of Danila Dilba. Recent correspondence with KWHB suggests that "risk management" may be becoming a major concern for OATSIH and eroding provisions such as the pooling of funding. Already KWHB is experiencing some erosion in its trust-based contract. This is linked not to KWHB's performance, but is rather the result of (1) financial difficulties experienced by another PHCAP site, the Tiwi Health Board, (2) the pressures associated with the rolling out of PHCAP nationally, and (3) with funder's perceptions of risk associated with potential non-performance that would challenges the credibility of the overall strategy. As discussed in chapter 6, the shift from relational to classic contracts is related to a number of factors. Relational contracts are used when new models are introduced (PHCAP, MDO, etc.) in part because future contingencies cannot be known. Relational contracts have more appeal, and may promote contract uptake by indigenous providers, thus ensuring that the initiative promoted by a government agency is legitimised. Once models have been deployed and service provision is on-going, the focus may shift to performance and monitoring. The cumulated experience is then used to increase the specificity of contracts. This shift may be related to the needs of mid-level administrators tasked to ensure that contractual obligations are respected. This would suggest that the use of relational contracts has less to do with trust and more to do with punctual administrative priorities.

All three countries show evidence of compromises in their indigenous health contracting practices. In Australia and New Zealand, as in Canada, the contractual environment embodies the last years of indigenous advocacy for self-determination, albeit to varying degrees. The Health Transfer Policy is an anomaly and could not have occurred outside of the context of First Nations advocating for self-government at national and international levels. The same can be said of the core funding provided to ACCHS, and of the more ambitious PHCAP. In New Zealand, compromises are also apparent in the requirement that DHBs show evidence of a Treaty-based partnership with local *iwi*, the requirement that all providers have policies of engagement with Māori to ensure responsiveness, and the repeated commitment to Māori provider development.

While theorists may be prepared to continue to recommend relational contracts because their flexibility can better accommodate the needs of community-based health services, practitioners may be more comfortable in recommending a compromise to ensure long-term political sustainability. A blended approach to contracting may also allow both the purchaser and the provider to mediate their risks (real and perceived). Indigenous people are unlikely to see the trade-off in the same light. Relational contracts provide the most flexible environment, and thus align much more readily with indigenous aspirations, and with indigenous health policies that promote self-determination and local responsiveness.

The optimal contractual environment may very well be a single blended contract with defined benchmarks to focus attention on key priorities, supported by a relational component for core functions (essential services) to ensure that flexibility and responsiveness to local needs are protected. It is unclear why the two perspectives have yet to be embodied into a single contract.

## 7.3    Situating the findings within their Larger Context

The review of findings presented here offers a number of avenues for reflection. These findings can inform macro-policy directions into four broad areas, namely the appropriate focus of stewardship; the trade-offs associated between integrated and separate services; issues associated with resourcing contracting in health; and the link between indigenous engagement and democracy.

### 7.3.1   The forest or the trees: the appropriate focus of stewardship

This research has shown that two strategic approaches have emerged in contracting health services to address health inequalities in indigenous minorities.  In New Zealand and in the case of ACCHS, the state fund providers for a selection of discrete and well-defined programs. The focus is on nationally defined health priorities. This approach had led to the development of health service patchworks rather than systems, funded as a collection of programs targeting narrowly-defined national priorities. While indigenous services are to some extent able to sew funding patches into a somewhat coherent and broader approach to service delivery, there is ground to wonder whether a patchwork approach is a strategically appropriate mechanism to deal with health inequalities, that themselves reflect complex and broad historical and societal processes. In other words, is the pursuit of efficiency in single contracts compromising the efficiency of the overall contractual environment.

The high level of contractual fragmentation documented in Australia in the pre-PHCAP era, in New Zealand and increasingly in Canada since 1995, reflects

worrisome a trend in indigenous health care contracting where a broad concept of stewardship over the overall performance of the health care system is being displaced in favour of a narrow concept of efficiency and accountability over small contracts. The shift is neither cost-effective neither likely to yield the benefits anticipated. Oversight over fragmented contracts is time consuming and costly, and yield little information on the performance of the overall system.

While monitoring contracts for outputs is necessary, this focus should not overshadow the importance of monitoring the performance of the overall system in addressing these inequalities. Future analysis and policy development must consider the overall coherence of contractual environments. A system's approach to health gains may be more readily achieved through the implementation of relational contracts that are population-based, flexible and comprehensive.

### 7.3.2 Integration versus separation: locating responsiveness within the overall system

Both Australia and New Zealand have expressed a commitment to ensuring that their overall health care system becomes and/or remains responsive to indigenous people's needs (King 2000, National Aboriginal and Torres Strait Islander Health Council & Australian Health Ministers' Conference 2003, New Zealand Ministry of Health 2002b). In contrast, the 1979 Indian Health Policy suggested the same goal (Health Canada 2000a). Its implementation arm has however focused exclusively on improving the responsiveness of on-reserve primary health care services (Health and Welfare Canada 1989). The Health Transfer Policy does not extent to provincial authorities. These differences are rooted in historical processes. In New Zealand, the colonial government's commitment to integration has shaped and is reflected in policy commitments to *rangatiratanga*, as opposed to *tino rangatiratanga.* The commitment to integration focuses responsiveness on the whole system, since it cannot be fragmented into Māori-specific and general components.

In Australia, the responsibility for ATSI health services was originally allocated to the states, but at least partially shifted to the Commonwealth Government in the 1970s to finally rest with the Commonwealth Department of Health in 1995. The states and territories still fund secondary and tertiary care from the five-year Health Care Agreements signed with the Commonwealth Government. Although the structure is now very similar to that of Canada, the historical difference appears conducive to the recent national policy framework, and its focus on improving the responsiveness of the overall system, being extended to and ratified by state and territorial Health Ministers

(National Aboriginal and Torres Strait Islander Health Council & Australian Health Ministers' Conference 2003).

Addressing health inequalities necessarily requires a whole system's approach, to ensure responsiveness at all levels. Policy makers in Canada would be wise to learn from the approaches adopted in New Zealand and emerging in Australia. This should however not be at the expense of investing in responsive primary health care services.

### 7.3.3   Resourcing

In all three countries, indigenous primary health care services seem to have emerged at the juncture between an indigenous commitment to self-determination, governments' attempt at giving voice to their indigenous constituency and ideological influences in the management of national health care systems. This paradox has been recognised, and indigenous peoples have been concerned that their respective government may be capitalising on the discourse of self-determination to off-load services onto the shoulders of poorly resourced indigenous health services (Assembly of First Nations 2002, Culhane Speck 1989, Durie 1998b). The Australian context has generated considerable amount of literature to support this argument (Aboriginal and Torres Strait Islander Commission 2000, Anderson 1997a, Australia Commonwealth Department of Health and Aged Care 2000a, 2000b, Australian Institute of Health and Welfare 2001, Burns et al 1998, Deeble et al 1998, Gardner 1997, Jan 1998, Markey 1997, McDermott 1995, 1998, Mooney 1996a, 1996b, 2000, Mooney et al 1998, Mooney & Wiseman 1998, Tsey & Scrimgeour 1996). This has led to debates and research on equity in Aboriginal health financing, which has been matched only to very limited extent in Canada.

The proposal-driven process of accessing funding, currently in place for ACCHS in Australia, embedded in the competitive funding model for Māori providers in New Zealand, and emerging in Canada, is remarkably adept at shifting the responsibility for accessing appropriate funding to providers, thereby making inquiries of equitable access to funding unlikely and methodologically problematic. It is impossible to gauge whether services funded under a competitive model are indeed appropriately funded for what they are asked to provide, or whether the sector experiences barriers in securing funding when compared to non-indigenous providers. Furthermore, the proposal-driven process is being imposed on populations with significant health inequalities and limited resources to access technical capacity. While proposal-driven processes can lead to innovation in service delivery, they are inadequate mechanisms to ensure that financial resources for core health activities are delivered where they are most needed.

The use of proposal-driven vertical strategies should be limited to promote innovation in key areas. Core services must be funded through mechanisms that ensure that services are delivered where needed.

### 7.3.4 History, Context and Trust

*The value of trust is that it is cheaper to trust people,*
*and to develop institutions that will ensure trust,*
*rather than to watch them (Walsh 1995).*

The work of Williamson suggests that the closer the relationship between the provider and the purchaser, the more likely the contractual relationship may be based trust and flexible, thus ensuring that services are responsive to needs (Williamson 2000). The goal is seductive. But what if trust is constrained by history?

Like the word control, the word trust is absolute. In practice, trust is a fluctuating notion that ebbs and flows depending on context and circumstances. From the government's perspective, the mistrust associated with the contracting out responsibilities where the minister nevertheless remains accountable, is compounded by the limited capacity available in the indigenous sector. The experience of colonisation has shaped and continues to influence indigenous people's relationship with the dominant society, as embodied by national and regional governments. It is nevertheless clear that in Canada, Australia and New Zealand, some measure of trust is more readily awarded to central as opposed to regional, state or provincial governments. First Nations have passionately opposed any proposal that would appear to shift the responsibility over First Nation health to provincial authorities. In Australia, the states had the responsibility for ATSI health until the 1970s. It was their lack of performance in improving ATSI health that led the Commonwealth government to take over this responsibility. In both countries, the responsibility for indigenous health is now vested in an indigenous-specific branch of the central government's Department of Health. Both FNIHB (Canada) and OATSIH (Australia) also fund indigenous providers. Māori have advocated for a similar arrangement. The Māori Health Directorate is also a branch of the Ministry of Health. Its functions are however limited to an advisory role in Māori policy development.

If appropriately resourced,[87] indigenous-specific government agencies have greater legitimacy, partly because their interventions are indigenous-focused, they have generally made efforts to indigenise their workforce and to engage indigenous communities in policy and program design. In the context of this study, indigenous-

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[87] ATSIC being a case in point.

specific funders have produced more favourable contractual environments (the HTP and PHCAP). Because of their focus, these agencies are generally more aware and believed more responsive to indigenous needs and realities. They are however agents of their government and their policies and practices must reflect the ideology of the leading party, respect existing national priorities, and be mindful of policy and legislative frameworks related to public administration.  In Australia and Canada, the indigenous population served by these agencies amounts to 2 to 3 percent of the overall national population. As a result, the level of compromise required of the central government to accommodate the particularities of the indigenous environment may be perceived as unreasonable or unwarranted by other sectors of the government. Thus, indigenous-specific government agencies find themselves caught between designing strategies that will meet indigenous needs and aspirations, and respecting constraints associated with the public administration framework and the political ideology in place.

In the Canadian context, trust-based contracts go against recent revisions of the public administration framework that requires all policies to be evidence-based and all programs to be evaluated against set standards. The vision favours standardised and clearly defined approaches. In New Zealand, relational contracts have yet to be seen as advantageous at least in the context of health services. This may be partly related to the quick succession of reforms and the funders being reluctant in making longer terms commitments that may not be seen as appropriate by the next government.  The adoption of a relational contractual framework as the basis of PHCAP is already being challenged by a heightened perception of risks associated with one ATSI provider. While risk management is necessary, all three countries appear to be choosing to respond to single providers difficulties with blanket risk management strategies. The cost-effectiveness of treating all providers equally appears to be ignored, in favour of standardised approaches.

It is important that governments and indigenous providers develop and implement processes that can attest to the performance of single providers in addressing health inequalities and in providing quality services.  The reporting framework in place in all three countries falls miserably short of doing that, because it focuses largely on outputs, rather than outcomes. Realising this objective will require the development of appropriate indicators (Crampton et al 2004, Nazarea et al 1999), that can highlight individual provider's achievement, and that can be aggregated to speak to the performance of the overall sector.

### 7.3.5 Failure or Successes

Indigenous health policies were designed to improve indigenous participation in the health care system. The ultimate goal was to address health inequalities. In all three countries, the policies have yet to show improvement in indigenous health. Part of the problem is that health services performance cannot be measured due to a lack of data that can be aggregated, and because of the limited number of years of implementation. There may be a tendency to claim that the policies have "failed" for a lack of evidence. There may also be a tendency to claim that the same policy "succeeded" because they have improved indigenous participation. The link between participation and improved health remains poorly articulated, although widely accepted.

Policies may be understood as having "failed" or "succeeded" depending on to extent to which the policy, as understood by on-lookers, has met its stated goals. Such categorical statements are perhaps easier to support for micro-level social policies. Because of their complexity, macro-level policies are more likely to go partway into meeting their stated goals. This is so for a number of reasons. First, the stated goals are generally over-optimistic, and their achievements influenced many factors and actors. And, second, the pursuit of these goals is generally longer term, spanning over shifts in government, ideology, allowing interest groups to self-advocate and change the direction of implementation, to better meet policy objectives or to better serve the interests of a selected number of actors. Fatigue can occur as a result of non-visible results.

"By indigenous for indigenous" policies have not failed indigenous people, in the sense that they have provided mechanisms through which indigenous people can engage as social actors and active participants in the health care system. The acquired expertise has led to increasingly sophisticated structures, methods of engagement, and analyses by indigenous scholars and practitioners. These policies have effectively given a voice to indigenous people in a manner unprecedented. The first meeting of the International Network in Indigenous Health Knowledge and Development (https://www.jcu.edu.au/mailman/listinfo/inihkd) in October 2003 is a case in point. This meeting brought together indigenous academics, government representatives, practitioners, and community representatives from Canada, the United States, Australia and New Zealand. Of the 200 or so delegates and experts, less than a dozen were non-indigenous. Of these, only one (the author) was invited to present. The definition of who is and who is not "an expert" on indigenous health and health care has changed.

"By indigenous for indigenous" policies have not failed government goals either, if the goal was indeed to create new opportunities for collective indigenous engagement, a stated goal of policies of self-government, self-determination and

*rangatiratanga.* Although the level of achievement of that goal has differed in all three countries, depending on the contractual environment created, all countries have made significant gains in indigenous engagement over the past 30 years.

Indigenous peoples remain committed to moving their aspirations forward, and have increasingly been able to draw on the international community to validate these aspirations. The International Decade of the World's Indigenous People (1995-2004) has come to an end, and resulted in the formation of the UN Permanent Forum on Indigenous Issues. The Permanent Forum met for the first time in May 2002. The Forum reaffirmed the vision that,

> *[The] underlying causes of poor health for indigenous people included colonization, homelessness, poor housing, poverty, lack of reproductive rights, domestic violence and addiction. Health care should be envisaged from an indigenous perspective, which encompassed mental, physical and spiritual health (United Nations 2002).*

The Forum recommended that the decade end with a World Conference on Indigenous Issues, and that a second International Decade be declared to ensure that the goals set for the first decade are advanced further. There is hope that the United Nation General Assembly will adopt the Declaration on the Rights of Indigenous People that reaffirmed three key principles of Indigenous rights:

> *Article 22: … the right to special measures for the immediate… improvement of social conditions… including health;*
>
> *Article 23: … the right to determine and develop priorities and strategies… for health programmes affecting them; and*
>
> *Article 24: … the right to their traditional medicines and health practices… (United Nations 2002).*

These three principles are an attempt to reaffirm key provisions first proposed in the ILO Convention 169,[88] which was ratified by only a handful of countries, namely Argentina, Bolivia, Columbia, Costa Rica, Equador, Guatemala, Honduras, Mexico, Paraguay and Peru (International Labour Office 1991).

Indigenous people have and will continue to draw on an international debate that has tied their demands for recognition and self-determination to issues of human

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[88] The three provisions stated:
- Government will gradually expand the coverage of social security schemes, which are applicable to all citizens, so as to encompass indigenous and tribal peoples;
- Governments are required to provide indigenous and tribal peoples with adequate community based health services, drawing upon their traditional preventive and healing practices and medicines (this constitutes a recognition of the value of traditional medicine and of the need to preserve and further develop it);
- Indigenous and tribal peoples shall participate in the planning and execution of these services, or undertake overall responsibility and control over health services; in both cases it is the State's responsibility to supply the needed resources; local community health workers should be given training and employment on a preferential basis (International Labour Office 1991).

rights. Global debates are now impacting national indigenous policies. Governments would be wise to negotiate compromises that satisfy indigenous aspirations. This is true for all three countries, but especially the case in New Zealand, where Māori now account for nearly 15 percent of the population. The Labour government in particular has so far been resultant in meeting Māori demands for parallel structures. While this may make sense from an administrative perspective, there are risks to ignoring Māori aspirations. Concessions, at least in the contractual environment, may at least go partway in meeting Māori demands and alleviate what appear to be increasingly polarised debates.

## 7.4    Generalising findings and direction for further research

Relational contracts better approximate indigenous aspirations. They also appear that make good economic sense. Two main obstacles stand in the way of implementing comprehensive contracts in indigenous environment. The first one is a trend in health care contracting towards smaller, more easily micro-managed contracts so that governments can ensure a higher level of accountability over single contracts, if not of the whole contractual environment. The choice here seems to be to focus on the tree rather than the forest. A second obstacle stems from the historical relationship of limited trust between government and indigenous people, and the discomfort associated with relinquishing control over the power to define. Additional research linking the cost-effectiveness of models of contracting to providers' ability to perform on outcomes, may go along way to help convince purchasers of the value or otherwise of relational contracts. There is also a need for further research into the cost-effectiveness of different risk management frameworks.

Pan-indigenous comparative health research can inform policy development and implementation. To date, only one study has focused on indigenous health services financing, with case studies from Australia, Norway and Canada (Scrimgeour 1996). International indigenous health policy analysis has tended to focus on Australia and the United States (Kunitz 1990, Kunitz & Brady 1995) or Canada (Crough 1997). The research presented here focused partly on the contractual environment created by different models of financing. It has shown that the reliance on vertical strategies creates an expensive environment, and leads to the creation of health services patchwork. Under this model, services are construed as if complementary to other non-indigenous services. It remains unclear to what extent and in what context indigenous services are used by indigenous people. To date, no research has documented the extent to which reliance on vertical strategies may create second rate services that nevertheless may act at the primary service delivery mechanism for marginalised

populations. More work is required to assess the impact of competitive (ACCHS, Māori providers) as opposed to relational (Health Transfer Policy, PHCAP) contractual environments in providers' ability to deliver effective services. In other words, what is the linkage between contractual inefficiencies and quality of care?

More work is also required to evaluate how different contractual arrangements may favour or impede the implementation of responsive health services. This is a central question for indigenous providers and one that is prioritised by policy. It appears doubtful that a patchwork of inflexible contracts could lead to the implementation of responsive models of service delivery.

Also, more work is required focusing on contractual environments, rather than single contracts. The accumulation of contracts by single providers may well reflect an ability to compete, but it also carries an administrative burden for both the purchaser and the provider. Work is required to define optimal threshold in term of contract size. Work is also required to document the cost effectiveness of different accountability frameworks to ensure that concerns over accountability are met with reasonable solutions.

The analysis presented in this thesis, although indigenous-specific, offers general lessons in two broad areas. First, it documents the context in which indigenous providers operate under two broad categories of funding models. The lessons learned may be generalised to NGO health providers managing a diversity of contracts. More comparative research is required before a definitive assertion can be made. Second, the research documented processes in place to ensure the active engagement of indigenous people in policies design and service delivery, with their strengths and limitations. The lessons learned can be extended to apply to all marginalised populations.

## 7.5    Conclusions: A patchwork approach to health gains?

What are the broad lessons to be drawn from the analysis reported in this thesis? As stated in the introduction, international comparative analyses can be of use to first, provide some perspective on existing policies, and second, explore possible alternatives. The term self-determination is widely used in the indigenous environment. Governments have adopted their own versions, self-government in Canada, self-determination in Australia and *rangatiratanga* in New Zealand, thereby signifying to their indigenous contingency that a convergence of goals exist.

The overall analytical framework developed in chapter 2 was used to explore the dichotomy of classic contracts/complex environments versus relational contracts/rationalised environments. What appears to emerge is that the latter category

generates a more manageable environment, where funding access and reporting are streamlined. Transaction and monitoring costs are also lower. This begs the question, why are simple contracts utilised at all in health care contracting. In the case of New Zealand, simple contracts were created at a time when the internal markets appeared a viable and attractive alternative. Small contracts provided an opportunity for competition. While that goal was quickly abandoned, the fragmented contractual environment has largely remained. Likewise in Canada, the initial focus on relational contracts was gradually supplanted by the proliferation of smaller short term contracts. One of the reasons is that small contracts appear more easily manageable: they have definite outputs, limited power and a short life-span. They maximise purchaser control over the contract. At one level, this may appear as a suitable goal. This goal must however be re-evaluated in light of the complexity and costly contractual environment this strategy generates. As Williamson pointed out, transactions are not free (Williamson 2000).

Strategic choices in health care contracting may therefore have more to do with the historical distrust existing between the purchaser and indigenous providers; purchaser's shifting perception of risk; bureaucratic structures of oversight that assigns contract management to regional mid-level administrators who may be more concerned with preventing problems than with creating cost-effective contractual environments. As a result, strategic choices appear to have less to do with cost efficiency, maximising flexibility and accountability, improving care or indeed government - indigenous providers relations as described in policy. Mistrust appears to survive reforms. It is a personal reflection that in the indigenous environment, increased indigenous engagement in health policy and service delivery has produced a more sophisticated level of engagement and arguments by indigenous people in the pursuit of the same goal: some measure of self-determination. Proficient and sophisticated indigenous organisations have generated a number of indigenous health leaders and scholars. Increased capacity and sophistication in arguments have not necessarily improved trust.

The compromise between indigenous aspirations and national priorities appears to be a contractual environment that looks more like a patchwork than a system, albeit to varying degrees. Is a patchwork approach a satisfactory compromise or is it the worst of both worlds? The question requires reflection at three levels. First, the patchwork is expensive to administer for both the purchaser and the provider, and appears to hold few advantages than that of facilitating indigenous engagement in health care delivery. Second, a patchwork approach to contracting also falls short of indigenous aspirations, a reality that adds political costs and risks to the mix. This is

particularly evident in New Zealand. Third, a patchwork approach is unlikely to bear the fruits of health equity sought through indigenous engagement. This question will regretfully remain largely unanswered for the time being. The patchwork approach, with its multiplication of activity reports and contract-defined quality indicators is unable to produce information that can be collated to produce a provider and health system report card. In an era where governments pride themselves on speaking of evidence-based policies, this issue remains outstanding.

# APPENDIX I, INTERNATIONAL COVENANTS, CONFERENCES AND THEIR RELEVANCE TO INDIGENOUS HEALTH

| International Covenants, Conferences and their relevance to Indigenous Health | | | | | | |
|---|---|---|---|---|---|---|
| **Covenant** | **Document** | **Relevance** | **Ratified (Office of the United Nations High Commissioner for Human Rights 2003)** | | **References** | |
| | | | **# Countries** | **Can OZ NZ** | **Primary** | **Secondary** |
| Universal Declaration of Human Rights United Nations 1948 | Universal Declaration | <ul><li>right to health,</li><li>right to enjoy the benefits of scientific progress</li><li>right to non-discrimination</li><li>right to take part in the government of the country</li></ul> | 50 | Yes although Canada was initially opposed along with the USSR and Saudi Arabia. | (United Nations 1948) | (Healy & McKee 2003a, Thornberry 2002) |
| International Labour Organisation Convention No. 107 on the Protection and Integration of Indigenous Tribal and Semi-Tribal Populations in Independent Countries 1957 | Legally binding agreement for signatories | <ul><li>Intro: recognition of the existence and significance of indigenous people</li><li>2. Promotion of integrative policies (assimilation)</li><li>3. equal rights between indigenous and non-indigenous</li><li>12 no forced removal from territory unless for health</li><li>19, 20: adequate services for social security and health, based on studies of social, economic and cultural conditions</li></ul> | 27 | Neither ratified nor denounced. Assimilationist | (International Labour Office 1957) | (Havemann 1999b, Magallanes 1999, Thornberry 2002) |
| International Convention on the Elimination of All Forms of Racial Discrimination (CERD) 1965 | UN Human Rights Treaty | <ul><li>right of all citizens to be treated as equal under the law</li><li>5(e): right to public health, health care, social security and social services</li></ul> | 166 | OZ: 30/9/75<br>Can: 14/10/70<br>NZ: 22/11/72 | (United Nations 1965) | (Havemann 1999b, Healy & McKee 2003a, Thornberry 2002) |

| International Covenants, Conferences and their relevance to Indigenous Health | | | | | | |
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| Covenant | Document | Relevance | Ratified (Office of the United Nations High Commissioner for Human Rights 2003) | | References | |
| | | | # Countries | Can OZ NZ | Primary | Secondary |
| International Covenant on Economic, Social and Cultural Rights (CESCR) United Nations 1966 | UN Human Rights Treaty | • 1. every peoples right to self-determination<br>• 12. right of everyone to the highest attainable standard of physical and mental health<br>• requires governments to report on a range of measures including access to health care. | 146 | OZ: 10/12/75<br>Can: 19/05/76<br>NZ: 28/12/78 | (United Nations 1966b) | (Havemann 1999b, Healy & McKee 2003a, Thornberry 2002) |
| International Covenant on Civil and Political Rights (CCPR) United Nations 1966[89] | UN Human Rights Treaty | • 1: right to self-determination for all peoples (not specifying indigenous peoples),<br>• right to freedom of movement (12), of religion and belief (18), of opinion (19) and of assembly (21) constrained by the need to protect public health<br>• 27: right for minorities to practice their culture, profess and practise their own religion, or use their own language<br>• Establishes the authority of the UN Human Rights Committee to hear grievances, ratified by Can, OZ & NZ | 149 | OZ: 13/08/80<br>Can: 19/05/76<br>NZ: 28/12/78 | (United Nations 1966a) | (Havemann 1999b, Healy & McKee 2003a, Thornberry 2002) |
| Draft Declaration of Principles for the Defense of the Indigenous Nations and Peoples of the Western Hemisphere 1977 | Not located | • Not located | | | Not located | (Havemann 1999b) |

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[89] Two optional protocols have been added to the original Covenant, the first dealing with defining the process for the Human Rights Committee to function (United Nations 1976), and the second dealing with the elimination of the death penalty (United Nations 1989). These are important but peripheral to the object of this review.

| International Covenants, Conferences and their relevance to Indigenous Health | | | | | | |
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| **Covenant** | **Document** | **Relevance** | **Ratified (Office of the United Nations High Commissioner for Human Rights 2003)** | | **References** | |
| | | | **# Countries** | **Can OZ NZ** | **Primary** | **Secondary** |
| UN Combat Racism Conference 1978 | Adopted by UN | • 21. the right of indigenous peoples to maintain their traditional structure of economy and culture, including their own language, and also recognizes the special relationship of indigenous peoples to their land and stresses that their land, land rights and natural resources should not be taken away from them; | UN Resolution | | (World Health Organisation 1978) | (Havemann 1999b) |

| International Covenants, Conferences and their relevance to Indigenous Health | | | | | | |
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| **Covenant** | **Document** | **Relevance** | **Ratified (Office of the United Nations High Commissioner for Human Rights 2003)** | | **References** | |
| | | | **# Countries** | **Can OZ NZ** | **Primary** | **Secondary** |
| Alma-Ata Declaration 1978 | Unilateral Declaration? | • Community participation in primary health care | | | (World Health Organisation 1978) | |
| Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) United Nations 1979 | UN Human Rights Treaty | • Article 10(h): access to specific educational information to ensure health and well-being;<br>• Article 12.1 Eliminate all discrimination in the field of health care;<br>• Article 14: Access to health care facilities. | 50 | OZ: 28/07/83<br>Can: 10/12/81<br>NZ: 10/01/85 | (United Nations 1979) | (Healy & McKee 2003a, Thornberry 2002) |
| UN Combat Racism Conference 1983 | Adopted by UN | • Recognizes that indigenous peoples are covered in existing international instruments,<br>• 22. The rights of indigenous populations to maintain their traditional economic, social and cultural structures, to pursue their own economic, social and cultural development and to use and further develop their own language, their special relationship to their land and its natural resources should not be taken away from them;<br>• 34.Governments should recognize and respect the basic rights of such populations: (a) To call themselves by their proper name and to express freely their own identity; (b) To have official status and to form their own representative organizations; (c) To maintain within the areas where they live their traditional economic structures and way of life; this should in no way affect their right to participate freely on an equal basis in the economic, social and political development of the country; (d) To maintain and use their own language, wherever possible, for administration and education; (e) To enjoy freedom of religion or belief; (f) To have access to land and natural resources, particularly in the light of the fundamental importance of rights to land and natural resources to their traditions and aspirations; (g) To structure, conduct and control their own educational systems.<br>• 35. Indigenous populations should be free to manage their own affairs to the fullest practicable extent, and should be consulted in all matters concerning their interests and welfare, wherever possible through formal consultative arrangements. Special measures should be taken to remedy past dispossession, dispersal and | UN Resolution | | (World Conference to Combat Racism and Racial Discrimination 1983) | (Havemann 1999b) |

| International Covenants, Conferences and their relevance to Indigenous Health | | | | | | |
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| **Covenant** | **Document** | **Relevance** | **Ratified (Office of the United Nations High Commissioner for Human Rights 2003)** | | **References** | |
| | | | **# Countries** | **Can OZ NZ** | **Primary** | **Secondary** |
| | | systematic discrimination. | | | | |
| | | • 36.  Funds should be made available by the national authorities for investments, the uses of which are to be determined with the participation of the indigenous populations themselves, in the economic life of the areas concerned, as well as in all spheres of cultural activity. | | | | |
| | | • 37.  Governments should allow indigenous populations within their territories to develop cultural and social links with related or similar populations, taking into account the important role of international organizations or associations of indigenous populations, and with due respect for the sovereignty, territorial integrity and political independence of those countries in which indigenous populations live. | | | | |
| | | • 38.  The Conference further urges States to facilitate and support the establishment of representative non-governmental international organizations for indigenous populations through which they can share experiences and promote common interests. The Sub-Commission on Prevention of Discrimination and Protection of Minorities should ensure that the urgent work being carried out by its Working Group on Indigenous Populations is continued so that the complex issues involved can be analyzed and appropriate measures taken at the international and national levels. | | | | |
| | | • 39.  In view of the vulnerability of indigenous populations to discrimination and violations of their human rights, and of the gravity of the threat faced by indigenous populations in some parts of the world, Governments should pay close attention to situations in which the rights of indigenous populations may be violated or denied, in order to prevent such violations, which should be widely publicized as soon as they are detected. | | | | |

| International Covenants, Conferences and their relevance to Indigenous Health | | | | | | |
|---|---|---|---|---|---|---|
| **Covenant** | **Document** | **Relevance** | **Ratified (Office of the United Nations High Commissioner for Human Rights 2003)** | | **References** | |
| | | | **# Countries** | **Can OZ NZ** | **Primary** | **Secondary** |
| Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) United Nations 1984 | UN Human Rights Treaty | • Peripheral, not reviewed. | 132 | OZ: 8/8/89 | (United Nations 1984) | (Healy & McKee 2003a) |
| Ottawa Charter on Health Promotion 1986 | | • Community participation in primary health care | | | (World Health Organisation 1986) | |
| ILO Convention No. 169 Concerning Indigenous and Tribal Peoples in Independent Countries 1989 | Legally binding agreement for signatories | • 25. Health services should be community-based, with local employment. | 17 | Not ratified by OZ, Can or NZ | (International Labour Office 1991) | (Havemann 1999b) |
| Convention on the Rights of the Child (CRC) United Nations 1989 | UN Human Rights Treaty | • 17d. encourage mass media to give regards to the linguistic needs of indigenous and minority groups;<br>• 30. the right for a child to enjoy their culture, process and practice their religion and use their own language. | 191 | OZ: 17/12/90<br>Can: 13/12/91<br>NZ: 6/4/93 | (United Nations 1990) | (Healy & McKee 2003a) |
| 1993 World Conference on Human Rights | Adopted by UN | • 20. recognises the unique contribution of indigenous people to the development and plurality of society, full participation of indigenous people in society;<br>• 28. Support the drafting of the Declaration on Indigenous Human Rights<br>• 29. 30. 31 and 32. all about representation at the UN. | UN Resolution | | (United Nations 1993b) | (Healy & McKee 2003a) |
| draft Declaration on the Rights of Indigenous Peoples 1993 Working Group on Indigenous Populations | Draft | • 31. Indigenous peoples, as a specific form of exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, including culture, religion, education, information, media, health, housing, employment, social welfare, economic activities, land and resources management, environment and entry by non-members, as well as ways and means for financing these autonomous functions. | | | (United Nations 1993a) | |

| International Covenants, Conferences and their relevance to Indigenous Health | | | | | | |
|---|---|---|---|---|---|---|
| Covenant | Document | Relevance | Ratified (Office of the United Nations High Commissioner for Human Rights 2003) | | References | |
| | | | # Countries | Can OZ NZ | Primary | Secondary |
| 1994 International Conference on Population and Development | Adopted by UN | • Equality | UN Resolution | | (United Nations 1994, 1999) | (Healy & McKee 2003a) |
| Health for all in the Twenty-First Century WHO Regional Office for Europe 1999 | Declaration | • No mention of community-based primary health care. | | | (World Health Assembly 1998) | (Healy & McKee 2003a) |
| UN Combat Racism Conference 2001 | Endorsed by UN | • Indigenous issues in light of gross violation of human rights. | | | | |

# APPENDIX II, POLICY ANALYSIS

| Canadian Policy Environment | |
|---|---|
| Source | Canada (Health and Welfare Canada (MSB) 1986a, 1986b, 1989, Health Canada 2000a) |
| Authority | Policy, implementation, and responsibility for outcome lies with one institution, Health Canada since 1944 |
| Indigenous-specific or integrated | FNIHB is Indigenous-specific branch within the Federal Ministry of Health. |
| Policy document(s) | Parent policy: 1979 Indian Health Policy<br>Implementation policy: 1989 Health Transfer Policy |
| Parent policy/strategy Foundation | Policy flows from constitutional and statutory provisions, treaties and customary practices.<br>Recognizes the intolerable conditions of poverty and community decline that affect many Indians, and seeks a framework in which Indian communities can remedy these conditions.<br>Federal Government recognizes its legal and traditional responsibilities to Indians, and seeks to promote the ability of Indian communities to pursue their aspirations within the framework of Canadian institutions. |
| Implementation mechanism(s) | The 1986 Health Transfer Policy,<br>promoting the transfer of on-reserve primary health services to First Nation control; and<br>ensuring that appropriate funding would be in place, allowing the community to undertake a community-based assessment, hire capacity to draft operational plans and undertake negotiations.<br>The Health Transfer Policy makes no provision to promote increased First Nation participation in all level of the Canadian health care system. |
| Policy objectives | Parent policy: To achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves.<br>Implementation policy: transfer of on-reserve services to a First Nation authority. |
| Values | Parent policy: looks at inequalities from a determinants of health's perspective; looks at the role of the whole health care system; assumes cross-sectorial cooperation, including federal-provincial; and supports community development as mechanism to improve health<br><br>Implementation policy: funding for three loosely-defined mandatory programs (immunization, environmental health and primary health intervention) and for complementary, flexible and community-driven health promotion, prevention and community well-being programs |

| Australian Policy Environment | |
|---|---|
| Source | Australia (Australia National Aboriginal Health Strategy Working Party 1989, National Aboriginal and Torres Strait Islander Health Council & Australian Health Ministers' Conference 2003) |
| Authority | In 1989, responsibility for policy, implementation, and outcome lie with ATSIC. In 1995, the Commonwealth Department of Health since 1995 took over this responsibility. The 2003 National Framework was however signed with all state/territorial Ministers of Health |
| Indigenous-specific or integrated | OATSIH is Indigenous-specific branch within the Commonwealth Department of Health. Implementation includes the territories/states. |
| Policy document(s) | 1989 National Aboriginal Health Strategy 2003 National Strategic Framework for Aboriginal and Torres Strait Islander Health |
| Policy/strategy Foundation | 1989 NAHS focused on community control of health services, funding remaining with DAA, the formation of a joint DAA and Health Council of Aboriginal Health, Commonwealth/state/territorial Minister of Health report on Aboriginal health. 2003 Framework sets nine principles that are necessary for sustained improvements in Aboriginal and Torres Strait Islander health into the 21st Century. 1. Cultural security: ensuring that the legitimate cultural rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected. 2. Improving the health of Aboriginal and Torres Strait Islander individuals, families and communities as a core responsibility and a high priority for the whole of the health sector. 3. A holistic approach to health issues including physical, spiritual, cultural, emotional and social well-being, community capacity and governance. 4. Community control of primary health care services as a preferred method of service delivery. 5. Working together with other government, non-government and private organisations and within and outside the health sector to improve the broader determinants of health. 6. Localised decision-making that responds to the needs and priorities set by local Aboriginal and Torres Strait Islander communities. 7. Promoting good health and preventing illness as a core activity for health services. 8. Building the capacity of health services and communities to respond to health needs and to take more responsibility for health outcomes. 9. Accountability for health outcomes to Aboriginal and Torres Strait Islander communities and governments. |
| Parent policy objectives | To ensure that Aboriginal and Torres Strait Islander peoples enjoy a long and healthy life enriched by a strong living culture, dignity and justice. Within this goal are given specific aims or desired outcomes: 1. Increased life expectancy. 2. Decreased mortality rates in the first year of life. 3. Decrease all-causes mortality rates across all ages. 4. Reduce the impact of: * chronic disease, particularly cardiovascular disease, diseases of the endocrine system and cancers; and * communicable disease, particularly infections in children and the elderly, and blood borne diseases. 5. Enhance social and emotional well-being and reduce the impact of: * mental disorder; * substance misuse; and * injury and poisoning. |

| Australian Policy Environment | |
|---|---|
| Values | • Equity in health;<br>• ATSI participation in planning forums and at the national level;<br>• Community controlled health services;<br>• Responsiveness of the whole system;<br>• Substantial resource investment. |
| Implementation mechanism(s) | Nine key result areas:<br>1. Improving coordination between programs and services, reforming mainstream health services, and supporting Aboriginal and Torres Strait Islander participation on management of all health services.<br>2. Improve training or non-Indigenous health workers in both mainstream and Aboriginal and Torres Strait Islander specific services, and to enhance Aboriginal and Torres Strait Islander participation in the health workforce.<br>3. Support the delivery of comprehensive primary health care to Aboriginal and Torres strait Islander communities, particularly through support for Aboriginal community-controlled services and ensure that primary health care for Aboriginal and Torres Strait Islander communities are adequately resourced, properly planned, integrated with the rest of the health system, and able to provide a full range of services including promotion and prevention programs.<br>4. Enabling, facilitating and supporting the capacity for Aboriginal and Torres Strait Islander communities to take responsibility for their own health. This means focusing in particular on the responsibilities of governments and services to provide programs, funding and staffing in ways that support community priorities and healthy choices.<br>5. Improve standards of environmental health, including housing and essential services, in Aboriginal and Torres Strait communities.<br>6. Develop partnerships with, and commitment from, other sectors whose activities impact on health.<br>7. Develop the infrastructure, strategic approach in data gathering, research.<br>8. Increase resources available to Aboriginal and Torres Strait Islander health services to levels commensurate with levels of needs, based on the real costs of services and capacity to deliver health outcomes.<br>9. Provide increased and equitable levels of accountability to Aboriginal and Torres Strait Islander communities and to governments for the delivery and effectiveness of health services. |

| New Zealand Policy Environment | |
|---|---|
| Source | New Zealand (New Zealand Ministry of Health 2002b, King 2000) |
| Authority | Policy is from New Zealand Ministry of Health, implementation is the District Health Board. The policy and implementation mechanisms are not indigenous specific. |
| Indigenous-specific or integrated | Māori policy written by the Māori Health Directorate of the Ministry of Health. Implementation requires the adoption of Māori specific provisions by all providers. |
| Policy document(s) | H. A. King, "The New Zealand Health Strategy" (Ministry of Health, 2000).<br>New Zealand Ministry of Health, "The primary health care strategy" (New Zealand Ministry of Health, 2001).<br>New Zealand Ministry of Health, "He Korowai Oranga, Maori Health Strategy: Discussion Document" (New Zealand Ministry of Health, 2001). |
| Policy/strategy Foundation | The 2000 New Zealand Health Strategy was a shift away from the competitive environment set in place in the early 1990s. It defines seven principles:<br>1. Acknowledging the special relationship between Maori and the Crown under the Treaty of Waitangi.<br>2. Good health and well-being for all New Zealanders throughout their lives.<br>3. An improvement in health status of those currently disadvantaged.<br>4. Collaborative health promotion and disease and injury prevention by all sectors.<br>5. Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.<br>6. A high-performing system in which people have confidence.<br>7. Active involvement of consumers and communities at all levels.<br>The first principle is further explained as,<br>This principle recognises that the Treaty of Waitangi is New Zealand's founding document and the Government is committed to fulfilling its obligations as a Treaty partner. This special relationship is ongoing and is based on the underlying premise that Maori should continue to live in Aotearoa as Māori. The nature of this relationship has been confirmed through interpretations of the Treaty of Waitangi, which stem from decisions of the Waitangi Tribunal, the Court of Appeal and the Privy Council.<br>Central to the Treaty relationship and implementation of Treaty principles is a common understanding that Maori will have an important role in implementing health strategies for Maori and that the Crown will relate to each other in good faith with mutual respect, co-operation and trust. |
| Parent policy objectives | The strategy highlights ten objectives:<br>1. A healthy social environment<br>2. Reducing inequalities in health status<br>3. Maori development in health, meaning building capacity for Maori participation in the health sector, enabling Māori communities to identify and to provide for their own health need, and fostering the development of a Maori health workforce.<br>4. A healthy physical environment<br>5. Healthy communities, families and individuals<br>6. Healthy lifestyles<br>7. Better mental health<br>8. Better physical health<br>9. Injury prevention<br>10. Accessible and appropriate health care services |

| New Zealand Policy Environment | |
| --- | --- |
| Values | The Māori Health Strategy further details the direction for Māori primary health care development, highlighting three threads:<br><br>• *Rangatiratanga*, meaning *whanau, hapu, iwi* and Māori aspirations to exercise some control over the direction and shape of institutions, communities and development as a people.<br><br>• Building on the gains, highlights improvements in Māori and *whanau ora* outcomes, service uptake and Māori participation throughout the health and disability sector.<br><br>• Reducing inequalities in health care. |
| Implementation mechanism(s) | The New Zealand Health Strategy involved the development of 21 District Health Boards funded on capitation model to regionalised health decision-making. The strategy was followed by a number of documents to direct implementation. The Primary Health Care Strategy directs the district health boards to encourage the development of Primary Health Organisations that will be funded on a capitation model for a registered population. The goal of the PHO is to rationalise and coordinate the primary health care sector, including services provided by general practices and non-government providers. It focuses on five objectives,<br>1. Work with local communities and enrolled populations<br>2. Identify and remove health inequalities<br>3. Offer access to comprehensive services to improve, maintain and restore people's health<br>4. Co-ordinate care across service areas<br>5. Develop the primary health car workforce<br>6. Continuously improve quality using good information<br>The strategy reaffirms a commitment to health services by Māori for Mori. |

# APPENDIX III, INTERVIEW GUIDES

**Interview Guide for Government Officials**

Two categories of Government officials will be approached for this study. The first category includes people who were key players in the development of PHC transfer mechanisms/policies. The second category includes people who are currently involved in the implementation of the mechanisms/policies (Governmental Programme Managers). Questions for each will have a different focus.

**Questions for Historical Key Players**

- What were some of the factors that led the Commonwealth/New Zealand Government to begin to fund community-based Aboriginal PHC initiatives?

- What were some of the key events that shaped the process?

- Who were some of the key players involved in shaping this process?

- What was your role/how did you become involved?

- What did you hope to accomplish, what was the vision?

- What were the obstacles along the way?

**Questions for Governmental Programme Managers**

- What is the scope of the transfer (Commonwealth/state/private or National/private), which community groups can apply to deliver themselves? Is this negotiable?

- How are the initiatives financed? Are they block-funded or funded per program? What is the process of application for funds? What kind of reporting is required for accountability?

- Can initiatives raise revenue, how? Can surpluses be kept from one year to the next?

- Who defines how providers are paid? Can aboriginal organisations set up their own insurance scheme? Who defines programmes standards?

- Are there national salary grid standards, are workers unionised still? Who hires/fires?

- Who can access services from these organisations (catchment area, terms for inclusion/exclusion, organisational discretion)?

**<u>Interview Guide for Indigenous Health Organisations Leaders and Administrators</u>**

In this category, I include leaders who were involved in the process at a political level.

- What were some of the factors that led the Commonwealth/New Zealand Government to begin to fund community-based Aboriginal PHC initiatives?

- What was the process?

- What were some of the key events that shaped the process?

- Who were some of the key players involved in shaping this process?

- What was your role?

- What did you hope to accomplish, what was the vision?

- Were there obstacles along the way?

- What is the scope of the transfer (Commonwealth/state/private), what can community groups apply to deliver themselves?  Is this negotiable?

- Tell me about the negotiation process.

- How are the initiatives financed?  Are they block-funded or funded per program? For how many years?

- What kind of reporting is required for accountability?

- Can initiatives raise revenue, how?  Can they keep surpluses?

- Who defines how providers are paid?  Can aboriginal organizations set up their own insurance scheme?

- Who defines programs standards?

- Are there national salary grid standards, are workers unionized still?  How hires/fires?

- Who can access services from these organizations (catchment area, terms for inclusion/exclusion, organizational discretion)?

- Is the governance structure limited/defined by the contract?

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Williams, Chief Judge Joe. 2002. *Treaty of Waitangi*. LexisNexis Butterworths Online, Wellington

Workman, Kim. 1996. Achieving the Crown's objective for Maori health.  Wellington.

## Danila Dilba

| Danila Dilba, Reference | Type of document | Cited in text |
|---|---|---|
| Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation. 1993. *Annual Report 1992-93*. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, Darwin | Annual Report | Yes |
| Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation. 1994. *Annual Report 1993-94*. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, Darwin | Annual Report | Yes |
| Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation. 1995. *Annual Report 1994-95*. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, Darwin | Annual Report | Yes |
| Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation. 1996. *Annual Report 1995-96*. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, Darwin | Annual Report | Yes |
| Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation. 1997. *Annual Report 1996-97*. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, Darwin | Annual Report | Yes |
| Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation. 1998. *Annual Report 1997-98*. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, Darwin | Annual Report | No |
| Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation. 1999. *Annual Report 1998-99*. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, Darwin | Annual Report | No |
| Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation. 2000. *Annual Report 1999-2000 - Special 10th Anniversary Issue*. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, Darwin | Annual Report | No |
| Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation. 2001. *Annual Report 2000-01*. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation, Darwin | Annual Report | Yes |
| Management Committee, 5-Dec-01, 01-026-170-015-02 (Management meetings Oct-Dec 01), Pat Anderson, CEO, Chief Executive Officer's Report | Minutes of meeting | No |

| Danila Dilba, Reference | Type of document | Cited in text |
|---|---|---|
| Management Committee, 8-Oct-01, 01-026-170-015-02 (Management meetings Oct-Dec 01) | Minutes of meeting | No |
| Management Committee, 10-Sep-01, 01-026-170-015-01 (Management Committee July-Sep 01) | Minutes of meeting | No |
| Management Committee, 10-Aug-01, 01-026-170-015-01 (Management Committee July-Sep 01) | Minutes of meeting | No |
| Management Committee, 19-Jul-01, 01-026-170-015-01 (Management Committee July-Sep 01) | Minutes of meeting | No |
| Management Committee, 21-Jun-01, 01-026-170-015-01 (Management Committee July-Sep 01) | Minutes of meeting | No |
| Management Committee, 14-Jun-01, 01-026-170-011-04 (Management Committee Apr to Jun 01) | Minutes of meeting | No |
| Management Committee, 10-May-01, 01-026-170-011-04 (Management Committee Apr to Jun 01) | Minutes of meeting | No |
| Management Committee, 12-Apr-01, 01-026-170-011-04 (Management Committee Apr to Jun 01) | Minutes of meeting | No |
| Management Committee, 15-Mar-01, 01-026-170-011-03 (Management Committee Jan-Mar 01) | Minutes of meeting | No |
| Management Committee, 8-Feb-01, 01-026-170-011-03 (Management Committee Jan-Mar 01) | Minutes of meeting | No |
| Management Committee, 14-Dec-00, 01-026-170-011-02 (Management Committee Oct to Dec 00) | Minutes of meeting | No |
| Management Committee, 9-Nov-00, 01-026-170-011-02 (Management Committee Oct to Dec 00) | Minutes of meeting | Yes |
| Management Committee, 12-Oct-00, 01-026-170-011-02 (Management Committee Oct to Dec 00) | Minutes of meeting | No |
| Management Committee, 14-Sep-00, 01-026-170-011-01 (Management Committee Jul - Sep 00) | Minutes of meeting | Yes |
| Management Committee, 10-Aug-00, 01-026-170-011-01 (Management Committee Jul - Sep 00) | Minutes of meeting | No |
| Management Committee, 13-Jul-00, 01-026-170-011-01 (Management Committee Jul - Sep 00) | Minutes of meeting | No |
| Management Committee, 26-Jun-01, 01-026-170-010-04 (Management Committee Apr - June 00 | Minutes of meeting | No |
| Management Committee, 8-Jun-01, 01-026-170-010-04 (Management Committee Apr - June 00 | Minutes of meeting | No |
| Management Committee, 19-May-00, 01-026-170-010-04 (Management Committee Apr - June 00 | Minutes of meeting | No |
| Management Committee, 13-Apr-00, 01-026-170-010-04 (Management Committee Apr - June 00 | Minutes of meeting | No |
| Management Committee, 9-Mar-00, 01-26-170-010-03 (Management meeting Jan-Mar 00) | Minutes of meeting | No |
| Management Committee, 10-Feb-00, 01-26-170-010-03 (Management meeting Jan-Mar 00) | Minutes of meeting | No |
| Management Committee, 13-Jan-00, 01-26-170-010-03 (Management meeting Jan-Mar 00) | Minutes of meeting | No |
| Management Committee, 9-Dec-99, 01-026-170-010-02 (Management Committee Oct-Dec 99) | Minutes of meeting | Yes |

| Danila Dilba, Reference | Type of document | Cited in text |
|---|---|---|
| Management Committee, 18-Nov-99, 01-026-170-010-02 (Management Committee Oct-Dec 99) | Minutes of meeting | Yes |
| Management Committee, 14-Oct-99, 01-026-170-010-02 (Management Committee Oct-Dec 99) | Minutes of meeting | No |
| Management Committee, 9-Sep-99, 01-026-170-010-01 (Management Committee Jul-Sep 99) | Minutes of meeting | No |
| Management Committee, 12-Aug-99, 01-026-170-010-01 (Management Committee Jul-Sep 99) | Minutes of meeting | No |
| Management Committee, 15-Jul-99, 01-026-170-010-01 (Management Committee Jul-Sep 99) | Minutes of meeting | No |
| Management Committee, 10-Jun-99, 01-026-170-008-04 (Management Committee Apr-June 99) | Minutes of meeting | No |
| Management Committee, 13-May-99, 01-026-170-008-04 (Management Committee Apr-June 99) | Minutes of meeting | No |
| Management Committee, 8-Apr-99, 01-026-170-008-04 (Management Committee Apr-June 99) | Minutes of meeting | No |
| Management Committee, 18-Mar-99, 01-026-170-008-03 (Management Committee Jan-Mar 99) | Minutes of meeting | No |
| Management Committee, 11-Feb-99, 01-026-170-008-03 (Management Committee Jan-Mar 99) | Minutes of meeting | No |
| Management Committee, 14-Jan-99, 01-026-170-008-03 (Management Committee Jan-Mar 99) | Minutes of meeting | No |
| Management Committee, 10-Dec-98, 01-026-170-008-02 (Management Committee Sep-Dec 98) | Minutes of meeting | Yes |
| Management Committee, 19-Nov-98, 01-026-170-008-02 (Management Committee Sep-Dec 98) | Minutes of meeting | No |
| Management Committee, 8-Oct-98, 01-026-170-008-02 (Management Committee Sep-Dec 98) | Minutes of meeting | No |
| Management Committee, 10-Sep-98, 01-026-170-008-02 (Management Committee Sep-Dec 98) | Minutes of meeting | No |
| Management Committee, 13-Aug-98, 01-026-170-008-02 (Management Committee Sep-Dec 98) | Minutes of meeting | No |
| Forum, 9-Jul-98, 01-026-170-008-01 (Management Committee June-July 98) | Minutes of meeting | No |
| Management Committee, 4-Jun-98, 01-026-170-008-01 (Management Committee June-July 98) | Minutes of meeting | No |
| Management Committee, 30-Apr-98, 01-026-170-007-03 (Management Committee Apr - June 98) | Minutes of meeting | No |
| Management Committee, 12-Mar-98, 01-026-170-007-02 (Management Committee Dec 97 - Mar 98) | Minutes of meeting | No |
| Management Committee, 12-Feb-98, 01-026-170-007-02 (Management Committee Dec 97 - Mar 98) | Minutes of meeting | No |
| Management Committee, 18-Dec-97, 01-026-170-007-02 (Management Committee Dec 97 - Mar 98) | Minutes of meeting | No |
| Management Committee, 11-Nov-97, 01-026-170-007-01 (Management Committee July - Nov 97) | Minutes of meeting | No |
| Management Committee, 10-Oct-97, 01-026-170-007-01 (Management Committee July - Nov 97) | Minutes of meeting | No |

| Danila Dilba, Reference | Type of document | Cited in text |
|---|---|---|
| Management Committee, 7-Aug-97, 01-026-170-007-01 (Management Committee July - Nov 97) | Minutes of meeting | No |
| Management Committee, 10-Jul-97, 01-026-170-007-01 (Management Committee July - Nov 97) | Minutes of meeting | No |
| Management Committee, 5-Jun-97, 01-026-170-006-02 (Management Committee Jan - June 97) | Minutes of meeting | No |
| Management Committee, 4-Apr-97, 01-026-170-006-02 (Management Committee Jan - June 97) | Minutes of meeting | No |
| Management Committee, 20-Feb-97, 01-026-170-006-02 (Management Committee Jan - June 97) | Minutes of meeting | No |
| Management Committee, 23-Jan-97, 01-026-170-006-02 (Management Committee Jan - June 97) | Minutes of meeting | No |
| Management Committee, 23-Oct-96, 01-026-170-006-01 (Management Committee  Jul - Oct 96) | Minutes of meeting | No |
| Management Committee, 17-Oct-96, 01-026-170-006-01 (Management Committee  Jul - Oct 96) | Minutes of meeting | No |
| Management Committee Meeting, 18-Sep-96, 01-026-170-009-02 (AGMs 96-97) | Minutes of meeting | Yes |
| Management Committee, 12-Sep-96, 01-026-170-006-01 (Management Committee  Jul - Oct 96) | Minutes of meeting | No |
| Management Committee, 8-Aug-96, 01-026-170-006-01 (Management Committee  Jul – Oct 96) | Minutes of meeting | Yes |
| Management Committee, 11-Jul-96, 01-026-170-006-01 (Management Committee  Jul - Oct 96) | Minutes of meeting | No |
| Management Committee, 17-Jun-96, 01-026-170-005-02 (Management Committee  Mar - June 96) | Minutes of meeting | No |
| Management Committee, 9-May-96, 01-026-170-005-02 (Management Committee  Mar - June 96) | Minutes of meeting | No |
| Management Committee, 4-Apr-96, 01-026-170-005-02 (Management Committee  Mar - June 96) | Minutes of meeting | No |
| Management Committee, 14-Mar-96, 01-026-170-005-02 (Management Committee  Mar - June 96) | Minutes of meeting | No |
| Management Committee, 8-Feb-96, 01-026-170-005-01 (Management Committee Aug 95 - Feb 96) | Minutes of meeting | No |
| Management Committee, 11-Jan-96, 01-026-170-005-01 (Management Committee Aug 95 - Feb 96) | Minutes of meeting | No |
| Management Committee, 7-Dec-95, 01-026-170-005-01 (Management Committee Aug 95 - Feb 96) | Minutes of meeting | No |
| Management Committee, 19-Oct-95, 01-026-170-005-01 (Management Committee Aug 95 - Feb 96) | Minutes of meeting | No |
| Management Committee, 25-Sep-95, 01-026-170-005-01 (Management Committee Aug 95 - Feb 96) | Minutes of meeting | No |
| Management Committee, 7-Sep-95, 01-026-170-005-01 (Management Committee Aug 95 - Feb 96) | Minutes of meeting | No |
| Management Committee, 3-Aug-95, 01-026-170-005-01 (Management Committee Aug 95 - Feb 96) | Minutes of meeting | No |
| Management Committee, 26-Jun-95, 01-026-170-004 (Management Committee July 94 - June 95) | Minutes of meeting | No |

| Danila Dilba, Reference | Type of document | Cited in text |
|---|---|---|
| Special General meeting, 5-Apr-95, 01-026-170-009-01 (AGM 1991-95) | Minutes of meeting | No |
| Management Committee, 20-Mar-95, 01-026-170-004 (Management Committee July 94 - June 95) | Minutes of meeting | No |
| Management Committee, 24-Jan-95, 01-026-170-004 (Management Committee July 94 - June 95) | Minutes of meeting | No |
| Management Committee, 6-Jan-95, 01-026-170-004 (Management Committee July 94 - June 95) | Minutes of meeting | No |
| Management Committee, 11-Nov-94, 01-026-170-004 (Management Committee July 94 - June 95) | Minutes of meeting | No |
| Management Committee, 7-Nov-94, 01-026-170-004 (Management Committee July 94 - June 95) | Minutes of meeting | No |
| Management Committee, 7-Jul-94, 01-026-170-004 (Management Committee July 94 - June 95) | Minutes of meeting | No |
| Management Committee, 2-Jun-94, 01-026-170-003 (Management Committee Jul 93 - Jun 94) | Minutes of meeting | No |
| Management Committee, 24-Mar-94, 01-026-170-003 (Management Committee Jul 93 – Jun 94) | Minutes of meeting | Yes |
| Management Committee, 4-Feb-94, 01-026-170-003 (Management Committee Jul 93 - Jun 94) | Minutes of meeting | No |
| Management Committee, 7-Jan-94, 01-026-170-003 (Management Committee Jul 93 - Jun 94) | Minutes of meeting | Yes |
| Management Committee, 29-Oct-93, 01-026-170-003 (Management Committee Jul 93 – Jun 94) | Minutes of meeting | Yes |
| Management Committee, 8-Oct-93, 01-026-170-003 (Management Committee Jul 93 - Jun 94) | Minutes of meeting | No |
| Management Committee, 1-Oct-93, 01-026-170-003 (Management Committee Jul 93 - Jun 94) | Minutes of meeting | No |
| Management Committee, 17-Sep-93, 01-026-170-003 (Management Committee Jul 93 – Jun 94) | Minutes of meeting | No |
| Management Committee, 30-Jul-93, 01-026-170-003 (Management Committee Jul 93 - Jun 94) | Minutes of meeting | No |
| Management Committee, 25-Jun-93, 01-026-170-002-03 (Management Committee Feb - Jun 93) | Minutes of meeting | No |
| Management Committee, 18-Jun-93, 01-026-170-002-03 (Management Committee Feb - Jun 93) | Minutes of meeting | No |
| Management Committee, 14-May-93, 01-026-170-002-03 (Management Committee Feb - Jun 93) | Minutes of meeting | No |
| Management Committee, 22-Apr-93, 01-026-170-002-03 (Management Committee Feb - Jun 93) | Minutes of meeting | No |
| Management Committee, 5-Apr-93, 01-026-170-002-03 (Management Committee Feb - Jun 93) | Minutes of meeting | No |
| Management Committee, 26-Mar-93, 01-026-170-002-03 (Management Committee Feb - Jun 93) | Minutes of meeting | No |
| Management Committee, 12-Mar-93, 01-026-170-002-03 (Management Committee Feb - Jun 93) | Minutes of meeting | No |
| Management Committee, 10-Feb-93, 01-026-170-002-02 (Management Committee Dec 92 - Feb 93) | Minutes of meeting | No |

| Danila Dilba, Reference | Type of document | Cited in text |
|---|---|---|
| Management Committee, 22-Jan-93, 01-026-170-002-02 (Management Committee Dec 92 - Feb 93) | Minutes of meeting | No |
| Management Committee, 8-Jan-93, 01-026-170-002-02 (Management Committee Dec 92 - Feb 93) | Minutes of meeting | No |
| Management Committee, 23-Dec-92, 01-026-170-002-02 (Management Committee Dec 92 - Feb 93) | Minutes of meeting | No |
| Management Committee, 16-Dec-92, 01-026-170-002-02 (Management Committee Dec 92 - Feb 93) | Minutes of meeting | No |
| Management Committee, 8-Dec-92, 01-026-170-002-02 (Management Committee Dec 92 - Feb 93) | Minutes of meeting | No |
| Management Committee, 14-Nov-92, 01-026-170-002-01 Management Committee Aug - Nov 92) | Minutes of meeting | No |
| Management Committee, 30-Oct-92, 01-026-170-002-01 Management Committee Aug - Nov 92) | Minutes of meeting | No |
| Special General meeting, 25-Oct-92, 01-026-170-009-01 (AGM 1991-95) | Minutes of meeting | No |
| Management Committee, 16-Oct-92, 01-026-170-002-01 Management Committee Aug - Nov 92) | Minutes of meeting | No |
| Management Committee, 12-Oct-92, 01-026-170-002-01 Management Committee Aug - Nov 92) | Minutes of meeting | No |
| Management Committee, 9-Oct-92, 01-026-170-002-01 Management Committee Aug - Nov 92) | Minutes of meeting | No |
| Management Committee, 20-Aug-92, 01-026-170-002-01 | Minutes of meeting | No |
| Management Committee, 12-Jun-92, 01-026-170-001 | Minutes of meeting | No |
| Special General meeting, 30-May-92, 01-026-170-009-01 (AGM 1991-95) | Minutes of meeting | No |
| Management Committee, 16-Jan-92, 01-026-170-001 | Minutes of meeting | No |
| Management Committee, 27-Oct-91, 01-026-170-001 | Minutes of meeting | No |
| Management Committee, 13-Oct-91, 01-026-170-001 | Minutes of meeting | No |
| AGM (1st) 12-Oct-91, 01-026-170-009-01 (AGM 1991-95) | Minutes of meeting | No |
| Management Committee, 31-Jul-91, 01-026-170-001 | Minutes of meeting | Yes |
| Management Committee, 24-Jul-91, 01-026-170-001 | Minutes of meeting | No |
| Crough, Greg and Cronin, Darryl. 1996. *Dalida Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation: Case Study for the Review of Aboriginal Councils and Association Act, Draft 11 June 1996*. Northern Australia Research Unit, Australian National University, Darwin | Other document | Yes |
| Danila Dilba. 1999. *Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation Certified Agreement 1999*. Danila Dilba, Darwin | Other document | No |

| Danila Dilba, Reference | Type of document | Cited in text |
|---|---|---|
| Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation. 2002. *Organisation Web Site*. Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation | Other document | Yes |
| Josif, Paul and Associates. 1993. *Organisational plan for Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation*. Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation, Darwin | Other document | No |
| Service Activity Report file review from Danila Dilba files | Other document | Yes |
| Danila Dilba Staff orientation manual | Other document | No |
| Contract number F-15-30 (initially F-15-09, F-15-14), Counseling services, Department of Health and Aging, OATSIH, NT, Under the Bringing them Home program, Response to Stolen Generation REPT, Project, multi-year, renewable one year commitments, began 98/99 | Contract | Yes |
| Contract number F15-39, Regional Indigenous Centre for emotional and social wellbeing, Department of Health and Aging, OATSIH, NT, under the Mental Health program (ATSI Emotional & Social Well Being), Multiyear, renewable yearly ( no commitment), 6 years | Contract | Yes |
| Contract number F-15-28, Primary health care services, OATSIH, NT, under Best practice initiative, with funding form Health, staff training and hearing pool. Recurrent core | Contract | Yes |
| Capital Works Grant, OATSIH Canberra, Project, one of | Contract | Yes |
| Contract number F-15-31, Eye Health Coordinator, OATSIH, NT, under NT indigenous eye health plan, Project, one of | Contract | Yes |
| Indigenous Education Strategic Initiative Programme, Commonwealth Dept of Education, Training and Youth Affairs, Indigenous Education (targeted assistance) NT office, Recurrent but vulnerable to political will | Contract | Yes |
| Nutrition Project, OATSIH, NT, Multiyear, renewable yearly ( no commitment), 3 years | Contract | Yes |
| Contract number F-15-33, Sexual health, OATSIH, NT, Multiyear renewable yearly, 1 year | Contract | Yes |
| National Illicit Drugs Strategy, NOG Treatment Grants Programs, OATSIH, NT, Multi year project | Contract | Yes |
| Purchase of vocational education and training programs and services from Registered Training Organisations, NT Employment and Training Authority (NTETA), Recurrent but vulnerable to political will | Contract | Yes |
| Contract number NT 2001/2002 – 012, Workplace English Language and Literacy (WELL), Commonwealth Dept. Education, Science & Training, Recurrent but vulnerable to political will | Contract | Yes |
| Contract number F-15-32, Regional Eye Health Coordinator, one of, establishment cost, OATSIH, NT Recurrent | Contract | Yes |
| Mobile clinic, THS, Recurrent | Contract | Yes |
| Medicare monies, Recurrent | Contract | Yes |
| AHW Training Program, OATSIH, Project, 3 year commitment | Contract | Yes |

| Danila Dilba, Reference | Type of document | Cited in text |
|---|---|---|
| Maningrida Aged Care Facility, as a fund holder on behalf of the Maningrida Health Board, tripartite with OATSIH, Project one of | Contract | Yes |
| Development of a Strategic Plan for the Youth Forum, ATSIC, Project one of | Contract | Yes |
| Contract number F-15-27, NT Indigenous Eye Health Plan Stage 2, purchase of equipment, OATSIH NT, Project, 19 June-30 June 01 | Contract | Yes |

## Katherine West Health Board

| KWHB, Reference | Type of document | Cited in text |
|---|---|---|
| d'Abbs, Peter, Togni, Samantha, Coulehan, Kerin, and Bailie, Ross. 1998. *Katherine West Coordinated Care Trial First Local Evaluation Report*. Menzies School of Health Research, Darwin | Refereed report | Yes |
| d'Abbs, Peter, Togni, Samantha, Bailie, Ross, Fitz, Joe, and Wales, Nonie. 2002. *Jirntangku Miyrta Katherine West Coordinated Care Trial Transition Year Evaluation Report*. Menzies School of Health Research, Darwin | Refereed report | Yes |
| d'Abbs, Peter. 1998. *Issues associated with Implementation of the Katherine West Coordinated Care Trial: a Discussion Paper*. Menzies School of Health Research, Darwin | Refereed report | Yes |
| Katherine West Coordinated Care Trial Local Evaluation Team. 1998. *Revised Local Evaluation Plan for the Katherine West Region Coordinated Care Trial*. Menzies School of Health Research, Darwin | Refereed report | Yes |
| Katherine West Coordinated Care Trial Local Evaluation Team. 1998. *Katherine West Coordinated Care Trial: Report on General Progress with the Local Evaluation*. Menzies School of Health Research, Darwin | Refereed report | Yes |
| Katherine West Coordinated Care Trial Local Evaluation Team. 1999. *Katherine West Coordinated Care Local Evaluation Mid-term Report*. Menzies School of Health Research, Casuarina, NT | Refereed report | Yes |
| Katherine West Coordinated Care Trial Local Evaluation Team. 1999. *Third Progress Report*. Menzies School of Health Research, Darwin | Refereed report | Yes |
| Katherine West Coordinated Care Trial Local Evaluation Team. 2000. *Jirntangku Miyrta, Katherine West Coordinated Care Trial Final Report*. Menzies School of Health Research, Casuarina, NT | Refereed report | Yes |
| Katherine West Health Board. 2001. *Jirntangku Miyrta Enterprise Agreement 2001*. | Refereed report | No |
| Katherine West Health Board. 2001. *Jirntangku Miyrta, One shield for all, orientation checklist and easy reference papers*. Katherine West Health Board Aboriginal Corporation, Katherine | Refereed report | No |

| KWHB, Reference | Type of document | Cited in text |
|---|---|---|
| Katherine West Health Board. 2003. *Something special: the inside story of the Katherine West Health Board*. Katherine West Health Board Aboriginal Corporation, Katherine | Refereed report | Yes |
| 5-Dec-01, Monitoring Group Meeting | Minutes of meeting | Yes |
| 15-Nov-01, Monitoring Group Meeting | Minutes of meeting | No |
| 12-Nov-01, Monitoring Group Meeting | Minutes of meeting | No |
| 29-Aug-01, Monitoring Group Meeting | Minutes of meeting | No |
| 24-Aug-01, Monitoring Group Meeting | Minutes of meeting | No |
| 24-Aug-01, Monitoring Group Meeting | Minutes of Meeting | No |
| 18-Jul-01, Monitoring Group Meeting | Minutes of meeting | No |
| 17-Jul-01, Monitoring Group Meeting | Minutes of meeting | Yes |
| 10-Jul-01, Monitoring Group Meeting | Minutes of meeting | No |
| 2-Jul-01, Monitoring Group Meeting | Minutes of meeting | Yes |
| 22-Jun-01, Monitoring Group Meeting | Minutes of meeting | No |
| 6-Apr-01, Monitoring Group Meeting | Minutes of meeting | No |
| 7-Oct-99, Monitoring Group Meeting | Minutes of meeting | Yes |
| 5-Mar-99, Monitoring Group Meeting | Minutes of meeting | No |
| 27-Jan-99, Monitoring Group Meeting | Minutes of meeting | No |
| 10-Sep-98, Monitoring Group Meeting | Minutes of meeting | Yes |
| 25-Jun-98, Monitoring Group Meeting | Minutes of meeting | Yes |
| 5-Mar-98, Monitoring Group Meeting | Minutes of meeting | No |
| 5-Mar-98, Monitoring Group Meeting | Minutes of meeting | No |
| 27-Nov-97, Monitoring Group Meeting | Minutes of meeting | No |
| 16-Oct-97, Monitoring Group Meeting | Minutes of meeting | No |
| 18-Sep-97, Monitoring Group Meeting | Minutes of meeting | No |

| KWHB, Reference | Type of document | Cited in text |
|---|---|---|
| 18-Jul-97, Monitoring Group Meeting | Minutes of meeting | No |
| 20-Feb-02, Binder, Agenda Items minutes of meetings Jan-June 2002, Executive Meeting | Minutes of meeting | No |
| 23-Jan-02, Binder, Agenda Items minutes of meetings Jan-June 2002, Executive Meeting | Minutes of meeting | No |
| 29-Nov-01, Binder, Agenda Items minutes of meetings Jan-June 2002, Full board Meeting | Minutes of meeting | No |
| 31-Oct-01, Binder, Minutes of meetings July - December 2001, Executive Meeting | Minutes of meeting | No |
| 26-Sep-01, Binder, Minutes of meetings July - December 2001, Full board Meeting | Minutes of meeting | No |
| 21 & 22 August 2001, Binder, Minutes of meetings July - December 2001, Executive Meeting | Minutes of meeting | No |
| 18-Jul-01, Binder, , Minute of Executive 2001, Executive Meeting | Minutes of meeting | No |
| 4-Jul-01, Binder, Minute of Executive 2001, Full Board Meeting | Minutes of meeting | No |
| 13-Jun-01, DIR2000/1040-02 Directorate Meetings board Executive Minutes 2001-2003, Executive Meeting | Minutes of meeting | No |
| 23-May-01, DIR2000/1040-02 Directorate Meetings board Executive Minutes 2001-2003, Executive Meeting | Minutes of meeting | No |
| 25-Jan-01, DIR2000/1040-02 Directorate Meetings board Executive Minutes 2001-2003, Executive Meeting | Minutes of meeting | No |
| Tripartite Agreement | Contract | Yes |
| Contract number 273-30, Remote Commmunity Initiative (RCI) Daguragu, 1/7/2001 - 30/6/2002 OATSIH, NT  QUARANTINED, January payments recombined with Tripartite Agreement | Contract | Yes |
| Contract number 273-31 contract, Non-Trial Admin, 6 months only, OATSIH NT Jan-June combined with 273-38 | Contract | Yes |
| Contract number 273-32/273-34  No documents for 273-32/ both contracts missing MBS/PBS Old Rate, OATSIH NT | Contract | Yes |
| Contract number 273-35 Contract Commonwealth sponsorship support on funds pool management, OATSIH NT | Contract | Yes |
| Contract number 273-39 Contract MBS Adjustment 1/4/2001-31/12/2001 One off payment | Contract | Yes |
| Contract number 273-38 Contract MBS/Non-trial Admin Sponsorship Daguragu RCI IT Jan-June 2002 | Contract | Yes |
| Contract number 273-33 Contract Sponsorship 1/7/2002 - 31/12/2001 | Contract | Yes |
| Contract number 273-36 Minyerri RCI, OATSIH, NT | Contract | Yes |
| Contract number 273-37 Office upgrade + telephones, one off grant | Contract | Yes |

| KWHB, Reference | Type of document | Cited in text |
| --- | --- | --- |
| Aged Care Pilot Timber Creek, Maluni, Bulla Coordination paid monthly incl GST, Recurrent no GST, Commonwealth of Australia, Health and Aged Care, signed by NT manager, and administered by South Australia State Office | Contract | Yes |
| Chronic Disease Self-management Payments | Contract | Yes |
| No contract or documentation, Mobile service | Contract | Yes |
| RHSET 00641A, Healthy Tucker Stores (Rural Health Support, Education and Training) | Contract | Yes |
| Aboriginal Mental Health Program, Commonwealth Dept. of Health and Aged Care, More Allied Health Services (MAHS) initiative | Contract | Yes |
| Sexual health, source unknown | Contract | Yes |
| AHW Training, Commonwealth Dept. of Workplace Relations, Small Business and Employment | Contract | Yes |

## Te Runanga O Raukawa

| TROR, Reference | Type of document | Cited in text |
| --- | --- | --- |
| Grafton Group. 2002. *Part B: A situational analysis of the Horowhenua/Otaki District and Issues regarding health services*. Grafton Group, Otaki | Report | No |
| Hartley, Ngahana and Mules, Chris. 1996. *Midland - Iwi Relationships in an integrated care environment: a discussion paper*. Midland Regional Health Authority, Wellington | Report | Yes |
| Hawke's Bay District Health Board. 2002. *Board Report, Wai 692 Progress Report*. Hawke's Bay District Health Board, Hawke's Bay | Report | No |
| MidCentral District Health Board. 2002. *Establishing primary health organisations in MidCentral District: Report to Community and Public health Advisory Committee*. MidCentral District Health Board, Palmerston North | Report | No |
| 8-Oct-02, July - November 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 16-Sep-02, AGM Book, AGM July 01-June 02 | Minutes of meeting | No |
| 10-Sep-02, July - November 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13-Aug-02, July - November 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13-Aug-02, July - November 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Jul-02, July - November 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |

| TROR, Reference | Type of document | Cited in text |
|---|---|---|
| 12-Jun-02, March - June 2002 Te Runanga O Raukawa, Special Meeting | Minutes of meeting | No |
| 14 May 2002, March - June 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Apr-02, March - June 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Mar-02, March - June 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Feb-02, Oct 2001 - March 2002 and March - June 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 11-Dec-01, Oct 2001 - March 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13-Nov-01, Oct 2001 - March 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | no |
| 9-Oct-01, Oct 2001 - March 2002 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 16-Sep-01, AGM Book, AGM July 00-June 01 | Minutes of meeting | No |
| 11-Sep-01, January - May 2001 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Aug-01, January - May 2001 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Jul-01, January - May 2001 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 15-Jun-01, Health files, Correspondence | Minutes of meeting | No |
| 12-Jun-01, January - May 2001 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Jun-01, June - October 2001 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 8-May-01, January - May 2001 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Apr-01, January - May 2001 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Mar-01, Health files, Correspondence | Minutes of meeting | No |
| 13-Mar-01, January - May 2001 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13-Feb-01, January - May 2001 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Dec-00, August - Dec 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Nov-00, August - Dec 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Oct-00, August - Dec 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |

| TROR, Reference | Type of document | Cited in text |
|---|---|---|
| 18-Sep-00, Health files, Correspondence | Minutes of meeting | No |
| 17-Sep-00, AGM Book, AGM July 99-June 00 | Minutes of meeting | No |
| 12-Sep-00, August - Dec 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 8-Aug-00, August - Dec 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 11-Jul-00, February - July 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 13-Jun-00, February - July 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 16 May 2000, February - July 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 18-Apr-00, February - July 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Mar-00, February - July 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 15-Feb-00, February - July 2000 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Dec-99, July to December 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Nov-99, July to December 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Oct-99, July to December 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 19-Sep-99, AGM Book, AGM July 98-June 99 | Minutes of meeting | Yes |
| 14-Sep-99, July to December 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Aug-99, July to December 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13-Jul-99, July to December 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 15-Jun-99, December 1998 - June 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 13-Apr-99, December 1998 - June 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 9-Mar-99, December 1998 - June 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Feb-99, December 1998 - June 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 8-Dec-98, December 1998 - June 1999 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Nov-98, June - November 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |

| TROR, Reference | Type of document | Cited in text |
|---|---|---|
| 20-Oct-98, June - November 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 20-Sep-98, AGM Book, AGM July 97-June 98 | Minutes of meeting | No |
| 8-Sep-98, June - November 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Aug-98, June - November 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Jul-98, June - November 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 9-Jun-98, June - November 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12 May 1998, December 1997 - May 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 31-Mar-98, December 1997 - May 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 25-Mar-98, December 1997 - May 1998 Te Runanga O Raukawa, Special Meeting | Minutes of meeting | No |
| 10-Mar-98, December 1997 - May 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Feb-98, December 1997 - May 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Dec-97, December 1997 - May 1998 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Nov-97, June - November 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Oct-97, June - November 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 28-Sep-97, AGM Book, AGM July 96-June 97 | Minutes of meeting | Yes |
| 9-Sep-97, June - November 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Aug-97, June - November 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 8-Jul-97, June - November 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Jun-97, June - November 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13 May 1997, December 1996 - May 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 22-Apr-97, December 1996 - May 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 8-Apr-97, December 1996 - May 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Mar-97, December 1996 - May 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |

| TROR, Reference | Type of document | Cited in text |
|---|---|---|
| 11-Feb-97, December 1996 - May 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Dec-96, December 1996 - May 1997 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Nov-96, June - November 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 8-Oct-96, June - November 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 22-Sep-96, AGM Book, AGM July 95-June 96 | Minutes of meeting | No |
| 10-Sep-96, June - November 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13-Aug-96, June - November 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 31-Jul-96, June - November 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Jul-96, June - November 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Jun-96, June - November 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 27 May 1996, November 1995 - May 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14 May 1996, November 1995 - May 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Apr-96, November 1995 - May 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Mar-96, November 1995 - May 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13-Feb-96, November 1995 - May 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Dec-95, November 1995 - May 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Nov-95, November 1995 - May 1996 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 18-Oct-95, April - October 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 17-Sep-95, AGM Book, AGM July 94-June 95 | Minutes of meeting | No |
| 12-Sep-95, April - October 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 8-Aug-95, April - October 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Jul-95, April - October 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13-Jun-95, April - October 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |

| TROR, Reference | Type of document | Cited in text |
|---|---|---|
| 9-May-95, April - October 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Apr-95, April - October 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Mar-95, Aug 1994 - March 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 17-Jan-95, Aug 1994 - March 1995 Te Runanga O Raukawa, Special Meeting | Minutes of meeting | No |
| 13-Dec-94, Aug 1994 - March 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 8-Nov-94, Aug 1994 - March 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Oct-94, Aug 1994 - March 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Sep-94, AGM Book, AGM July 93-June 94 | Minutes of meeting | Yes |
| 6-Sep-94, Aug 1994 - March 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 9-Aug-94, Aug 1994 - March 1995 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Jul-94, Jan - July 1994 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Jun-94, Jan - July 1994 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Apr-94, Jan - July 1994 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 8-Mar-94, Jan - July 1994 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Dec-93, July - December 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 28-Nov-93, July - December 1993 Te Runanga O Raukawa, Special Meeting | Minutes of meeting | No |
| 5-Nov-93, July - December 1993 Te Runanga O Raukawa, Special Meeting | Minutes of meeting | No |
| 9-Nov-93, July - December 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 19-Oct-93, July - December 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 19-Sep-93, AGM Book, AGM July 92-June 93 | Minutes of meeting | No |
| 14-Sep-93, July - December 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Aug-93, July - December 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 23-Jul-93, July - December 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |

| TROR, Reference | Type of document | Cited in text |
|---|---|---|
| 15-Jun-93, December 1992 to June 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| May 11, 1993, December 1992 to June 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13-Apr-93, December 1992 to June 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Mar-93, December 1992 to June 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Feb-93, December 1992 to June 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 8-Dec-92, December 1992 to June 1993 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Nov-92, June - November 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 23-Oct-92, June - November 1992 Te Runanga O Raukawa, Special Meeting | Minutes of meeting | No |
| 13-Oct-92, June - November 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 20-Sep-92, AGM Book, AGM July 91-June 92 | Minutes of meeting | No |
| 8-Sep-92, June - November 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 25-Aug-92, June - November 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 19-Jul-92, June - November 1992 Te Runanga O Raukawa, Special Meeting | Minutes of meeting | No |
| 5-Jul-92, June - November 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Jun-92, June - November 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| May 12, 1992, Oct. 1991 - May 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14-Apr-92, Oct. 1991 - May 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 2-Apr-92, Oct. 1991 - May 1992 Te Runanga O Raukawa, Special Meeting | Minutes of meeting | No |
| 17-Mar-92, Oct. 1991 - May 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 4-Feb-92, Oct. 1991 - May 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 17-Dec-91, Oct. 1991 - May 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 19-Nov-91, Oct. 1991 - May 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 22-Oct-91, Oct. 1991 - May 1992 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |

| TROR, Reference | Type of document | Cited in text |
|---|---|---|
| 29-Sep-91, AGM Book, AGM July 90-June 91 | Minutes of meeting | Yes |
| 10-Sep-91, May 1991 - Sept. 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 13-Aug-91, May 1991 - Sept. 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Jul-91, May 1991 - Sept. 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Jun-91, May 1991 - Sept. 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 14 May 1991, May 1991 - Sept. 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-Apr-91, Sept. 1990 to April 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Mar-91, Sept. 1990 to April 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 12-Feb-91, Sept. 1990 to April 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 18-Dec-90, Sept. 1990 to April 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 3-Dec-90, Sept. 1990 to April 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 30-Oct-90, Sept. 1990 to April 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 2-Oct-90, Sept. 1990 to April 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 11-Sep-90, Sept. 1990 to April 1991 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 7-Aug-90, August 1989 to August 1990 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 4-Jul-90, August 1989 to August 1990 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 10-Jun-90, AGM Book, AGM April 89-March 90 | Minutes of meeting | No |
| 6-Jun-90, August 1989 to August 1990 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 5/15/1990, August 1989 to August 1990 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 9-May-90, August 1989 to August 1990 Te Runanga O Raukawa, Special Meeting | Minutes of meeting | No |
| 24-Apr-90, August 1989 to August 1990 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | Yes |
| 26-Mar-90, August 1989 to August 1990 Te Runanga O Raukawa, Special Meeting | Minutes of meeting | No |
| 20-Mar-90, August 1989 to August 1990 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |

| TROR, Reference | Type of document | Cited in text |
|---|---|---|
| 13-Feb-90, August 1989 to August 1990 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 17-Jan-90, August 1989 to August 1990 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| 21-Dec-89, August 1989 to August 1990 Te Runanga O Raukawa, Regular Meeting | Minutes of meeting | No |
| Contract number 196977/00, HFA to DHB, Kaupapa Maori Mental Health and Alcohol & Drug Services, Nothing on file for 2001-02 | Contract | Yes |
| Contract number 193197, 193197/03, HFA to DHB, Comprehensive nursing services | Contract | Yes |
| Contract number 161640/193197/02, Health Funding Authority, Tamariki Ora - Wellchild Services | Contract | Yes |
| Contract number 161640/265837/00, Ministry of Health, Maori Provider Development Scheme | Contract | Yes |
| MidCentral funded from the HFA, Cervical Screening Programme | Contract | Yes |
| Contract number 161640/193197/00, Health Funding Authority, Mobile Maori Nursing Disease State Management Service | Contract | Yes |
| Contract number 161640/250957/00, Ministry of Health, Aukati Kaipaipa, tobacco control | Contract | Yes |
| Contract number 161640/254836/00, Mid-Central DHB but correspondence/ invoices is with the Ministry of Health, Otaki Intersectoral Contract for Community Workers, Mobile outreach service to improve access to primary care services for people in Otaki. | Contract | Yes |
| Not numbered, Health Funding Authority, Comprehensive primary care service | Contract | Yes |

## Te Roopu Huihuinga Hauora Inc.

| TRHHI, Reference | Type of document | Cited in text |
|---|---|---|
| Ngati Kahungunu Iwi Incorporated. 2001. *Business case to the Hawke's Bay District Health Board, Resourcing the Treaty of Waitangi Partnership*. Ngati Kahungunu Iwi Incorporated, Whakatu | Report | No |
| Ngati Kahungunu Iwi Inc. 2003. *Maori Health Plan for Hawke's Bay 2003-2005*. Ngati Kahungunu Iwi Inc., Hastings | Report | Yes |
| Pania Communications. 2000. *Te Roopu Huihuinga Hauora, Report on Current Health State Analysis, Sept 2000*. Pania Communications, Wellington | Report | No |
| Te Roopu Huihuinga Hauora Incorporated. 2001. *Constitution, Te Roopu Huihuinga Hauora Incorporated, Incorporated Societies Act 1908*. Te Roopu Huihuinga Hauora Incorporated, Whakatu | Governing document | Yes |
| Te Roopu Huihuinga Hauora Incorporated. 2002. *Annual Report 2000-2001*. Te Roopu Huihuinga Hauora Incorporated, Whakatu | Annual Report | No |

| TRHHI, Reference | Type of document | Cited in text |
|---|---|---|
| Te Roopu Huihuinga Hauora Incorporated. 2002. *Application for Section 88 Notice, Te Roopu huihuinga Hauora Inc.* Te Roopu Huihuinga Hauora Inc., Whakatu | Report | No |
| Te Roopu Huihuinga Hauora Incorporated. 2003. *Annual Report 2001-2002*. Te Roopu Huihuinga Hauora Incorporated, Whakatu | Annual Report | No |
| Te Roopu Huihuinga Hauora Incorporated. 2000. *Annual Report 1999-2000*. Te Roopu Huihuinga Hauora Incorporated, Whakatu | Annual Report | Yes |
| Te Roopu Maori Takawaenga Tohuohu Ki te Minita Hauora (Ministerial Advisory Committee on Maori Health). 1992. *Hui Hauora a Iwi, Kaupapa, Te Ara Hou Mo Te Hauora O Te Iwi Maori, Pathways for the advancement of Iwi health*. Te Roopu Maori Takawaenga Tohuohu Ki te Minita Hauora (Ministerial Advisory Committee on Maori Health), Takapuwahia Marae, Porirua | Report | No |
| Te Roopu Huihuinga Hauora Incorporated. 2001. *Te Arawhata Ki Te Rangi [A Path-way to enlightenment and progress]: Maori Strategic Plan 2001-2004*. Te Roopu Huihuinga Hauora Incorporated, Whakatu | Governing document | Yes |
| 27-Sep-02, Regular meeting, Letter dated 27 September 2002 from Joe Puketapu, TRHHI to Rob Cooper, General Manager, Maori Health Group, HFA | Minutes of meeting | Yes |
| 23-Aug-02, Regular meeting, CEO Report, Joe Puketapu | Minutes of meeting | No |
| 26-Jul-02, Regular meeting, Letter to Ria Earp DDG, Ministry of Health | Minutes of meeting | Yes |
| 28-Jun-02, Regular meeting, Except out of the relocation plan to Whakatu | Minutes of meeting | No |
| 28 May 2002, Regular meeting, CEO Report, Joe Puketapu | Minutes of meeting | Yes |
| 19-Apr-02, Regular meeting, Minutes of the Maori Health Committee Meeting | Minutes of meeting | Yes |
| 27-Mar-02, Regular meeting, Hawke's Bay District Health Board Board report, WAI 692 Progress Report | Minutes of meeting | No |
| 23-Nov-01, AGM | Minutes of meeting | No |
| 28-Sep-01, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 17-Aug-01, Regular meeting, Correspondence | Minutes of meeting | Yes |
| 26-Jul-01, Board/Providers meeting, Minutes | Minutes of meeting | No |
| 2-Jul-01, Provider meeting, Minutes | Minutes of meeting | No |
| 8-Mar-01, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 9-Feb-01, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 31-Oct-00, AGM, ACEO Report, Kim Workman | Minutes of meeting | Yes |

| TRHHI, Reference | Type of document | Cited in text |
|---|---|---|
| 17-Oct-00, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 12-Sep-00, Regular meeting, Board meeting minutes | Minutes of meeting | Yes |
| 11-Aug-00, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 26-Apr-00, Regular meeting, CEO Report, Joe Puketapu | Minutes of meeting | No |
| 15-Mar-00, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 9-Dec-99, AGM, Minutes | Minutes of meeting | No |
| 2-Dec-99, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 3-Sep-99, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 5-Aug-99, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 25-Jun-99, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 25 May 1999, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 3-May-99, AGM, Minutes | Minutes of meeting | No |
| 24-Mar-99, Regular meeting, Board meeting minutes | Minutes of meeting | Yes |
| 23-Feb-99, Regular meeting, Board meeting minutes | Minutes of meeting | No |
| 5-Feb-99, Regular meeting, Board meeting minutes | Minutes of meeting | Yes |
| Contract number F132, CO1, , T434687/ 197757/01, HFA, Maori Development Organisation contract | Contract | Yes |
| Contract number F131, CO2, 197757/02, HFA, Mobile Maori Nursing Disease State Management | Contract | Yes |
| Contract number F132, CO4, HFA, Community based asthma | Contract | Yes |
| Contract number F131, CO5, 231937/00, HFA, Integrated Diabetes Management Programme | Contract | Yes |
| Contract number F132, CO6, 240079-01, HFA, Integrated Child Asthma Management Programme | Contract | Yes |
| Contract number F131, CO7, 228618/00, HFA, Rongoa Maori (traditional healing) | Contract | Yes |
| Contract number CO10, CO8, 248126, Ministry of Health, Maori Provider Development Scheme 2000/2001 | Contract | Yes |
| Contract number CO10, CO8, 265437, Ministry of Health, Maori Provider Development Scheme 2001/2002 | Contract | Yes |

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