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Aboriginal Health
RESEARCH

Indigenous Primary Health Care Services in Australia, Canada and New Zealand:

Policy and Financing Issues

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September 2003

The Centre for Aboriginal Health Research (CAHR)

CAHR is a joint initiative of the Assembly of Manitoba Chiefs, the Faculty of Medicine at the University of Manitoba, and the Foundations for Health. The CAHR was established through a generous contribution from the Assembly of Manitoba Chiefs to the fundraising campaign of the Foundations for Health for the construction of the Buhler Centre for Health Research. Development of the CAHR was also facilitated by a research infrastructure grant awarded to the University of Manitoba by the Canadian Foundation for Innovation and the Manitoba Innovation Fund. Operating funds have been awarded by the Canadian Institutes for Health Research and the Social Science and Humanities Research Council.

This document is available on line at
http://www.umanitoba.ca/centres/centre_aboriginal_health_research/

ISBN 1-8950034-09-4

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Table of Contents

Executive Summary	i
Acknowledgements	iii
Introduction	1
First Nations in Canada	2
A. Background	2
B. Health Services for First Nations.....	2
C. First Nation Responses	5
Australia: An Emerging Model	7
A. Background	7
B. Health Services for Aboriginal Peoples.....	7
C. Two Models.....	8
New Zealand: Partnership or Competition	11
A. Background	11
B. The Development of Māori Health Providers	11
Strengths and Challenges	15
Conclusions.....	22
Appendix 1, Abbreviations/Glossary	23
Appendix 2, Danila Dilba	28
Appendix 3, Katherine West Health Board – Pioneering a Model	43
Appendix 4, Te Runanga O Raukawa.....	63
Appendix 5, Te Roopu Huihuinga Hauora Inc.	83
References.....	102

Executive Summary

Since the 1960's, indigenous organisations have sought to achieve some control over community-based primary health care services to improve access to health care and alleviate health inequalities. In Canada and New Zealand, the emergence of indigenous health providers can be linked in part to government downsizing and increased reliance on non-government organisations in the delivery of health services. But the same process is also linked to indigenous demands for greater autonomy across a wider sector of activities. In Australia, Aboriginal health services emerged from community mobilisation, and has only recently received meaningful financial support from the Commonwealth government.

As of 2000, the Canadian government reports that 67% of First Nations have taken control of their health services, and that another 14% is in the process of negotiation (Health Canada 1999b, 2000b). In Australia, over 130 Aboriginal health organisations receive funding from the Commonwealth government. In New Zealand, the number of Māori providers now exceeds 200. The contractual environment that emerged in all three countries to support indigenous health providers reflects differences in history, health care systems and relationship with the indigenous population. Indigenous primary health care services seem to serve both indigenous aspirations and government's commitment to control health expenditures. In that process, the responsibility for indigenous health inequalities, a cause of concern for governments, may well be shifted onto indigenous health providers as well.

Despite broad similarities, there exist interesting differences in the contractual environment created in all three countries. This document reports on five case studies conducted in Canada, Australia and New Zealand. Based on these case studies, two broad categories of indigenous control health services have emerged, depending on access to funding.

- In the first category, providers must compete for funding with other service providers. Included in this category are Raukawa Hauora and Te Roopu Huihuinga Hauora in New Zealand, and Danila Dilba in Australia.
- In the second category, providers are understood by their government to be the sole legitimate provider to serve a geographically and culturally-defined population. This is the case for Katherine West in Australia and for First Nations in Canada.

It appears that 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, including the cost of building and maintaining facilities that may, depending on access to funding and national priorities, be fully utilised one year and partially utilised the year after;
- 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.

In the cases of Raukawa Hauora and Danila Dilba, there was no evidence to suggest that these costs were actually acknowledged and compensated for by the funder. Rather, the evidence suggests that these costs were simply passed on to the provider. In the case of Te Roopu Huihuinga Hauora, the costs and demands were implicitly acknowledged by the former funder (HFA),¹ but appear to be disputed by the current funder (DHB).

As well, a fragmented contractual environment is less likely to enable a provider to provide comprehensive primary health care services for a defined population. This makes it difficult to assess whether a provider's approach is leading to better outcomes. It is no surprise to find that Raukawa Hauora and Danila Dilba's reports focus mostly on the health activities undertaken. In contrast, First Nations and Katherine West, who are funded to provide comprehensive primary health care for a defined population, may be able to link their activities with health outcomes in the long run, thus justifying continued support from their constituency, government and the tax payer.

In many ways, the emergence of indigenous health providers has led to a new relationship between the government and indigenous population - that of **governance by contract**. Some have remarked that this may lead to a highly fragmented and rigid approach to health services, and erode government's accountability (Stewart 1993).

¹ A list of abbreviations and glossary is available in Appendix.

Acknowledgements

This research project is funded by the *Fondation Ricard* of Canada, a charitable foundation that supports French Canadians pursuing secondary and tertiary university education (<http://www.fondationricard.com/>). It is the generosity of Ms. Alma Ricard, a 94 year old French Canadian woman who established this foundation, and her foresight in allowing fellowship recipients the freedom to pursue their own research projects, that made this undertaking possible. *Madame Ricard, avec toute ma gratitude.*

I am indebted to a large number of people who have supported my work in Australia. This includes the Boards and staff of the Katherine West Health Board and of Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation. The National Centre for Epidemiology and Population Health at the Australian National University in Canberra, and in particular Professor Beverly Sibthorpe, provided me with invaluable support in the initial stage of this process. In Darwin, the Menzies School of Health Research and Professor Ross Bailie generously offered academic and logistical support. In New Zealand, I am indebted to the Board and staff of Te Roopu Huihuinga Hauora and Te Runanga O Raukawa. The Māori Health Unit of Massey University provided me with priceless on-site support. A particular thank you to Professors Mason Durie and Chris Cunningham. In Canada, I am indebted to the Centre for Aboriginal Health Research and to its director, Professor John O'Neil. In addition to the above, I am grateful to all people who took the time to help me with on journey.

Finally, I wish to thank Dr. Stephen Jan and Dr. Lucy Gilson, my supervisors at the London School of Hygiene and Tropical Medicine for their contribution to the many drafts of this report, and for their on-going support and personal investment.

The views expressed in this document remain my own, and I take full responsibility for any error or misunderstanding that might have occurred. I welcome any feedback that may contribute to furthering my understanding. I can be reached at lavoiej@ms.umanitoba.ca.

Introduction

It is well documented that the indigenous populations of Canada, Australia and New Zealand experience substantial health inequalities when compared to their national counterparts. Since the 1960's, indigenous organisations have sought to achieve some control over community-based primary health care services as a preferred strategy to improve access to health care and alleviate these inequalities.

This process has to some extent been supported financially and through policy by the governments of Canada, Australia and New Zealand. In Canada and New Zealand, the emergence of indigenous health providers can be linked to government downsizing and increased reliance on non-government organisations in the delivery of health services. In contrast, Australian Aboriginal health organisations surfaced in the early 1970's to develop new services or to complement existing services which had previously failed to address the needs of the Aboriginal community. They have only recently been officially endorsed by the Australian government as the preferred mechanism to improve Aboriginal health.

The contractual environment that emerged in all three countries to support indigenous health providers reflects differences in history, health care systems and relationship with the indigenous population. This report provides an overview of the contractual environment experienced by indigenous providers in each country. It has been produced primarily to inform and hopefully assist indigenous health organisations.

The document is divided into four sections. The first three sections provide a brief overview of the situation in each country, beginning with Canada, then Australia, followed by New Zealand. The last section discusses the strengths and weaknesses of each model.

This report presents findings based on four case studies conducted in Australia and New Zealand between July 2001 and May 2003. Each case study has been reviewed by the Board of the organisation under study to ensure accuracy, and its publication has been approved. They are reproduced as approved in Appendix. The Canadian case study is built on public information, and ten years of experience working with this policy. The overall report builds on the work and thoughts of numerous indigenous practitioners, scholars and policy makers, as well as non-indigenous people involved in bringing equity to indigenous health.

I wish to acknowledge the work of my predecessors and colleagues, and to thank them for their insights.

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First Nations in Canada

A. Background

In Canada, the term Aboriginal includes First Nations (previously known as Indians),² Inuit (previously known as Eskimos) and Métis. As shown in Table 1, Aboriginal people altogether constitute nearly 3 percent of the overall Canadian population.³

In administrative terms, there are currently 627 First Nations recognised by the federal government (Indian Affairs and Northern Development 2002). These are political and administrative organisations that emerged to satisfy the requirements of the *Indian Act 1876*.⁴ Since 1982, the Canadian Constitution recognises the Aboriginal right to self-government. Government policies of self-government generally amount to mechanisms for self-administration of on-reserve services (Lavoie 2003b, Scott 1993).

Table 1: Indigenous Population in Canada, Statistic Canada Census 1996 (Statistics Canada 1996)

Total Canadian	First Nations	Non-Status Indians	Métis	Inuit
28,528,125	461,510	92,780	210,190	41,080
2.7%	1.6%	0.3%	0.7%	0.1%

The case study presented here relates to health services provided by First Nations themselves with funding from the federal government, for First Nations living on reserve.

B. Health Services for First Nations

The Canadian health care system is a publicly financed, publicly administered, and at least partially privately delivered national health care system. Primary health (general practitioners and public health) and secondary and tertiary (i.e. hospital) care is entirely funded through provincial and federal income tax. The *Canada Health Act 1984* guarantees “reasonable access” for all Canadians, including the indigenous population. All off-reserve services are the responsibility of the provinces. Public health, doctors,

² 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. It should be clear however that the administration of Indian Affairs by Canada has not reflected this understanding.

³ Participation in the Canadian census is not mandatory, and it is generally acknowledged that it underestimates the Aboriginal population.

⁴ 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 Bands (i.e. Cree, Mohawk, Micm’ac, etc.) into more “manageable” administrative subgroups. For example, many First Nations share the Cree culture.

specialists and hospital care can be accessed at no direct cost to the individual,⁵ via Medicare, the publicly funded health insurance scheme (Health Canada 1999a). On-reserve services have historically been and remain funded by the federal government.

First Nations health services were set up following the signature of 11 Treaties across the prairies. Of these, only one Treaty, known as Treaty 6 (1876), makes a provision for health care:⁶

That a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent...

That in the event of the Indians comprised within this treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by Her Indian Agent or Agents, will grant to the Indians assistance of such character and to such extent as Her Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians for the calamity that shall have befallen them.

First Nations have argued that this is the basis for a Treaty right to free health care that includes all contemporary aspects of health care delivery in Canada. However, the Saskatchewan Supreme Court ruled for a more literal interpretation, stating that the provision of health services is at the discretion of the federal government, and therefore a matter of policy (Backwell 1981).

The original push for the development of health services to First Nations came from the settlers who arrived at the turn of the last century to settle the prairies and farm the land. They found themselves neighbouring Indian Reserves where appalling health conditions 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 (Waldram et al 1995). The first federally funded on-reserve nursing station was set up 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. Currently, nearly all First Nation reserves have access to services delivered by a Health Centre located on-reserve. These Health Centres offer public health and treatment services, delivered by nurse-practitioners and local community health representatives (hereafter CHRs). Other services include addiction counselling and transportation. Physicians funded by the province visit these communities on a regular basis. Patients requiring care in between visits or in an emergency situation are transported to the nearest referral centre, which is under provincial jurisdiction.⁷

⁵ Co-payments and access fees were made illegal in 1984.

⁶ All Treaties were written in English only. Health care was brought up by the Chiefs in the negotiations of Treaties 8 and 11 as well, but their request was not incorporated in the final text (Fumoleau 1973).

⁷ See Waldram for a more extensive discussion of the system (1995).

The first Indian Health Policy was adopted in 1979, after much consultation and discussion with First Nations. The policy, which is still in force today, recognises three pillars: community development, the traditional relationship of the Indian people to the Federal Government, and the Canadian health system (Health Canada 2000a). The policy specifically recognises that First Nations should play a more active role in primary health care planning and delivery. This policy led to the implementation in 1982 of the Community Health Demonstration Program to allow First Nations to experiment with different models of community-based service delivery (Garro et al 1986). The Health Transfer Policy was announced in 1986, and the first transfer completed in 1988 (Bird & Moore 1991).

The Health Transfer Policy aims specifically at transferring the administration of existing federal on-reserve services to First Nations. Although the federal government has made it clear that it no longer wishes to be a direct provider of services to First Nations, the transfer process was and remains presented as entirely voluntary. Under the Health Transfer Policy, First Nations are encouraged to apply for funding for the first stage, the Pre-Transfer community-based needs assessment, which forms the basis of the community health plan. The second phase is that of negotiations with Health Canada. The third phase is implementation. Here contracts may be signed for three or five years depending on the First Nation's previous experience with program administration.

The services targeted for transfer are defined by the federal government, and include mandatory services such as communicable disease control, environmental/occupational health and safety, and treatment services (in health centres located either off the road system and/or at least 60km from the nearest referral centre) (Health Canada 1999b). Medical and Hospital Insurance Services are excluded (these are under provincial jurisdiction), as well as what is commonly known as Non-Insured Health Services which include medication, medical transportation, eye care and dental care.⁸

More recently, the federal government introduced two alternatives to this model: the Integrated Community-based Health Services (1994) and Self-Government (1995). Under the Integrated Community-based Health Services model, First Nations can opt to sign one Contribution Agreement to administer selected community health services. The Federal Government sees this model as an opportunity for capacity building before moving on to the Health Transfer Policy. Alternatively, the Self-Government option provides an opportunity for First Nations to reconcile all government funding agreements under one framework agreement, including:

⁸ These are services that Health Canada offers outside the umbrella of Medicare (insured services) and have been made available free of charge (although terms of admissibility have been changing) to Status and Treaty Indians, and Inuit. Indigenous people argue that these services are an Aboriginal Right entrenched in the Medicine Chest Clause of Treaty 6, whereas the federal government argues that these services are offered on humanitarian grounds.

- Indian and Northern Affairs which provides funding for Band governance, infrastructure, economic development, welfare, primary and secondary education, on reserve housing;
- Health Canada which funds health services; and
- Provincial governments which provide limited funding for child protection, as well as other minor programs (Health Canada 1999b).

Table 2 shows the prevalence of each model. There has been some discomfort expressed by First Nations over the self-government model which is seen as a way for the federal government to side step its Treaty and Constitutional obligations, and to cut its administration cost.

	% of First Nations in each model	Features
Integrated Community-based Health Services Approach (1994)	21%	<ul style="list-style-type: none"> • Funding for a 1 year planning phase; • One master agreement for all Health Canada health programs operating in the community, generally signed for one year; • Additional health management funding (50% of which is allocated under the Health Transfer Policy) to enable the development of community health management capacity; • Programs funded at historical levels; • Health Canada retains 100% of the risks; • Limited budgetary line flexibility
Health Services Transfer Approach (1986)	Under negotiation 14%	<ul style="list-style-type: none"> • Funding for a 1 year training and planning process, plus 9 months negotiation process; • Agreements for 3 to 5 years; • Greater budgetary line flexibility, one master reporting system, limited ability to negotiate for program enhancement, greater flexibility in program planning and delivery; • Community take over of moveable assets; • Community assumes a much greater part of the risks.
	Transferred 45%	
Self-Government Approach (1995)	1%	<ul style="list-style-type: none"> • Brings together all funding by Health Canada, Indian and Northern Affairs Canada and the province under one master agreement. Health remains funded at the same level as that of the Health Transfer Policy.

C. First Nation Responses

As of December 2000, Health Canada reports that sixty-seven percent (67%) of eligible First Nations have taken over their health services, and that another fourteen percent (14%) are engaged in pre-transfer negotiations (Health Canada 2001). Sixteen years after it was first announced, it is obvious that the policy has had some relevance in meeting indigenous communities' aspirations. But it has not escaped substantial criticisms. It has been noted that,

The transfer policy fail[s] to recognise and continue to place the issue of indigenous health outside the framework of aboriginal title and treaty rights claimed by the Canadian indigenous community (Culhane Speck 1989).

Further, because First Nations health care financing is administered separately from services provided to non-indigenous people, and because First Nations constitute such a small minority, appropriate financing that reflects needs and geographical contingencies remains a contentious issue (Lavoie 2003a). The recent Assembly of First Nations' presentation to the Commission on the Future of Healthcare in Canada summarises the complexity of the issue:

Health Transfer is a practical example of what happens with the trickle-down funding and its impact on First Nations. Health Transfer has become a multi-year agreement in healthcare capped at a 3% growth rate. This growth rate does not allow for program to accommodate real costs like inflation, a true population growth rate, wage parity or other things that escalate cost, First Nations have less money, a larger services population and fewer options with each passing fiscal year. By attempting to offer the same services for the same money and to avoid default on their agreements, First Nations can incur enormous debt for which they will be stigmatized for being fiscally irresponsible (Assembly of First Nations 2002).

The Health Transfer Policy is an opportunity for First Nations to administer services previously delivered on-reserve by the federal government, to improve responsiveness to community needs and to generate information that can be used for self-advocacy. While a valued opportunity, the power to define what is appropriate remains in the hands of Health Canada, and agreements can be changed midway, without consultation, despite provisions to the contrary. It remains deeply embedded in the historical relationship between First Nations and the nation-state, and in the intricacies of the Canadian health care system as it developed for First Nations.

Australia: An Emerging Model

A. Background

The Australian Bureau of Statistics estimates the Aboriginal population at around 2 percent of the overall Australian population. Although participation in the census is mandatory, it is nevertheless recognised that this number may underestimate the overall Aboriginal population. The Australian Institute of Aboriginal and Torres Strait Islander Studies documents 390 separate cultural groups (Australian Institute of Aboriginal and Torres Strait Islander Studies 1999). Unlike Canada, Australia never systematically supported the development of an Aboriginal political infrastructure that it could then rely on to engage Aboriginal people in implementing government programs. Rather, Aboriginal “development” has been fed by a patchwork of initiatives and programs. This has led to the development of an Aboriginal sector that now numbers over 1000 organisations, although not necessarily appropriately funded, engaged in the delivery of government-defined schemes (Rowse 2002). Over 130 receive funding for health services.

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 that 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 Aboriginal 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, Saggars & Gray 1991a). By the 1960s, attitudes were shifting at all levels of the Australian society, leading to legislative changes aimed to end discriminatory practices. Constitutional changes in 1967 gave the Commonwealth government the authority to make laws in relation to all Aboriginal peoples. From 1968 onward, the government’s responsibility for Aboriginal health shifted six times, before finally landing with the Commonwealth Department of Health & Aged Care in 1995.

B. Health Services for Aboriginal Peoples

Aboriginal health first became a national priority in 1968, with the establishment of the Commonwealth Office of Aboriginal Affairs. The Commonwealth government was, however precluded from taking an active role in Aboriginal affairs until 1973, when it officially took over that responsibility from the state governments. Aboriginal self-determination became the official policy. In matters of health care, self-determination

came to mean the transfer of a nominal amount of funding from the Commonwealth Government to Aboriginal Community Controlled Health Services (ACCHS).⁹

The Ten Year Plan for Aboriginal Health was released in 1979 to inform this new government interest. The stated objective was to “raise the standard of health of the Aboriginals of Australia to the level enjoyed by their fellow Australians” (National Aboriginal Health Strategy Working Party 1989). Aboriginal access to adequate services, however, was problematic. 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 Aboriginal people, which implies a higher secondary and tertiary care utilization rate, over primary health care. The reasons for this are two-fold.

- 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-funded services is simply nil.
- Second, 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 Aboriginal 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).¹⁰

C. Two Models

The Aboriginal Community Controlled Health Services (ACCHS) movement emerged in the early 1970's as a direct result of community mobilization. Their goal was to offer free and culturally-appropriate primary health care services to Aboriginal peoples. Stories of their emergence speak of resistance against adversity, the lack of collaboration and governmental funding, success in implementing innovative strategies where previous attempts failed, as well as hard work and dedication (Briscoe 1974, Campbell & Ellis 1995b, Campbell & Ellis 1995a, Carter et al 1987, Crawshaw & Thomas 1992, Fagan 1984, Fagan 1991, Foley 1982, Foley 1991, Fulton 1985, Siggers & Gray 1991b, Waterford 1982).

The first ACCHS was set up in the urban centre of Redfern (a suburb of Sydney) in 1971, Fitzroy (near Melbourne) followed in 1973, and Perth in 1974. In the Northern Territory, 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 Aboriginal Board of Directors, offered primary health care, and initially functioned with volunteer staff (including physicians, nurses and community staff) securing rent and

⁹ These are the services previously known as Aboriginal Medical Services or AMSs.

¹⁰ The requirement for identification is generally served by a birth certificate. This document is however not necessarily available to Aboriginal people from more remote communities.

other necessities with in-kind donations. Commonwealth funding came later. Some nominal core funding was extended to ACCHS in the late 1970's. Since the Commonwealth Department of Health took over with the responsibility for Aboriginal health in 1995, core funding has increased, but remains based on historical allocation. Program funding is accessed competitively. Some ACCHS 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 in the mid 1970's (Scrimgeour 1997). NAIHO was replaced by the National Aboriginal Community Controlled Health Organisation (hereafter NACCHO) in 1992. State and territorial peak bodies emerged thereafter. The movement has grown remarkably since it first emerged in 1971, with ACCHS in each state and in the territories, operating in urban, rural and remote environments.

The context in which ACCHS operate has changed considerably since the 1970s. Increased access to government funding has meant an increasingly complex environment. Today's ACCHS find themselves fully imbedded into the legislative and policy complexities of the Australian health care system (Duncan & Bartlett 2001). At the same time, they also find themselves somewhat excluded from effectively shaping that environment, and from some of its benefits, such as access to adequate and stable funding. Although there have been substantial gains in the past two decades, these have mostly been secured through activism.

Aboriginal health services, however, appear to be moving into a new phase. With the on-going implementation of the Primary Health Care Access Program, newly formed Regional Aboriginal Health Boards will be funded and tasked with the planning and delivery of comprehensive primary health care for a geographically defined Aboriginal population. The plan is to carve out Australia into Aboriginal health regions, each with its own Board and primary health care funding. Each Board will be funded on a per capita basis, at the average Australian yearly health care expenditures, multiplied by two for Aboriginality in recognition for higher needs, and by two again if the region is remote. The Boards may opt to be fund holders, to fund pre-existing ACCHS for certain services, and/or to be a direct provider of services. Two pilots have already been conducted in the Northern Territory, one in the Tiwi Islands, and one in the Katherine West region. Seven additional regions are in the planning for the Northern Territory. Development is also progressing in South Australia.

This is a bold move for Australia, and a sharp departure from its former *ad hoc* approach to Aboriginal health care services. PHCAP, if implemented as planned, is perhaps the most exciting development in indigenous health care. It is the result of thirty years of lobbying.

Nothing has been given. If you listen to people when they speak about Aboriginal people, [they use] a lot of passive verbs. [But] not a single thing has been given, it is through our 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 ... I mean, accessing better primary health care and the funding of a sound and qualified health system, that has come from us, not from the state government system, [PHCAP is] new Commonwealth funding coming into the system, they were not even doing the thinking about it, we've done [the thinking for them] too (Pat Anderson, Chief Executive Officer of Danila Dilba, Personal Communication, March 2002).

New Zealand: Partnership or Competition

A. Background

In many ways, the relationship of Māori with the Crown is very different from that of First Nations and Aborigines. Firstly, 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*¹¹ and other Māori (urban, pan-*iwi*) communities, as long as they could demonstrate their exercise of *tino rangatiratanga*¹² (New Zealand Waitangi Tribunal 1998). In contrast, Aboriginal people in Australia have no such protection.

Secondly, at 14.5% of the overall New Zealand population, Māori have the opportunity to influence New Zealand development through the democratic process. At between 2 and 3 percent of the national population, Aboriginal people and First Nations must utilise other mechanisms to ensure that their voice is heard.

Thirdly, the educational attainment of Māori far exceeds that of other First Nations and Aborigines.

Fourthly, and despite some shifts, government policy on Māori health constantly reasserts the importance of a Treaty-based partnership. The same position is echoed in contracts with Māori health providers.

Interestingly, however, these marked advantages do not appear to have translated into a more favourable contractual environment for Māori health providers. As it stands today, and in comparison with indigenous health providers in Canada and Australia, the contractual environment experienced by Raukawa Hauora and Te Roopu Huihuinga Hauora is by far the most limiting.

B. The Development of Māori Health Providers

During the seventies and early eighties, 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).

¹¹ Māori traditional governance structures were based on *whanau*, the extended family and *hapu*, the sub-tribe as the key units of governance. The *iwi*, or whole tribe, generally came together in times of conflicts.

¹² *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 2002). The exercise of *Tino rangatiratanga* is the exercise of self-government following tribal processes.

While Māori argued that health could be described as *taonga*,¹³ and therefore is protected under article two of the Treaty, this interpretation was rejected by the New Zealand government, which argues that its responsibility in matters of health care is the same for all citizens. Article three of the Treaty guarantees the same rights for all citizens, including health. Although this 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 1998) 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*, to be tasked and funded to deliver services on the Crown’s behalf. The Runanga Act 1990 recognised the *iwi*, the tribal political structure. It supported the incorporation of *iwi*, and the transfer of government-delivered services to *iwi*. It made no provision for Māori living in urban centres (1990). The Act was repealed the same year it was passed.

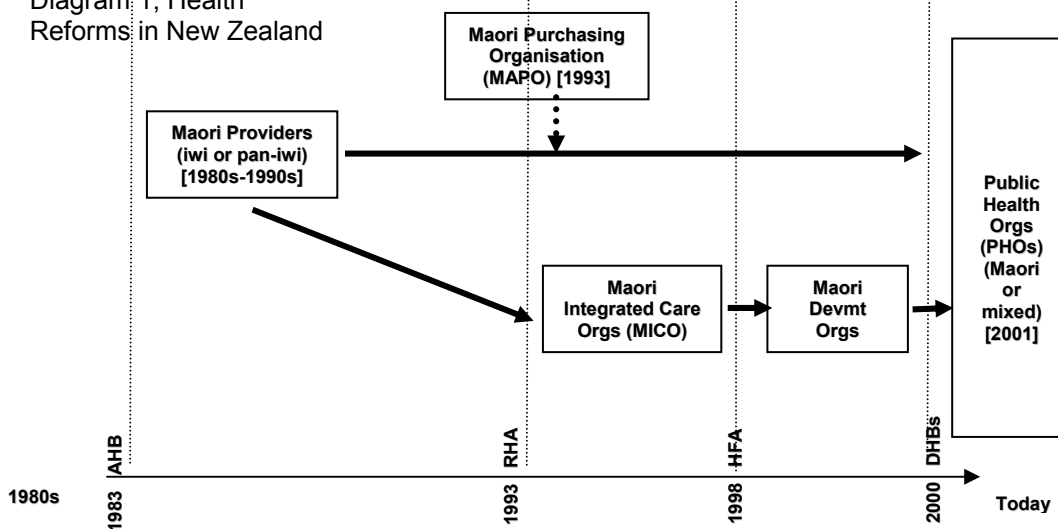
A Board of Health Standing Committee on Māori Health had been set up in 1984 to advise on policy. It was replaced by a Ministerial Advisory Committee on Māori Health in 1989. Both initiatives were short lived and had limited success, but eventually led to the current structure of the Māori Health Directorate located within the Ministry of Health, in place since 1993 (Durie 1998).

Recently, the commitment to a partnership between the Crown and *iwi* has been diluted considerably. The Crown has now adopted a fairly narrow view of the Treaty of Waitangi. A Treaty-based health policy has yet to emerge. It is this position that has informed the development of Māori health providers.

New Zealand’s national health care system was first set up in 1938 through the Social Security Act, providing affordable and universal access to general practitioners, hospitals, pharmaceutical and maternity services. It remained somewhat unchanged until 1980, when an economic downturn coupled with rising costs, led to the introduction of cost cutting measures. Major reforms were again introduced in 1991. This led to what has become known as the ‘big bang’ approach to health care reform, the introduction of the purchaser-provider split, and a shift to managing health services via contractual relationships with independent providers. The following decade was to see continued experimentation, in the pursuit of efficiency and responsiveness. Each reform led 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). The sequence of reforms and impact on Māori provider development is shown in diagram 1.

¹³ The expression *taonga katoa* implies cultural as well as material properties (Durie 1998).

Diagram 1, Health Reforms in New Zealand



With each reform, the new purchasing authority(ies) received guidelines to ensure the continued inclusion of Māori and Māori issues at three levels:

- Partnership: working together with *iwi* (tribe), *hapū* (sub-tribe), *whānau* (family) and Māori communities to develop strategies for Māori health gains 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 that Māori enjoy at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices (Durie 1987, 1994a, 1994d, 1994c, 1994b, 1995a, 1995c, 1996a, 1996b, New Zealand Ministry of Health Māori Health Directorate 2001).

The Ministry of Health reports that the sector grew from 23 providers in 1993 to 240 in 1998 (New Zealand Te Puni Kōkiri 2000). While endorsed as a sign of success by some on-lookers (National Aboriginal and Torres Strait Islander Health Council 2001), the rapid growth of the Māori health sector has not been without problems.

Although providers receive health funding from one or two sources (regional health boards and Ministry of Health), the funding is fragmented under separate contracts, each with monthly invoicing and payment processes,¹⁴ separate administrative requirements and contingencies, defined population, and quarterly reporting requirements. The administrative cost is reportedly considerable (New Zealand Te Puni Kōkiri 2000) and appears to carry few advantages (Ashton 1998). A cursory review of the Māori Health Directorate funding 2000/01 database undertaken by the author in October 2001 showed

¹⁴ Contrary to their Canadian and Australian counterparts, Māori providers are paid in arrears. It appears that even the health boards are paid monthly, the advantage of which being rather obscure. Nothing in the Treasury Guidelines for Contracting with NGO suggests that this required for accountability purposes (New Zealand Treasury 2001).

that 40 Māori providers received direct funding from the Directorate.¹⁵ The number of contracts per agency ranged from 1 to 35, and averaged \$136,000NZ per year,¹⁶ which seems remarkably small considering the administrative work each contract carries, both for the funder and the Māori provider.

The recent emergence of District Health Boards has been associated with the development of Public Health Organisations. The new PHO will be funded from the DHB budget on a per capita basis, adapted for need, ethnicity, economic deprivation and gender. PHOs will be responsible for funding and/or delivering all public health activities for a registered population. It is an important innovation for New Zealand, and an unprecedented financial investment in public health.

DHB-PHO developments are the last in a series of top-down reforms that have required adaptation from Māori providers, each involving costs in terms of establishing a new relationship with the funder and its officers, creating new structures (from MICO to MDO to PHO), and in meeting new administrative requirements (from competition to public administration). All of these changes happened in a very short period of time, at great cost to the Crown and providers.

It remains unclear how this development will impact existing Māori providers. As in the past, regional differences are anticipated (Cunningham & Durie 1999). In Auckland, the formation of a Māori-driven PHO has led to the development of a consortium of previously independent Māori providers. It is unclear whether this development will become the model elsewhere, whether existing Māori providers may find themselves associated with and funded by non-indigenous PHOs, or whether PHO developments may require the creation of consortiums including non-indigenous and Māori providers.

It is noteworthy that the development of PHOs may displace or reshape existing Māori providers. This is occurring with or without minimum provider consultation, despite a policy and strategy statement that speaks to a Treaty-based partnership between the Crown and Māori, and a commitment to Māori provider development.

¹⁵ In addition from funding secured from other sources such as the Minister of Health, Te Puni Kokiri, the District Health Boards, etc.

¹⁶ This translates roughly as \$111,000CAD or \$120,000 AUD.

Strengths and Challenges

Indigenous primary health care services seem to serve both indigenous aspirations and political commitment toward leaner government. At this juncture, governments carefully define the sphere over which indigenous people can exercise some influence, despite continued references to indigenous self-government (Canada), Aboriginal self-determination (Australia) or the Treaty of Waitangi (New Zealand). Indigenous providers have recognised this paradox, and have expressed concerns that all three governments may be capitalizing on indigenous aspirations for self-determination to off-load services onto the shoulders of poorly resourced indigenous health providers. In that process, the responsibility for indigenous health inequalities, a cause of concern for governments, may well be shifted onto indigenous health providers as well.

Despite broad similarities, there exist interesting differences in the contractual environment created in all three countries. Table 3 summarises the findings from five case studies:¹⁷

- Raukawa Hauora, an iwi-based Māori provider;
- Te Roopu Huihuinga Hauora, a Māori Development Organisation set up to provide support to smaller Māori health providers;
- Danila Dilba, an Aboriginal Community Controlled Health Service in Darwin, Australia;
- The Health Transfer Policy as implemented for First Nations in Canada; and
- Katherine West, a Northern Territory based Regional Aboriginal Health Board funded under the newly developed Primary Health Care access Program.

Table 3 explores dimensions of government jurisdiction over indigenous health; the relationship between indigenous people and the Crown; features of the contractual environment; services provided, population served, ownership of health care facilities; access to funding; number, length and payment process for contracts; reporting requirements; contract linkage to outcome; and equity in access to funding. These dimensions were selected as they show how certain decisions in health care system design directly impact on how indigenous providers operate. In the context of this research project, they provide ground for a clear assessment of the congruence or distance between policy and implementation.

It appears that the contractual environment in which providers must operate bears a weak resemblance to the official policy put in place by their respective governments. Indeed, New Zealand has taken a much stronger policy position, on paper, as compared to Australia. Yet Australian Aboriginal health providers have access to a slightly more favourable climate, if one looks at the ACCHS model, and a much more favourable environment in the case of the emerging PHCAP.

¹⁷ The Australian and New Zealand case study reports are submitted in Appendix.

The five case studies conducted can be classified into two broad categories, depending on access to funding:

- In the first category, providers must compete for funding with other service providers. Included in this category are Raukawa Hauora, Te Roopu Huihuinga Hauora and Danila Dilba.
- In the second category, providers are understood by their government to be the sole legitimate provider to serve a geographically and culturally defined population. This is the case for Katherine West in Australia and for First Nations in Canada.

It appears that 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.

Services which operate in a competitive environment, such as Raukawa Hauora, Te Roopu Huihuinga Hauora and Danila Dilba, are more likely to access funding via a multiplicity of fragmented contracts. This has two main consequences.

First, it increases administrative costs for both the funder and the provider. And it also increases risks for the provider. Specifically, it leads to increased and duplication in reporting requirements that do not necessarily contribute to the overall goals of health status monitoring or accountability. It creates coordination costs with other providers, in order to ensure that the overall services provided are as seamless as possible. And it also generates increased risks and operational costs for the provider, including the cost of building and maintaining facilities that may, at the whims of the funder, be fully utilised one year and partially utilised the year after. There is no evidence to suggest that these costs were actually acknowledged and compensated for by the funder. Rather, the evidence suggests that these costs were simply passed on to the provider.

Second, a fragmented contractual environment is less likely to enable a provider to provide comprehensive primary health care services for a defined population. This makes it difficult for the funder to assess whether a provider's approach is leading to better outcomes. It is no surprise to find that Raukawa Hauora, Te Roopu Huihuinga Hauora and Danila Dilba's reports focus mostly on the health activities undertaken. In contrast, First Nations and Katherine West are funded to provide comprehensive primary health care for a defined population. As a consequence, they are more likely to be able to link their activities with health outcomes, thus justifying continued support from their constituency, government and the tax payer. This ability is understandably limited by the small size of the population they serve. Thus results on outcome may be evident only after a significant lapse of time.

Table 3: Indigenous health providers contractual environment

	Māori Health Provider (Raukawa Hauora)	Māori Development Organisation (Te Roopu Huihuinga Haoura)	Aboriginal Community Controlled Health Services (Danila Dilba in Darwin, NT)	Health Transfer Policy	Primary Health Care Access Programme – PHCAP (Katherine West)
Country	New Zealand	New Zealand	Australia	Canada	Australia
Government jurisdiction over indigenous health	<ul style="list-style-type: none"> Integrated Held by the New Zealand government, delegated to the DHBs. Same as any other provider. 	<ul style="list-style-type: none"> Integrated Held by the New Zealand government, delegated to the DHBs. Same as any other provider. 	<ul style="list-style-type: none"> Integrated Historically state/territorial. This model reflects this history, although ACCHS are now under the Commonwealth Department of Health Office of Aboriginal and Torres Strait Islander Health 	<ul style="list-style-type: none"> Separate in 1876 Jurisdiction for First Nation health with Health Canada First Nation and Inuit Health Program, whereas it is with provincial health ministries for other Canadians. 	<ul style="list-style-type: none"> Separate technically since 1972, but in effect since 1995 This new program reflects the relatively recent Australia shift in jurisdiction over Aboriginal health to a single Commonwealth health authority.
Relationship with the Crown	<ul style="list-style-type: none"> Treaty of Waitangi Partnership 	<ul style="list-style-type: none"> Treaty of Waitangi Partnership, although increasingly the funder appears to favour partnership only with the <i>iwi</i>. 	<ul style="list-style-type: none"> Official policy of support to Aboriginal health providers 	<ul style="list-style-type: none"> Royal Proclamation Self-government provision in the Constitution 	<ul style="list-style-type: none"> Official policy of support for Aboriginal health providers

Table 3: Indigenous health providers contractual environment

	Māori Health Provider (Raukawa Hauora)	Māori Development Organisation (Te Roopu Huihuinga Haoura)	Aboriginal Community Controlled Health Services (Danila Dilba in Darwin, NT)	Health Transfer Policy	Primary Health Care Access Programme – PHCAP (Katherine West)
Main features of the contractual environment	<ul style="list-style-type: none"> Highly fragmented contractual environment; The organisation is considered a preferred provider for Māori, but required by contract to offer services to different populations. No core funding to support the provider. 	<ul style="list-style-type: none"> Core funding for the organisation’s mandate to support independent Māori providers. Unsustainable financially on the core funding provided. Funder unwilling to abide by independent Māori providers’ decision to see their independent contracts rerouted to the MDO. Financially vulnerable. 	<ul style="list-style-type: none"> Fragmented access to funding. Documented underfunding. This model is being phased out in favour of PHCAP 	<ul style="list-style-type: none"> First Nation is the sole provider for on-reserve services. Comprehensive primary health care. One master contract, for 3-5 years. Inequities in financing compared to provinces. 	<ul style="list-style-type: none"> Regional Aboriginal Health Board as sole fund holder for comprehensive primary health care services. May also be the provider. One master contract, for 3 years. Currently being rolled out.
Services provided	Patchwork of primary health care, public health, mental health and disability services, depending on funding available.	Patchwork of primary health care, public health, mental health and disability services, depending on funding available.	Patchwork of primary health care services, depending on funding available.	Comprehensive primary health care delivered by nurses with extended scope of practice, Community Health Representatives and visiting physicians (who remain under provincial control).	Comprehensive primary health care delivered by physicians and Aboriginal Health Workers.
Population Served	Depends on the contract. Although the main focus is Māori, some contracts include Pacific Islanders, others all living in poverty, others still include all residents of one town with particular emphasis.	Serves independent Māori Health providers.	Aboriginal people who decide to access services, although some services have funding for outreach.	First Nations living on reserve	All Aboriginal people living in a geographically defined region.

Table 3: Indigenous health providers contractual environment

	Māori Health Provider (Raukawa Hauora)	Māori Development Organisation (Te Roopu Huihuinga Haoura)	Aboriginal Community Controlled Health Services (Danila Dilba in Darwin, NT)	Health Transfer Policy	Primary Health Care Access Programme – PHCAP (Katherine West)
Health care facilities	<ul style="list-style-type: none"> Must be provided by the provider at their own risk 	<ul style="list-style-type: none"> Must be provided by the provider at their own risk 	<ul style="list-style-type: none"> Must be provided by the provider at their own risk 	<ul style="list-style-type: none"> Owned and maintained by the government 	<ul style="list-style-type: none"> Owned and maintained by the government, at least at this point.
Access to funding	<ul style="list-style-type: none"> Mainly competitive, multiple contracts negotiated separately, or sometimes applied for by proposal. 	<ul style="list-style-type: none"> Aside from the core funding, mainly competitive, multiple contracts negotiated separately, or sometimes applied for by proposal. 	<ul style="list-style-type: none"> Mainly competitive, multiple sources of funding (Territorial/state governments, multiple programs within the Commonwealth government) secured by proposal. Some dedicated core funding. 	<ul style="list-style-type: none"> Mainly non-competitive. The main contract is from a single source to a single provider. Other more minor sources of funding accessed separately provide some flexibility. Some attempts to keep nursing salaries on scale with federal providers. 	<ul style="list-style-type: none"> Mainly non-competitive. The main contract is from two sources (state/territorial and Commonwealth government s) pooled into a single contract to a single provider. Other more minor sources of funding accessed separately provide some flexibility.
Number of contracts	<ul style="list-style-type: none"> Access to fragmented funding on a competitive basis. 	<ul style="list-style-type: none"> Limited core funding with access to fragmented funding on a competitive basis. 	<ul style="list-style-type: none"> Limited core funding with access to fragmented funding on a competitive basis. 	<ul style="list-style-type: none"> One master agreement that provides funding for administration, capacity building and core programs. Providers can compete for additional program funding if they wish. 	<ul style="list-style-type: none"> One master agreement that provides funding for administration, capacity building and core programs. Providers can compete for additional program funding if they wish.
Length of contract	No core funding Others vary.	Core funding for three years. Others vary.	Varies, on-going core funding, many yearly contracts, and some pilot for 2-3 years.	3-5 years	3 years
Payments	<ul style="list-style-type: none"> Monthly, after expenditure 	<ul style="list-style-type: none"> Monthly, after expenditure 	<ul style="list-style-type: none"> Quarterly, in advance 	<ul style="list-style-type: none"> Quarterly, in advance 	<ul style="list-style-type: none"> Quarterly, in advance

Table 3: Indigenous health providers contractual environment

	Māori Health Provider (Raukawa Hauora)	Māori Development Organisation (Te Roopu Huihuinga Haoura)	Aboriginal Community Controlled Health Services (Danila Dilba in Darwin, NT)	Health Transfer Policy	Primary Health Care Access Programme – PHCAP (Katherine West)
Reporting	<ul style="list-style-type: none"> Financial statements yearly Fragmented, quarterly activity reports required for many contracts. 	<ul style="list-style-type: none"> Financial statements yearly Fragmented, quarterly activity reports required for many contracts. 	<ul style="list-style-type: none"> Financial statements yearly Fragmented, quarterly activity reports required for many contracts. 	<ul style="list-style-type: none"> Financial statements yearly Activity reports yearly, providing information to Health Canada for its national health status-monitoring role. Five year evaluation 	<ul style="list-style-type: none"> Financial statements yearly One master report yearly, with 64 indicators to be reported on.
Provider health activities can be linked with outcomes	No. The contractual environment is too fragmented to be able to link the providers' activities with outcome, with perhaps the exception of mental health services.	No, not in terms of health outcomes. Yes, in terms of improvements with Māori Health Providers.	With difficulties. The AMS is not funded to serve a specific population. The primary health care funding is provided for a self-referred population only, and does not contain a comprehensive proactive/preventive component.	To some extent, yes, with the 5 year evaluation.	Yes, to some extent. It would, however, be more productive to have a comprehensive outcome evaluation every five years instead of a lengthy report every year.

Table 3: Indigenous health providers contractual environment

	Māori Health Provider (Raukawa Hauora)	Māori Development Organisation (Te Roopu Huihuinga Haoura)	Aboriginal Community Controlled Health Services (Danila Dilba in Darwin, NT)	Health Transfer Policy	Primary Health Care Access Programme – PHCAP (Katherine West)
Equitable access to funding compared to other primary health care services providers	To date, no study seems to have attempted to study this question. Further, the high level of fragmentation and the competitive framework that remains, make it impossible to assess whether there is equity in funding between providers, and for the same service.	To date, no study seems to have attempted to study this question. Further, the high level of fragmentation and the competitive framework that remains, make it impossible to assess whether there is equity in funding between providers, and for the same service.	Gross underfunding documented for Aboriginal health care services altogether, especially for AMSs located in the Northern Territory. ¹⁸	<ul style="list-style-type: none"> • A matter of debate. The federal government reports funding First Nations at 1.5 to 2 times the national health care expenditure.¹⁹ • Alternatively, independent analysis from two sources, and anecdotal reports from providers suggest underfunding.²⁰ 	Under this new program, Aboriginal Health Board receives a per capita allocation equal to the average health care expenditure for Australians times 2 for higher needs, times 2 for remoteness.

¹⁸ (Deeble et al 1998)

¹⁹ See the report of the Royal Commission on Aboriginal Peoples (Royal Commission on Aboriginal Peoples 1996) and more recently the report of the Commission on the Future of Health Care in Canada (Romanow 2002). The latter report provides no analysis to support this statement, and no reference.

²⁰ Manga et al. (Manga & Lemchuk-Favel 1993) and Eyles et al. (Eyles et al 1994).

Conclusions

In many ways, the emergence of indigenous health providers has led to a new relationship between the government and indigenous population, that of **governance by contract**. Some have remarked that this may lead to a highly fragmented and rigid approach to health services, and erode government's accountability (Stewart 1993). The cost of coordinating this system may well be borne partly by providers, and partly by indigenous clients themselves, and the more fragmented, the higher the cost. Under such a system, it is important to consider whether non-performance in improving health is linked to provider non-performance or to a funder-purchaser's incomplete definition and funding of services.

Single, multi-year funding contract for comprehensive primary health care for a defined population would go a long way in limiting the impact of fragmentation, reducing administrative costs and increasing provider flexibility in service delivery. It will go a long way in making the system more efficient, and allowing the funder and providers to assess the impact of health interventions on health status. Perhaps more importantly, such a system is more likely to meet the aspirations of indigenous people who, ever since conquest, have sought to regain control over their lives.

Appendix 1, Abbreviations/Glossary

Two conventions have been adopted in this report:

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 and for all Departments of Health, whether state, territorial, provincial or federal, to facilitate a reading by people who may 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.

Indigenous controlled health sector: In Australia, discussions of the Aboriginal community controlled sector is made more complex by terminology. Aboriginal controlled clinics emerged in the 1970's under the label Aboriginal Medical Services or AMSs. They have since become 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 "community controlled" but have opted not to become members of NACCHO. In New Zealand, Māori controlled health services may be *iwi*-based or pan-*iwi*. Models have included MAPOs (Māori Purchasing Organisations), MICOs (Māori Integrated Care Organisations) and, more recently, MDOs (Māori Development Organisations). I have used these abbreviations when speaking directly to these phenomena.

<u>Terms/ Abbreviation</u>	<u>Country of use</u>	<u>Definition</u>
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
AHB	New Zealand	Area Health Board
AHW	Australia	Aboriginal Health Workers
AMS	Australia	Aboriginal Medical Services: the term emerged in the early 1970's 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
Aotearoa	New Zealand	Māori's name for New Zealand.
ATSIC	Australia	Aboriginal and Torres Strait Islander Commission Replaced the Department of Aboriginal Affairs (DDA)

<u>Terms/ Abbreviation</u>	<u>Country of use</u>	<u>Definition</u>
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 labour market.
CDNANZ	Australia	Communicable Diseases Network Australia New Zealand
CHR	Canada	Community Health Representative
Danila Dilba	Australia	Danila Dilba Biluru Butji Binnilutlum Health Service Aboriginal Corporation in Darwin
DAA	Australia	See ATSIC
Commonwealth Department of Health	Australia	2001, 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
DHB	New Zealand	District Health Board
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 Services Branch (MSB) in 1997.
<i>hapu</i>	New Zealand	Sub-tribe, in the Māori language Te Reo

<u>Terms/ Abbreviation</u>	<u>Country of use</u>	<u>Definition</u>
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).
HFA	New Zealand	Health Funding Authority
<i>Hui</i>	New Zealand	Assembly or meeting, sometimes for government consultations.
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.
<i>iwi</i>	New Zealand	Tribe, in the Māori language Te Reo. The <i>iwi</i> , or whole tribe, generally came together in times of conflicts.
<i>Karanga rangatanga</i>	New Zealand	Māori ceremonial protocol.
<i>Kaupapa Māori</i>	New Zealand	Following Māori policy or protocol (secular).
<i>Kaumatua</i>	New Zealand	Elder. Kuia is an elder woman, koroua is an elder man.
KWHB	Australia	Katherine West Health Board
Marae	New Zealand	Community facility, carved and ornated, a symbol of tribal identity. All activities at a marae are governed by ceremonial protocols.
MBS	Australia	Medicare Benefit Scheme

<u>Terms/ Abbreviation</u>	<u>Country of use</u>	<u>Definition</u>
Medicare	Australia Canada	<p><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:</p> <ul style="list-style-type: none"> 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. <p><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.</p>
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 counselors on-reserve
NNDSS	Australia	National Notifiable Diseases Surveillance System
NT	Australia	Northern Territory
OATSIH	Australia	The Office of Aboriginal and Torres Strait Islander Health, which is part of DHAC.
PBS	Australia	Pharmaceutical Benefit Scheme
PHCAP	Australia	Primary Health Care Access Program
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.
<i>rohe</i>	New Zealand	Border of land, boundary defining Māori traditional lands.

<u>Terms/ Abbreviation</u>	<u>Country of use</u>	<u>Definition</u>
<i>Runanga</i>	New Zealand	Iwi governance structure or Council.
<i>Tangata whenua</i>	New Zealand	Indigenous person.
<i>Taonga</i>	New Zealand	Property or wealth.
<i>Te Reo</i>	New Zealand	Māori language.
<i>Tikanga</i>	New Zealand	Correct procedure or custom followed on the marae.
<i>Tino rangatiratanga</i>	New Zealand	<i>Tino rangatiratanga</i> is the term used most often as the expression of Māori self-determination. <i>Tino</i> roughly translates as self. <i>Rangatiratanga</i> roughly translates as “evidence of breeding and greatness” (Williams 2002) Māori traditional governance structures were based on <i>whanau</i> , the extended family
<i>Tiriti O Waitangi</i>	New Zealand	Treaty of Waitangi
<i>Tumuaki</i>	New Zealand	Literally the top of the head, term used for Chairperson.
<i>Whakapapa</i>	New Zealand	Genealogy, lineage, “to lay one thing upon another.” Whakapapa is what determines the place one holds in the universe, and within Māoridom.
<i>Whanau</i>	New Zealand	The extended family in the Māori language Te Reo.

Appendix 2, Danila Dilba²¹

Danila Dilba Biluru Butji Binnilutnum Health Service Aboriginal Corporation (hereafter Danila Dilba) 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, and "*biluru butji binnilutnum*" means "blackfella" getting better (Danila Dilba Biluru Butji Binnilutnum Health Service Aboriginal Corporation 2002). The corporation was established in 1991. The objectives of the organisation are:



- To provide Aboriginal peoples and Torres Strait Islanders with free primary preventive, public health care;
- To ensure that referrals to other health agencies are provided when necessary;
- To promote knowledge and understanding among other relevant agencies to ensure adequate health provision for Aboriginal peoples and Torres Strait Islanders;
- To ensure, by employment of Aboriginal and Torres Strait Islander Health Workers, that the type of service provided meets the needs and wishes of the Aboriginal and Torres Strait Islander community;
- To organise such ancillary services as are necessary for the effective provision and use of medical, hospital, pharmaceutical and other services;
- To make continuous assessment, where appropriate, of health education programs in the Aboriginal and Torres Strait Islander community;
- To implement and undertake, where appropriate, health education programs in the Aboriginal and Torres Strait Islander community;
- To conduct training and further education courses for employees to enable them to assist in carrying out the objects of the health service;

²¹ 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 Binnilutnum Health Service Aboriginal Corporation 2002).

- To encourage and assist Aboriginal peoples and Torres Strait Islanders to undergo training in medicine and other health and allied professions;
- To promote and strengthen Aboriginal and Torres Strait Islander identity whenever and wherever possible;
- To hold title to any land in the Darwin area which may be granted to the Association (Danila Dilba Biluruj Butji Bjinlutnum Medical Service Aboriginal Corporation) on behalf of its members;
- To pay money to and provide other benefits for Aboriginal peoples and related Aboriginal communities or associations of the region; and;
- To assist in any way Aboriginal communities, groups or individuals living in the region in their determination of the use to which monies paid to them will be put (Danila Dilba Biluru Butji Binnlutlum Health Service Aboriginal Corporation 2002).

The organisation provides services to Aboriginal people living in Darwin and Palmerston, and in the 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.

The Emergence of Danila Dilba

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 leveled by cyclone Tracy in 1974. Today, Darwin is the home of 68,802 people, one third of the overall Northern Territory population, and remarkably cosmopolitan. The 1996 census showed a total of 5,723 Aboriginal people in Darwin (8.5%), 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%) (McLennan 1996). According to the Larrakia Nation Aboriginal Corporation (Larrakia Nation Aboriginal Corporation 2001), there are currently 1500 Larrakia people living in the Darwin area. Bartlett et al. described Darwin in the following manner:

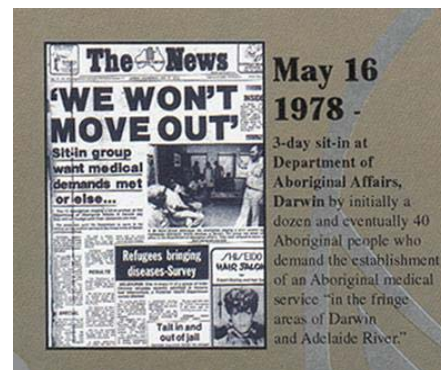
Darwin is difficult to compare with other population groups in the Top End. It certainly cannot be considered remote, but it has other health needs which remote communities do not. The complexity of issues in Darwin include the local people being overwhelmed by the processes of colonisation and their influence over what happens on their country markedly reduced; there is an influx of other Aboriginal people into Darwin from remote communities for a wide range of

reasons including serious illness, prison matters, and to rage (Bartlett & Duncan 2000).

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.²² 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 controlled health services in Alice Springs (Central Australian Aboriginal Congress, established in 1973) and Redfern (Aboriginal Medical Services, established in 1971). The late seventies were a time of change in the Northern Territory. The Commonwealth Government had begun to emphasise and resource the training of Aboriginal Health Workers in 1972. The territorial program began in 1976 in Darwin, Nhulunbuy and Alice Springs (Fleming & Devanesen 1985). Remote environments were able to secure access to Aboriginal Health Workers, who provided a spectrum of services in a way that was more acceptable to Aboriginal people. It, however, appears that this option was not available in Darwin.

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

Towards the end of the 1970's, 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. This “solution” fell short of aspirations, and there was vocal dissatisfaction with the Department. 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,

²² This is an Aboriginal community located within the boundaries of Darwin.

provoking angry responses from workers and the Aboriginal community. 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 submissions, 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 1991,²³ and the first patient was seen in October 1991. The original clinic was set up on McLachlan street, in facilities leased from the Northern Territory government. This site was later handed over by the Minister of Health as a lease in perpetuity.

The first five years of Danila Dilba's life were a constant struggle for funding (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1993, 1994a, 1995, 1996a). 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 ongoing funding. This caused ongoing problems thereafter, as the organisation remained underfunded for core funding, having 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 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* (Anonymous 1994b). Although Danila Dilba was fighting to secure its own stable funding, the issue was tied with health funding being managed by ATSIC.

²³ Under the Aboriginal Council and Association Act, 1976.

[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) 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...

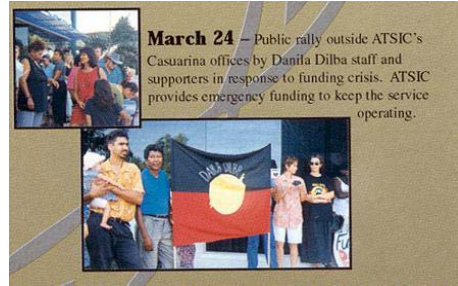
The federal health budget is already more than \$33billion dollars and rationalisation will occur within his overall budget to either set up a Division of Aboriginal Health or make funds more accessible to community organisations on a triennial based funding level.

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 was allocated yearly through a submission-driven process. The need to compete for funding created tensions with other Aboriginal 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.²⁴ Most of my time since I took up the job as



²⁴ The Royal Commission on Aboriginal Deaths in Custody described the ATSIC funding cycle as follows:

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 triennial basis.

Director and 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).

There was no equity in funding under ATSIC. 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).*

It is worthwhile to read the press and media releases of the time, simply to note the level of debates coming from the Northern Territory government of the day, with off-hand allegations suggesting mismanagement and simply no evidence of a grasp of the issues (Anonymous 1994a, Reed 1994, Tondorf 1994).

Once funding was transferred from ATSIC to the Commonwealth Department of Health, Danila Dilba's attention shifted to another debate, that of securing an effective voice in Aboriginal health policy and planning in the Northern Territory. This meant the creation of the Aboriginal Medical Services Alliance of the Northern Territory (AMSANT), the peak body formed in October 1994 to be the voice of NT ACCHS. 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 which has not signed and [sic] Framework Agreement. It is unlikely that the NT government will. This meeting was called by Peter Plummer [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 Stone and Burke were making public statements denigrating AMSANT...

The discussion went backwards and forwards and culminated with Peter Plummer 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 access to unequal resources).²⁵ Next on the agenda was the question of ACCHS accessing direct funding, including Medicare and Pharmaceutical Benefits monies. 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 1996a).

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, [PHCAP is] new Commonwealth funding coming into the system, they were not even doing the thinking about it, we've done that too (Pat Anderson, Chief Executive Officer of Danila Dilba, Personal Communication, 2002).

The Current Situation

Danila Dilba is a western health care organisation that is governed, managed and, to a large extent, staffed by Aboriginal people. It operates as an extension of the Australian health care system, its operations ruled by 29 separate pieces of legislation, and programs to some extent defined by 18 separate funding contracts, each with its own sets of performance indicators. The following sections provide an overview.

²⁵ Although the issue lies outside the scope of this particular project, 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.

a. Governance

Danila Dilba²⁶ 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 Aboriginal organisations to limit membership to Aboriginal people and their spouse,²⁷ and has been preferred by Aboriginal organisations for that reason. The Board of Danila Dilba has always been clear that, although it delivers services to non-Aboriginal spouses, its membership should be limited to Aboriginal 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 Aboriginal ancestry. Thus, no other incorporation mechanism exists that would better meet the Board's wishes.²⁸

The Management Committee (which acts as a Board of Directors) is elected from the membership, and consists of ten members, including four office bearers with the titles of Chairperson, Deputy Chairperson, Secretary and Treasurer. The organisation's rules require that at least one seat be nominated by the Larrakia people. The five other

²⁶ The organisation was initially incorporated under the name Darwin Aboriginal and Islander Medical Service (1991). The name was changed to Danila Dilba Biluru Butji Binnlutnum Medical Service Aboriginal Corporation in 1992. The term Medical was replaced by Health in 2001.

²⁷ The spouse may be Aboriginal or not.

²⁸ The Act is currently undergoing its second review process, following some complaints by Aboriginal organisations. Danila Dilba participated in the first review, and a draft case study was produced (Crough & Cronin 1996), Danila Dilba declined participation and the case study was never released (Danila Dilba Biluru Butji Binnlutnum Medical Service Aboriginal Corporation 1996c). The case study documented that Danila Dilba had one main issue with the Act: it objected in principle to being required to submit a list of its membership to the Registrar. A review of Danila Dilba's files shows that, with the exception of a mishap in 1991-92, the Registration process, and the adoption of changes to rules and organisation name, seem to proceed fairly smoothly. The second review is happening concurrently with this research. This review has already identified a number of issues that will be incorporated in the planned amendment of the Act, including,

- The adoption of a more flexible approach to the corporation rules and the design of corporations, to harmonise the Act with the Corporations Act 2001 and modern corporate philosophy;
- Changing the role of the registrar from that of a punitive body to providing assistance, capacity building and mediation;
- Streamlining reporting requirements; and
- Limiting membership to Indigenous natural persons.

The proposed changes may address some of Danila Dilba's concerns with regards to membership. But the review is also questioning whether a separate Act for Aboriginal corporations should exist at all, and if there is such a need, whether access to this mechanism should be limited to small, simple corporations (Coors Chambers Westgarth Lawyers 2002). The potential elimination of the ACA 1976 raises some concerns, but I have found no evidence that Danila Dilba has been alerted to the potential impact of this proposed change.

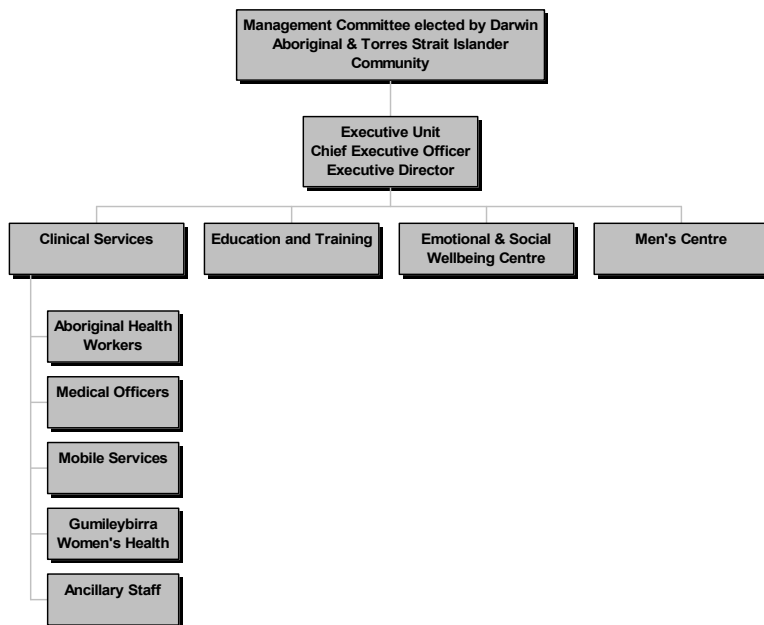
positions are for members at large (Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation 1996b).

The Management Committee is responsible for the organisation’s compliance with all legislations and regulations relevant to its day-to-day operations. Each Committee Member carries a personal liability, and could be held responsible in the case of fund mismanagement. The organisation’s rule requires the Committee to meet at least once every two months. It generally meets monthly.

The organisation is managed by policies, and the day-to-day operations are delegated to the Chief Executive Officer and the Executive Director. It is evident from the minutes of meetings that much of the senior staff time continues to be dedicated to lobbying for better funding arrangements, responding to new government initiatives, and being consulted on a spectrum of issues.

b. Service Organisation

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% are of Aboriginal ancestry. The organisation operates from 4 different locations: an administration building on



Knuckey street, a clinic located next to the administration, an Emotional & Social Well Being Centre and an Education and Training Centre.

The Clinic provides medical services free of charge. A men’s clinic operates on Tuesdays, and a women’s clinic on Tuesdays and Thursdays.²⁹ 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.

²⁹ 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 onset, the organisation adopted a policy of Aboriginal Health Workers First.³⁰ 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% of consultations managed by AHWs alone, 53.5% managed by both an AHW and a General Practitioner, and 3.9% 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 & Social Wellbeing Centre provides one to one and family 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 Aboriginal and non-Aboriginal people unable to pay.³¹ Serving a non-Aboriginal population causes some problems, as most of its funding is Aboriginal-specific. Danila Dilba was able to argue the case with Territorial clinics and stop the practice. 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.

³⁰ Danila Dilba does not employ nurses.

³¹ This can be interpreted as both 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.

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 1993) to one of 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 Reporting³² 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.

Recruitment and retention remain a challenge, especially for multiyear projects. However, statistics in this area are not compiled. With the exception of AHWs, Danila Dilba is not able to keep salaries at par with the Territorial and Commonwealth grid. The organisation operates with two industrial awards (union collective agreements). This, in a sense, does limit some administrative flexibility. Further limitation is imposed by funding agencies who refuse to adjust funding to match the salary increase negotiated under an industrial award. Although a majority of the organisation's funding is specifically earmarked for Aboriginal programming, Danila Dilba has nevertheless been required to apply for an exemption under the Anti Discrimination Commission to be able to preferably employ Aboriginal people.

c. Finance

The organisation's budget draws from 18 contracts with as many funding government sources.³³ Table 4 provides a breakdown. 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 strategies tied to performance indicators. Danila Dilba currently accesses less than two percent of its funding from a strategy that requires a percentage of the initiative from other sources of funding. Generally, the last two categories (nearly twenty percent of funding) are accessed on a competitive basis, rather than on needs. These are funds from vertical strategies that are usually short lived.

³² The Service Activity Reporting is a mandatory yearly reporting attached to funding from the Office of Aboriginal and Torres Strait Islander Health.

³³ 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.

Only the core funding component offers the organisation some flexibility in allocation. This includes funds from Medicare. The Commonwealth 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 meant that consultations managed by AHWs were not billable to Medicare, this despite being a more efficient use of resources. This issue will only be resolved by pooling Medicare monies.

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 budget, from capital, to salaries to operation. Funding comes with pre-drafted contracts, performance indicators and limited budgets that may represent a fraction of what was requested in the original submission (especially true for multiyear and one off projects). The Commonwealth Health and

Table 4: Danila Dilba, Percentage allocation of funding per category, sample year 2001-02³⁴

Category	Definition	Number of contracts	Example	%of budget
Core	Recurrent operational funding that is not tied to specific programs	2	OATSIH Best Practice Initiative	48.46%
Strategies Recurrent Funded 100%	Relatively stable funding sources tied to specific initiatives	5	OATSIH Bring them Home Program	29.91%
Strategies Recurrent, Requiring Employer Financial Contribution	Relatively stable funding source tied to specific initiatives and requiring a sizeable organisation contribution (partial funding)	1	Commonwealth Dept. of Education, Science and Training, Workplace English Language and Literacy (WELL)	1.98%
Multiyear projects	Funding for multiyear innovative project	4	OATSIH National Indigenous Sexual Health	11.39%
One of	Single year or shorter term project	6	ATSIC	8.26%
		18		100.00%

project to another, and within the project budget, from capital, to salaries to operation. Funding comes with pre-drafted contracts, performance indicators and limited budgets that may represent a fraction of what was requested in the original submission (especially true for multiyear and one off projects). The Commonwealth Health and

³⁴ 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.

Aged Care (including OATSIH) actually requires the organisation to set up separate **bank accounts** for each new project.³⁵

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 effect. 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 (John Anderson, Executive Director of Danila Dilba, Personal Communication, 2002).

Submission-driven funding demands a significant time investment and the expertise of more technically proficient staff or consultants. 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 (months to 3 year projects), and a drain on administrative energies. 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 may find 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. The moral or political obligation overrides administrative concerns.

³⁵ This is simply micro-management, and absolutely unnecessary. That funding authorities would not be satisfied with audited financial statements and accounting conventions speaks volume to their limited administrative capacity.

d. Reporting, Accountability and Dispute Resolution

The organisation'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 SAR and the submission of financial statements. All other funding sources have stringent performance indicators and reporting requirements. OATSIH requires the organisation to participate in the annual national Service Activity Reporting (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 provide 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. 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.

It is noteworthy that OATSIH, as the core funder, does not require a comprehensive evaluation. Also, there does not seem to be a standard data collection process in place across the NT that would allow some comparison with THS managed facilities. Indeed, I have found no evidence that THS produces or publishes a performance review of its facilities. SAR remains the only mechanism for comparison, but applies only to OATSIH-funded organisations.

Reflections

This case study shows to what extent current and past debates in Aboriginal health are and were grounded in the daily difficulties of an ACCHS attempting to provide health services to an underserved population. It also shows to what extent the sector has developed from the bottom up, and has had to negotiate to have a voice in the process. It is difficult to ascertain precisely to what extent Danila Dilba's experience is representative of the sector, especially its diversity. Its experience is more likely

representative of pioneer ACCHS: Redfern, Fitzroy, Perth and Congress. This is simply an assumption, not an assertion. One has to wonder to what extent the NT might have created a rather unique environment.

What the case study also shows is the extent to which Danila Dilba's autonomy is largely contained by external contingencies. The ACCHS movement, and Danila Dilba, were born out of commitment to community control and self-determination. What this has meant in practice, however, calls for some nuancing:

[Self-determination] is becoming more difficult, it rolls off the tongue really well and it is becoming more and more difficult.

[It] was the politics behind setting up the [ACCHS] and the way we see it now, is a way to improve Aboriginal health is for Aboriginal people to be making as many decisions as possible being involved in health and we do that. All the [ACCHS] do, with Aboriginal Boards, with Aboriginal directors, with Aboriginal staff and the experience and expertise that we don't have we buy in but they are more of a technical nature. We are responsible for the politics, the philosophy vision and direction...

We say that we do practice [self-determination]. But in the scheme of things we do wonder how much of this is a reality. It is political in that sometimes systems also play the game, they like us to think that we are practising self-determination but in fact they run us ragged with, you know, piling on all these different things, these games that they play... Self-determination is the fundamental backbone of the [ACCHS] and it is, but sometimes I wonder how much really control Aboriginal people do have (Pat Anderson, Chief Executive Officer of Danila Dilba, Personal Communication, 2002).

The environment over which Danila Dilba has control is largely defined at a national and territorial levels, and can only be challenged through lobbying.

Danila Dilba is currently engaged in discussions regarding Primary Health Care Access Program (PHCAP). The Bartlett et al. study (Bartlett & Duncan 2000) ranked the Darwin region a priority zone for PHCAP implementation because its Aboriginal population remains largely underserved, with ratios of 1 AHW per 499; 1 nurse per 1,525; and 1 doctor per 2,515. It is clear that, given current resources, Danila Dilba is able to meet only a fraction of the need. What the PHCAP process will mean for Danila Dilba however, remains unclear. It will hopefully be a step forward, but will invariably lead to yet more complexities.

Appendix 3, Katherine West Health Board – Pioneering a Model

The story of the Katherine West Health Board Aboriginal Corporation (hereafter KWHB) must 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 and the possibility of extermination, until the Daguragu strike 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 first Chairperson, cited in (Creswell 2001).

The origin of KWHB is also rooted in the Aboriginal Community Controlled Health Services' movement explored earlier, and in its relentless lobby for better access to primary health care and stable funding.

The coordinated care trials were basically a framework that put together lots of ideas that were already being talked about. People were trying to look at ways of implementing ideas such as care planning, proper access to Commonwealth funding and models of community control (Andrew Bell, former District Medical Officer for THS Katherine region, and one of the authors of the CCT proposal, cited in (Creswell 2001).

The third perspective relates to the opportunity that was taken by a group of people including Jo Wright, District Medical Officer for the Top End, and Andrew Bell, 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.

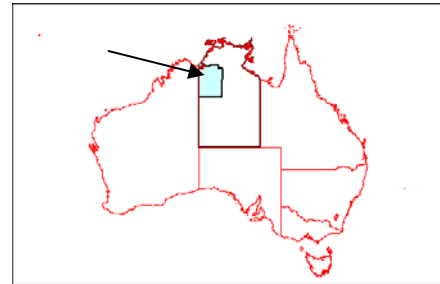
This case study focuses on the process, financing and service delivery model that emerged as a result of these three converging perspectives, focusing on a *technical* viewpoint. What is presented is but a summary of a very complex process. A more detailed description and evaluation of the process can be obtained from the Menzies School of Health Research's evaluation reports (d'Abbs et al 1998, d'Abbs 1998a, 1998b, 2002, Katherine West Coordinated Care Trial Local Evaluation Team 1998b, 1998a, 1999a, 1999b, 2000, Katherine West Health Board Aboriginal Corporation 2001).

The Region

The Katherine West 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 (below), with the Board of Directors having input into the inclusion of communities and outstations. The town of Katherine is not part of the trial, although the Board's offices are located in town. The region is 162,000 km, with an estimated population of 2800, 84 percent of Aboriginal ancestry.

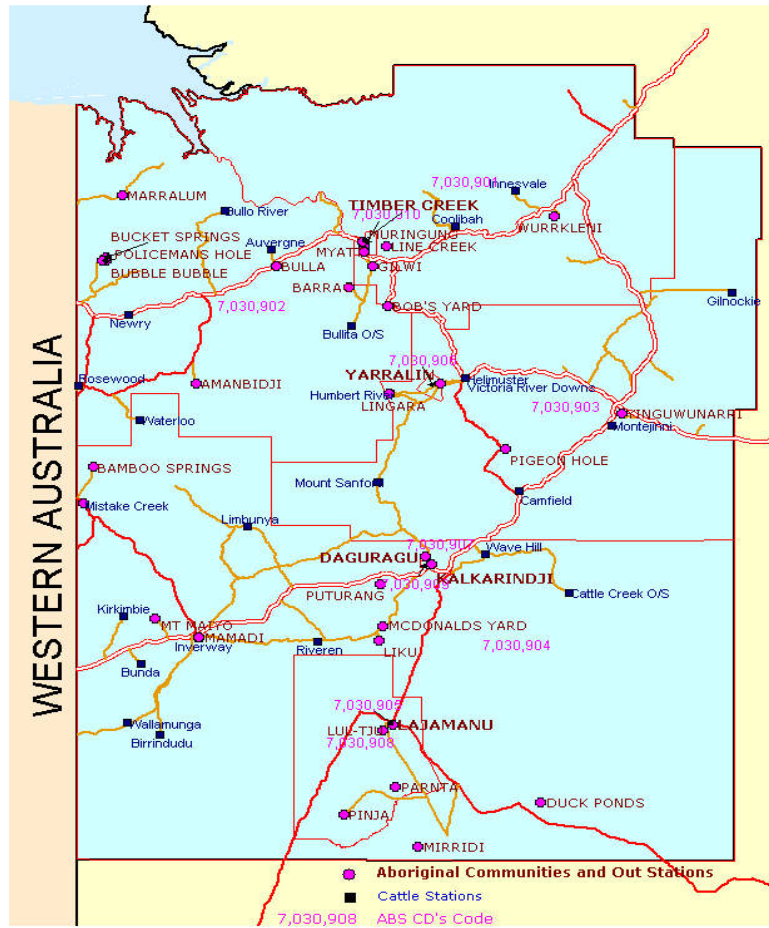
Located 8 km from the Buchanan Highway, 460 km south-west of Katherine, Daguragu was born as a result of protest by Gurindji people over the poor living and working conditions on cattle stations. On August 22, 1966, Gurindji leader Vincent Lingiari headed a walk off of workers, setting up camp at Wattie 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



Katherine West Health Board (KWHB)
Coordinated Care Trials Service

Cattle Stations and Aboriginal Communities and Out Stations



This map was created on request from Katherine Health Board. The data was supplied by the Katherine Health Board and meant to use for health service administration purposes only.

Based on Katherine West Health Board Service Area Source: KWHB, CDATA98, DPE Produced by: Planning Unit, Commonwealth Dept. of Health and Aged Care © Commonwealth of Australia, 1999

Daguragu, their example to be 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. Today, the population of Daguragu is estimated at 297. The main language groups at Daguragu are Gurindji, Walpiri, Mudbara and English. It was declared a dry community in 1979 (d'Abbs et al 1998). Kalkarinji, formerly known as Wave Hill, was shaped by the event 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 as an illegitimate community, a striker's camp. Whereas police, welfare entitlement, health and postal services were delivered to Wave Hill, Daguragu received nothing. The 1981 Gurindji land claim included Kalkarinji. The community includes 322 people, of which over 80 percent are Aboriginal. The major languages represented include Gurindji, Walpiri and English. Daguragu, along with Kalkarinji, serve a small number of outstations, including the Aboriginal owned cattle station of Mistake Creek (d'Abbs et al 1998).

Aboriginal people on Victoria River Downs and Humbert River 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. Two other outstations emerged as a result, in Lingara and Pigeon Hole. Yarralin is located 380 km southwest of Katherine, and 150 km from Timber Creek. Yarralin's population is 307, with over 90 percent of Aboriginal ancestry. Lingara has an estimated population of 20-30 persons, and Pigeon Hole, 71-75 persons. The main language groups are Ngarinman, Gurindji, Bilinara and Mudburra (d'Abbs et al 1998).

Located in the northern part of the region, Timber Creek is a town of 559 people, 284 km west of Katherine. According to the 1996 Census, over 40 percent of the population is Aboriginal.³⁶ The town developed in the late 1800's, and was then known as the Victoria River Depot, and was a shipping hub for cattle stations at the time accessible only by donkey. Today Timber Creek is a service and transit centre for people traveling between Katherine and Kunumurra in the Kimberleys. It also acts as a service centre 12 outstations, the homes of over 500 people. The main language groups in the area are Ngarinman and Ngaliwurri. The Ngarinman Resource Centre at Timber Creek, also

³⁶ Although these number include the town of Timber Creek, the community of Bulla and Amanbidgi and a number of outstations.

known as the Ngaliwurru Wuli Association, was established in 1986 and services 13 Aboriginal communities in the district in matters of housing, mechanical services and work assistance (CDEP) programs. Bulla occupies a small Aboriginal landholding, on the banks of the East Baines River 65 km south of Timber Creek. The community generally gets cut off for short periods of time in the wet season. The main language groups in Bulla are Ngarinman and Murrinpatha. Bulla is a dry community.³⁷ Mialuni³⁸ became an incorporated Aboriginal community on April 30, 1974. It is located 464 km southwest of Katherine, 184 km southwest of Timber Creek. Access is by 4 wheel drive only. Mialuni is also a dry community (d'Abbs et al 1998).

A devastating measles epidemic in 1948 led the Northern Territory government to relocate Warlpiri people from Yuwarli/Yuendumu to a government/welfare settlement then known as Hooker Creek (now Lajamanu), 555 km southwest of Katherine on the edge of the Tanami Desert. In 1952, another large group of Aborigines was moved to Hooker Creek, but many of these subsequently crossed the Tanami desert to return to their home. Hooker Creek was then known as a place of hunger and malnutrition. According to the Northern Territory Department of Housing and Local Government, the population of Lajamanu totals 1081, of which over 90 percent are Aborigines, predominantly Warlpiri. The town also serves 13 outstations with a combined population of 280 (d'Abbs et al 1998).

The Vision

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 1980's 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.

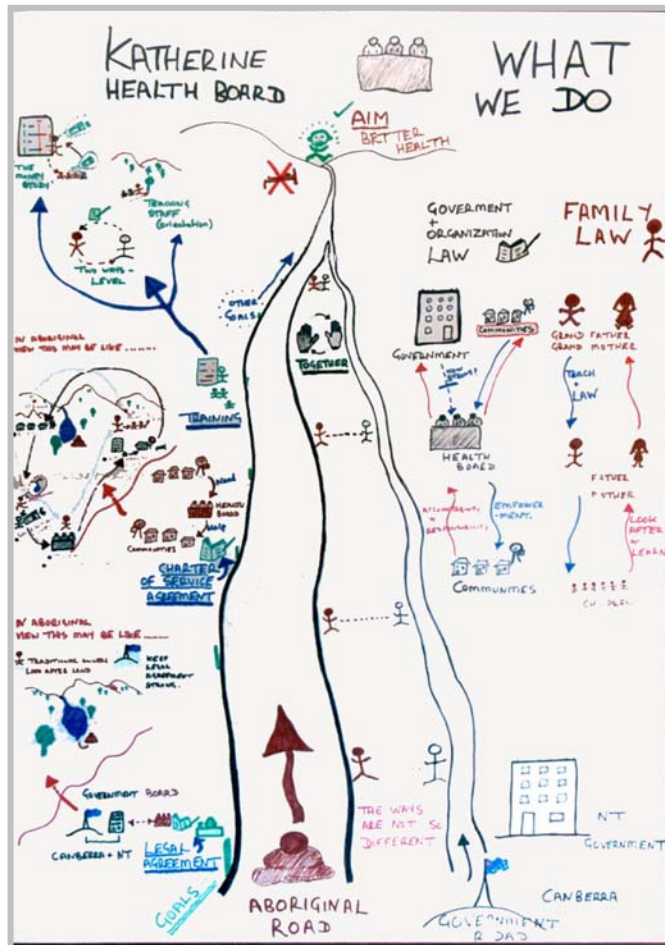
³⁷ Under the NT Liquor Act, communities may opt to ban the use of alcohol, or to restrict its use in certain area.

³⁸ The community is often referred to as Kildurk after the name of the pastoral land lease on which it was built, or as Amanbidji.

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).



From the CCT to the Transition Year to PHCAP

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"³⁹ and four Aboriginal and Torres Strait Islanders CCTs were undertaken. All mainstream CCTs were located in areas where services were readily accessible (Commonwealth Department of Health and Aged Care Information and Research Branch and University of Adelaide National Key Centre for Social Applications of Geographical Information Systems (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 (Commonwealth Department of Health and Community Services 1995). 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.

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.⁴⁰ 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. 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

³⁹ 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.

⁴⁰ 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).

regional Aboriginal Health Boards to act as a fundholder,⁴¹ 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, at least 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 fundholders.

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

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 fundholder, and merely a mechanism for THS to secure access to Commonwealth funding. A contributing factor may have been that there were limited Aboriginal communities and authorities' 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. 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. This is explored in more details in the Financing section, below.

Early in 1997, consultations began to explain the concept and gauge community support. Initial discussions and consultation were spread over four months.

We didn't get paid for it. We been passing on something that they never heard before and we board members, we thought about it we are doing something not for the Katherine West (but) for the people in the communities. And that's the reason why. We wanted to run as quickly as we can to build up the idea to community people so they can understand really (Jack Little, KWHB Board Member and former first Chairperson, cited in (Creswell 2001).

Once they understood, members of communities in the Katherine West region expressed "a real commitment" (Katherine West Coordinated Care Trial Local Evaluation Team 2000).

⁴¹ According to both Joe Wright and Andrew Bell, the 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 expression of interest for the CCT was submitted to the Commonwealth late in October 1995. Consultations with the Aboriginal sector began shortly after. There were apparently less debates with the Tiwi CCT than in the Katherine West region. The Tiwi Health Board was set up by December 1995, and planning was underway. Katherine West, however, took yet another year of consensus building before the process began to “gel”. Discussions with Katherine West communities began early in 1997. Following the initial consultation a two days meeting was held in Katherine with representatives from all the major communities. From this meeting, a working executive was elected, tasked to disseminate information in their community on the CCT and to provide feedback as to the structure of the Katherine West Health Board. The Board was officially approved in July 1997. Katherine’s only Aboriginal Medical Service, the Wurli-Wurlinjang Aboriginal Corporation, provided the initial administrative structure and fund holding body. On February 3, 1998, KWHB became incorporated under the Commonwealth *Aboriginal Councils and Associations Act 1976*. The first Board was elected in April 1998 (Katherine West Coordinated Care Trial Local Evaluation Team 2000). Meanwhile, the monitoring group set up to oversee the process, with representation from OATSIH, THS and some Katherine West representatives, had begun to meet monthly to iron out the implementation details.⁴² The minutes of these meetings show that a main focus was the “recruitment” of the Katherine West residents into the trial, which meant the signing of a consent form to entitle KWHB to pool a per capita Medicare amount into the trial pool. Another concern was the details of the funding pool.

The minutes of the June 25, 1998 meeting show that the concept of purchaser/provider split outlined in the proposal was considered by the Board, although some ambiguity is obvious:

Marion [Scrymgour, then Director of Katherine West] outlined the concept of a service provider body, being developed by KWHB to maintain purchaser/provider separation. KWHB would be major shareholder. No KWHB member could be on new body's Board. Staffed by coordinator and book-keeper. Able to manage services, such as health centres.

KWHB determined to ensure equity across Katherine West, not favour one provider over any other. Each provider would be subject to same conditions of service agreement.

Re Lajamanu: Marion informed the project team that KWHB has decided not to commence management of Lajamanu Health Centre for at least 6 months, to enable THS to improve its service there prior to KWHB's takeover. In reality unlikely that Board would want to take over before Jan/Feb 1999.

KWHB interested in managing the following services asap: Bulla, Kildirk, Pigeon Hole.

⁴² The first minutes located are from July 18, 1997.

As shown in Table 5, 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 Katherine West 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, (Katherine West Health Board Aboriginal Corporation 1998).

KWHB took over the clinics at Daguragu/Kalkarindji, Yarralin and Pigeon Hole on November 1st, 1999. The live phase finished at the end of 1999. The first indication that the Commonwealth government was considering continuing its funding of the KWHB after the end of the Live Phase was brought up at a meeting of the Monitoring Group on May 21, 1999. At that time, the Commonwealth government indicated that they had made budgetary provisions to allow the trial to continue to be funded for another year after the end of the Live Phase, provided that THS continued its support (d'Abbs et al 2002). This one year transition was to provide the Commonwealth time to review the KWHB and national evaluations of the CCT, expected by June 2000.

Coordinated Care Trial Phase Planning	January 1997 to June 30th, 1998
Coordinated Care Trial Live Phase	July 1 st , 1998 to March 31 st , 2000
Transition Year	April 1 st 2000 to December 31 st , 2001
Primary Health Care Access Program	January 1 st , 2002

A formal commitment was made on June 21. Negotiating the contract for the Transition Year proved a long and arduous process. While construed by the Commonwealth government as a mechanism for marking time, KWHB continued to make changes to its operation during the transition year. For examples, KWHB took over the clinic at Lajamanu in September 2000, and the clinics at Timber Creek, Bulla and Mialuni in June 2001.

As it turned out, the transition year extended to 21 months. Again, the delay incurred related to the negotiation of the contract.

The Health Board is becoming increasingly concerned about delays in the commencement of discussions regarding our funding arrangements for the post-December 2000 period. The Health Board was initially advised that discussions would start during September 2000 this year. It is now mid-October, and we have yet to hear from your Department in regard to this.

We appreciate the Commonwealth's verbal assurances that our general existence next year is not in question, and that the funding model currently being

implemented in some zones in Central Australia may be indicative of future funding levels for the Katherine West region.

However, we wish to emphasise that such general assurances are not a sufficient basis on which we can seriously plan our activities for the future. This in turn means significant delays in the implementation of our planned activities. In order to implement even a modest expansion in the level of program activity from the beginning of 2001 (which we have planned for), we need to definitely know by September or October of 2000 if we will have the money to do so. You will appreciate that if we do not know this until December 2000, we cannot start to implement programs until at least several months later, given the time inevitably needed for recruitment etc. processes.

This gives the appearance of poor implementation of our plans, and sets back our whole budgetary process. It also leaves the Health Board vulnerable to a situation such as occurred early this year, when we received no funding for some months due to delays in signing a new agreement.

I would therefore be grateful if you could notify me of a firm date on which negotiations about a new agreement can commence... (Letter from Marion Scrymgour, Director, KWHB to Mary MacDonald, OATSIH, Canberra, dated 12 Oct 2000).

The negotiations began soon after, ending with the signature of a three years contract on December 19th, 2001, funded under the Primary Health Care Access Program (PHCAP).

Overseeing the Live Phase was a Monitoring Group, composed of representatives from the KWHB Board, THS and OATSIH. That forum had been established during the planning phase, and continued to meet regularly to iron out issues emerging from the trial. Since the trial was, in fact, structured as a research project, an evaluation team from the Menzies School of Health Research was also involved in data gathering throughout the Live Phase, submitting punctual reports throughout (July 3, 1998; September 25, 1998; December 10th, 1998, December 21, 1998; October 1999). These reports raised issues and provided solid ground for reflections by staff, the Board and the Monitoring Group. When the Live Phase ended in December 1999, the Board requested that the Monitoring Group remain, and that the Transition Phase be evaluated. The Monitoring Group remained after the transition to PHCAP.

The Current Situation

KWHB is a complex organisation, led by Aboriginal people from the Katherine West region, and tasked with the delivery of comprehensive primary health care services. The extensiveness of the services now provided is unprecedented in the region; the financing model is now the prototype for a national policy. KWHB is the flagship, considering the endless list of visitors who have come to learn from its experiences. The following sections detail the framework under which the organisation operates.

a. Governance

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 Aboriginal ancestry and their spouses.⁴³ While 84% of the region population is Aboriginal, the remaining 16% are generally associated with the cattle industry that was historically responsible for the massacres and dispossession of Aboriginal 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 the lack of formal representation on The Katherine West Board. 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. Despite this, there is significant support for the mobile clinic service established by KWHB to serve the cattle stations (d'Abbs et al 2002).

The Katherine West Health Board 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 Katherine West communities:

- Lajamanu and outstations: 3 members;
- Yarralin and outstations: 3 members;
- Pigeon Hole: 1 member;
- Bulla: 2 members;
- Doojun: 1 member.
- Kalkaringi/Daguragu: 3 members;
- Yingawunarri outstation: 1 member;
- Timber Creek: 3 member;
- Mialuni: 1 member; and

The Board is distinct yet integrated with other Aboriginal 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 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) that 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. 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

⁴³ The spouses may be non-Aboriginal.

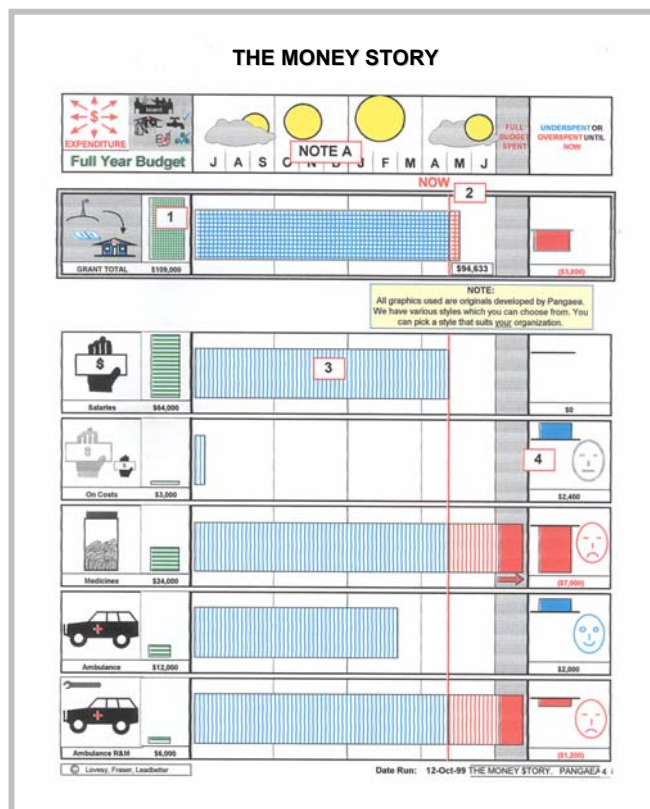
roles and responsibilities of the Health Committees, and how these will relate to the Board, is still at the drafting stage.

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 in 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 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 Panagea Inc.'s Money Story, a software accounting package that provides a pictorial representation of the financial statements. With



appropriate support, this allows Board members with limited English literacy and numeracy to understand and exercise control over the organisation's budget.⁴⁴

The Executive Committee of the Board meets monthly to ensure that emerging issues are addressed in a timely manner. The policies and procedures of the organisation are still being developed and fine tuned. This can be attributed to the rapid growth experienced by the organisation. Effective policies will emerge in due time through experimentation.

b. Finance

The organisation's budget draws from 11 contracts with as many funding government sources. Table 6 provides a detailed review of the 2001-2002 funding year. Core funding, over two-thirds of KWHB's current funding, comes from a

Table 6: KWHB Percentage allocation of funding per category, sample year 2001-02⁴⁵

Category	Definition	Number of contracts	Example	%of budget
Core (pooled funding)	Recurrent operational funding that is not tied to specific programs	146	Pooled funding under the Tripartite Agreement	67,74%
Strategies Recurrent Funded 100%	Relatively stable funding sources tied to specific initiatives	4	DHAC Mental Health Strategy	7,82%
Multiyear projects	Funding for multiyear innovative project	3	DHAC Nutrition Strategy	20,27%
One of	Single year or shorter term project	3	Remote Community Initiative for Minyerri ⁴⁷ (Mentorship)	4,17%
		11		100,00%

⁴⁴ I attended the Annual General Meeting of the Board in November 2001, where the Chairperson and the Vice-Chairperson did the review 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.

⁴⁵ 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.

⁴⁶ During the transitional phase, core funding was divided under 6 contracts. These were combined under one master contract in December 2001.

⁴⁷ KWHB is involved in the management of the Minyerri clinic for a period of one year, at the request of the community. This is in effect a mentorship project. This is a one off not so much due to the nature of the funding, but rather to the task itself.

single contract, and is both stable and flexible. The pooling of funding does not prevent KWHB from applying for additional funding from other sources. Recurrent funding strategies, nearly eight percent of the total, are also fairly stable, but are linked to specific medium term strategies tied to performance indicators. 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).

The pooling of funding has replaced the previously fragmented flow of health funding to communities. This is best shown in diagram 2.⁴⁸ 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 in the first diagram may have been mostly theoretical.

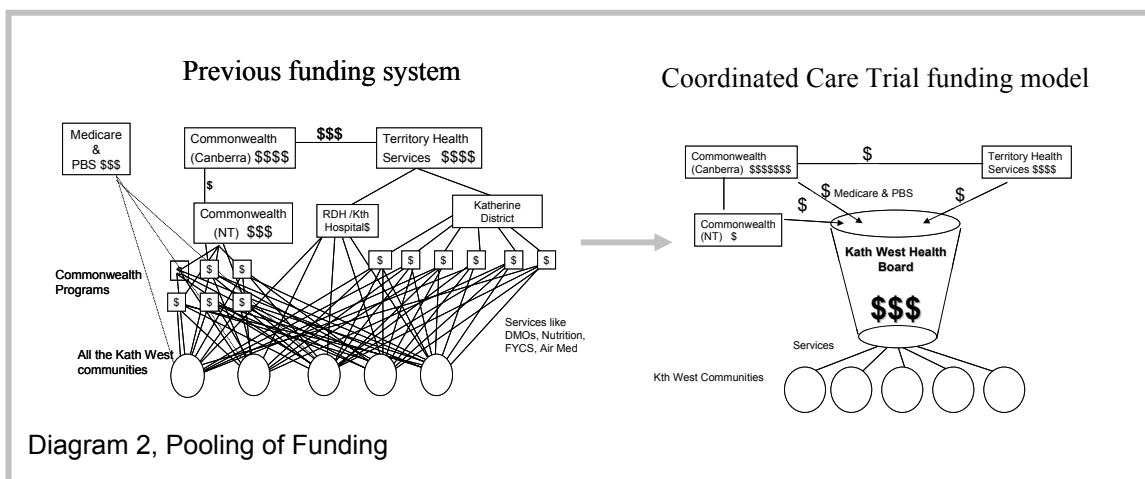


Table 7 shows how the fund pool has changed from the CCT to the current PHCAP-like model. Under the CCT, Medicare was pooled at the average Australian utilisation rate. Under the current model, a so-called mix mode funding has been applied to Medicare whereby KWHB can both bill Health Insurance Commission for Medicare services and still receive pooled Medicare funding. There is a phasing in of Medicare funding. KWHB is currently receiving \$1,700/per capita (three times the average Australian utilisation rate) and can bill Medicare 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:

⁴⁸ 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.

	CCT Pool	Post-CCT Pool
Medicare/ Pharmaceutical Benefits	<ul style="list-style-type: none"> Medicare and Pharmaceutical Benefit, calculated at \$536.40 per capita per year. This is based on the average amount spent yearly in Australia on a per capita basis, an amount that does not take into consideration either remoteness or health status and needs. The amount was increased slightly during the trial. 	<ul style="list-style-type: none"> Phase 1: Medicare funding initially pooled at \$1,700/per capita with the possibility of billing HIC for Medicare activities. Phase 2: A choice of either \$2,000/per capita and end any HIC billing, or \$1,800/per capita and to continue to bill HIC to Medicare activities. Pharmaceutical Benefits not pooled but rather accessible under Section 100 of the Pharmaceutical Benefits Act.
Administration	<ul style="list-style-type: none"> A Department of Health and Aged Care Contribution one off payment for additional expenses; A Department of Health and Aged Care Contribution for administration, based on historical figures; 	<ul style="list-style-type: none"> A Department of Health and Aged Care Contribution for administration, based on historical figures;
CCT specific expenses	<ul style="list-style-type: none"> A sponsorship fundholder contribution, to pay for the finance manager and recruitment costs; 	<ul style="list-style-type: none"> N/A
THS	<ul style="list-style-type: none"> A contribution from Territorial Health Services (THS) for the purchase of health services, based on historical figures, and including funding for community health centres, dental services, medical services (District Medical Services), mental health, patient assisted travel, public health and management & administration 	<ul style="list-style-type: none"> A contribution from Territorial Health Services (THS) for the purchase of health services, based on historical figures, and including funding for community health centres, dental services, medical services (District Medical Services), mental health, patient assisted travel, public health and management & administration. THS to refund savings from drops in hospitalisation.
Funds from other initiatives pooled under the same contract		<ul style="list-style-type: none"> Other selected Health & Aged Care funds.

- To either receive the full Medicare amount of \$2,000/per capita and end any HIC billing. Under this option, services received by Katherine West 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 HIC for Medicare activities. Under this option, services received by Katherine West residents outside of the region would not be billed back to KWHB. This scenario is the preferred one at this time.

The current agreement also provides for KWHB to be refunded for THS savings resulting from a drop in KWHB resident hospitalisation. This is a meaningful provision. A THS report dated May 2001 suggests that, indeed, the hospitalisation rate for Katherine West has 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.

c. Service Organisation and Human Resources

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 clinics to serve cattle stations;
- An investment of human resources intended to shift service utilisation from secondary and tertiary to primary health care (Foley 2001, Katherine West Health Board Aboriginal Corporation 2001).

When the management of THS clinics was taken over by Katherine West, the Board had the option of continuing to employ the same individuals if there was a mutual agreement. In some cases, KWHB asked THS to take their staff with them.

Staffing in 2000/01 included 40 staff, of which 57.5 percent were of Aboriginal ancestry. Clinical staff included 4 doctors, 10 nursing positions and 9 Aboriginal Health Workers. 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.

The challenges of recruitment and retention in remote communities limit the Board's options in that salaries and incentives must be provided for doctor and nurse positions to be filled. This includes housing, which is in high demand in Aboriginal communities. Invariably this creates issues with regard to non-Aboriginal staff receiving benefits that Aboriginal community staff does not get. This problem stems from forces outside the reach of the Board, but that may impact on team cohesion at the local level. There is no easy solution.

KWHB operates under a certified (union) agreement. Since the CCT provided for a yearly allocation of funding, it was KWHB's practice to sign one year contracts with employees. The current two and one half years legal contract has provided the opportunity to rethink that, and contractual processes are being reconsidered to ensure that staff feel more secure in their employment.

d. Reporting, Accountability and Dispute Resolution

The reporting requirements under the new tripartite agreement are extensive, covering 64 distinct indicators. KWHB submitted its first report this past March. In a letter dated March 21, 2002, Kirk Whelan, the CEO, made the following remarks:

"Whilst this has been an exceptionally tedious process, it has been worth while 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] 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).

It is obvious that the process requires some further thinking and streamlining.

The negotiation of the funding pool for the CCT and the post-CCT phase has not been without controversy. In the lead up to and the live phase of the CCT, ample evidences point to power relations in negotiations being skewed towards THS and the Commonwealth, with governmental parties apparently capitalising on this opportunity to offload responsibilities onto the other governmental body, this process effectively leaving the least resourced body, Katherine West, in a position of having to spend considerable

time and human resources in order to ensure a fair deal. Four examples were documented by the Independent Evaluator, including:

- Following the take over of the four clinics included in the trial region on November 1, 1999, THS advised KWHB that pharmaceutical supplies purchased from THS would incur a 25% handling surcharge.⁴⁹ This cost had not been included in the pool.
- The THS pooled funding for salaries were calculated at base salaries plus on-costs (superannuation, long service leave, property management, workers' compensation, corporate management, etc.). There was much debate over what the actual on-cost figure should be. The actual amount pooled was initially 22%. However, THS routinely charges 52% of salaries for on-costs. This was an issue in cases where KWHB either opted to purchase services from a provider other than THS or to purchase from THS services additional to those traditionally offered by THS.
- THS initially refused to pool the travel costs of the District Medical Officer (DMO). Thus the cost of the DMO visits in the initial live phase were not charged to KWHB. An issue arose when KWHB opted to hire general practitioners to work at the clinics, thus reducing the need for DMO visits resulting in savings for THS. And
- KWHB is of the opinion that the THS funding for 2 clinics was pooled at a level lower than what was historically expended by THS (Katherine West Coordinated Care Trial Local Evaluation Team 2000).

Many other issues emerged during the transition phase, and yet another list was debated in the context of negotiating the tripartite agreement. The latter are legal rather than financial, and worth mentioning.

1. Indemnity: the Live Phase Legal Agreement included a clause for mutual indemnification. In the negotiations for the Transition Year, the Commonwealth government insisted in a new indemnification clause where KWHB would indemnify the Commonwealth and THS (without reciprocity). A three month debate ensued, ending with a compromise where KWHB responsibilities are more defined, but also where there continues to be a three way indemnification.
2. Intellectual property: The Commonwealth put forward a draft clause recognising that the intellectual property over any material produced during the Transition Year was vested the KWHB, but nevertheless obliging the Board to extend to the Commonwealth and THS "permanent, irrevocable, royalty-free, non-exclusive" license to use and sub-license this material. The Board was successful in curtailing this clause to identify and set out constraints over culturally significant or sensitive material (d'Abbs et al 2002).

The point to be made here is that the pooling of resources is not a neat process, and disputes abounded. The same reflection applies to contractual negotiations. Planning

⁴⁹ THS applies this policy to all NGOs.

for the CCT, Transition Year and current PHCAP-like phase has been marked by lengthy debates between KWHB, THS and the Commonwealth over a number of legal and financial issues. Many battles were won by KWHB. Others led to compromises. As frustrating and time consuming as this process may have been for KWHB, the main point is that it occurred within the context of contract negotiations or via the mechanism of the Monitoring Group.

The Monitoring Group emerged to meet the needs of the Coordinated Care Trial, and remained when the Katherine West Health Board 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 the Health Board. 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 Coordinated Care Trial, in that 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 a resolution of contentious issues (Monitoring Group 2001).

What is required in that case is an explicit delineation of responsibilities, a transparent process of pooling, meaning an equitable access to information, and an effective dispute resolution process. But KWHB can also count on another process: that of the Monitoring Group.

Reflections

Under the KWHB-PHCAP model, access to Medicare has shifted from a demand-driven process to a capitation model, facilitating the adoption of a primary health care model of service delivery.⁵⁰ This is something the ACCHS movement lobbied for over many years. It is therefore not surprising that KWHB is now considered a remarkable success story that promises to have repercussions for all Australian Aboriginal 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 services delivery.

KWHB now operates eight community clinics, and oversee 72 staff. It is a complex health care organisation, ruled by the same 29 pieces of legislation as any other health care organisations in the Northern Territory. 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 over which the Board exercises control is carefully defined

⁵⁰ A primary health care model has four main components: curative, rehabilitation, prevention and health promotion. The first two components are individual focused, and may be accommodated by a demand driven model of health care financing. But prevention and health promotion are population-based components that are better served by capitation model.

by legislation, finances, performance indicators, geography, recruitment and retention, and a spectrum of other factors as well.

Having said that, this model of financing is a tremendous step forward, creating opportunities not only for better care but also for KWHB to garner information and experience to be used to shape public policy.

While the current KWHB's financing structure is portrayed as being an example of PHCAP, it is too early to ascertain to what extent the PHCAP program, which is still at the drafting stage, will actually look like the KWHB. Significant similarities are likely, and differences may indeed be subtle. Differences are likely to be at the implementation stage.

Appendix 4, Te Runanga O Raukawa

Te Runanga O Raukawa Inc. is an iwi-based organisation, located in Otaki, with offices in Levin, Palmerston North and Feilding. It was incorporated in February of 1988. The objects of the organisation are,



- (1) *To conserve promote advance and assist;*
 - (a) *whanau, hapu and iwi of Ngati Raukawa ki te Tonga who are tangata whenua in the rohe which is popularly known as Mai I Waitapu ki Rangataua, Mai I Miria Kakara ki Kukutauaki;*
 - (b) *karangarangatanga who are normally resident in the rohe of the whanau, hapu and iwi referred [above] and who are not Ngati Raukawa ki te Tonga;*
 - (c) *whanau, hapu and iwi closely related to those referred to in [a] living outside the rohe admitted to participate in the Runanga in accordance to succeeding Rules.*
- (2) *To act as a recognised Māori authority.*
- (3) *To consider discuss and take action on matters relevant to the raising of the mana, and to the advancement of the people referred to in Rule [1].*
- (4) *To actively promote productive relationships between those people referred to in Rule [1] and other karangarangatanga, and other citizens of Aotearoa.*
- (5) *To assist all of the popple referred to in Rule [1] to strengthen their taha Tirana, taha hinengaro, taha wairua and taha whanau and to develop to their full potential.*
- (6) *To halt the decline and to promote the revival of te reo Māori and of the tikanga of those people referred to in Rule [1].*
- (7) *To find ways to ensure that for those people referred to in Rule [1]:*
 - (a) *they all know or have access to information on their origins and whakapapa and are contributors in one way or another to the well-being of their whanau, hapu, iwi or marae.*
 - (b) *An increasing number of them are competent in te reo Māori and in other languages of relevance to their well being.*
 - (c) *Their children whether born out of the conventional and publicly announced state of wedlock or not, are embraced by and raised under the influence of their whanau, hapu and iwi.*
 - (d) *All of their children are so instructed as to ensure that all of their capacities and potential are fully developed.*
 - (e) *The quality of health among them be as high as that of any group in the world.*

(f) *All of them contribute to their whanau, hapu and iwi and to Aotearoa and in particular, that none:*

- (i) *is in jail or in any other place of detention,*
- (ii) *is in an orphanage,*
- (iii) *is in ill health or in a hospital with any avoidable illness,*
- (iv) *is without an occupation in which he or she is productively engaged,*
- (v) *is in an old person's home, or,*
- (vi) *can justify the claim that he or she is without a place to stand.*

(8) *To cooperate with local, national or international agencies, governmental or private, to achieve the following among the people referred to in Rule [1]:*

- (a) *abundant employment opportunities particularly within whanau, hapu or iwi arrangements,*
- (b) *a wide range of exciting training and educational opportunities including those which are whanau, hapu or iwi based,*
- (c) *housing and other living conditions which are highly conducive to the enhancement and fulfillment of personal, whanau, hapu or iwi aspirations, and*
- (d) *the strengthening of communication and other systems for social advancement.*

(9) *To design policies which will ensure that the people referred to in Rule [1] have increasing responsibility for their present and future circumstances (Te Runanga O Raukawa Inc. 1998).*

The organisation's guiding principles are as follows:

Our wealth is our people who are our most valuable asset. The personal development and active participation of our people in an environment of opportunity and choice, is central to whanau, hapu and iwi strengthening.

The good health and well being of our people is achieved when the mauri, the spiritual sense and essence of the individual, whanau, hapu and iwi, is awake and alert, and proper attention is given to the needs of;

<i>Te Taha Hinengaro</i>	<i>The Mind</i>
<i>Te Taha</i>	<i>The Body</i>
<i>Te Taha Wairua</i>	<i>The Spirit</i>
<i>Te Taha Whanau</i>	<i>The Family</i>

Our marae is our principle home and as such must be well maintained and thoroughly respected.

The strength of our cultural base and cultural identity must be upheld through the revival and active usage of Te Reo Māori, the maintenance and development of

tikanga and taha Māori and the preservation and protection of all of our other taonga of our people.

The Treaty of Waitangi, as a covenant between two peoples, must be honoured to allow the growth of a united nation.

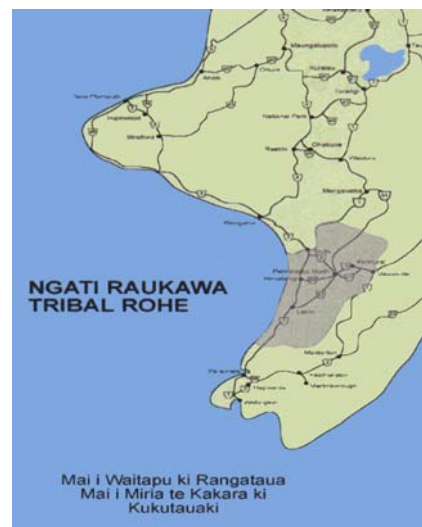
Under the principle of Tino Rangatiratanga, self-determination and authority over our present and future circumstances, are fundamental to achieving our preferred development (Te Runanga O Raukawa Inc. n.d.).

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, services are delivered to those who seek them, including the larger Māori population living in the area as well as all other cultural groups. 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.

	Māori			Total Population		
	1991	2001	% Increase	1991	2001	% Increase
Rangitikei	3,630	3,474	-4.49%	16,578	15,102	-9.77%
Manawatu	2,802	3,417	18.00%	27,135	27,510	1.36%
Palmerston North	7,041	9,516	26.01%	69,537	72,036	3.47%
Horowhenua	4,959	5,694	12.91%	29,814	29,823	0.03%
Kapiti Coast	3,120	4,881	36.08%	34,941	42,447	17.68%
Total	21,552	26,982	20.12%	178,005	186,918	4.77%

The Emergence of Te Runanga O Raukawa Inc

The engagement of self-governing *iwi* in public policy has a relatively recent history. Historically, New Zealand has perhaps strategically 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 with powers in the areas



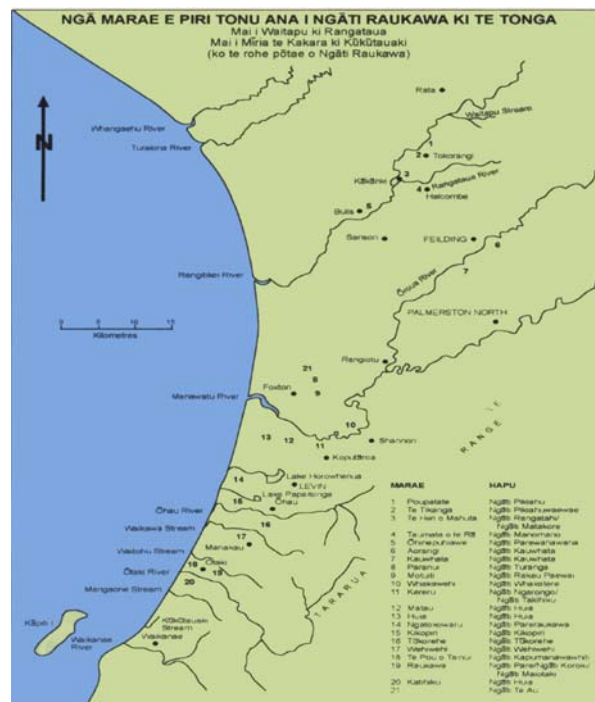
of welfare, housing and economic development. The Council's historical role in promoting Māori development has been important. However, these structures were never independent agents of Māori self-determination (Ward 1999).

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. It was also the continued discussions with the Palmerston North Hospital Board that led to the hiring of a Māori Liaison Officer.

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 was echoing Māori demands for greater participation and autonomy in Māori affairs. The Runanga Iwi Act was adopted in 1990, enabling iwi to register as the authorised voice of that iwi, 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 Te Runanga O Raukawa.

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 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. 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 (Durie 1991).

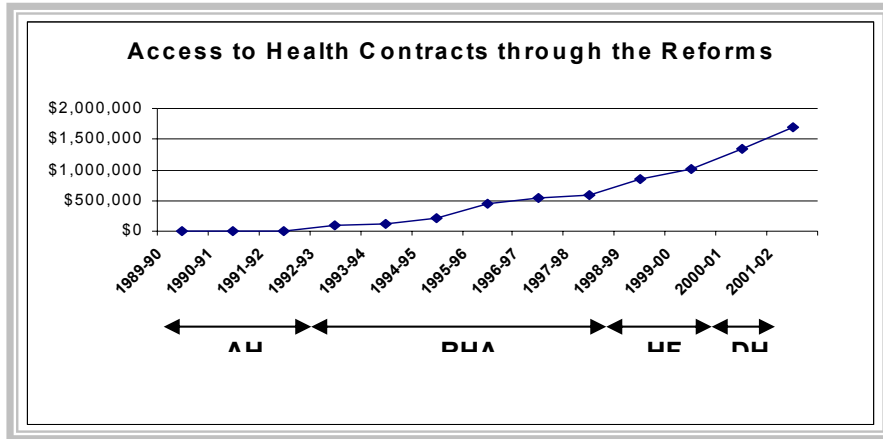
The overall goal of the organisation was to integrate all of public policy under a single organisation and single contract, and deliver kaupapa Māori services to whanau and hapu:

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 (Mason Durie, Personal Communication, 2002).

The following sections provide an overview of the history of the organisation's experience as a health service provider. It explores the constraints that the system, and the continuous process of reform that characterised the system, have place on the organisation.

The Health Sector Reforms

Te Runanga O Raukawa has lived through 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). These are summarised in Table 9. As shown, Te Runanga O Raukawa has thrived through the reforms, continuously expanding its access to funding. But the reforms have brought many challenges to the organisation.

Era	Authority	Party in power	Leading Ideology	Billing	Number nationally	Impact on Māori organisations
1983-1993	Area Health Boards	Labour Government	Privatisation Competition	Regional authority	17	<ul style="list-style-type: none"> Theoretically funded on a capitation basis, although this was never implemented fully. Purchaser and provider of services.
1993-1997	Regional Health Authorities	National Government (1990)	Privatisation Competition	Regional authority	4	<ul style="list-style-type: none"> Separation of funder, purchaser and provider functions. Regional development of models for Māori health providers. Stated policy commitment to Māori provider development.⁵²
1997-1998	Transitional Health Authority	National Government (1990)	Public Administration Status quo	National office	1	<ul style="list-style-type: none"> Transfer of all powers back to the Ministry of Health.
1998-2000	Health Funding Authority	New Zealand First-National Coalition (1996)	Public Administration Competition	Regional authority	1	<ul style="list-style-type: none"> Active promotion on Māori provider development through contracting services. Attempt at a national standardisation of service specification. Minimal contract monitoring and provider support.
2001-current	District Health Boards	Labour Party (1999)	Public Administration Coordination	National office	21	<ul style="list-style-type: none"> Division of funding between primary care, and secondary/tertiary care. Aim to rationalise primary care including general practice and non-government providers, including Māori providers, through the formation of Primary Health Organisations that will be funded on a capitation basis. Unclear whether existing providers will continue to exist. Regional variations are expected.

⁵¹ Based on Gauld's Revolving doors: New Zealand's health reforms (Gauld 2001).

⁵² A commitment to purchasing health services from Māori providers first appears in the 1995/96 policy guidelines to the RHA (New Zealand Ministry of Health 1995a).

For example, the transition from the Manawatu/Whanganui Area Health Board (1983-1993) to the MidCentral Regional Health Authority (1993-1998) created some disruption for the organisation. As noted by Ran Jacobs, CEO at the time, in his report to the Whaiti,

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.

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 (Jacob 1993).

The Whanau Ora programme had already been in the planning since October 1992, and 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.

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 Te Runanga O Raukawa 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 was now supporting the development of Māori Integrated Care Organisation (MICO) proposals. A MICO was to be a fund holder for a defined enrolled population, with a per capita funding allocation. The model was to provide Te Runanga O Raukawa with an opportunity to move forward to implement its vision. The development of a MICO proposal was first brought up at the 31 March 1998 Whaiti meeting. By the 10 November 1998 Whaiti meeting, funding had been secured and a consultant hired to develop a proposal. But the HFA's commitment to the MICO concept eventually lost momentum, partly due to pressures from general practitioners (Central Region Māori/Iwi Integrated

Care Organisations 1998) and was abandoned by the HFA in the winter of 1999. 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 ten or so partnerships with iwi (Health Strategic Planning Committee 1999).

The most recent reform, being the transition from the Health Funding Authority to the MidCentral District Health Board, 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 Area Health Boards. Consequently, Iwi Māori Health Providers have expressed major concern about the effect that this will have on Iwi Māori around the motu. Ngati Raukawa has been quoted, particularly as a "preferred provider" 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 (Emery 2000).

Hopes that *iwi* health providers may be funded directly by Central Government, rather than the District Health Board (Emery 1999) did not materialise either.

Over the years and through the reforms, access to funding has generally been reaffirmed on a yearly basis. Historically, all contracts have been funded on a 12 month basis. This is documented in Table 10. The HFA was the first to break the cycle and renew Te Runanga O Raukawa's contracts on a three year basis in July 1999. Most recently, the DHB reversed this by returning to 12 month contracts. While it is understandable that a new funding agency may require some time to develop its processes, train its staff and review historical procedures in light of new policy requirements, providers have to shoulder some costs associated with these changes.

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. The goal is to create a mechanism that will bring together general practice clinics and providers under a coordinating community-based authority, in order to ensure the planning and delivery of comprehensive primary health care services. Te Runanga O Raukawa, 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.

Table 10, Access to Funding through the Reforms

Era	Date of Meeting	Issue
AHB	01-Jul-92	<ul style="list-style-type: none"> Māori Health Workers contract signed for 12 months.
RHA	01-Jul-93	<ul style="list-style-type: none"> 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. 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	<ul style="list-style-type: none"> Māori Health Workers contract signed, with an ending date of June 30, 1994.
	01-Jul-94	<ul style="list-style-type: none"> Māori Health Workers extended for a year. Whanau Ora contract still being negotiated.
	06-Sep-94	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Whanau Ora contract signed, with end date of June 30 1995.
	11-Oct-94	<ul style="list-style-type: none"> Note that contracts do not allow for more than a 5% margin for contingency (including capital expenditures).
	01-Jul-95	<ul style="list-style-type: none"> Whanau Ora and Māori Health Workers contracts rolled over for 12 months. Mental Health contract signed. Timeline not minuted.
	01-Jul-96	<ul style="list-style-type: none"> Contracts rolled over to August 31, 1996, because of delays in the renewal process. They are eventually renewed for 12 months. Contract for disability support services signed. 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	<ul style="list-style-type: none"> 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. Other contracts renewed for one year. Mental Health contract downgraded by the HFA, who no longer sees the need 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
15-Jun-99		<ul style="list-style-type: none"> Te Runanga O Raukawa requests that contracts be renewed for 2 years.
13-Jul-99		<ul style="list-style-type: none"> All contracts renewed for 3 years, i.e. until June 30, 2002.
01-Jul-00		<ul style="list-style-type: none"> New Mobile Nursing contract signed for 2 years.
	18-Sep-00	<ul style="list-style-type: none"> Letter sent to the HFA to request meeting to discuss price increase.
DHB	12-Jun-01	<ul style="list-style-type: none"> Auaki Kore (smoking) contract signed for three years.
	16-Sep-02	<ul style="list-style-type: none"> All contracts are renewed for 12 months.

Depending on the direction taken in the development of the Primary Health Organisations (PHO) in the region, Te Runanga O Raukawa Inc. may see its funding coming from yet another authority, this time a PHO of which it may be a stakeholder. It is yet unclear whether the organisation will continue to exist as an independent provider.

In summary, Te Runanga O Raukawa's original and continued vision has been challenged by and subjected to national health care reforms. The organisation has shouldered the costs of these reforms in three main areas.

- The continuous process of reform has limited the opportunity for the development of a close funder-provider relationship that would facilitate the development of contracts better reflecting kaupapa Māori.
- The changes in staff at the funder level has been associated with increased administrative costs for the provider, in tasks such as contract negotiations, billing and relationship building.
- It has created a climate of insecurity, especially in regard to access to funding. This insecurity favours staff turnover, and leads to increased costs associated with contract negotiations.

The Current Situation

Te Runanga O Raukawa is a complex, modern organisation that delivers services in the areas of health, social services, education, employment readiness, economic development and justice. It employs 66 employees, and is the largest Māori provider in the region. The following sections provide an overview of the organisation's involvement as a health care provider.

a. Governance

Te Runanga O Raukawa became incorporated as a Non-Profit Society under the Societies Act 1908, on the 9th February 1988. Te Runanga O Raukawa's founding members were Māori organisations located in the region, including,

- Raukawa Trustees (Ngati Raukawa, Te Ati Awa Ki Whakarongotai and Ngati Toa Rangatira);
- Raukawa District Māori Council;
- Otaki/Porirua Trusts Board;
- Otaki Māori Racing Club;
- Te Wananga O Raukawa; and
- Rangiatea Vestry.

As mentioned above, the governance structure was changed in 1991 to better reflect the wishes of the 23 hapu in the region.

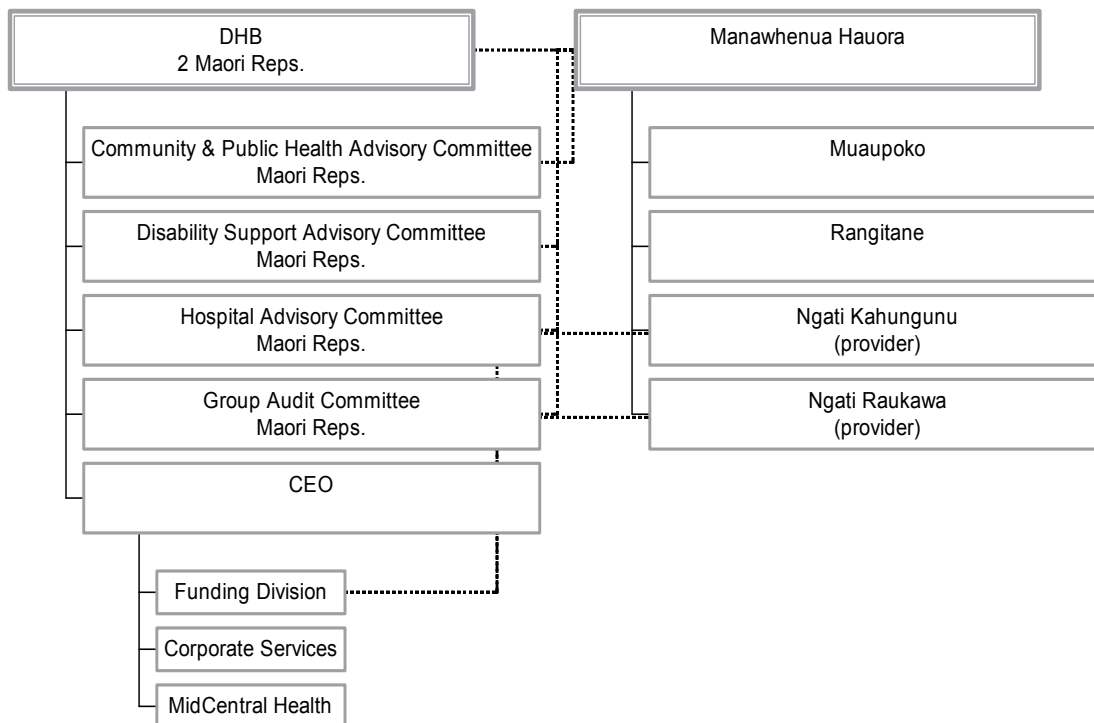
The overall organisation is governed by Te Runanga Whaiti, composed of the Tumuaki of the Runanga, and one person elected by each hapu. Members may hold office for a maximum of three years. The organisation's bylaws provide for a kaumatua, whether kuia or koroua, to be present at each meeting, to provide guidance (Te Runanga O Raukawa Inc. 1991). 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 in strategic decisions related to health. The Health Reference Committee meets monthly.

Te Runanga O Raukawa is a member of Manawhenua Hauora, a pan-iwi consortium made up of Muaupoko, Rangitane, Ngati Kahungunu and Ngati Raukawa representatives. The purpose of this organisation is to ensure multi-level Māori representation within the MidCentral District Health Board. A Memorandum of Understanding has been signed with the District Health Board (April 2001) to reflect a Treaty partnership.

Te Runanga O Raukawa's Sphere of Influence



The organisation is currently reviewing its legal status in view of future development needs, and exploring the potential that would be afforded by incorporating as a non-profit corporation.

...A more corporatised focus... allows us a more adventuresome, a more aggressive, more entrepreneurial approach on how we will do business... So taking a more entrepreneurial, more advanced, proactive enhancing approach to a lot of stuff. You know at the moment we're sitting and reacting to and providing

service, whereas I'm thinking we can step out of that. A new paradigm and step onto this one. And say right we now have the ability to control our destiny better and this is what we really want to do and our development is along these lines and we don't actually give a toss what anybody else thinks. Another tribe may say that's not good but Ngati Raukawa is very clear in their minds where they want to see how their nation looks like in 50 years from now, 100 years from now (Dennis Emery, CEO, Personal Communications, 2002).

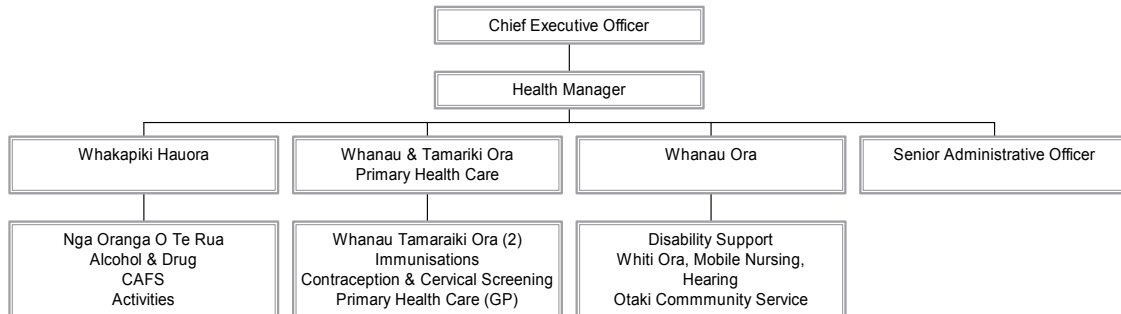
b. Service Organisation

The organisation delivers health services in the areas of,

- Whanau Tamariki Ora Well Child and Support Service
- Disability Support Service
- Nga Oranga O Te Rae Mental Health Support Service
- Alcohol and Drug Support Service
- Child Adolescent and Family Support Service
- Mental Health
- Contraception Service
- Whiti Ora Smoking Cessation Programme
- Hearing Assessment Service
- Mobile Nursing Service (known as the Disease State Management contract).



As shown by the map, right, the Ngati Raukawa Tribal rohe (dark grey) lies largely within the MidCentral District Health Board boundaries (lighter grey). This simplifies the contractual environment and service delivery greatly.



The Health Programme's organisational chart closely resembles the contractual breakdown in services. While the organisation may be able to reflect kaupapa Māori at

the delivery level, the contractual fragmentation restricts or simply precludes the organisation from being able to organise itself in a way other than that prescribed via contracts. It also precludes the implementation of an integrated approach to service delivery as originally envisioned.

Most contracts require the delivery of services to a narrowly defined population. This is documented in Table 11. In a way, this leaves the organisation in a bind, in that it is funded for a particular set of activities, but remains accountable to all of Ngati Raukawa and its affiliated hapu and iwi.

Contract	Volume and specifications	Rangitikei	Horowhenua	Manawatu	Kapiti	Town specific
Free contraception	Māori and Pacific Islander women under 25 years of age		x			
Support services for mothers and their pepe	79 women	x	x	x	x	
Tamariki support/well child	300 tamariki	x	x	x	x	All between Bulls and Otaki
Tamariki support/well child	0 to 5 years old, 300 tamariki	x	x	x	x	
Tamariki ora/facilitation	0 to 5 years old, 150 tamariki/whanau	x	x	x		
Tamariki Ora/whanau/family support services	0 to 5 years old, 150 tamariki/whanau	x	x	x		
Additional Tamariki ora/well child services	75 tamariki		x			Feilding, Bulls
Māori Primary Health	Comprehensive primary health and dental care service development		x			And surrounding areas
Māori mobile nursing disease state management services	120 clients	x	x	x		
Māori disability support	Māori with disabilities, 0 to 65 years +, no volume or boundaries specified.					
Kaupapa Māori Mental health	None specified					

It is not surprising that this issue gets renegotiated at the delivery level.

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 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 (Aroha Ellwood, Personal Communication, December 2002).

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 (Mason Durie, Personal Communication, 2002).

The organisation is exploring alternatives in contracting to facilitate the development of a more integrated approach to health and other services.

c. Finance

As shown in Table 12, Te Runanga O Raukawa was administrating 15 contracts in the 2001-02 year. The Māori Provider Development Scheme contract 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, making up nearly 80 percent of its health funding. As previously mentioned, access to funding has not only been stable, but also constantly grown.

According to the Ministry of Health's 2001 profile of the organisation, (New Zealand Ministry of Health 2001b), Te Runanga O Raukawa is recognised as a Preferred Provider in the areas of health and social services, education, employment, cultural services, and justice. 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.

As an organisation, Te Runanga O Raukawa 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.⁵³ The second is for the development of a primary health care service. All other contracts are for service delivery only. New service contracts generally provide for an upfront payment termed an establishment fee that allows the organisation to accommodate up front expenditures. This establishment fee is on cost recovery basis.

Second, although increased contracts usually mean new 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.

An exception to this rule is the primary health care development contract that includes capital expenditure for renovation, but conversely provides limited opportunity for service development. Given the

Table 12: Raukawa Hauora, Percentage allocation of funding per category, sample year 2001-02⁵⁴

Category	Definition	Number of contracts	Example	%of budget
Core	Recurrent operational funding that is not tied to specific programs	0	This type of funding is not available	0%
Strategies Recurrent Funded 100%	Relatively stable funding sources tied to specific initiatives	11	Mobile Māori Nursing Disease State Management Service	79.59%
Strategies Recurrent, Requiring Employer Financial Contribution	Relatively stable funding source tied to specific initiatives and requiring a sizeable organisation contribution (partial funding)	0	None found	0%
Multiyearch projects	Funding for multiyearch innovative project	2	Aukati Kaipapa, tobacco control	9.57%
One of	Single year or shorter term project	2	Comprehensive primary care service	10.84%
		15		100.00%

⁵³ 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 access.

⁵⁴ 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.

historical practice of renewing contracts on a yearly basis, Te Runanga O Raukawa has had to shoulder all risks associated with capital expansion, with little 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, and some include a fee-for-service component.⁵⁵ Furthermore, each contract specifies provisions for monthly billing on a cost recovery basis. Contracts secured in the early 1990s were generally paid quarterly. It is under the Health Funding Authority that a monthly cost-recovery payment mentality was entrenched in the non-profit sector. The logic of requiring non-profit organisations to expend resources they are precluded from securing in order to pay for services and salaries, is at the least obscure and definitely not the norm compared with other countries. It is noteworthy that the New Zealand Treasury Guidelines for contracting with non-government organisations for services sought by the Crown make no such requirement, but rather acknowledge the high cost of short term, multiple contracts and multiple invoicing (New Zealand Treasury 2001). As the system stands, Te Runanga O Raukawa must, monthly, send 14 invoices 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). Required reports are 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. From the outside, the system appears cumbersome, inefficient, and unlikely to ensure a level of accountability commensurate with the costs it carries for both the funder and the provider.

The stated objectives of the Crown to favour Māori provider development and to promote Māori models of health (New Zealand Ministry of Health 2001a) are poorly reflected in the contractual environment currently in place. Senior staff report some success in negotiating fairer output for given contracts, but limited influence in creating a contractual environment that better reflects the organisation's vision.

d. Reporting, Accountability and Dispute Resolution

Each contract includes specific reporting requirements, namely,

- Quarterly activity reporting,
- Bi-annual narrative report, addressing eligibility criteria for the program, and
- Annual financial reports.

⁵⁵ The fee-for-service provision is in many ways theoretical, since it is associated with maximum volume that tends to underestimate needs. The organisation sees the volume provision as a target for service delivery, and delivers services to that level and beyond.

As discussed before, each contract targets 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 can contribute useful information on health outcomes. Indeed, the high level of fragmentation in the contractual environment makes it difficult to establish whether this provider's, or any other provider's, interventions produce better outcomes. Conversely, the funder cannot have its funding strategy evaluated in light of its obligation to produce better outcomes.

All contracts make a provision for audit requirements (articles A12 to A14), 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.

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 (B28) is present in all contracts, with the exception of the Māori Provider Development Scheme contract. The purpose of a dispute resolution provision is to ensure that a low cost recourse is available, to the funder and the provider, in case of dispute. This represents a measure of **reciprocal accountability** that is more meaningful for the provider.⁵⁶ 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 Te Runanga O Raukawa as it may be to the District Health Board.

The contracts reflect an attempt at integrating a Treaty of Waitangi partnership in the funder-provider relationship. Although the Treaty provision (B2, above) acknowledges the “unique and special relationship between iwi, Māori and the Crown”, contract provisions related to Māori focus on the individual participation, on the health needs of Māori, and the need for the provider to be mindful of these needs in service delivery. The contracts themselves, by virtue of being fragmented, requiring service delivery to a fragmented population, and by virtue of being narrowly defined, cannot reflect Māori models of health, as required by the Crown.

⁵⁶ The funder can defund a non-compliant provider. The funder can also more readily afford litigation. In contrast, the provider has limited recourse, other than a low cost dispute resolution mechanism..

Treaty Provisions

B2.1 The Treaty of Waitangi establishes the unique and special relationship between iwi, Māori and the Crown. As a Crown agency the Health Funding Authority considers the Treaty of Waitangi principles of partnership, proactive protection of Māori health interests, co-operation and utmost good faith, to be implicit conditions of the nature in which the internal organisation of the Health Funding Authority responds to Māori health issues.

B2.2 Equally the Health Funding Authority shall require that these principles shall be explicitly expressed in contracts between the Health Funding Authority and contracted service providers. Therefore all contracted providers, whose clientele may include Māori, shall demonstrate how the policies and practices of their provider organisation and service delivery shall benefit that Māori clientele.

B4 Māori Health Priority

Both of us will abide by the Māori Health Statement set out in clause B2 of these Standard Conditions.

B4.1 You agree that Māori Health is a specifically identified health gain priority area. You must therefore establish and implement a Māori Health Policy that reflects that fact. In developing this policy, and without limitation, you must take into account our 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 us.

B4.2 You must specify how you intend to implement this policy. In particular, you will identify those services you will deliver as explicit contributions to Māori health gain priorities, how these services will be measured as to ascertain what benefit is evident and other additional opportunities that may exist for furthering Māori health gain.

B4.3 On commencement of the Agreement, you must develop your Māori health policy and operational plans after consultation with us, subject to agreement between both of us as to our respective responsibilities for ensuring that the plans are adequately resourced within the current levels of funding.

Reflections

In many ways, the contractual environment that emerged as a result of a New Zealand shift toward competition in the early 1990's has created opportunities for Māori participation in service delivery. Te Runanga O Raukawa has thrived on these opportunities. But the opportunities offered have continually fallen short of facilitating the implementation of a kaupapa Māori approach to health. The initial vision of the organisation, to funnel all government funding through a single contact facilitating the breakdown on jurisdictional barriers and western categorisation in service delivery, has been reshaped by the contractual environment. The organisation is now delivering services defined narrowly by highly defined 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 Te Runanga O Raukawa's opportunity to implement its vision.

The Crown has repeated its commitment to,

- 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 Ministry of Health 2001a).

These values are barely reflected in the current contractual environment. Contracts continue to be designed as patches to the current health system delivery, serving more readily the current ideology of equity that permeates western medicine, rather than a Treaty partnership. The organisation remains vulnerable to shifts in political ideology and health care reforms. A Treaty partnership is much less apparent.

Appendix 5, Te Roopu Huihuinga Hauora Inc.

Te Roopu Huihuinga Hauora Incorporated (hereafter TRHHI) is a Māori organisation based in Whataku, near Hastings. It



**TE ROOPU HUIHUINGA
HAUORA INC.**

coordinates contracts and health provider services in the Hawke's Bay region. The organisation was incorporated in May 1997. TRHHI's mission is,

To improve the funding and delivery of services to Māori, with responsibilities for achieving specified Māori health gain priorities, coordinating service delivery, and working with both Māori and mainstream providers to build their capacity to deliver comprehensive and responsive services to Māori. The services will be:

- Community based*
- Consumer and whanau focused*
- Affordable*
- Appropriate*
- Quality driven*
- Relevant and timely*
- Coordinated and integrated*
- Provide positive and demonstrable outcomes (Te Roopu Huihuinga Hauora Incorporated 2003).*

In its role as a Māori Development Organisation, TRHHI provides support services to 9 independent Māori health provider member organisations. The objects of the organisation are,

- i) To assist and support the establishment of their provider members by first offering health and disability support services to its provider members, and to contract with other providers to support the furtherance of its objects as specified in clause 4.1; and*
- ii) To purchase and provide an integrated continuum of services through a kaupapa Māori approach to health to people living in the region through the pursuit of the following objects ("kaupapa");*
 - a. To increase the level of accessible health and disability support services for people living within the region.*
 - b. To recognise the disparity of health status amongst Māori as compared to non-Māori and implement positive strategies to address these issues, working to attain optimal health status for all people in Ngati Kahungunu, Rangitane and Rongomaiwahine region.*
 - c. To ensure that the community is involved in the development and pursuit of our objects.*
 - d. To provide a forum for the discussion of issues affecting Māori health in the rohe.*

- e. *To provide an information brokerage service to provider members.*
- f. *To provide culturally appropriate services through a network of providers.*
- g. *To work alongside other Māori and non-Māori providers in a co-operative way for the benefit of people.*
- h. *To encourage wellness, promotion and education as an alternative to medical models of health.*
- i. *To encourage vertical integration for the Māori integrated care organisation and eventually move to horizontal integration throughout Aotearoa and overseas; and*
- iii) *To support or oppose bills, legislation or other measures, policies, ordinances, regulations or by-laws affecting the interests of the Society and Māori health and well-being; and*
- iv) *To make representations or otherwise bring to the notice of government or any other constituted authority such matters as required by the members, through the Board members, which require attention or alteration; and*
- v) *To evaluate and monitor the provision of health services in the Ngati Kahungunu, Rongowaiwahine and Rangitane rohe; and*
- vi) *To facilitate research and training for affiliated members (Te Roopu Huihuinga Hauora Incorporated 2001a).*

The organisation's philosophy is guided by the Māori *tikanga* (principles) of

- *Wairua*, spirit or spirituality: A recognition that the Māori view of spirituality is inextricably related to the wellbeing of the Māori consumer;
- *Aroha*, compassionate love: the unconditional acceptance which is the heart of care and support;
- *Turangawaewae*, a place to stand: The place the person calls home, where their origins are. Must be identified for all Māori consumers;
- *Whanaungatanga*, the extended family: Which takes responsibility for its members and must be informed of where its member is;
- *Tapu/Noa*, sacred/profane: The recognition of the cultural means of social control in *tapu* and *noa* including its implications for practices in working with Māori consumers;
- *Mana*, authority, standing: Services must recognise the mana of Māori consumers;
- *Manaaki*, to care for and show respect to: Services show respect for Māori values, traditions and aspirations
- *Kawa*, protocol of the marae, land, iwi: Determines how things are done in various circumstances.

TRHHI's philosophy statement reflects the current Crown interpretation of the Tiriti O Waitangi framework, that includes participation, partnership and protection (Te Roopu Huihuinga Hauora Incorporated 2003).

The organisation covers a wide region reflecting the Ngati Kahungunu rohe. As in all regions of New Zealand, the Māori population is growing much faster than other populations (Table 13). In regions characterised by out-migrations (Wairoa for example), Māori migrations occur at a lower pace. Ngati Kahungunu is the largest and fastest growing *iwi* in the country, with 51,552 members claiming *whakapapa* back to the tribe (Statistics New Zealand 2002a).

	Māori			Total Population		
	1991	2001	% Increase	1991	2001	% Increase
Wairoa	5,253	4,950	-5.77%	10,128	8,913	-12.00%
Hastings	13,638	15,576	14.21%	64,029	67,428	5.31%
Napier	7,317	9,306	27.18%	51,288	53,661	4.63%
Central Hawke's Bay	2,301	2,769	20.34%	12,828	12,825	-0.02%
Total	28,509	32,601	14.35%	138,273	142,827	3.29%

THHRI crosses administrative and district health board boundaries, compounding governance and administrative complexity.

The Emergence of Te Roopu Huihuinga Hauora Inc.

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 interests 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. TRHHI's plan was to secure funding as a Māori Integrated Health Organisation (MICO). By October, the Board was advised that its MICO proposal would not be funded. Instead, the organisation was offered funding under the Māori Health Organisation model (November).

As shown in Table 14, TRHHI's beginnings overlapped with a succession of health care reforms. This has meant a shift in government priorities, funding authority and funding officers. The following section presents a synopsis of these developments.

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

a. Māori Provider Development and the Reforms

Māori providers are a recent occurrence in the New Zealand health care system. The vast majority are less than a decade old. The Regional Health Authorities (RHAs) were created to implement a shift in New Zealand health care, which involved the separation of purchasing and providing functions (Upton 1991). Health care purchasing was delegated by the Ministry of Health to four Regional Health Authorities, tasked to purchase health services from independent providers. This approach was expected to improve cost-effectiveness through competition.

The RHAs were instructed to follow the recommendations of the joint Department of Health and Te Puni Kokiri policy document *Whaia te ora mo te iwi*,⁵⁷ promoting the purchase of health services by Māori for Māori, and the adoption of a developmental approach to Māori providers (New Zealand Ministry of Health & New Zealand Te Puni Kokiri 1993). The policy guidelines 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 (New Zealand Transitional Health Authority Māori 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 Māori Health Groups 1997).

⁵⁷ Strive For The Good Health Of The People.

- 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 on how Māori themselves preferred to see the direction of Māori provider development (New Zealand Transitional Health Authority Māori Health Groups 1997).
- The Southern Regional Authority promoted a “community-driven” approach, where Māori played an advisory role in the overall purchase of health and disability services (New Zealand Transitional Health Authority Māori Health Groups 1997).

Both the Central and Midland Regional Health Authorities endorsed a more aggressive approach to contracting to encourage competition, thus favouring the multiplication of small providers (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.

- Co-ordinated care was introduced in 1995 to describe the MAPO, population-based approaches and initiatives that overlapped 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 funded as fund holders and tasked to provide a defined range of services for a defined population. Māori joint-venture Boards were encouraged to develop new structure 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).

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 four Regional Health Authorities. The move was an attempt by the Minister to shift the focus from regionalized and competitive development to the implementation of national standards in purpose, contracting and pricing (Gauld 2001). In terms of Māori development, 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 developed by the Midland Regional Health Authority (New Zealand Transitional Health Authority Māori Health Groups 1997). This second commitment was, however, short-lived.

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 (Te Roopu Huihuinga Hauora Incorporated 2000).

The Māori Development Organisation model reflected a new commitment to fund developmental organisations to assist existing Māori providers.

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 (Bob Henare, TRHHI Board Member, Personal Communication).

From the onset, no matter what the funding model was to be, TRHHI's mandate was to support existing Māori providers who faced challenges associated with limited funding and low capacity in administration (Te Roopu Huihuinga Hauora Incorporated 1998). This commitment by the Board may have limited the organisation's opportunities for development. While it is understood that the organisation did not want to compete for contracts with its member-providers, regional positions and roles could be appropriately housed at TRHHI (dietitian, podiatrist, environmental health, etc.), and support local provider's practice. This has not been pursued.

b. The Māori Development Organisation Model

The MDO model's focus was two prongs:

- 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 (see Table 15). The HFA initially defined 8 such priorities. This has now been extended to 13 (New Zealand Health Funding Authority 2000).

It is clear that the MDOs were expected to target nationally identified priorities, as opposed to locally identified needs. The approach to priority setting had shifted from local to national.

The initial intent was that MDOs would be funded on a capitation basis for a registered population. This has not occurred. The main reason can be linked to Rob Cooper, the General Manager for Māori Services in 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 contracts 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 related to their tribal populations and tribal districts. And this provided them with quite some flexibility really in the application of the funding (Rob Cooper, Personal Communication, 2003).

If funded on a capitation basis, MDOs may have been able to implement services in all or at least many priority areas (New Zealand Health Funding Authority 2000). Since this was never implemented, the focus of the contract eventually shifted to

provider support and coordination (New Zealand Ministry of Health 2001c). Funding to address Māori health priorities was to be secured through separate contracts.

What is clear is that the MDO model, as described in the MDO contract, reflected tendencies in stream-lining the health care system. 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 and managed care, and promoting Māori provider participation in all aspects of Māori health services delivery for which the provider could secure funding for.

Initially, only a few large Māori providers were funded through the MDO model. Discussions began early on the need to form a national MDO association to represent

Table 15, Service Priority Area for the MDO (New Zealand Health Funding Authority 2000)	
HFA Māori Health Gain Priority Areas	NZHS Population Health Objectives
Immunization	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
Injury prevention	Reduce violence in interpersonal relationships, families, schools and communities
	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
Hearing	Reduce the incidence and impact of cancer
	Reduce the incidence and impact of cardiovascular disease
	Improve nutrition
Asthma	

common interests. Te Matarau Ltd was registered under the 1993 Companies Act in January 2001. It is a national organisation representing the interests of the six Māori Development Organisations, Te Roopu Huihuinga Hauora, Tui Ora Ltd, Taumata Hauora Trust, Ngati Porou Hauora, Poumanawa Oranga and Poutiri Trust. Collectively, the MDOs mentioned above represent seventy-two Māori health providers, serving twenty-four percent of the national Māori population (Te Matarau Inc. 2002). Te Matarau Inc. is in its early stage of development. However, as the only national Māori health provider representative, it may be key in advancing the interests of Māori providers.

c. The Latest Reform

The HFA replaced the THA early 1998. The end of the HFA was announced in December 1998. With it came the end of centralized 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). Perhaps to facilitate the rapid deployment of the required infrastructure, each Health Board is attached to a hospital that was formally administered by a Board of Directors. That mechanism has now been reoriented and tasked with primary, secondary and tertiary health care planning. In addition, the Primary Health Care Strategy requires the formation of Primary Health Organisations (New Zealand Ministry of Health 2001d), tasked with rationalizing the primary health care sector, currently divided into a myriad of Māori, mainstream and general practitioner providers offering services in a fragmented manner.

The Primary Health Care strategy has specifically defined a role for 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 is 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 it to Māori organisations and Independent Practitioner Associations to sort out ownership and governance issues. Discussions are on-going.

In summary, TRHHI has been at the centre of the New Zealand health care reforms since it came into being. Every change in policy has been felt. Further, the speed and magnitude of each reform has tended to absorb a great deal of capacity at the funder and purchaser levels, leaving the implementation of the MDO model unfinished. The most recent reform builds on this history, adding cross-jurisdictional challenges to the mix.

The Current Situation

Te Roopu Huihuinga Hauora Inc. has managed to establish itself, in some ways as a result, and in some ways in spite of, the continuous climate of health care reforms. The organisation now employs four full time employees, and provides support to nine providers that collectively deliver services to 11,551 clients. While not all providers

disclose the percentage of Māori amongst their clientele, those who do (7 out of 9) report that between 77 and 97 percent of their clientele is Māori. The following sections provide an overview of the organisation as it exists and operates today.

a. Governance

Te Roopu Huihuinga Hauora Inc. is an iwi-based organisation. Its 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. The Board of Directors meets monthly.

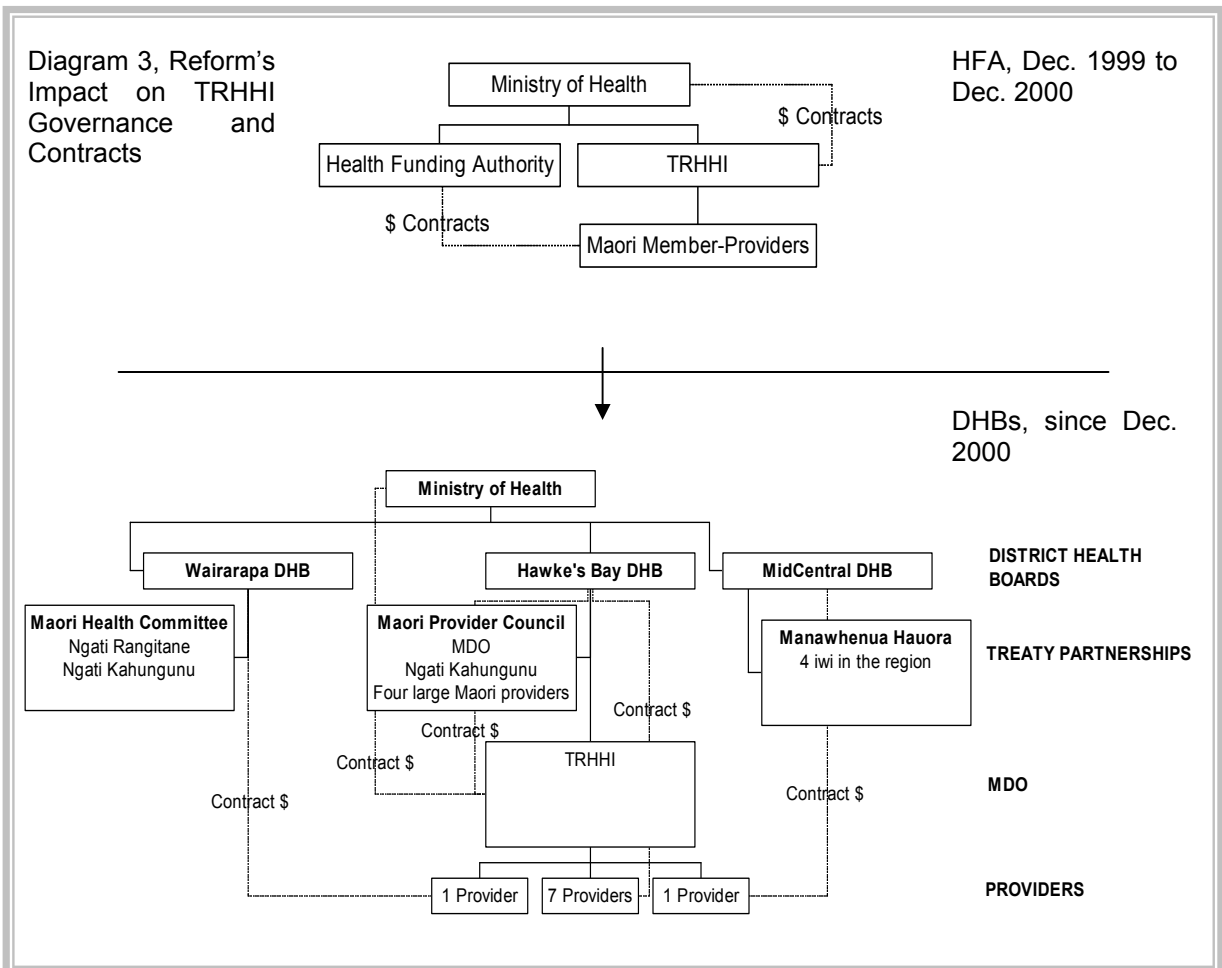
Name	Location	In operation since	Number of clients
Kahungunu Health Services “Choices”	Hastings	1995	4500 registered clients, of which a majority is Māori.
Mangaroa Marae Health	Hastings	1997	533 registered clients, 522 are Māori.
Nga Kaitiaki O Waikaremoana	Tuai	1996	469 registered clients, 362 are 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.

At the time of incorporation, the Board of Directors was formed exclusively by member-provider representatives. The organisation had 16 members, three of these being 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, allowing for the nomination of three non-provider Board members to be supported by two representatives from member-providers. 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. Table 16, above, shows the current membership.

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 Māori Health Groups 1997). This was a departure from the former MidCentral Regional Health Authority, which promoted a community development approach.

TRHHI maintains positive on-going discussions with Ngati Kahungunu, but its governance has always been and remains independent from tribal governance. As a result of the recent reform, the DHBs have been instructed to develop Treaty-based partnerships with *iwi* and Māori communities (New Zealand Ministry of Health 2001a). This requirement, while legitimate, has added complexity to the MDO-*iwi* relationship, as shown in Diagram 3I. The Hawke's Bay District Health Board has entered into a Memorandum of Understanding with Ngati Kahungunu, 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 (Bob Henare, Personal Communication, 2003).

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. The Treaty-based relationship with Ngati Kahungunu, and Ngati Kahungunu arm length relationship with TRHHI, however, appears to have created some confusion at the Hawke's Bay District Health Board. 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 a pan-iwi organisation, Manawhenua Hauora, representing the four *iwi* located in the region. TRHHI has representation on 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 is somewhat tense. This is explored below.

b. Service Organisation

TRHHI is a rather small organisation, with only four full time staff:

- a Chief Executive Officer who oversees the organisation's operations, assists with negotiations and participates in the development of strategic partnership with other organisations;
- a Business and Finance Manager who manages the contractual environment between the DHB, the organisation and the providers, and assists providers in developing sound policies and processes;
- a Clinical Services Manager who oversees and supports all clinical aspects of contract implementation in partnership with providers; and
- an Office Manager who coordinates communications with member-providers.

TRHHI's Constitution allows for both a purchaser and a provider role. TRHHI's primary focus is that of supporting its member-provider's development. TRHHI completed a 2001-2004 health strategic plan in September 2001, prioritising ten strategic goals:

1. To promote, assist and support Māori enrolment;
3. To continue to provide and build capacity of contract management to its members;
4. To promote and support the recognition and adequate resourcing of Māori Rongoa;
5. To increase the Māori Health workforce in Hawke's Bay, Wairoa;
6. To examine the feasibility of establishing a Primary Health Organisation;
7. To promote and maintain effective partnerships with all key stakeholders that provide services to Māori;
8. To build Māori Primary Health service capacity;
9. To advocate and build capacity of whanau development in the health sector;
10. To develop a Māori Development Organisation of Excellence; and
11. To develop and implement a Public Relations and Marketing Strategy (Te Roopu Huihuinga Hauora Incorporated 2001b).

TRHHI's current focus on capacity development is being pursued in three separate ways. The first one is through the implementation of **Te Ara Kairangi Performance Monitoring Programme**. This programme was developed by TRHHI. Te Ara Kairangi (The Path to Excellence) objectives are:

- To provide the service with a comprehensive and detailed assessment of its operation as a whole, and make recommendations for better attainment of quality standards.
- To stimulate and guide a range of quality improvements and evaluation activities.
- To enhance accountabilities to customers, funders and communities.
- To identify capacity and capability gaps within the service and develop strategies to fill them.
- To elicit from key staff a range of views and perceptions concerning its operation.
And
- To encourage a culture of continuous quality improvement.

The programme is run by both the Business and Clinical Managers. The first comprehensive process took place from April to November 2002, involving a review of the member organisations in areas shown in Table 17, the drafting of a report, sharing the report with the provider, and providing support to the provider in areas that require development. TRHHI is now summarising its findings and developing a skill development and training strategy to further assist its providers.

Governance & Leadership	<ul style="list-style-type: none"> • Governing Body • Accountability to stakeholders • Leadership
Business & Administration	<ul style="list-style-type: none"> • Human resource • Finance, administration and IT • Planning • Kaupapa Māori • Work environment
Clinical Practice	<ul style="list-style-type: none"> • Clinical practice & safety • Services & programmes

A second approach has been the undertaking of a **child health and community health workers workforce development** service project (contract 227938/00), coordinating training opportunities in the areas of asthma education, whakarongo mai (hearing), hearing awareness, families in crisis, tamariki ora (well child), kaiawhina, first aid, CPR instructor training, and evaluation and planning, among others (S.H.E.(Shingleton Health Expertise) 2001). This project has led to another plan, this time for the establishment of a Māori Health Wananga in the Hawke’s Bay region. TRHHI has submitted a proposal to TPK (December 2002), and is awaiting a response. The Wananga will build on Rongoa Māori guiding principles, values, beliefs, faith, practices, science and spiritual healing.

A Wananga provides the best practical solution to the Māori health workforce dilemma as there is a lot of health research and anecdotal evidence to suggest that a Māori-led solution of establishing a “Kaupapa Māori Health Wananga” will result in higher numbers of Māori seeking to enter the Māori health workforce (Te Roopu Huihuinga Hauora Incorporated 2002a).

Finally, a **Kaupapa Māori Best Practice Standard Manual** is currently being developed. Two consultants have been contracted to help with this work, one focusing on the clinical guidelines, and the other on community health guidelines. A process has now been defined to elicit practices utilized from Māori providers. This will then be used to generate “best practices.”

TRHHI is working towards the development of General Practitioner services in its Whakatu facility. A proposal was submitted to the Hawke’s Bay District Health Board to secure funding under Section 88 of the New Zealand Public Health and Disability Act 2000 (Te Roopu Huihuinga Hauora Incorporated 2002b). This is an important development for TRHHI, first because it is believed that Māori are currently underserved by General Practitioners, and second, because it is strategically an important development in light of the PHO implementation process. Although an official response has yet to be received, it appears that the proposal was not received favourably by the

Hawke's Bay District Health Board (Joe Puketapu, Chief Executive Officer, Personal communication, 2003). The reasons are unclear.

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 DHB 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 limiting of 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 (Bob Henare, Board Member, TRHHI, Personal Communication).

As of April 2003, the organisations' membership has been increased to twelve providers.

c. Finance

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.

The original vision for TRHHI was that it would be funded on a capitation basis, and would contract independent Māori providers to deliver services following national and regional priorities. Five years after it first began to receive funding, the organisation is not yet funded on a capitation basis, and has remained simply a channel for a few pre-determined contracts with narrowly defined targets and activities.

As shown in Table 18, 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.

As shown in Diagram I, 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, and all others from the Hawke's Bay District Health Board. As

Table 18, Te Roopu Huihuinga Inc., Percentage allocation of funding per category, sample year 2001-02

Category	Definition	Number of contracts	Example	%of budget
Core	Recurrent operational funding that is not tied to specific programs	1	Māori Development Organisation funding	29.90%
Strategies Recurrent Funded 100%	Relatively stable funding sources tied to specific initiatives	3	Mobile Māori Nursing Disease State Management Service	44.75%
Strategies Recurrent, Requiring Employer Financial Contribution	Relatively stable funding source tied to specific initiatives and requiring a sizeable organisation contribution (partial funding)	0	None found	0%
Multiyear projects	Funding for multiyear innovative project	2	Integrated Diabetes Management Scheme	12.95%
One of	Single year or shorter term project	2	Māori Provider Development Scheme	12.40%
		8		100.00%

mentioned above, this has complicated TRHHI's communications considerably.

TRHHI has developed an assignation policy that allows for the transfer of all DHB provider contracts to TRHHI. Once assigned, TRHHI will assume the responsibility for negotiating, signing, administrating these contracts, while subcontracting service delivery directly to its member-providers. This has 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.

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 (Thompson & Fakahau 2003).

As shown in Table 19, four member-providers have so far signed the assignment policy, three within the Hawke's Bay DHB boundaries, and one associated with the MidCentral DHB. These were signed in the winter of 2002. Although the Hawke's Bay DHB was initially supportive of this process, it has now halted its progress.

According to DHB staff, this followed a decision of TRHHI to remove the responsibility for contract delivery from the hands of one of its member-providers, Ngati Pahauwera Hauora, who was experiencing serious administrative difficulties. TRHHI opted to instead hire the provider staff directly to ensure continuity of care, while working with the provider to redress administrative weaknesses. The Hawke's Bay DHB interpreted TRHHI's risk management intervention in a different light, and advocated for a return of the contract funding to the provider. It is unclear why the Hawke's Bay District Health Board would opt to involve itself in TRHHI governance matters. It is further unclear why a risk management strategy has been interpreted as inappropriate, rather than being seen as good stewardship of public finances. But it is clear that this difference of understanding continues to overshadow the relationship between the Hawke's Bay DHB and TRHHI, and undermines TRHHI's access to funding.

It may be noteworthy that this dispute follows another dispute initiated by TRHHI, this time over the defunding by the MidCentral District Health Board of one of its providers, allegedly for non-performance. It is noteworthy that TRHHI's review of this provider (through its Te Ara Kairangi programme) found some areas of weakness but no major issues. Although the two disputes appear unrelated, as they involve two different District Health Boards, they in fact involve the same District Health Board manager, as a result of a job change.

d. Reporting, Accountability and Dispute Resolution

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.

Table 19, Te Roopu Huihuinga Membership and Contract Assignment as of January 2003 (Te Roopu Huihuinga Hauora Incorporated 2001b)

Name	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			TR 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
- W: Wairarapa District Health Board

- HB: Hawkes Bay District Health Board
- TR: Te Roopu Huihuinga Hauora Inc.

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 as 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.

All contracts make a provision for audit requirements (articles A12 to A14), 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. As mentioned above, 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 are not mentioned in the audit.

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 (B28) is present in all contracts, with the exception of the Māori Provider Development Scheme contract. The purpose of a dispute resolution provision is to ensure that a low cost recourse is available, to the funder and the provider, in case of dispute. This represents a measure of **reciprocal accountability** that is more meaningful for the provider.⁵⁸ 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 TRHHI as it is to the District Health Board.

⁵⁸ The funder can defund a non-compliant provider. The funder can also more readily afford litigation. In contrast, the provider has limited recourse, other than a low cost dispute resolution mechanism.

Reflections

Since its beginning, 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 that impede the development of a *kaupapa* Māori structure and approach to primary health care delivery.

The evidence collected suggests that the New Zealand contractual environment, as it developed in health, has created opportunities that have facilitated the emergence of Māori health providers. Many experiments were conducted during the RHA-THA-HFA era, including managed care, integrated care, coordinated care, and of course the MDO. Māori health capacity has developed considerably as a result.

However, TRHHI has shown considerable vulnerability to shifts in policy. The latest involved a fragmentation of boundaries that cut across Ngati Kahungunu rohe, multiplying players with whom to establish relationships, and administrative complexities. For reasons as yet unclear, TRHHI has been made to carry the full responsibility of the success of these relationships.

The New Zealand health care system has developed clear policies that acknowledge a Treaty partnership with Māori *iwi* and encourages Māori participation in planning and service delivery. It is, however, very clear that the system has only a weak commitment to existing Māori providers, at least in two of three District Health Boards. In a way, Māori providers may have remained interchangeable units, as they were in the previous competitive environment. At this time, it appears that TRHHI's opportunities for development are thwarted by divergences of opinion and approaches. The organisation's MDO funding may be threatened. The results of the audit alone would not justify this conclusion. This brings into question the District Health Board's commitment to stewardship and partnership, and to the maintenance of gains.

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