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Indigenous Health Policy in Australia, New Zealand, and Canada

A Comparative Overview

Presented by: E.J. Allard-Côté, S. Bradford, L. Durocher | December 2 & 6, 2016

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ABSTRACT

Description

This presentation provides an overview of the complex relations of Indigenous communities to their national health systems, through a comparative study of the New Zealand, Australian, and Canadian cases. Examining the laws, programming, and practices across these countries, this survey identifies remaining challenges and possible courses of action undertaken in each country, with a particular consideration for the respective Indigenous health frameworks.

While the contexts vary, all three countries face similar health disparities between Indigenous and non-Indigenous populations. The most promising paths to equity combine elements from the social determinants of health and Indigenous perspectives on well-being, as well as incorporation of Indigenous voices into the decision-making process.

Presenters

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Outline

- 1. Introduction**
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- 2. Main Findings**
 - a. Demographic Information
 - b. Health Statistics
 - c. Health Frameworks
 - d. Legislative Frameworks
 - e. Overview of Health Care Systems
 - f. Promising Initiatives in Indigenous Health
- 3. Conclusions**

INTRODUCTION

The context

- Despite significant differences, Canada, Australia and New Zealand share a remarkable number of similarities, making them amenable to comparative analysis (Lavoie, 2004).
- The sharing of best practice methods, approaches and experiences between countries as well as work on the international level with organizations on Indigenous health issues are of great importance (Pulver *et al.*, 2010, p.12).
- Despite a number of global achievements that have improved population health, one key marker of the impact of inequities in health status globally, is the constancy of conspicuously poor health status of Indigenous populations [...], whether we look across the globe as a whole or within the wealthiest of nations (Pulver *et al.*, 2010, p.7).
- The phenomenal gains and advantages that development has thus far provided to Australia, Canada and Aotearoa New Zealand [...] have not achieved a *present* that embraces equity in Indigenous health determinants, access or outcomes within their own borders (Pulver *et al.*, 2010, p.7).
- An estimated seven million of these people live within the high income countries of [...] Canada, Aotearoa New Zealand and Australia (Pulver *et al.*, 2010, p.7).

- The health status and challenges faced today in striving *for recovery* emerge as a shared legacy of *unfinished business* (Pulver *et al.*, 2010, p.7).
- The Indigenous peoples from all [three] countries face administrative, physical, cultural and economic barriers to access mainstream health systems (Pulver *et al.*, 2010, p.30).

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<http://www.who.int/healthsystems/topics/financing/healthreport/IHNo33.pdf>

Methodology

- **Environmental Scan of Public Sources**
 - Government websites and reports, national censuses (AUS, CAN, NZ)
 - Intergovernmental organizations' websites and reports
 - NGOs' websites and reports
 - Scholarly articles
 - Guest speakers' presentations & course material
- **Scope of research:** 2004-2016
- **Non-Exhaustive** : ~200 person-hours of research
- Consideration of **availability** and **accessibility** of information

METHODOLOGY

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- **Scope of research:** 2004-2016
- **Non-Exhaustive** : ~200 person-hours of research
- Special consideration given to **availability** of and **accessibility** to recent statistics, reports, and accurate general information as indicators of overall awareness of government regarding Indigenous affairs and of their level of priority in the national agenda.

Demographic Information (2001-2015)

- Lower Disparity
- Moderate Disparity
- Higher Disparity

DEMOGRAPHIC INFORMATION	Australia	New Zealand	Canada
Indigenous Groups	Aboriginal: 90% of Indigenous pop. Torres Strait Islander: 6% Both: 4% (ABS, 2013)	Māori: Main group <i>Pacific Peoples in NZ:</i> 6.8% of total population (Census, 2013)	First Nations: 60% of Indigenous pop. Métis: 32% Inuit: 4% Other: 2% I+: 0.8% (Census, 2011)
Total Indigenous Population	669,900 (Self-identified) (ABS, 2013)	712,000 (Self-identified) (Est. June 2015)	1,400,685 (Self-identified) (Census, 2011) 936,225 (Registered) (AANDC, 2014)
% of Total Country Population	3% of total population (ABS, 2013)	15% of total population (2015)	Indigenous Identity: 4% of total pop. First Nations: 2.6% Métis: 1.4% Inuit: 0.2% (Census, 2011)
Urban/Rural	79% Non-remote areas (ARIA) 35% Major cities (ABS, 2014-2015)	84% Urban (Census, 2013)	Registered Indian: 45% On reserve - 42% Urban - 12% Rural Non-Status Indian: 75% Urban Métis: 71% Urban Inuit: 43% Urban (AANDC, 2011)
Median Age	21 years old (37 years old non-Indigenous) (ABS 2011)	24 years old (40 years old non-Māori) (2015)	First Nations: 26 years old Métis: 31 Inuit: 23 (41 yrs old non-Indigenous) (Census, 2011)
Fertility Rate	2.2 (1.8 overall) (ABS, 2014)	2.5 (1.9 non-Māori pop.) (2012-14)	2.6 (2001) (1.6 overall population) (Census, 2011)

DEMOGRAPHIC INFORMATION

It is worth mentioning that while some information was up-to-date and easily accessible, some other, mainly for Canada, was hard to find, outdated, or incomplete. This can be an issue for advocacy, research, policy and programming, especially for non-governmental organizations and associations that must often rely on publicly available data. This remark echoes in some way an observation made in a report on Indigenous health prepared by the World Health Organization in 2010, to the effect that “information on Government spending, health and social outcomes, infrastructure and health transfer are publicly available, but not easily collated due to multiple sites of collection and lack of coordinated reporting. Government indicators are macro-level and do not include relevant community level indicators for First Nations.” (Pulver *et al.*, 2010, p.47)

Slide 4 offers a brief summary of the main demographic characteristics of each Indigenous population, as well as of how they compare to the non-Indigenous population, when relevant.

Highlights

- In Australia, the Indigenous population is composed at **90% of Aboriginal people and at 6% of Torres Strait Islander people**, representing **3%** of the

- total population.
- In New Zealand, the context is quite different, with the **main Indigenous group, the Māori**, making up **15%** of the total population.
- The situation is more complex in Canada, as the Indigenous population is composed of **three main groups (First Nations, Inuit, Métis)**, and the **legal status is determined by a set of rules**, whereas in New Zealand and Australia, status is determined through self-identification. However, we observe that the proportion of Indigenous people in the Canadian population is around the same as in Australia, at **4%**.
- In the three countries, we can see that the Indigenous population is for the most part **increasingly urban**.
- The Indigenous populations are **significantly younger** than the non-Indigenous populations.
- **Fertility rates are higher** for the Indigenous populations than for the non-Indigenous population (Māori) or the overall population (Australia, Canada).

The reader should refer to the complete table (Table A1) presented in Appendix A.

References

- Pulver, L. J., Haswell, M. R., Ring, I., Waldon, J., Clark, W., Whetung, V., ... & Sadana, R. (2010). Indigenous Health—Australia, Canada, Aotearoa New Zealand and the United States-Laying claim to a future that embraces health for us all. World Health Organization, 107 pages.
<http://www.who.int/healthsystems/topics/financing/healthreport/IHNo33.pdf>

Health Statistics (1999-2015)

- Lower Disparity
- Moderate Disparity
- Higher Disparity

HEALTH STATISTICS	Australia	New Zealand	Canada
Life Expectancy	Males: 69 (-11 years) (Non-Indigenous males: 80) Females: 74 (-9 years) (Non-Indigenous females: 83) (2010/12)	Males: 73 (-7 years) (Non-Māori males: 80) Females: 77 (-7 years) (Non-Māori females: 84) (2012/14)	First Nations M: 74 (-5) F: 80 (-3) Métis M: 73 (-6) F: 78 (-5) Inuit M: 64 (-15) F: 73 (-10) (Overall pop. - Males: 79 Females: 83) (Projected 2017)
Infant Death Rate	8/1000 live births (1.9X) (Overall population: 4.2) (ABS & AIHW 2012)	6.8/1000 live births (1.5X) (Overall population: 4.5) (2010-12)	First Nations: 8/1000 (1.45X) (Overall population: 5.5) (1999) Nunavut pop.: 16/1000 (2.9X) (2008)
Suicide	Males: 39.2/100 000 (2.1X) (Non-Indigenous males: 19) Females: 12.9 (2.1X) (N.-Indigenous females: 6.2) (2015)	Males: 25.6/100 000 (1.6X) (Non-Māori males: 16.3) Females: 10.5 (2X) (Non-Māori females: 5.2) (2012)	First Nations: 24/100 000 (2X) (1999-2003) Inuit: 135 (11.3X) (Overall population: 12) (2001)
Risk Factors			
Obesity	40% (1.6X) (AIHW 2012/13)	47% (1.5X) (Overall population: 31%) (2015)	First Nations: 26% (1.6X) Inuit: 26% (1.6X) Métis: 22% (1.4X) (Non-Indigenous: 16%) (2007/10)
Hazardous Drinking	Males: 64% (1.4X) (Non-Indigenous males: 47%) Females: 44% (1.6X) (N.-Indigenous females: 27%) (2012/13)	Males: 23% (1.5X) (Non-Māori males: 15%) Females: 17% (2X) (Non-Māori females: 8%) (2014)	First Nations (off-reserve): 35% (1.5X) Métis: 30% (1.3X) Inuit: 39% (1.7X) (Non-Indigenous: 23%) (APS, 2012)
Smoking Rate	39% (2.4X) (Non-Indigenous: 16%) Males: 42% Females: 36% (NATSISS 2014-15)	38% (2.2X) (Overall pop.: 17%) Males: 34% Females: 42% (2015)	First Nations (off-res.): 27% (1.8X) Métis: 26% (1.7X) Inuit: 49% (3.3X) (Non-Indigenous: 15%) (APS, 2012)

HEALTH STATISTICS

Slide 5 offers a brief summary of some chosen health indicators, comparing for each country the data for the Indigenous population and the non-Indigenous population.

Highlights

- The data often reveals **significant disparities** between Indigenous and non-Indigenous populations for all chosen indicators.
- Overall, the prevalence for the Indigenous population is on average between 1 ½ to 2 times higher than for either the non-Indigenous population or the total population, again, across all chosen indicators.
- Inuit communities appear to be affected by the largest gaps in the first three categories (life expectancy, infant death rate, suicide).
- Statistics are higher for Indigenous populations for the selected risk factors of chronic conditions (obesity, hazardous drinking, smoking rate). However, it is important to stress that the social determinants of health are also contributing to the prevalence of some chronic diseases, for instance poor quality of housing and overcrowding as factors in respiratory conditions, or food insecurity as a factor in nutrition-related chronic diseases, such as diabetes and cardiovascular diseases. Stress and trauma must also be mentioned as

- factors affecting mental health.

The reader should refer to the complete table (Table A2) presented in Appendix A.

Health Frameworks - Overview

Commons Threads

- Gap between Indigenous peoples' and Western **conceptions of health**
- **Self-determination and self-governance** as key components towards improved Indigenous health
- Recognition of the importance of **social determinants of health** - Reaching **equity**
- Effects of **history and colonization** on Indigenous peoples' health
- Mention of **collaboration/partnership** with the State

Difference

- **Level of integration** of Indigenous community in building this framework/strategy

HEALTH FRAMEWORKS - OVERVIEW

Relevance of Analyzing Health Frameworks

- Frameworks, or visual depictions, can improve understanding of complex issues such as the determinants of health by explaining the impact of the determinants on the well-being of individuals, communities and populations. Through clear depictions of the complex relationships among determinants, frameworks can support innovative planning and policy development by identifying opportunities for health and other sectors to act to reduce health inequities experienced by certain population groups (Canadian Council on Social Determinants of Health, 2015).

Similarities

- Gap between Indigenous and Western **conceptions of health**
 - Western medical models, which view disease as arising from the body and its components, do not account for the physical, emotional, intellectual and spiritual elements of Indigenous conceptions of life, health, and well-being (Lavoie, 2011).
 - Hence, we should promote the synergy of Traditional and Western Health Philosophies (Lemchuck-Favel & Jock, 2004, p.29-30).
- **Self-determination and self-governance** as key components towards

- improved Indigenous health.
- Recognition of the importance of **Social Determinants of Health (SDoHs)** - reaching **equity**
 - At a time when equity theory dominates the health care literature, there is a need for it to be applied to Indigenous health (Lavoie, 2004).
 - Most referred to SDoHs by the 3 nations: culture and language; income, housing, education; availability of health services (including notions of cultural safety and remoteness); and the environment.
- Effects of **history and colonization** on Indigenous peoples' health
 - **Colonization:**
 - These four nations share a colonial history associated primarily with the British that commenced between 400 and 500 years ago in the Northern hemisphere (USA, Canada) and just over 220 years ago in the Southern hemisphere (Australia, Aotearoa New Zealand) (Pulver *et al*, 2010, p.7).
 - Loss of languages and cultures were a result of intentional and unintentional actions by the colonizers, often with oppressive regulations and legislations aimed at assimilation into the body politic of the developing nation states (UN, 2016, p.153).
 - From *Terra nullius* (land belonging to no one) to the logic of the Crown needing to protect/take responsibility of Indigenous peoples through assimilation policies.
 - Colonization has also been shown to have residual effects across generations through the protracted effects of land dispossession, marginalization, discrimination, personal and institutional racism and other factors that limit the ability of Indigenous peoples to participate fully in the major institutions of the societies in which they live (UN, 2016, p.136).
 - **Christianity:**
 - The impact of Christianity included significant impact on attitudes related to health and illness, which are often described as traditional cultural practices. Colonization and Christianity destroyed many local healing and other customary health practices so effectively that many of the traditional methods have been lost, and Indigenous peoples are struggling to reclaim some of these ancient healing practices (UN, 2016, p.137).
 - **Urbanization:**
 - Migration to urban areas is usually associated with increased isolation from family, land, language, traditions and cultures but urbanization also improves education, employment prospects

- and socioeconomic circumstances of many Indigenous families (UN, 2016, p.138).
 - **Globalization:**
 - Globalization was often primarily focused on the economic side, such as trade, foreign direct investment and international capital flows but more recently the term has been expanded to include a broader range of areas and activities such as culture, media, technology, sociocultural and political factors (UN, 2016, p.138).
 - Following this logic, this new cultural globalization led to the loss of many Indigenous traditions and facilitated access to harmful products and practices (e.g. alcohol & drugs). However, it also raised the potential for mobilization and political voice among the various Indigenous communities of the world (e.g. The United Nations Declaration on the Rights of Indigenous Peoples).
- Mention of **collaboration/partnership** with the State
 - Good working relationships between Aboriginal and non-Aboriginal systems need not be more than implementing effective referral mechanisms and sharing of patient information. It will depend on attitudes and open-mindedness of all parties (Lemchuck-Favel & Jock, 2004, p.30).

Difference

- **Level of integration** of Indigenous community in building these framework
 - **New Zealand**
 - The framework was produced by the Ministry of Health, but it mentions that this strategy represents the perspectives of all the different people who work together to make Māori healthy.
 - In fact, a reference group composed of a range of actors including the government and its agencies, Māori scientists and researchers, mainstream and Māori health providers, whānau (families), iwi (tribes), hapū (sub-tribes), and pan-Māori groups and consumers guided the development of this framework (Walton, 2007, p.3).
 - The use of Māori language within the framework also enhanced the integration of Māori knowledge.
 - For more information :
 - <http://www.health.govt.nz/system/files/documents/publications/g>

- [uide-to-he-korowai-oranga-maori-health-strategy-jun14-v2.pdf](#)

- **Australia**

- The framework was produced by the Australian Government based on the *Close the Gap* commitment.
- The Aboriginal and Torres Strait Islander peoples are involved to a lesser extent than Māori as their engagement in developing this Health Plan was mainly limited to providing input and feedback to the Government.
 - No plan will succeed without a robust partnership, particularly between the Australian Government and Aboriginal and Torres Strait Islander people, Aboriginal and Torres Strait Islander community organisations and their peak bodies. This Health Plan has been developed in partnership with all these groups, a partnership that has been over twelve months in the making. The National Congress of Australia's First Peoples has provided a critical role through the National Health Leadership Forum in ensuring input and feedback into the development of this Health Plan. Partnerships require effort and commitment as we work to find common ground.
- For more information :
[http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/\\$File/health-plan.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/$File/health-plan.pdf)

- **Canada**

- In Canada, the situation is quite different. The Canadian government does not seem to have a model integrating the Indigenous vision of health and wellness.
- For that reason, the Assembly of First Nations (AFN) suggested in 2005 a First Nations Wholistic Policy & Planning Model to structure policy interventions.
 - For more information:
<http://caid.ca/AFNUNIndWelBei2006.pdf>
- However, this framework has not been recognized as the official model for Indigenous conception of health in Canada, although the government refers to some of its components in few strategic documents.
 - Example 1: In FNIHB's Strategic Plan featured on their website and dating from 2012, it is mentioned that their programs value *wellness* and *promotes holistic*

- *perspectives that help protect and promote the health, safety and well-being of First Nations and Inuit.*
However, the AFN model is not concretely showed in the strategic document.
(<http://www.hc-sc.gc.ca/fniah-spnia/pubs/strat-plan-2012/index-eng.php>)
- Example 2: In Blueprint on Aboriginal Health: A 10 years transformative plan produced in 2005, the following principles are accepted by the government as key aspects of Aboriginal health: holistic vision of health (including the spiritual dimension of health and the use of traditional healing and medicines), importance of SDoH, and partnership between the State and Indigenous populations.
(<http://healthycanadians.gc.ca/publications/health-system-systeme-sante/blueprint-aboriginal-plan-autochtones/index-eng.php>)
- It is important to note that the research also found evidences of other visual depictions of health produced by the Inuit Tapiriit Kanatami (ITK) and the Métis National Council (MNC). This being said, those models were not as complete and seemed to be less referred to in terms of policy-making.
 - ITK: more of a diagram outlining the key social determinants of health affecting specifically Inuit health, which can differ from those related to Aboriginal or Métis health, for instance food security. (See p.8 : https://www.itk.ca/wp-content/uploads/2016/07/ITK_Social_Determinants_Report.pdf) and further details on slide 9 Health Framework Canada)
 - MNC: more of a project cycle (from strategic analysis to planning, delivery and assessment) describing the steps towards improved Métis health. (See: <http://www.metisportals.ca/healthportal/framework17907.htm>) and further details on slide 9 Health Framework Canada)
- Therefore, although the AFN framework may be not equally applicable to First Nations, Inuit, and Métis populations in *all* manners, it is reasonable to say that many shared principles and ideas are featured in this framework.

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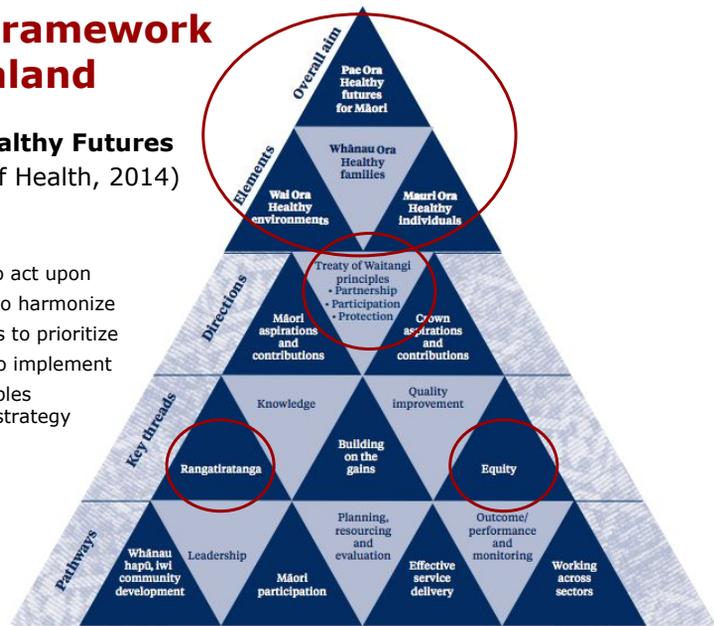
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Health Framework New Zealand

Pae Ora - Healthy Futures (NZ Ministry of Health, 2014)

- 1 overall aim
- 3 Elements to act upon
- 2 Directions to harmonize
- 3 Key threads to prioritize
- 4 Pathways to implement
- 6 Core principles to guide the strategy

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HEALTH FRAMEWORK - NEW ZEALAND

For complete information :

<http://www.health.govt.nz/system/files/documents/publications/guide-to-he-korowai-oranga-maori-health-strategy-jun14-v2.pdf>

Description

- The most commonly used framework to portray Māori's health is called *Pae Ora*, which means “healthy futures” in Māori language.
- It is the Government's vision for Māori health and it aims to think beyond narrow definitions of health, and to provide high-quality and effective services.
- *Pae Ora* (small triangle at the top, in the red circle) is implemented within the bigger pyramid which represents the Māori Health Strategy, called *He Korowai Oranga*, which guides the Government and the health and disability sector to achieve the best health outcomes for Māori.
- It takes the form of a pyramid and is organized as follows :
 - 1 overall aim;
 - 3 elements to act upon;
 - 2 directions to harmonize;
 - 3 key threads to prioritize;
 - 4 pathways to implement;

- 6 core principles to guide the strategy.

Key Features

- **Holistic approach**

- The *Pae Ora* triangle shows the interconnectedness of :
 - *Mauri Ora* – meaning “healthy individuals”
 - The concept of *mauri ora* captures the importance of the individual.
 - Achieving *mauri ora* will mean that Māori individuals of all ages are healthy and have access to effective and appropriate health services, from prevention to treatment.
 - *Whānau Ora* – meaning “healthy families”
 - *Whānau ora* is driven by a focus on the Māori community being self-managing, living healthy lifestyles, and confidently participating in the society.
 - *Wai Ora* – meaning “healthy environments”
 - The concept of *wai ora* refers to the importance of the environments in which Māori live and that have a significant impact on the health and wellbeing of individuals, *whānau* (families) and communities.
 - Achieving *wai ora* will mean that the environment in which Māori, and all New Zealanders, live, work and play is safe.
 - This includes appropriate access to quality housing, safe drinking water and air, and healthy food.
 - *Wai ora* also reminds us that addressing the determinants of health is essential to improve outcomes for Māori.

- **Social Determinants of Health & Equity**

- The framework presents equity as one of the key threads and acknowledges that the differences in health status between Māori and New Zealanders are the results of unequal access to the resources necessary for people to lead healthy lives.
- Therefore, in order to achieve health equity between Māori and New Zealanders, it is necessary to need to address the social determinants of health such as education, poverty, and housing.

- **Collaboration** between the State and the Maori population

- The principles of partnership, participation and protection underpin the

- relationship between the Government and Māori under the Treaty of Waitangi and should guide the actions towards achieving *pae ora*.
- **Rangatiratanga** (or self-determination)
 - This dimension attempts to enable *whānau* (families), *iwi* (tribes), *hapū* (sub-tribes) and Māori to exercise control over their own health and wellbeing, as well as the direction and shape of their own institutions, communities, and development.
 - *Rangatiratanga* recognizes that Māori are both a legitimate and an essential part of decision-making in the health and disability sector. There are formal and less formal ways to include them, such as the mandatory representation of Maori in District Health Boards, or advocacy mechanisms to influence the way services are designed and delivered.

*** Research also found evidences of other Māori health models. However, the concepts they present all appear in the Pae Ora framework, which is more complete and more commonly used. Some examples of alternative models include: Te Whare Tapa Whā (Four Cornerstones) / Te Wheke (Octopus) / Te Pae Mahutonga (Star Constellation).*

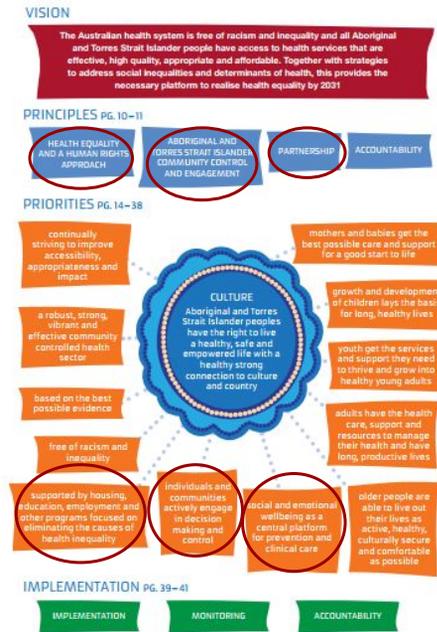
<http://www.health.govt.nz/our-work/populations/maori-health/maori-health-models>

Health Framework Australia

National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (Commonwealth of Australia, 2013)

- 1 Vision
- 4 Guiding principles
- 12 Priorities of action (with culture as a central point)
- 3 Steps for implementation

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HEALTH FRAMEWORK - AUSTRALIA

For complete information :

[http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/\\$File/health-plan.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/$File/health-plan.pdf)

Description

- In Australia, the conceptual health framework is included within the pictorial representation of the National Aboriginal and Torres Strait Islander Health Plan 2013-2023.
- It includes :
 - 1 main vision;
 - 4 guiding principles;
 - 12 priorities of action (with culture as a central point);
 - 3 steps for implementation.

Key Features

- **Holistic approach**
 - It appears in *Priority 7 - Social and emotional wellbeing as a central platform for prevention and clinical care.*
 - Aboriginal and Torres Strait Islander peoples view health in a holistic context as reflected by the holistic definition of health contained within

- the National Aboriginal Health Strategy (1989): “Aboriginal health’ means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life.”
 - Social and emotional wellbeing is a holistic concept which recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual.
 - Good health also integrates the spiritual dimension and is demonstrated by the use of traditional knowledge and the practices of traditional healers.
- **Health equity and the human rights approach**
 - It appears in *Principle 1 - Health equality and a human rights approach*.
 - This approach believes in providing equal opportunities to be healthy.
 - In this way, a rights-aware approach is not necessarily about more services, but about better services through better informed policy, practice and service delivery decisions, and the processes that enable Aboriginal and Torres Strait Islander peoples to participate in all levels of health care decision-making.
 - This relates directly to the need to address environmental, economic, and social inequalities which are pivotal to achieve health equality.
 - *Priority 5* also goes in that direction by stating that fostering Indigenous health has to be: “*supported by housing, education, employment and other programs focused on eliminating the causes of health inequality*”.
 - Wealth of evidence supporting positive associations of health, education and employment outcomes as well as general well-being with language and culture.
 - Main social determinants of health (SDoH) affecting Indigenous populations in Australia: improving education participation, regional economic development, housing and environmental health, spiritual healing and the lack of equal access to primary health care, inadequate infrastructure and support services due to racism and remoteness.
- Respectful and efficient **partnership** between Indigenous groups and the State
 - Partnership and shared ownership between Aboriginal and Torres

- Strait Islander peoples, governments and service providers operate at all levels of health planning and delivery.
- **Full participation by Aboriginal and Torres Strait Islander people**
 - It appears in *Principle 2 - Aboriginal and Torres Strait Islander community control and engagement*. in *Priority 2 - A robust, strong, vibrant and effective community controlled health sector*, and *Priority 6 - Individuals and communities actively engage in decision making and control*.
 - This active participation can be enhanced by their contribution as individuals to the health workforce, by greater involvement in strategic planning to achieve Aboriginal and Torres Strait Islander wellbeing, and more broadly by political representation in institutional structures.
 - Constitutional recognition is also seen by many Australians as a pivotal and desirable reform which provides the constitutional architecture upon which strategies for Aboriginal and Torres Strait Islander health gain can be mobilised. The Australian Government is committed to pursuing meaningful change in the Australian Constitution – change that unites the nation and reflects the hopes and aspirations of Aboriginal and Torres Strait Islander people

***Research found evidences of other visuals used to portray the National Aboriginal and Torres Strait Islander Health Plan.*

(See p.2 :

[http://www.health.gov.au/internet/main/publishing.nsf/Content/AC51639D3C8CD4EC CA257E8B00007AC5/\\$File/DOH_ImplementationPlan_v3.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/AC51639D3C8CD4EC CA257E8B00007AC5/$File/DOH_ImplementationPlan_v3.pdf))

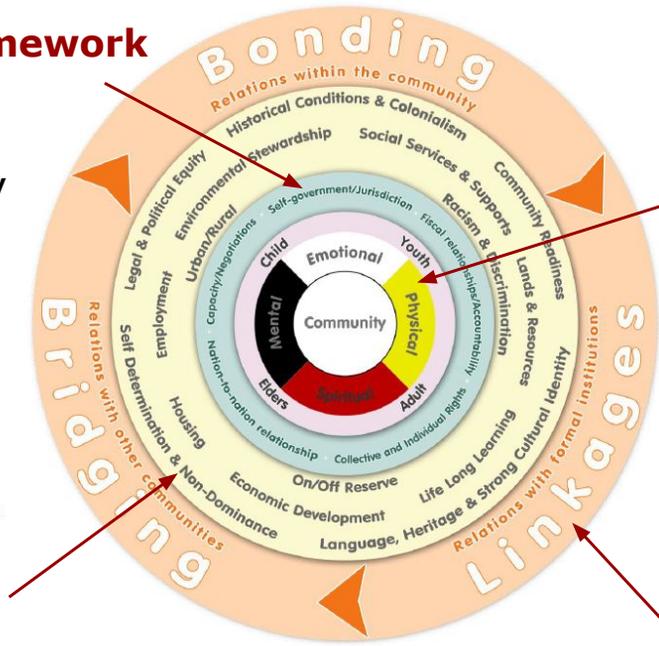
Health Framework - Canada

First Nations "Wholistic" Policy & Planning Model (AFN, 2005)

Legend

-  Medicine Wheel
-  Lifespan
-  First Nations Self-Government
-  Health Determinants
-  Social Capital

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HEALTH FRAMEWORK - CANADA

For complete information : <http://caid.ca/AFNUNIndWelBei2006.pdf>

Description

- The chosen Assembly of First Nations' framework for Indigenous health takes the form of a wheel.
- It is composed of five concentric circles, which are :
 - the medicine wheel circle;
 - the lifespan circle;
 - the self-government circle;
 - the health determinants circle;
 - the social capital circle.

Key Features

- **Holistic approach**
 - The two central circles express the understanding of health as rising from the interconnectedness of mental, physical emotional and spiritual wellness, with a critical focus on the community.
 - Balance is an important concept of Indigenous health and it requires the need for an individual to live in harmony with others, their

- community, and the spirit world. Hence, Indigenous peoples' idea of sickness or illness tends to refer to an absence of well-being.
- **Social Determinants of Health**
 - The various Canadian Indigenous groups experience disparities in the health determinants compared to non-Indigenous but also within First Nations, Métis, and Inuit groups and between rural and urban Indigenous people (UN, 2016)
 - Some of the determinants affecting the Canadian Indigenous groups include disparities in education, income, labour force participation/employment, housing indicators, unsafe drinkable water, food insecurity and lack of access to health facilities due to remoteness (Pulver *et al*, 2010).
- **Partnership and collaboration** between the Indigenous groups and the State
 - Social capital is measured using a combined scale that incorporates the concepts of bonding (relations within the community), bridging (relations with other communities), and linkage (relations with formal institutions).
- **Self-government**
 - Self governance implies a greater control by Indigenous peoples on their own health and includes aspects like jurisdiction, accountability, collective and individual rights, and negotiation.

Review of the AFN Model

- As part of A Review of Frameworks on the Determinants of Health, produced by the Canadian Council on Social Determinants of Health. Refer to : http://ccsdh.ca/images/uploads/Frameworks_Report_English.pdf

First Nations Mental Wellness Continuum Framework

- Mental health and substance abuse issues continue to be a priority concern for many First Nations communities.
- The First Nations and Inuit Health Branch (FNIHB), the Assembly of First Nations (AFN), and Indigenous mental health leaders from various First Nations non-government organizations jointly developed the First Nations Mental Wellness Continuum Framework.
- The key themes of this framework are:
 - Culture as Foundation;
 - Community Development, Ownership and Capacity Building;
 - Quality Care System and Competent Service Delivery;

- Collaboration with Partners;
- Enhanced Flexible Funding.
- See framework p.3 :
http://www.hc-sc.gc.ca/fniah-spnia/alt_formats/pdf/pubs/promotion/mental/2014-sum-rpt-continuum/2014-sum-rpt-continuum-eng.pdf

Métis Framework

- This initiative resulted in the Aboriginal Health Reporting Framework, which was essentially completed by 2005. Although the framework may be not equally applicable to First Nations, Inuit and Métis populations in all manners, it is a reasonable first step. A report by the Métis National Council (MNC) said the Framework was a useful foundation for MNC activities, particularly in relation to the Aboriginal Health Blueprint Initiative.
- The key principles or beliefs to be embraced throughout the work of developing a framework of determinant for Métis are: holistic, intertwined and fluid determinants, well-being driven, and culturally/contextually relevant.
- The central components found in the literature scan include: self-determination, colonization, spirituality, land, and culture and tradition.
- This continuum demonstrates that the social determinants of Métis health are not only social, but are primarily and more specifically political and historical. As opposed to being a framework, this continuum—and indeed this paper—is a first step towards a Métis framework of health (Dyck, 2009, p.13).
- Also see : <http://www.metisportals.ca/healthportal/framework17907.htm>

Inuit Framework

- More of a diagram outlining the key social determinants of health affecting specifically Inuit health, which can differ from those related to Aboriginal or Métis health, for instance food security.
- Based on a broad review of the literature focusing on Inuit health and on recent consultations with representatives from Inuit organizations, agencies and governments, the key social determinants have been revised to the following eleven factors: quality of early childhood development, culture and language, livelihoods, income distribution, housing, personal safety and security, education, food security, availability of health services, mental wellness, and the environment (ITK, 2014, p.2).

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Legislative Frameworks

	New Zealand	Australia	Canada
Historical Laws, Acts, Treaties & Policies Impacting Health	<ul style="list-style-type: none"> ▪ <i>Treaty of Waitangi</i>, 1840 ▪ <i>The Tohunga Suppression Act</i>, 1907 ▪ <i>Health Act</i>, 1956 	<ul style="list-style-type: none"> ▪ <i>Aboriginal Protection Act</i>, 1869 (Victoria) ▪ <i>NSW Aborigines Protection Board</i>, 1883 ▪ <i>National Health Act</i>, 1953 	<ul style="list-style-type: none"> ▪ <i>Royal Proclamation</i>, 1763 & various Treaty Agreements (Land Claims & Aboriginal Title) ▪ <i>Indian Act</i>, 1876 ▪ <i>Gradual Civilization Act</i>, 1857 & <i>Gradual Enfranchisement Act</i>, 1869 ▪ <i>Indian Health Policy</i>, 1979 ▪ <i>Canadian Health Act</i>, 1984. ▪ <i>Health Transfer Policy</i>, 1989
And More Recently...	<ul style="list-style-type: none"> ▪ <i>New Zealand Public Health and Disability Act</i>, 2000 	<ul style="list-style-type: none"> ▪ <i>National Apology to Australia's Stolen Generations</i>, 2008 & <i>National Indigenous Reform Agreement (NIRA/ Closing the Gap Initiative)</i>, 2008 	<ul style="list-style-type: none"> ▪ <i>National Apology to Former Students of Indian Residential Schools</i>, 2008 & <i>Truth and Reconciliation Committee of Canada</i> ▪ <i>BC Tripartite Framework Agreement</i>, 2013

LEGISLATIVE FRAMEWORKS (1)

- Past and present policy decisions can have enduring effects on the health and lives of Indigenous Peoples.
- Slide 10 presents an overview of some landmark pieces of legislation that continue to be of relevance today when discussing Indigenous health challenges.
- Some recurrent themes can be identified in these documents.

As for **historic Laws, Acts, Treaties & Policies Impacting Health**, the identified acts seem to follow a similar logic as the three countries share a similar British colonial past :

- assimilation and suppression of Indigenous customs and traditional practices;
- establishing the terms of the relationship between the Crown and Indigenous groups.

As for **more recent** ones, some common themes are:

- enactment of the functioning of national health systems;
- transfer of ownership to Indigenous groups (mainly in Canada);
- national apologies for harmful past policies and measures to address the consequences of these policies (in Canada and Australia).

NEW ZEALAND

Historical

- **Treaty of Waitangi, 1840**
 - The principles of partnership, participation and protection underpin the relationship between the Government and Māori under the Treaty of Waitangi.
 - The Treaty of Waitangi was signed in 1840 between Māori and the British Crown. The Waitangi Tribunal was established by the Treaty of Waitangi Act 1975.
 - For more information : <http://www.teara.govt.nz/en/treaty-of-waitangi>
 - The Treaty of Waitangi appears as one of the 6 core principles to guide the Māori health strategy, *He Korowai Oranga*.

- **Tohunga Suppression Act, 1907**
 - Act designed to replace traditional Māori healers with “modern” science-based medicine.
 - For more information :
<http://www.teara.govt.nz/en/document/28223/tohunga-suppression-act>
and <http://www.teara.govt.nz/en/rongoa-medicinal-use-of-plants/page-5>

- **Health Act, 1956**
 - The Health Act 1956 gives the Ministry of Health the function of improving, promoting and protecting public health.
 - For more information :
<http://www.health.govt.nz/nz-health-statistics/access-and-use/legislation>

Recent

- **New Zealand Public Health and Disability Act, 2000**
 - Introduced a major change to the public funding and provision of personal health services, public health services, and disability support services. It also established new publicly owned health and disability organisations, such as District Health Boards and the Pharmaceutical Management Agency (Pharmac).
 - For more information :
<http://www.health.govt.nz/nz-health-statistics/access-and-use/legislation>

AUSTRALIA

Historical

- **Aboriginal Protection Act, 1869 (Victoria) & NSW Aborigines Protection**

- **Board, 1883**
 - Confinement of Aboriginal people on mission settlements; dispossession from ancestral land; forcible removal of Aboriginal and Torres Strait Islander children (often referred to as the Stolen Generations).
 - For more details on the Aboriginal Protection Act & NSW Aborigines Protection Board:
 - http://www.foundingdocs.gov.au/resources/transcripts/vic7i_doc_1869.pdf & <https://www.findandconnect.gov.au/guide/nsw/NE00034>
 - For more details on Stolen Generations:
 - <https://www.findandconnect.gov.au/guide/nsw/NE01008>

Recent

- **National Health Act 1953**
 - An Act relating to the provision of pharmaceutical, sickness and hospital benefits, and of medical and dental services.
 - For more information :
 - <https://www.legislation.gov.au/Details/C2014C00353>
- **National Apology to Australia's Stolen Generations, 2008**
 - In February 2008, Australia made a significant move towards reconciliation and recovery with the National Apology to Australia's Stolen Generations and their families and communities. Prime Minister Mr Kevin Rudd delivered the apology.
 - For more information :
 - <http://www.australia.gov.au/about-australia/australian-story/sorry-day-s-tolen-generations> and
 - <http://www.australia.gov.au/about-australia/our-country/our-people/apology-to-australias-indigenous-peoples>
- **National Indigenous Reform Agreement (NIRA / Closing the Gap Initiative), 2008**
 - The NIRA has established a framework of national targets and policy building blocks. Two of the *Closing the Gap* targets, to halve the gap in child mortality by 2018 and close the life expectancy gap by 2031, go directly to health outcomes, while others address social determinants of health such as education and employment.
 - For more information on NIRA & Close the Gap Initiative:
 - <https://www.coag.gov.au/node/145>,
 - https://www.coag.gov.au/sites/default/files/20081129_national_indigenous_reform_factsheet.pdf and <https://www.coag.gov.au/node/65>

CANADA

Historical

- **Royal Proclamation, 1763 & various Treaty agreements** (land claims & Aboriginal Title)
 - The Royal Proclamation of 1763 was issued by King George III to establish a basis of government administration in the North American territories. However, the Royal Proclamation explicitly states that Aboriginal title has existed and continues to exist, and that all land would be considered Aboriginal land until ceded by treaty.
 - It established the constitutional framework for the negotiation of treaties with the Aboriginal inhabitants of large sections of Canada.
 - Eleven numbered treaties were negotiated in the Prairie provinces, northeastern British Columbia, northern and northwestern Ontario, and the western part of the Northwest Territories in the late 19th and early 20th centuries on the principles outlined in the Royal Proclamation of 1763.
 - Treaty 6, which includes the Medicine Chest Clause, was part of the eleven numbered treaties and is often referred to in relation to the responsibility of the Federal government to provide health for the Indigenous population of Canada (Hall, 2015).

- **Gradual Civilization Act, 1857 & Gradual Enfranchisement Act, 1869**
 - The Gradual Civilization Act sought to assimilate Indigenous peoples by encouraging enfranchisement, and adherence to the European concept of private land ownership and wealth accumulation.
 - Residential schools are considered one of the many tragic and damning examples of efforts to purge Indigenous identity to serve the purposes of Canadian state formation (Robinson, 2016).

- **Indian Health Policy, 1979**
 - The Federal government began to develop administrative arrangements to provide First Nations and Inuit communities with the opportunity to exercise more control over community-based health services.
 - The stated goal of the Indian Health Policy adopted by the Federal Government on September 19, 1979, is "to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves".
 - 1979 Indian Health Policy recognized three pillars: community development, the traditional relationship of the Indian People to the federal government, and the Canadian health system (Lavoie, 2004, p.12).

- **Health Transfer Policy, 1989**

- The 1988 Indian Health Transfer Policy provided a framework for the assumption of control of health services by First Nations people, and set forth a developmental approach to transfer centred on the concept of self-determination in health (as the foundation of BC Tripartite Agreement).
 - Services targeted for transfer are defined by the federal government. They include mandatory services such as communicable disease control, environmental health and treatment services (Lavoie, 2004, p.12).
 - Medical and Hospital Insurance Services are excluded, as well as Non-Insured Health Benefits that includes medication, medical transportation, eye care, and dental care (Lavoie, 2004, p.12).
 - The Health Transfer Policy has focused exclusively on on-reserve services (Lavoie, 2004, p.17).
- For more information on both Indian Health Policy & Health Transfer Policy :
http://www.hc-sc.gc.ca/fniah-spnia/pubs/finance/_agree-accord/10_years_ans_trans/index-eng.php#health_transfer
- Other related scholarly articles : Lavoie, 2011; Lavoie, 2004; Lemchuck-Favel & Jock, 2004.

- **Canadian Health Act, 1984**

- Overarching legislation covering Canada's national medicare program.
- The Canada Health Act is the federal legislation that puts in place criteria and conditions for insured health care services, and the national standards that provinces and territories must meet in order to get federal funding from the Canada Health and Social Transfer (CHST).
- Five principles: accessibility, universality, portability, comprehensiveness, public administration.
- For more information :
<http://www.loppar.gc.ca/content/lop/researchpublications/944-e.htm>

Recent

- **National Apology to former students of Indian Residential Schools, 2008 & TRC / NCTR**

- Prime Minister Harper offers full apology on behalf of Canadians for the Indian Residential Schools system. The government now recognizes that the consequences of the Indian Residential Schools policy were

- profoundly negative and that this policy has had a lasting and damaging impact on Aboriginal culture, heritage and language.
- The National Centre for Truth and Reconciliation (NCTR) is a creation of the Indian Residential Schools Settlement Agreement, signed in 2007 by representatives of former students of the schools, the Government of Canada, Churches, the Assembly of First Nations, and the Inuit Tapiriit Kanatami.
- One part of the Settlement Agreement created the Truth and Reconciliation Commission of Canada (TRC).
 - Call to action #19 from TRC: We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long term trends.
- For more information :
 - <https://www.aadnc-aandc.gc.ca/eng/1100100015644/1100100015649>,
 - <http://umanitoba.ca/centres/nctr/mandate.html> and
 - http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf
- **British Columbia Tripartite Framework Agreement, 2013**
 - Health Canada transferred its role in the design, management, and delivery of First Nations health programming in British Columbia to the new First Nations Health Authority (FNHA) (with the agreement of the province of British Columbia).
 - For more information :
 - <http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/tripartite/framework-accord-cadre-eng.php>
 - Further information on slide 20.

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LEGISLATIVE FRAMEWORKS (2)

The reader should refer to the information presented in Appendix B.

This section observes how status is conferred to Indigenous peoples in the three countries, if they are recognized in the constitution, and their political representation at the state level.

Status

There is variation in how Indigenous peoples are identified, classified and enumerated in data sources and surveys, and in the census (Pulver *et al.*, 2010, p.12).

NEW ZEALAND

- In New Zealand, status is self-determined.
 - Since 1998, Statistics New Zealand's definition of a Māori is based on cultural affiliation with the "New Zealand Māori Ethnic Group" and reads as follows : a 'Māori' means a person of the Māori race of New Zealand; and includes any descendant of such a person."
<http://www.stats.govt.nz/methods/classifications-and-standards/classification-related-stats-standards/maori-descent/definition.aspx>)

AUSTRALIA

- In Australia, status is self-determined.
 - Since 1996, the Australian Bureau of Statistics uses the following definition : "An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent, who identifies as being of Aboriginal or Torres Strait Islander origin and who is accepted as such by the community with which the person associates."
<http://www.abs.gov.au/websitedbs/cashome.nsf/4a256353001af3ed4b2562bb00121564/7464946b3f41b282ca25759f00202502!OpenDocument>).

CANADA

- In Canada, status is conferred by a set of rules that appears in the Indian Act

- of 1876.
 - A Registered or Status Indian recognized by the federal government is entitled to a wide range of programs and services offered by federal agencies and provincial governments.
(<http://www.aadnc-aandc.gc.ca/eng/1100100032374/1100100032378>)
 - Emphasis on registration in Canada and the United States reflects a longer history of federal government involvement in Indigenous affairs but has resulted in problems of exclusivity (Dow & Gardiner-Garden, 1998).

Recognition in the constitution

NEW ZEALAND

- The Māori are not mentioned in the Constitution Act of 1986.
- However, they are in the Treaty of Waitangi of 1840, which is recognized as the founding document of New Zealand and is still used to guide Māori/Crown relations.
 - Māori and the Crown have had different conceptions of the meaning and legal status of the Treaty.
 - Waitangi Act, 1975 : An act to provide for the observance, and confirmation, of the principles of the Treaty of Waitangi by establishing a Tribunal to make recommendations on claims relating to the practical application of the Treaty and to determine whether certain matters are inconsistent with the principles of the Treaty.
(<http://www.legislation.govt.nz/act/public/1975/0114/latest/DLM435368.html>)

AUSTRALIA

- The Australian Constitution of 1901 was intended to unite Australia, but the first peoples of Australia were not (and are still not) included in this agreement.
 - Drafted in spirit of *terra nullius* excluding Aboriginal and Torres Strait Islander peoples.
 - Referendum 1967 : Amending of two sections (51 and 127) of the Australian Constitution - landmark achievement for Indigenous Australians, created new sense of autonomy and led to Aboriginal community-controlled health services (which also led to the creation of NACCHO) (Hetzl, 2000).

CANADA

- The first mention of Aboriginal Peoples appear in the Constitution Act of 1867.
- It is then reaffirmed in the Constitution Act of 1982 and in particular in section

- 35 which recognizes Aboriginal peoples' inherent right to self-government (Lavoie, 2011; Pulver *et. al*, 2010).
 - Note on Métis: Métis are acknowledged as one of the Aboriginal Peoples in Canada under Section 35 of the Constitution Act, 1982. Although existing Aboriginal rights are recognized and affirmed in the Constitution Act, the federal government has not fully accepted fiduciary responsibility for the Métis. There is no comprehensive government policy to address Métis health issues (Lemchuck-Favel & Jock, 2004).
 - In a landmark ruling (April 14, 2016), the Supreme Court of Canada (SCC) recognized and affirmed that the federal government's duties and responsibilities apply to all three of Canada's Indigenous Peoples including the Métis. Without dictating what the Government has to do, this historic decision nonetheless places a clear obligation upon the federal government to negotiate with the elected government of the Métis Nation.
<http://www.metisnation.ca/index.php/news/supreme-court-of-canada-affirms-canada-has-a-constitutional-and-jurisdictional-responsibility-to-deal-with-the-metis-nation>

Political representation / Reserved seats

NEW ZEALAND

In New Zealand, the political representation of Māori is guided by several measures.

- The Māori Representation Act of 1867:
 - This act established that four seats should be reserved to Māori in order for them to have a direct say in Parliament.
- Then, when the Mixed-Member Proportional Electoral System was implemented in 1993, the number of seats reserved to Māori became proportional to the size of the Māori electoral population, using a similar quota used to determine the number of General electorates.
<http://www.elections.org.nz/voting-system/maori-representation>
- Finally, the Māori Party was created in 2004 and is now forming a coalition, along with two other minor political parties, with the national party-led Government to increase Māori's presence in decision-making.
 - Their presence in parliament has been widely regarded as being influential in a number of significant policy and funding that benefit Māori and other minority groups, to become more self-managing and to take responsibility for their economic, social and cultural development.
- According to Statistic NZ, in 2014, 22% of members of parliament identified as

- Māori.
(http://www.stats.govt.nz/browse_for_stats/snapshots-of-nz/nz-social-indicator/s/Home/Trust%20and%20participation%20in%20government/rep-ethnic-grps-govt.aspx)

AUSTRALIA

- There are no dedicated seats in Parliament or any special measures to promote the election of Aboriginal and Torres Strait Islander candidates to Commonwealth, State or Territory Parliaments.
- There are currently 2 Aboriginal and Torres Strait Islander representatives in the federal parliament, which shows that they are still very much underrepresented.
(http://www.aph.gov.au/about_parliament/parliamentary_departments/parliamentary_library/pubs/rp/rp0809/09rp23#_Toc223150954)

CANADA

- There is no reserved seats for Indigenous people in Canada but the geography has been used to create some predominantly Indigenous population electorates which pretty much guarantee the election of an Indigenous representative.
 - For example, the creation of Nunatsiag in the former Northwest Territories virtually guarantees the election of an Inuit representative.
- Political representation of Indigenous people in Canada is also characterized by highly influential informal bodies like the Assembly of First Nations or Inuit Tapiriit Kanatami (Dow & Gardiner-Garden, 1998).
- According to CBC, there was in 2015, 3% of members of parliament who identify as Indigenous.
(<http://www.cbc.ca/news/indigenous/indigenous-guide-to-house-of-commons-1.3278957>)

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Overview of Health Care System - New Zealand (1)

- **Public health system** subsidized by the government :
 - NZ\$15.6 billion for the 2015/16 financial year
 - Total health expenditure : 11% of GDP in 2014

System Component	Support Programs
Health Services Delivery Community-oriented model District Health Boards (DHBs) <ul style="list-style-type: none"> ■ Public Hospitals ■ Primary Health Organisations (PHOs) 	<i>Universal</i> <ul style="list-style-type: none"> ■ Accident Compensation Corporation
	<i>Income-based</i> <ul style="list-style-type: none"> ■ Community Services Card (CSC)
Medication and Medical Devices Approved drugs and devices are covered through the public health system. <ul style="list-style-type: none"> ■ NZ\$5 charge/prescription, free under 13. 	<i>Based on Medical Needs</i> <ul style="list-style-type: none"> ■ High Use Health Card (HUHC) ■ Care Plus ■ Prescription Subsidy Card ■ Other condition-specific programs

OVERVIEW OF HEALTH CARE SYSTEM - NEW ZEALAND (1 OF 2)

New Zealand has a **public health system** subsidised by the government.

- NZ\$15.6 billion for the 2015/16 financial year.
(<http://www.treasury.govt.nz/government/expenditure/health>)
- Total health expenditure : 11% of GDP in 2014.
(<http://www.who.int/countries/nzl/en/>)

(For more information on New Zealand health system - general :

<http://www.health.govt.nz/new-zealand-health-system>)

(For more information on the whole range of publicly funded health care and disability services, including dental services :

<http://www.health.govt.nz/new-zealand-health-system/publicly-funded-health-and-disability-services>)

Health Services Delivery

Health services delivery is structured on a **community-oriented model**. (<https://www.mcnz.org.nz/alpinfo/public-and-private-health-systems>)

The Ministry of Health funds **District Health Boards (DHBs)**, which are responsible

for funding, planning, and providing health and disability services in their district.

(For more information on DHBs:

<http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards>)

Public hospitals are owned and funded by their DHB.

DHBs also provide funding to **Primary Health Organizations (PHOs)**, which are local structures for delivering and coordinating primary health care services. A PHO provides services either directly or through its provider members. These services should improve and maintain the health of the entire enrolled PHO population, as well as providing services in the community to restore people's health when they are unwell. The aim is to ensure general practitioners' services are better linked with other primary health services (such as allied health services) to ensure a seamless continuum of care, in particular to better manage long-term conditions.

(For more information on PHOs:

<http://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/primary-health-organisations?mega=NZ%20health%20system&title=Primary%20health%20organisations>)

While most health care is provided free of charge, there may be fees involved for some **primary care** services. Indeed, although PHOs are non-profit organizations, doctors' practices and medical centres are privately owned and set their own fees.

However, the government subsidises the fees through a **capitation system** (general practices, clinics or groups of service providers receive a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care).

(For more information on capitation funding :

<http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/capitation-funding>, and on current capitation rates :

<http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/capitation-rates>)

- Are qualified for subsidised care: citizens, residents or holders of a work visa that is valid for two years or more from when person first arrives. If an individual meets these criteria, then their children aged 17 years or under will also be eligible for publicly funded health care.

<http://www.health.govt.nz/new-zealand-health-system/eligibility-publicly-funded-health-services/guide-eligibility-publicly-funded-health-services>)

- Mothers of babies born in New Zealand are entitled to free essential care during and after their pregnancy. Children immunization is free even if they

- aren't usually eligible for publicly funded health services.
(http://www.health.govt.nz/your-health/services-and-support/health-care-services/visiting-doctor?utm_source=newzealandnow.govt.nz)

There is no fee for children under 13, with some restrictions : the “zero fees” scheme applies to a standard daytime visit to a general practitioner or nurse at the child’s regular practice (where they are enrolled) or an after-hours visit to a participating clinic.

(For more information on the scheme :

<http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/zero-fees-under-13s>)

Some general practices also join the **Very Low Cost Access (VLCA) scheme** run by their PHO. The VLCA scheme supports general practices with an enrolled population of 50% or more high needs patients (defined as **Māori**, Pacific or New Zealand Deprivation Index quintile 5) where the practice agrees to maintain patient fees at a low level. VLCA payments provide:

- extra funding in return for PHOs and general practices agreeing to maintain fees within the fees thresholds;
- recognition of the extra effort involved in providing services to high need populations, and keeping fees low for the people who can least afford primary health care and improving health outcomes for those most likely to have the worst health.

(For more information on the VLCA scheme:

<http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/very-low-cost-access-scheme>)

Private sector : Private healthcare in New Zealand includes specialist services, primary care and private hospitals which provide non-urgent and elective treatments that complement the public health service's focus on urgent and essential treatments. There are also many private accident, emergency and medical clinics that operate in the private sector, often providing services outside the usual hours of doctors and clinics in the public system.

(<https://www.mcnz.org.nz/alpinfo/public-and-private-health-systems>)

Private insurance is available, although many New Zealanders choose not to get one. (<https://www.newzealandnow.govt.nz/living-in-nz/healthcare>)

Medication and Medical Devices

The cost of many medicines and medical devices is covered through the public health system.

(<https://www.newzealandnow.govt.nz/living-in-nz/healthcare/paying-for-healthcare-services>)

- Approved drugs are available on prescription, in *most* circumstances for a NZ\$5 co-payment (free for children under 13).
(<http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/pharmaceutical-co-payments>)
- If a medicine is not fully subsidised, there may be an additional costs.
(http://www.health.govt.nz/your-health/conditions-and-treatments/treatments-and-surgery/medications/prescription-charges?utm_source=newzealandnow.govt.nz)
- For the list of funded drugs - Pharmaceutical Management Agency (PHARMAC):
(http://pharmac.govt.nz/patients?utm_source=newzealandnow.govt.nz).

Support Programs

In addition, a wide range of support programs are available to eligible individuals and families. Some are universal, others are income-based, and many are based on the medical needs.

Universal

Accident Compensation Corporation (ACC)

ACC provides no-fault personal injury insurance cover to all residents and visitors in New Zealand for injuries resulting from accidents (for instance, car crashes, work injuries, slips, trips and falls at home, skiing accident, and so on) even if the person who is injured caused the accident.

- ACC helps cover medical and treatment fees and rehabilitation costs, such as physiotherapy or residential care, although there are part-charges for some treatments. ACC will also make a payment to families in the case of accidental death, even if the family live outside of New Zealand.
- Residents pay for ACC cover through a levy on their income and charges for running a car.

(<https://www.newzealandnow.govt.nz/living-in-nz/healthcare/paying-for-healthcare-services>) and for more information on ACC : <http://www.acc.co.nz/>)

Income-based

Community Services Card (CSC)

Individuals on a low income or families on a low to middle income may be eligible for a Community Services Card. This provides higher government subsidies on the cost of visits to a general practitioner and buying prescription items. The card can be used

for dependent children aged under 18 years.

The Community Services Card can reduce the cost of:

- prescription fees;
- fees for after-hours general practice visits;
- visits to a general practice where the individual is not enrolled;
- glasses for children under 16;
- emergency dental care provided by hospitals and approved dental contractors (ask the dental provider if they are an approved contractor);
- travel and accommodation for treatment at a public hospital outside the home area when the patient has been referred (at least 80 km away for adults and 25 km for children);
- home help.

(For more information on the CSC :

http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/community-services-card-and-high-use-health-card?utm_source=newzealandnow.govt.nz)

Based on Medical Needs

High Use Health Card (HUHC)

If a patient does not qualify for a Community Services Card but faces ongoing doctor's visits for a particular medical condition, he/she may be eligible to get a High Use Health Card to help with the costs. To be eligible for this card, the patient needs to have visited a health practitioner at the general practice they are enrolled in, 12 or more times in a year, with the consultations being related to a particular condition or condition(s) which are ongoing. This card is not means tested.

The High Use Health Card gives a general practice a higher government subsidy for patients with high health needs. This means that the practice can spend more time on developing plans to better manage the patient's health condition(s). The HUHC gives the same amount of subsidy as the Community Services Card on general practice visits and prescription charges but the CSC applies to all dependent family members, whereas the HUHC applies only to the individual.

(For more information on the HUHC :

http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/community-services-card-and-high-use-health-card?utm_source=newzealandnow.govt.nz)

Care Plus

Care Plus is a primary health care funding initiative to support people with high health needs due to chronic conditions, acute medical or mental health needs, or terminal

illness. Care Plus services are usually provided at a low or reduced cost.

Care Plus differs from the HUHC in that it coordinates a *comprehensive approach* to improve outcomes for people with chronic conditions, including lower cost access, whereas the HUHC is a subsidy approach tied to general practice visits.

Overall funding allows for 5% of the New Zealand population to be Care Plus patients. Care Plus funding is based on a capitation formula, and the level of funding paid to PHOs is dependent on the percentage of the eligible number of Care Plus patients receiving Care Plus services.

(For more information on Care Plus :

<http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/care-plus>)

Prescription Subsidy Card

Once patients and their families have collected 20 new prescription items in a year (from February 1), they become eligible for a Prescription Subsidy Card, which means they won't have to pay any more prescription charges until January 31 the following year. Medicines that are not funded by the government are not included in this total.

(For more information on the Prescription Subsidy Card:

<http://www.health.govt.nz/your-health/conditions-and-treatments/treatments-and-surgery/medications/prescription-subsidy-card>)

Other condition-specific programs

For the complete list of benefit programs (not only health-related):

<http://www.workandincome.govt.nz/products/a-z-benefits/index.html>.

Medical Transportation

Emergency Ambulance Services (EAS)

National Ambulance Sector Office (NASO) manages funding from ACC and the Ministry of Health for the following Emergency Ambulance Services :

Road Ambulance

Wellington Free Ambulance

Greater Wellington region (including the Wairarapa) is serviced by Wellington Free Ambulance. It is free for patient. (<http://www.wfa.org.nz/>)

St John Ambulance

St John Ambulance Services are not fully funded by the government. Contracts with

the Ministry of Health, ACC and DHBs fund fewer than 70% of the direct operating costs. The ambulance part charges is NZ\$98.00, unless it is an accident related injury that is covered by the ACC for ambulance transport within 24 hours of the injury and if the injury meets ACC criteria, or if the patient is a Supporter Scheme subscriber. The cost of ambulance transfers between hospitals - where the DHB has ordered the transfer - will be covered by the DHB.

(<http://www.stjohn.org.nz/What-we-do/St-John-Ambulance-Services/Part-Charges/>)

Air Ambulance

New Zealand Air Ambulance Service (NZAAS) provides Level 1 and 2 inter hospital transfers to all District Health Boards in New Zealand. For Government agencies such as DHBs and ACC, accounts are be forwarded for payment on usual commercial terms. (<http://www.nzaas.co.nz/national-service>)

Transportation Support Programs

St John Health Shuttle

This is a free community service that transports people to essential medical and health-related appointments, and then brings them home again. There is no charge for shuttle transport, however a donation is appreciated to cover costs.

(<http://www.stjohn.org.nz/What-we-do/Community-programmes/Health-Shuttles/>)

Primary Response In Medical Emergencies (PRIME)

The PRIME program is funded by the Ministry of Health and ACC, and administered by St John. It was developed to provide a coordinated response and appropriate management of emergencies in rural locations. The programme uses the skills of specially trained rural general practitioners and/or rural nurses to support the St John ambulance service in areas where response times may be longer than usual, or where more specialised medical skills would assist the patient's condition.

(<http://www.stjohn.org.nz/What-we-do/Community-programmes/Partnered-programmes/PRIME/>)

National Travel Assistance Scheme

A patient eligible for travel assistance may be able to claim for kilometers traveled by private car, public transport, accommodation, and specialised transport (such as taxis, mobility taxis, or air travel). Patient may be eligible for travel assistance if :

- They have been referred to the specialist they are going to see by another specialist (not a general practitioner);
- and, both specialists are publicly funded – that is, they are part of a government-funded health and disability service (for example, a renal dialysis centre or a specialist disability service);

- and, they can answer 'yes' to one or more of the questions in the checklist.

(For more information on the National Travel Assistance Scheme :

<http://www.health.govt.nz/your-health/services-and-support/health-care-services/hospitals-and-specialist-services/travel-assistance>)

Travel and Accommodation Costs from Ministry of Social Development

A patient may be able to get help if they :

- are 16 or over;
- are a New Zealand citizen or permanent resident;
- normally live in New Zealand and intend to stay here;
- have an immediate and essential need;
- are referred to a hospital or other health service for medical treatment, assessments or services by a registered medical practitioner;
- are not receiving help for that travel or accommodation cost:
 - from a Health Agency;
 - under the National Travel Assistance Scheme;
 - from a Disability Allowance.

It also depends on:

- how much the patient and their partner earn;
- any money or assets the patient and their partner have.

The Ministry of Social Development only helps with travel costs if they are for a one-off appointment, e.g. day surgery or consultations. The Ministry generally pays up to NZ\$300 in a year, but it may vary depending on the patient's situation. The Ministry can pay for actual and reasonable:

- travel costs for a return journey of at least 8 km to the place of treatment, assessment or services;
- accommodation and meal costs if the patient needs to stay away from home overnight to attend the treatment, assessment or services.

(For more information :

<http://www.workandincome.govt.nz/eligibility/health-and-disability/travel-costs.html#nu>
ll)

Overview of Health Care System - New Zealand (2)

Māori health and health care included under the authority of the
Ministry of Health
 (Te Kete Hauora Māori Health Business Unit : advisory group)

↓

- **District Health Boards**

- Board must have at least 2 Māori members, out of 11
- Iwi (tribe) Health Board/ DHB Partnerships



- **Māori Health Providers**
 (Part of Māori Health Strategy)

- NZ\$170 million (2014/15)
- 1.49% of DHBs' overall Crown funding for health services (2014/15)

↓

- **Rongoā Māori (traditional healing) Providers**

- (Part of Māori Health Strategy)
- Approx. NZ\$1.9 million in Ministry of Health contracts (2015)
 - Some also contracted by PHOs

OVERVIEW OF HEALTH CARE SYSTEM - NEW ZEALAND (2 OF 2)

Māori health and health care have been included **under the authority of the Ministry of Health** (Lavoie, 2004, p.7).

Within the Ministry, the **Māori Health Business Unit, also named Te Kete Hauora** (“The basket of health”, an oblique reference to ancient *tauparapara* (legend) which related the exploits of *Tane-nui-a-rangi* in his pursuit of knowledge), acts as an advisory group.

Its role is to provide policy advice on the overall strategy for achieving the government’s objective for Māori health, which is to reduce inequalities in health status for Māori and improve Māori health and disability status. It will work with other business units, sections and teams within the Ministry to enable them to increase their understanding and responsiveness to the needs and aspirations of Māori and to equip them in their role to improve Māori health. Its role is also to develop relationships with the key organisations and agencies that contribute to a health and disability sector with a view to improving Māori health and disability status, and facilitating leadership within the Māori health sector. The Unit aims to improve quality by being :

- knowledge based;
- people centered, and;
- systems minded.

(For more information on the Unit :

<http://www.health.govt.nz/about-ministry/ministry-business-units/maori-health-business-unit/welcome-te-kete-hauora-maori-health-business-unit>)

In New Zealand, there is no health benefits program similar to what is in place here through the Non-Insured Health Benefits program. There are, however, components of the health care system aimed specifically at improving both Māori health outcomes and Māori participation in the system.

District Health Boards (DHBs)

- Each District Health Board must have at least **2 Māori members** out of 11, whom the Minister will appoint if they are not elected. (He Korowai Oranga Māori Health Strategy, 2002, p.16 and <http://www.waikatodhb.health.nz/about-us/board/>)
- They must also be in an active partnership with their **Iwi (tribe) Health Board**, which advises the DHB on strategic matters that affect the health and disability status of Māori. (Ministry of Health, 2002, p.15; and <http://www.nmdhb.govt.nz/quicklinks/about-us/governance/iwi-health-board/>)

Māori Health Providers

DHBs are the primary funders of Māori Health Providers. Under legislation, the New Zealand Public Health and Disability Act 2000, DHBs have a responsibility to support Māori involvement in service delivery. Most DHBs demonstrate this through a wide range of service contracts to Māori health providers.

<http://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers/funding-maori-health-providers-dhbs>)

DHBs' combined funding to Māori health providers was NZ\$170 million in 2014/15, an increase of NZ\$23 million, or 15.6%, from 2010/12. This increase was higher than the percentage increase in DHBs' Crown funding for health services (13.6%) during the same time. Although DHBs' funding to Māori health providers is increasing, it remains a small percentage of DHBs' overall Crown funding for health services, increasing from 1.46% in 2010/11 to 1.49% in 2014/15.

<http://www.health.govt.nz/publication/funding-maori-health-providers-district-health-boards-dhbs-2010-11-2014-15>)

Rongoā Māori (traditional healing) Providers

Traditional Healing Providers receive funding as well, although directly from the

Ministry of Health.

(<http://www.health.govt.nz/our-work/populations/maori-health/rongoa-maori-traditional-maori-healing>)

- Approximately NZ\$1.9 million in Ministry of Health contracts (Ahuri-Driscoll, Boulton, Stewart, Potaka-Osborne, & Hudson, 2015).

Both Māori Providers and *Rongoā* Māori Providers are part of the Māori Health Strategy, which will be discussed more in depth on slide 18.

Primary Health Organizations (PHOs) can receive **additional funding** in relation to Māori health through the following channels :

- Health promotion funding is calculated based on NZ\$2.20 per enrollee (from July 2015) with different multipliers for differing groups of need. Multipliers are applied for Māori (1.2 for Māori in Deprivation decile 1-8, 1.4 for Māori in Deprivation decile 9-10). (For more information : <http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/health-promotion-primary-health-care>)
- Services to Improve Access (SIA) funding is available for all PHOs to reduce inequalities among those populations that are known to have the worst health status, among them the Māori. The funding is for new services or improved access for high needs patients and is additional to the main PHO capitation funding for general practice-type care. Funds are allocated according to the number of people from these population groups enrolled in the PHO. (For more information on SIA funding : <http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/services-improve-access>)

References :

- Ahuri-Driscoll, A., Boulton, A., Stewart, A., Potaka-Osborne, G., & Hudson, M. (2015). Mā mahi, ka ora: by work, we prosper—traditional healers and workforce development - New Zealand Medical Journal. *The New Zealand Medical Journal*, 128(1420), 34-44.
<https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1420-21-august-2015/6623>
- Ministry of Health. (2002). He Korowai Oranga Māori Health Strategy. Wellington, N.Z. 47 pages.
<https://www.health.govt.nz/system/files/documents/publications/mhs-english.pdf>
- Lavoie, J. G. (2004). Governed by contracts: The development of indigenous primary health services in Canada, Australia and New Zealand. *International Journal of Indigenous Health*, 1(1), 6-24.

- http://www.naho.ca/jah/english/jah01_01/journal_p6-25.pdf

Overview of Health Care System - Australia (1)

- **Medicare System:** Universally accessible and affordable health care funded by Commonwealth government
→ \$162 billion, 10% of GDP (2014/15)

System Component	Support Programs
Health Services Delivery Medicare Benefits Schedule <ul style="list-style-type: none"> ■ Public hospitals and primary health care (state/territory) ■ National Health Reform: 31 Primary Health Networks ■ Private health care 	<ul style="list-style-type: none"> ■ Chronic Medical Condition Assistance ■ Medicare Safety Net ■ Medicare Indigenous Access Program <p>*Private insurance</p>
Drugs and Medication <ul style="list-style-type: none"> ■ Pharmaceutical Benefits Scheme ■ Co-payment 	<ul style="list-style-type: none"> ■ PBS Safety Net ■ Concession and health care cards <p>*Private insurance</p>

OVERVIEW OF HEALTH CARE SYSTEM - AUSTRALIA (1 OF 2)

The Australian Government's funding contributions include a universal public health insurance scheme, **Medicare**.

- AUS\$162 billion for 2014/15 financial year.
- Total expenditure: 10% of GDP in 2014/15.

(<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129557188>)

(For more information on the Australia health system - general:

<http://www.aihw.gov.au/australias-health/2014/health-system> / and

<http://www.health.gov.au/internet/publications/publishing.nsf/Content/natsihp-compani-on-toc~health-system>)

Medicare was introduced in 1984 to provide free or subsidised treatment by health professionals such as doctors, specialists and optometrists.

- The Medicare system has three components : **hospital, medical and pharmaceutical**
(http://www.ombudsman.gov.au/_data/assets/pdf_file/0027/29295/PHIO-Annual-Report-2014.pdf).
- The schemes are supplemented by social welfare arrangements, such as smaller out-of-pocket costs and more generous safety nets for those who receive certain income-support payments

- (<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422169>).
- **Funding** : Almost 70% of total health expenditure during 2011-12 was funded by governments, with the **Australian Government** contributing 42.4% and **state and territory** governments 27.3%. The remaining 30.3% (AUS\$42.4 billion) was paid for by patients **out-of-pocket** (17%), **private health insurers** (8%) and **accident compensation schemes** (5%) (<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422169>).
- **Medicare Benefits Schedule** : Free or subsidised treatment by health professionals such as doctors, specialists, optometrists and in specific circumstances dentists and other allied health practitioners, and accommodation as a public patient in a public hospital - set by the Australian Government after discussion with the medical profession.
- Practitioners are not required to adhere to the schedule (except for optometry) and can charge more than the scheduled fee. In these instances, the patient is required to pay the extra amount, often called a 'gap' payment (<http://www.qgso.qld.gov.au/products/reports/qld-govt-pop-proj-reference-info/qld-govt-pop-proj-2013-background-research.pdf>)

(For more information on what is covered under Medicare:

<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Downloads-201607> - July 1, 2016 Medicare Benefits Schedule)

Medication

Under the Pharmaceutical Benefits Schedule (PBS), Australians pay only part of the cost of most prescription medicines bought at pharmacies. The rest of the cost is covered by the PBS. The amount paid by the patient varies, up to a maximum of AUS\$38.30 for general patients, down to AUS\$6.20 for those with a concession card

- If a medicine is not listed under the PBS schedule, the consumer has to pay the full price as a private prescription. Non-PBS medicines are not subsidised by the Australian Government. However, medicines provided in public hospitals are generally provided to public patients for free, with the cost covered by state and territory governments.

(For an A-Z medicine listing : <http://www.pbs.gov.au/browse/medicine-listing>)

(For additional information on the Safety Net Threshold for low-income residents :

<https://www.humanservices.gov.au/customer/services/medicare/pharmaceutical-benefits-scheme-pbs-safety-net>)

(For additional information on the Pharmaceutical Benefits Schedule :

<http://www.pbs.gov.au/pbs/home>)

Additional Support Programs - General

There are a number of support programs based on income, specific to certain populations, or specific to health conditions to fill in the gaps of the Medicare system.

(For general information:

<https://www.humanservices.gov.au/customer/subjects/concession-and-health-care-cards>)

Chronic Medical Condition Assistance

The Australian Government provides financial support to help people with a chronic medical condition. Patients can claim benefits and payments for certain health care services and equipment.

(For additional information:

<https://www.humanservices.gov.au/customer/subjects/chronic-medical-condition-assistance>)

Medicare Safety Net

If a patient must see a doctor often, or have tests regularly, their medical costs could be high. Visiting a doctor or having tests may cost them less once they reach a Medicare Safety Net threshold. Once they reach the relevant threshold, the Medicare Safety Net may provide a higher Medicare benefit for all eligible services for the rest of the calendar year. This may mean that visits to their doctor or having tests could cost less. For example, once a patient reaches the relevant threshold, they still pay the same amount upfront to their doctor; however, they may receive a higher Medicare benefit, making their out-of-pocket expenses much less.

(For additional information:

<https://www.humanservices.gov.au/customer/services/medicare/medicare-safety-net>)

Medicare Indigenous Access Program

Aboriginal or a Torres Strait Islander Australian can receive help to get better access to Medicare services, including the:

- [Medicare Safety Net](#);
- [Pharmaceutical Benefits Scheme \(PBS\)](#);
- [Australian Organ Donor Register](#); and
- [Australian Immunisation Register](#).

The program provides :

- The **Medicare Aboriginal and Torres Strait Islander Access Line**.
(<https://www.humanservices.gov.au/customer/services/medicare/medicare-aboriginal-and-torres-strait-islander-access-line>)
- **Medicare Liaison Officers** : In keeping with the Government's promise to deliver great service to all Australians, it works with Aboriginal and Torres

- Strait Islander communities and health care providers to improve access to services. This includes Medicare Liaison Officers across Australia who have culturally appropriate skills and expertise. They communicate sensitively and work closely with communities, Aboriginal medical services and other health service providers to :
 - provide Medicare education and training to health service staff about Indigenous health care plans and the Medical Benefit Schedule (MBS) items available for Indigenous customers;
 - increase Aboriginal and Torres Strait Islander Australians enrolments in Medicare;
 - ensure correct Medicare benefits are claimed;
 - visit health services to provide support and advice about new Medicare initiatives and assist with any issues;
 - represent and promote Medicare programs and services at local Indigenous forums and events
- **Aboriginal and Torres Strait Islander health checks** : Aboriginal and Torres Strait Islanders have higher rates of chronic diseases. Aboriginal and Torres Strait Islander health checks must be done by the patient's usual doctor, nurse or clinic. They include :
 - asking about the patient's health;
 - doing a physical examination;
 - organising any tests needed, and;
 - writing up a health plan for the patient.
- **Closing the Gap for PBS prescriptions** : The Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) Co-payment Measure helps Aboriginal or Torres Strait Islander Australians with chronic disease or who are at risk of chronic disease get most prescription medicines :
 - at a lower price, or;
 - free of charge if they have a Health Care Card.
- **The Voluntary Indigenous Identifier program** : Aboriginal or Torres Strait Islander Australians who wish to do so can identify as such by completing the [Medicare Voluntary Indigenous Identifier form](#).

(For complete information on the Indigenous Access Program :

<https://www.humanservices.gov.au/customer/services/medicare/indigenous-access-program>)

Additional Programming - Pharmaceutical

PBS Safety Net

- When a patient is close to reaching the **PBS Safety Net threshold**, they can

- ask their pharmacist about a PBS Safety Net card. With this card, their PBS medicine is less expensive, or free, for the rest of the calendar year.
- Patient can choose a more expensive brand of medicine, but they may need to pay more. The extra amount will not count towards their PBS Safety Net threshold.
- If a patient goes over the threshold before they get their PBS Safety Net card, they may get a refund.

(For additional information:

<https://www.humanservices.gov.au/customer/services/medicare/pharmaceutical-benefits-scheme-pbs-safety-net>)

Low Income Health Care Card

Individuals may be eligible for a Low Income Health Care Card if they are on a low income and meet the Low Income Health Care Card income test. A Low Income Health Care Card entitles the cardholder to **cheaper medicines under the Pharmaceutical Benefits Scheme**. They may also be entitled to concessions offered by private companies, state/territory government, and local council concessions, such as: **energy and electricity bills, healthcare costs, including ambulance and dental and eye care, public transport costs, educational fees, and water rates.**

(For Additional information:

<https://www.humanservices.gov.au/customer/services/centrelink/low-income-health-care-card>)

There are a number of other different types of concession and health care cards. Each card has its own eligibility requirements and concessions:

- [Commonwealth Seniors Health Card](#)
- [Ex-Carer Allowance \(Child\) Health Care Card](#)
- [Foster Child Health Care Card](#)
- [Health Care Card](#)
- [Medicare Card](#)
- [Pensioner Concession Card](#)

Out-of-pockets costs

The Report: Out-of-Pocket Costs in Australian Healthcare 2014 - Community Affairs References Committee describes how out-of-pocket costs act as barrier to Aboriginal and Torres Strait Islander individuals accessing health care services.

(http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Australian_healthcare/Report)

- (NACCHO) noted: On average **12 per cent of Aboriginal Australians defer GP visits for more than a year because of costs, more than twice the rate of the general population**. Aboriginal Australians also present disproportionately high “potentially avoidable GP-type presentations” to hospital outpatients particular in major cities and inner regional centres.
- The committee received evidence that existing out-of-pocket health expenses create an environment where individuals already defer medical treatment or filling prescriptions because of financial reasons. Further, **evidence suggests that out-of pocket costs impact disproportionately on individuals with the greatest health needs including Aboriginal and Torres Strait Islander people**, people with chronic illnesses and people living in rural and remote areas.

Private sector

- Physicians, community-based medical and dental treatment, private hospitals and private insurance provision are privatized.
- Private sector health service providers include private hospitals, medical practices and pharmacies.
- In 2011-2012, the 592 private hospitals in Australia accounted for 44% of Australia's 1,345 hospitals and 33% of all available hospital beds.
(<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~Health%20care%20delivery%20and%20financing~235>)
- More than 40% of all hospitalisations occurred in private hospitals, including 2 out of every 3 hospitalisations involving elective surgery.

The **growing role for private hospitals** in Australia's health system has been supported by the Australian Government through measures such as the Private Health Insurance Rebate, and reflected in the inclusion of private hospitals in national performance monitoring initiatives such as those of the National Healthcare Agreement, and in the Performance and Accountability Framework of the National Health Reform Agreement.

(http://www.coag.gov.au/agreements_and_reports)

(<http://www.aihw.gov.au/national-health-priority-areas>)

(<http://www.aihw.gov.au/australias-health/2014/preventing-ill-health/#t11>)

Private Insurance

- Private insurance offers cover for some or all of the costs of a range of other items or services not covered by Medicare, such as ambulance services, dental services, prescription glasses, and physiotherapy

(<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/1301.0~2012~Main%20Features~Health%20care%20delivery%20and%20financing~235>)

- Private patients have more control in choosing their treating doctor in hospital and may be able to reduce their waiting time for elective surgery by having treatment in a private hospital.
- In Australia, only 15% of Indigenous peoples versus 51% of non-indigenous peoples have private health insurance coverage (Pulver *et al.*, 2010, p.11).
- The National Aboriginal Community Controlled Health Organisation submitted that studies have indicated that Aboriginal and Torres Strait Islander people have a much lower uptake of private health insurance. Any moves to expand the role of private health insurers into the delivery of primary health care services risks further alienation of Aboriginal and Torres Strait Islander people from health care services.

(http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Australian_healthcare/Report)

Health Service Delivery

State/Territory Health Service Delivery

Responsibility outlined by National Agreements Concerning National Healthcare.

(For more information :

http://www.federalfinancialrelations.gov.au/content/national_agreements.aspx)

The **National Healthcare Agreement**: Outlines responsibility for health service provision and funding between Commonwealth, State and Territory, private sector and community.

The **National Health Reform Agreement** was entered into by all states, territories and the Commonwealth in August 2011. It sets out the shared intention of the Commonwealth, and state and territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.

These arrangements aim to deliver a nationally unified and locally controlled health system through :

- Introducing a number of financial arrangements for the Commonwealth and states and territories in partnership;
- Confirming state and territories' lead role in public health and as system managers for public hospital services;
- Improving patient access to services and public hospital efficiency through the use of activity based funding (ABF) based on a national efficient price;
- Ensuring the sustainability of funding for public hospitals by the Commonwealth providing a share of the efficient growth in public hospital services:

- Improving the transparency of public hospital funding through a National Health Funding Pool;
- Improving local accountability and responsiveness to the needs of communities through the establishment of local hospital networks (LHNs) and Medicare locals;
- New national performance standards and better outcomes for hospital patients.

(For more information on the National Healthcare Agreement 2011 :

http://www.curtin.edu.au/research/jcipp/local/docs/National_Healthcare_Agreement_2011.pdf)

Local/Regional Delivery of Health Services

The implementation of National Health Reform Agreement 2011 activities is strengthening local decision-making and community involvement in health service delivery. To achieve greater local engagement, the National Health Reform is delivering **better access to services, improved local accountability and transparency and greater responsiveness to local communities**, through :

- the establishment of 61 Medicare locals - replaced by **Primary Health Networks** in 2015 - , which are coordinating primary health care delivery and addressing local health care needs and service gaps, by driving improvements in primary health care (including after hours primary care) and ensuring that services are tailored to meet the needs of local communities;
- **136 Local Hospital Networks**, funded nationally to localise the management of public hospitals.

Under National Health Reform, the Australian Government will invest at least AUS\$16.4 billion in additional efficient growth of funding from 2014-2015 to 2019-2020 to ensure all Australians can access the care they need, where and when they need it.

(For more information:

<http://www.health.gov.au/internet/publications/publishing.nsf/Content/natsihp-compani-on-toc~health-system>)

Primary Health Networks (PHNs)

The Australian Government is committed to delivering an efficient and effective primary health care system through the establishment of PHNs. Evidence indicates that health systems with strong integrated primary health care at their core are both effective in improving patient outcomes and experiences and efficient at delivering appropriate services where they are needed most.

- On 1 July 2015, 31 PHNs were established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor

- health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time. PHNs will achieve these objectives by working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for patients.
- The Government has agreed to six key priorities for targeted work by PHNs. These are mental health, **Aboriginal and Torres Strait Islander health**, population health, health workforce, eHealth and aged care.

(For additional information:

<http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Home>)

References

- Pulver, L. J., Haswell, M. R., Ring, I., Waldon, J., Clark, W., Whetung, V., ... & Sadana, R. (2010). Indigenous Health—Australia, Canada, Aotearoa New Zealand and the United States-Laying claim to a future that embraces health for us all. World Health Organization, 107 pages.
<http://www.who.int/healthsystems/topics/financing/healthreport/IHNo33.pdf>

Overview of Health Care System - Australia (2)

- **Aboriginal and Torres Islander Strait health** under authority of **Department of Health**
- **National Indigenous Reform Act** (2008) endorsed by *Council of Australian Governments*
- **Closing the Gap Framework:** Health equality by 2031
 - Implementation Plan
 - Aboriginal and Torres Strait Islander Health Performance Framework
- **National Aboriginal Community-Controlled Health Organizations**
Aboriginal Community-Controlled Health Services

OVERVIEW OF HEALTH CARE SYSTEM - AUSTRALIA (2 OF 2)

The responsibility for Aboriginal and Torres Islander Strait health falls under the authority of the **Department of Health**. There is a national healthcare plan that attempts to address these “gaps” in the system for Indigenous Health.

(For general information : <https://www.health.gov.au/Indigenous>)

In 2008, the Council of Australian Governments created the **National Indigenous Reform Act**, implementing the **Close the Gap Framework** to address these health disparities.

Background: Close the Gap Campaign

The targets under the *Close the Gap* framework are :

- 1) close the life expectancy gap within a generation (by 2031);
- 2) halve the gap in mortality rates for Indigenous children under five within a decade (by 2018);
- 3) ensure all Indigenous four-year-olds in remote communities have access to early childhood education within five years (by 2018);
- 4) halve the gap for Indigenous students in reading, writing and numeracy within a decade (by 2018);

- 1) halve the gap for Indigenous people aged 20-24 in Year 12 attainment or equivalent attainment rates (by 2020); and
- 2) halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade (by 2018).

The program/commitment is based on:

- a new **partnership** between Indigenous Australians and their representatives and Australian governments to underpin the national effort to achieve Indigenous health equality;
- the development of an appropriately funded, long-term comprehensive national plan of action to achieve Indigenous health equality.

The last few years have seen a fundamental shift in government policy towards Aboriginal and Torres Strait Islander people, influenced at least partially by the *Close the Gap* campaign. All Australian governments agreed to “a partnership between all levels of government to work with Indigenous communities to achieve the target of closing the gap on Indigenous disadvantage”. The Statement of Intent includes commitment to:

- propose a plan of action;
- ensure full participation of Aboriginal and Torres Strait Islander peoples;
- work collectively to systematically address the social determinants;
- build on the evidence base supporting what works in Aboriginal and Torres Strait Islander health;
- support and develop Aboriginal and Torres Strait Islander community-controlled health services in urban, rural and remote areas; and
- achieve improved access :
 - respect and promote the rights of Aboriginal and Torres Strait Islander peoples, including by ensuring that health services are available;
 - measure, monitor, and report on joint efforts, in accordance with benchmarks and targets.

Close the Gap campaign goes beyond health and addresses other social determinants of health such as employment and education.

Areas of focus for the *Close the Gap* campaign: chronic diseases, maternal and child health, primary health care and substance use services, social and mental wellbeing & workforce capability (Pulver *et al.*, 2010)

These *Close the Gap* commitments are central to the **National Aboriginal and Torres Strait Islander Health Plan**. (To access the National Aboriginal and Torres Strait Islander Health Plan :

[http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/\\$File/health-plan.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/B92E980680486C3BCA257BF0001BAF01/$File/health-plan.pdf))

Vision: The Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable.

These *Close the Gap* commitments have also directed more funding towards Indigenous Australian's health programming.

Closing the Gap National Partnership Agreements (2008)

Overview of Partnership Agreements:

<http://www.healthinonet.ecu.edu.au/closing-the-gap/key-facts/what-are-the-national-partnership-agreements-and-how-do-they-fit-in>

The *National Partnership Agreements* (NPAs) are agreements between the Commonwealth of Australia and the states and territories. They ensure that all levels of government are committed to the same framework of outcomes, measure of progress, and policy directions. NPAs build on current initiatives, address shortfalls, and may provide additional funding.

The six agreements included in the *Close the Gap* policy are detailed below. These agreements are applicable from 2009.

- [Indigenous early childhood development](#) [1]
- [Remote service delivery](#) [2]
- [Indigenous economic participation](#) [3]
- [Remote Indigenous housing](#) [4]
- [Indigenous health outcomes](#) [5]
- [Remote Indigenous public internet access](#) [6]
- [Northern Territory](#) [7]

The Aboriginal and Torres Strait Islander Health Plan is accompanied with **Implementation Plan** and **Health Performance Framework** to evaluate progress towards these *Close the Gap* targets.

Implementation Plan

[http://www.health.gov.au/internet/main/publishing.nsf/Content/AC51639D3C8CD4EC CA257E8B00007AC5/\\$File/DOH_ImplementationPlan_v3.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/AC51639D3C8CD4EC CA257E8B00007AC5/$File/DOH_ImplementationPlan_v3.pdf))

- The Implementation Plan takes forward the overarching vision of the National

- Aboriginal and Torres Strait Islander Health Plan 2013-2023 by progressing strategies and actions that improve health outcomes for Aboriginal and Torres Strait Islander peoples and prevent and address systemic racism and discrimination in the health system.
- The introduction of twenty new Implementation Plan goals provides the infrastructure for a strong **accountability** mechanism and the precursor **towards realising the 2013-2023 Health Plan's goals**. Strategies and actions such as empowering youth and adolescents to be proud of their identity and culture recognise the centrality of culture in the health and wellbeing of Aboriginal and Torres Strait Islander peoples.

Health Performance Framework

(<http://www.dpmc.gov.au/indigenous-affairs/evidence/aboriginal-and-torres-strait-islander-health-performance-framework-hpf>)

- This report series measures progress on health outcomes, health system performance and determinants of health (such as employment, education and safety).
- Beginning in 2006, HPF reports are released every two years. They cover analysis of data from 65 national data collections, over 600 research articles and the policy context and implications of the evidence.
- The report is intended for policy makers, providers of health and other key services and interested members of the public.

Indigenous Australians' Health Programme (IAHP)

The Department of Health also has developed an Indigenous Australians' Health Programme (IAHP).

(For additional information on IAHP:

[http://www.health.gov.au/internet/main/publishing.nsf/Content/09AEEA5F377AE5B5CA257F1C00159135/\\$File/Accessible-IAHP-Programme-Guidelines.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/09AEEA5F377AE5B5CA257F1C00159135/$File/Accessible-IAHP-Programme-Guidelines.pdf))

The Indigenous Health Division is responsible for the Indigenous Australians' Health Programme, which commenced on 1 July 2014. **This program consolidated four Indigenous health funding streams:**

- primary health care based funding;
- child and maternal health activities;
- Stronger Futures in the Northern Territory (Health); and
- the Aboriginal and Torres Strait Islander Chronic Disease Fund.

The following **themes** comprise the program :

- Primary Health Care Services;
- Improving Access to Primary Health Care for Aboriginal and Torres Strait Islander People;
- Targeted Health Activities;
- Capital Works; and
- Governance and System Effectiveness.

Indigenous Health Budget Outcomes

(For additional information: <https://www.health.gov.au/Indigenous>)

- AUS\$920 million for 2014-2015, and commitment to grow over next four years - Australian Government will invest AUS\$3.1 billion in Indigenous-specific health programs and activities.
- This funding allocation methodology will include funding under the Indigenous Australians' Health Programme for Indigenous-specific comprehensive primary health care, child and maternal health services, the Stronger Futures in the Northern Territory (Health), and activities under the former Aboriginal and Torres Strait Islander Chronic Disease Fund.
- 2014-2015 Budget will also expand activities in key areas to close the gap and achieve health equality between Indigenous and non-Indigenous Australians, including child and maternal health, and improved chronic disease prevention and management.
- The Government is expanding programs that have demonstrated their effectiveness in improving health outcomes including:
 - \$94 million to expand efforts to improve child and maternal health through Better Start to Life; and
 - \$36.2 million to expand the Healthy for Life programme into a further 32 Aboriginal community controlled health organisations to improve the management of chronic disease.

Primary Health-care Networks (PHNs)

(Map :

[http://www.health.gov.au/internet/main/publishing.nsf/content/03F3D39E5C44403DC A257FB000095CA8/\\$File/phnNatSep15.pdf](http://www.health.gov.au/internet/main/publishing.nsf/content/03F3D39E5C44403DC A257FB000095CA8/$File/phnNatSep15.pdf))

- In 2015, the Australian Government selected organisations to establish and operate 31 PHNs through open competitive funding round; funding based on number of factors including population, rurality and socioeconomic factors.
- AUS\$852 million allocated to PHNs over three years.

- Additional flexible funding for Indigenous health, mental health, alcohol treatment...
- PHNs were established to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time.
- PHNs will achieve these objectives by working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to facilitate improved outcomes for patients.

The Government has agreed to six key **priorities** for targeted work by PHNs. These are mental health, **Aboriginal and Torres Strait Islander health**, population health, health workforce, eHealth, and aged care.

(For more information :

<http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background>)

PHNs present a strategic challenge to National Aboriginal

Community-Controlled Health Organizations: The Australian Government and some State Governments accelerated and extended their related policies of “commissioning” and creating “markets” of contracted service providers through the creation of Primary Health Networks. This was without Aboriginal or ACCHO sector representation nationwide and by using a competitive commissioning process for Indigenous Advancement Strategy, and introducing a new funding allocation methodology through the Indigenous Australians Health Programme, it has challenged some of the funding received by NACCHO.

National Aboriginal Community-Controlled Health Organizations (NACCHO)

Annual Report: <http://www.naccho.org.au/about-nacho/naccho-vision/>

Program information: <http://www.naccho.org.au/programmes/healthy-futures/>

For additional information: <http://www.naccho.org.au/about/>

NACCHO is the **national peak body** representing over **150 Aboriginal Community Controlled Health Services (ACCHSs)** across the country on Aboriginal health and wellbeing issues. It has a history stretching back to a meeting in Albury in 1974.

In 1997, the Federal Government funded NACCHO to establish a Secretariat in Canberra which greatly increased the capacity of Aboriginal Peoples involved in ACCHSs to participate in national health policy development.

An Aboriginal Community-Controlled Health Service is a primary health care service **initiated and operated by the local Aboriginal community** to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.

Aboriginal communities operate over 150 ACCHSs in **urban, regional and remote Australia**. They range from large multi-functional services employing several medical practitioners and providing a wide range of services, to small services which rely on Aboriginal Health Workers and/or nurses to provide the bulk of primary care services, often with a preventive, health education focus. The services form a network, but each is autonomous and independent both of one another and of government.

The integrated primary health care model adopted by ACCHSs is in keeping with the philosophy of Aboriginal **community control and the holistic view of health**. Addressing the ill health of Aboriginal people can only be achieved by local Aboriginal people controlling health care delivery.

Local Aboriginal community control in health is essential to the definition of Aboriginal holistic health and allows Aboriginal communities to determine their own affairs, protocols and procedures. NACCHO represents local Aboriginal community control at a national level to ensure that Aboriginal people have greater access to effective health care across Australia. NACCHO provides a coordinated holistic response from the community sector, advocating for culturally respectful and needs based approaches to improving health and wellbeing outcomes through ACCHSs.

What NACCHO does :

- **Promoting, developing and expanding** the provision of **health** and wellbeing **services** through local ACCHSs.
- **Liaison with organisations and governments** within both the Aboriginal and non-Aboriginal community on health and wellbeing policy and planning issues.
- **Representation and advocacy** relating to health service delivery, health information, research, public health, health financing and health programs.
- **Fostering cooperative partnerships and working relationships** with agencies that respect Aboriginal community control and holistic concepts of health and wellbeing. The National Aboriginal Community Controlled Health Organisation (NACCHO) is a living embodiment of the aspirations of Aboriginal communities and their struggle for self-determination.

NACCHO identified the **barriers** impeding Aboriginal and Torres Strait Islander people's access to health services :

- **economic** barriers: cannot afford doctor, PBS co-payments and invisible costs such as having a home phone to make appointments or enquiries or travel costs;
- **physical or geographical** barriers: rural and remote areas;
- **administrative** barriers: they may neither procure, nor carry current Medicare and health care cards;
- **cultural** barriers: unfamiliar (and possibly unwelcoming) non-Aboriginal service and lack of culturally competent staff. A serious problem facing Aboriginal-focused primary health care services is workforce recruitment and retention. This can lead to services resorting to a constant stream of agency staff that is not committed to developing long term relationships with clients or service improvement.

Numerous reports now acknowledge the importance of providing health services for Aboriginal and Torres Strait Islander people that are culturally secure and free from all forms of discrimination (Pulver *et al.*, 2010).

References

- Pulver, L. J., Haswell, M. R., Ring, I., Waldon, J., Clark, W., Whetung, V., ... & Sadana, R. (2010). Indigenous Health—Australia, Canada, Aotearoa New Zealand and the United States-Laying claim to a future that embraces health for us all. World Health Organization, 107 pages.
<http://www.who.int/healthsystems/topics/financing/healthreport/IHNo33.pdf>

Overview of Health Care System - Canada (1)

- **Primary health care mainly publicly funded**
 - CAD\$219.1 billion (anticipated, 2015)
 - Total health expenditure : 10.9% of GDP (anticipated, 2015)
- **Source of funds :**
 - 71% Public
 - 29% Private
- **Administered on a provincial or territorial basis, within guidelines set by the federal government (Canada Health Act 1984)**

OVERVIEW OF HEALTH CARE SYSTEM - CANADA (1 OF 2)

Overview

- In Canada, **primary health care is mainly publicly funded** through taxation mechanisms.
 - CAD\$219.1 billion (anticipated, 2015).
 - Total health expenditure : 10.9% of GDP (anticipated, 2015).
(<https://www.cihi.ca/en/spending-and-health-workforce/spending>)
- Funding comes from a **mix of public and private** (anticipated, 2015):
 - 71% Public (provincial and territorial government 66% / public sector 5%);
 - 29% Private (out-of-pocket 14% / private insurance 12% / other 3%).
(<https://www.cihi.ca/en/spending-and-health-workforce/spending/national-health-expenditure-trends/nhex2015-topic5>)
- Health care is administered on a **provincial or territorial basis**, within **guidelines set by the federal government**, mainly under the **Canada Health Act 1984**.
 - The Canada Health Act specifies a narrow portion of health services, namely physician and hospital care, which must be provided in order for provinces to obtain federal transfer payments (Lemchuck-Favel & Jock, 2004, p.39).
 - Provincial and territorial health care insurance plans must meet the

- standards described in the Canada Health Act. These standards include:
 - public administration;
 - comprehensiveness;
 - universality;
 - portability;
 - accessibility.

(<http://healthycanadians.gc.ca/health-system-systeme-sante/system-systeme/about-apropos-eng.php>)

- The **federal government** is responsible for :
 - setting and administering national standards for the health care system through the [Canada Health Act](#);
 - providing [funding support](#) for provincial and territorial health care services;
 - supporting the delivery for health care services to [specific groups](#), including First Nations and Inuit;
 - providing [other health-related functions](#).

(<http://healthycanadians.gc.ca/health-system-systeme-sante/system-systeme/about-apropos-eng.php>)

Medications and Medical Devices

- Under the Canada Health Act, all necessary drug therapy administered within a Canadian hospital setting is insured and publicly funded.
- Outside of the hospital setting, provincial and territorial governments are responsible for the administration of their own publicly-funded prescription drug benefit programs. There is no National Drug Formulary.
 - The federal, provincial and territorial governments offer varying levels of coverage, with different eligibility requirements, premiums and deductibles.
- Most Canadians have access to insurance coverage for prescription medicines through public and/or private insurance plans.

(<http://www.hc-sc.gc.ca/hcs-sss/pharma/acces/index-eng.php>)

Support Programs

- The publicly-funded drug programs generally provide insurance coverage for those most in need, based on age, income, and medical condition.

(<http://www.hc-sc.gc.ca/hcs-sss/pharma/acces/index-eng.php>)
- These programs also vary across provinces and territories.

- (<http://www.hc-sc.gc.ca/hcs-sss/pharma/acces/ptprog-eng.php>)

References:

- Lemchuk-Favel, L., & Jock, R. (2004). Aboriginal health systems in Canada: Nine case studies. *International Journal of Indigenous Health*, 1(1), 28-51.
http://www.naho.ca/jah/english/jah01_01/journal_p28-51.pdf

Overview of Health Care System - Canada (2)

Special branch for Indigenous peoples within Health Canada:

FIRST NATIONS & INUIT HEALTH BRANCH (FNIHB)

- Overview and role of FNIHB
- Programs managed under this branch
 - Non-Insured Health Benefits Program
 - Community programs
 - Primary Health Care
 - Public Health
- Legacy Medicine Chest Clause, Treaty 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." - Treaty Texts - Treaty No. 6 (transcript from 1876)

OVERVIEW OF HEALTH CARE SYSTEM - CANADA (2 OF 2)

First Nations and Inuit Health Branch

In Canada, Inuit and First Nations' health has been under the federal department of health (**Health Canada**) since **1944** (Lavoie, 2004, p.11). The specific sector is the **First Nations and Inuit Health Branch (FNIHB)**.

- FNIHB's **mandate** is to :
 - ensure the availability of, or access to, health services for First Nations and Inuit communities;
 - assist First Nations and Inuit communities address health barriers, disease threats, and attain health levels comparable to other Canadians living in similar locations; and
 - build strong partnerships with First Nations and Inuit to improve the health system.
- (<http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/mandat-eng.php>)
- Some of FNIHB's **roles** include :
 - supporting the delivery of public health and health promotion services on-reserve and in Inuit communities;
 - providing drug, dental and ancillary health services to First Nations and Inuit people regardless of residence;
 - ensuring primary care services on-reserve in remote and isolated

- areas, where there are no provincial services readily available.
(<http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/index-eng.php>)
- There are several **programs** managed under this branch, such as :
 - Non-Insured Health Benefits - which provides registered First Nations and recognized Inuit coverage for a range of medically necessary health related benefits to supplement benefits provided through private insurance plans, provincial/territorial health and social programs. Coverage under the NIHB Program includes:
 - prescription drugs and over-the-counter medications;
 - dental care;
 - vision care;
 - medical supplies and equipment;
 - mental health counselling; and
 - medical transportation.
 (<http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/nihbd-dssna/index-eng.php>)
 - Community programs;
 - Primary Health Care;
 - Public Health.
 (<http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/index-eng.php>)
- FNIHB is in part a **legacy of the Medicine Chest Clause** included in Treaty 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.”
Treaty Texts - Treaty No. 6 (transcript from 1876)
 - This clause has been interpreted differently by Indigenous communities and the federal government as to whether it means that health should be understood as an entrenched right, or if services are provided as a matter of policy.
 - At the time of signature of Treaty 6, smallpox was spreading amongst the Indigenous population.
 - Medicine chest clause & Famine clause: One of the selling points of the treaty was that a medicine chest would be kept at the home of the Indian agent for use by the people. Another of the selling points was the guarantee of assistance for famine or pestilence relief (Filice, 2016).
 (<http://www.aadnc-aandc.gc.ca/eng/1100100028702/1100100028704>)

References

- Lavoie, J. G. (2004). Governed by contracts: The development of indigenous

- primary health services in Canada, Australia and New Zealand. International Journal of Indigenous Health, 1(1), 6-24.
http://www.naho.ca/jah/english/jah01_01/journal_p6-25.pdf
- Filice, M. (2016). Treaty 6.
<http://www.thecanadianencyclopedia.ca/en/article/treaty-6/>

Promising initiatives in Indigenous Health - New Zealand (1)

New Zealand Health Strategy (2000) ➔ Maori Health Strategy (2002, last updated in 2013/14)

He Korowai Oranga (“The Cloak of Wellness”)

- Based on the *Pae Ora* vision for Māori Health
- **Extensive consultation** throughout New Zealand
- **Reference group :**
 - Policy practitioners, including the Ministry of Māori Development
 - District Health Boards representatives
 - Iwi-based (rural) & pan-Maori (urban) organisations
 - Māori scientists and researchers
 - Community and disability representatives
- **Whakata taka (“Weaving Strands”) Action Plan**

PROMISING INITIATIVES IN INDIGENOUS HEALTH - NEW ZEALAND (1 OF 2)

New Zealand has created the **Māori Health Strategy (2002)** as a population-specific section of the national New Zealand Health Strategy (2000).

The strategy was updated with input from across the sector during 2013/14 to ensure its relevance for the future. *Pae Ora* (Healthy Futures), as discussed on slide 7, is the vision and aim for the refreshed strategy. It builds on the initial foundation of *Whānau Ora* (Healthy Families) to include *Mauri Ora* (Healthy Individuals) and *Wai Ora* (Healthy Environments).

(For more information :

<http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga>; and, Ministry of Health, 2014)

- The strategy, named **He Korowai Oranga (“The Cloak of Wellness”)**, sets out the following objectives:
 - **Affirming Māori approaches :** The strategy strongly supports Māori holistic models and wellness approaches to health and disability. It will also *tautoko*, or support, Māori in their desire to improve their own health. He Korowai Oranga seeks to support Māori-led initiatives to improve the health of *whānau* (families), *hapū* (sub-tribes) and *iwi* (tribes). The strategy recognises that the desire of Māori to have

- control over their future direction is a strong motivation for Māori to seek their own solutions and to manage their own services.
- **Improving Māori outcomes** : Achieving this will mean a gradual reorientation of the way that Māori health and disability services are planned, funded and delivered in New Zealand. Government, District Health Boards (DHBs) and the health and disability sector will continue to have a responsibility to deliver improved health services for Māori, which will improve Māori outcomes.

(Ministry of Health, 2002, p.3)

- The original 2002 strategy has been developed through a process of **extensive consultation** throughout New Zealand. Consultation has occurred at all stages in the form of *hui* (meetings), and oral or written submissions from individuals and a range of organisations within and associated with the health sector and the community. Submissions have revealed stakeholder differences in the approach to implementing the Strategy and Action Plans. Tensions can be summarised as:
 - The Treaty of Waitangi needs to be central and more visible in the Strategy and Action Plans;
 - Action Plans should reflect greater commitment to traditional Māori healing practices;
 - Primacy and allocation of funding: iwi-based (rural) versus than pan-Māori (urban) organisations;
 - Tensions around giving primacy to scientific definitions of evidence versus evidence gained in a “Kaupapa Māori” process (by and for Maori).

(Walton, 2007, p.3)

- A **reference group**, composed of policy practitioners including the Ministry of Māori Development, DHB representatives, iwi-based & pan-Māori organisations representatives, Māori scientists and researchers, and community and disability representatives, has been charged with mediating and integrating the various perspectives.

(Walton, 2007, p.3)

He Korowai Oranga is implemented through the **Whakata taka (“Weaving Strands”)** **Action Plan**, prepared with input from District Health Boards and Māori health groups. The action plan is updated every two or three years, as implementation progresses (Ministry of Health, 2002, p.4).

- Implementing *He Korowai Oranga* is the responsibility of the whole of the health and disability sector, but it has implications for other sectors as well. DHBs in particular should consider *He Korowai Oranga* in their planning, and

- in meeting their statutory objectives and functions for Māori health. *He Korowai Oranga* assists Māori providers and communities, and other providers, when planning their own strategic development. (<http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga>)

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Promising initiatives in Indigenous Health - New Zealand (2)

- *Whakata tika* Action Plan - Main initiatives :
 - **Māori Health Plans** (DHBs, in partnership with Iwi Health Boards)
 - **Māori Health Providers**
 - **Rongoā Māori (traditional healing) Providers**
 - **Whānau Ora** - Extended family wellbeing program
 - **Mahere** - Information system designed to support health and social service providers work collaboratively with whānau
 - **Kia Ora Hauora** - National Māori health workforce development program
 - **Hauora Māori Scholarships** in health and disability studies
 - **Te Pātaka Auahatanga Hauora Māori** (The Storehouse of Māori Health Innovation), financed by the **Te Ao Auahatanga Hauora Māori Innovation Fund**

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PROMISING INITIATIVES IN INDIGENOUS HEALTH - NEW ZEALAND (2 OF 2)

The *Whakata tika* Action Plan is quite comprehensive. However, the section below offers a summary of some the main initiatives:

Māori Health Plans (DHBs, in partnership with *Iwi* Health Boards)

District health boards (DHBs) are required to prepare Māori Health Plans (MHPs) annually, in collaboration with their *Iwi* (tribe) Health Board.

Māori Health Plans are fundamental planning, reporting and monitoring documents, which underpin DHBs' efforts to improve Māori health and reduce the disparities between Māori and non-Māori. As **key planning and monitoring documents**, it is essential that these plans are comprehensive, complete and robust.

- An MHP provides a summary of a DHB's Māori population and their health needs (i.e., DHB Māori Health Needs Assessment). Better planning is also underpinned by better collection and administration of ethnicity data, high-quality research and the growing body of knowledge that tell the stakeholders what works to improve health outcomes.
- The plan then documents and details the interventions and actions the DHB

- plans to undertake to address health issues in order to achieve indicator targets set nationally, regionally and at district level. MHPs are also used as accountability mechanisms.

(For more information:

<http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/key-threads/building-gains> and <http://www.health.govt.nz/our-work/populations/maori-health/dhb-maori-health-plans-profiles-and-summaries#mhp>)

Māori Health Providers

Māori health providers are generally described as **Māori owned and Māori governed**. While the government and DHBs put in place service and contract requirements for these providers, Māori owners and governors set the overall direction and shape of these organisations. (<http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/key-threads/rangatiratanga>)

The types of services delivered by Māori health providers cover a range of health priorities, from child health, oral health, maternity, community health, specialist medicine, mental health and health of older people, to public health. The services can be categorised as health and disability services, and home and community support services.

(<http://www.health.govt.nz/system/files/documents/publications/funding-maori-health-providers-by-dhb-030816.pdf>)

Māori health providers tend to deliver health and disability services to predominantly Māori clients, although certainly not exclusively to Māori clients. What distinguishes the service is the *kaupapa* (a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society) and the delivery framework which is distinctively Māori.

(For more information on Māori health providers:

<http://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers>)

The **Māori Provider Development Scheme** provides grants to support the development of Māori providers. Funding is available to health providers, or health organisations that are owned, governed and operated by *iwi* and/or Māori organisations. Māori organisations and individuals must meet certain eligibility criteria before they can apply for funding. Funding for organisations is available for:

- provider assistance;

- workforce;
- service integration;
- quality, and;
- best practice.

(For more information on the Scheme:

<http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pathways-action/te-ara-tuarua-pathway-2-maori-participation-health-and-disability-sector>
and

<http://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers/maori-provider-development-scheme>)

Mainstream services have begun working with Māori providers and communities to take greater responsibility for Māori health in many areas. For example, publicly funded hospitals and major primary health care organisations have been required (through their contracts) to specify how they will identify and meet the needs of Māori. Many hospitals now have Māori and *whānau* (families) units, which focus on ensuring the services better meet the needs of Māori patients and that cultural safety issues are addressed. These initiatives need to continue alongside the relationships with the Māori community organisations, providers and communities (Ministry of Health, 2002, p.20).

The New Zealand Health Strategy, the New Zealand Disability Strategy and *He Korowai Oranga* are committed to the development of a health and disability support sector that embraces a culture of continual improvement in the delivery of services.

This must:

- be system wide;
- use a risk management approach to reduce preventable harm;
- foster consistency of practice through shared learning, benchmarking and clinical governance within a standards framework;
- take account of *whānau*, *hapū* (sub-tribes), *iwi* and Māori community views on quality of care, and;
- take account of the need for cultural as well as clinical safety.

(Ministry of Health, 2002, pp.21-22).

Rongoā (remedy, cure, or solution to a problem) Māori Providers (traditional healing)

Rongoā Māori is informed by a body of knowledge that has as its core the enhancement of Māori wellbeing. In this way, *rongoā Māori* differs from a Western medical paradigm, whose focus is principally the absence of health and wellbeing and treatments/interventions to return to a state of health.

- *Rongoā Māori* traditional healing is formulated in a Māori cultural context, in which the understanding of events leading to ill health and its impacts are addressed through a range of culturally bounded responses.
- These responses include *rakau rongoā* (native flora herbal preparations), *mirimiri* (massage) and *karakia* (prayer) and *whitiwhiti kōrero* (cultural support).

The Ministry of Health works with Māori traditional healing practitioners to support *rongoā Māori* within the health and disability sector. For a number of years, the Ministry has discussed with *rongoā whānau* – including traditional healers, Māori health providers and *iwi* – the role that traditional healing has with mainstream services.

- In December 2011, a new national *rongoā* governance body – *Te Kāhui Rongoā Trust* – was established to protect, nurture and promote *rongoā Māori*. (For more information on the Trust: <http://www.rongoamaori.org.nz/index.php/Home> - mainly in *Te reo Māori*, however.)
- *Rongoā* providers are supervised in collaboration with the national *rongoā* governance body, which has developed **standards of practice**, including training and assessment providers, patient confidentiality and safety, and continuity of service with the health and disability system, to name a few examples:
 - *Tūroro* (patient) receives services from *rongoā* practitioners who are trained and assessed as competent by the *rongoā* sector. A training plan relevant to the *rongoā* practitioner's scope of practice is maintained.
 - An individual service plan is developed to reflect the *tūroro* goals, support needs and requirements.
 - Links are identified and maintained with key groups, including the *rongoā* national association, district health boards, Ministry of Health and primary health-care organisations to facilitate continuity of service for the *tūroro*.
 (For more information on the *Tikanga ā-Rongoā/Standards of practice*:

<http://www.health.govt.nz/publication/tikanga-rongoa>)

The Ministry of Health currently funds **19 providers** across the country to deliver *rongoā* services.

(For more information from the Ministry of Health:

<http://www.health.govt.nz/our-work/populations/maori-health/rongoa-maori-traditional-maori-healing>)

- It is important to point out that while some *rongoā healers* are paid employees (full or part-time), such as the 19 providers contracted by the Ministry, there exist many others healers who are volunteers, working on a casual basis and accepting *koha* (gift, present, offering, donation, contribution - especially one maintaining social relationships, has connotations of reciprocity) for their healing work (Ahuri-Driscoll, Boulton, Stewart, Potaka-Osborne, & Hudson, 2015).

(For additional information on traditional healing :

<http://www.bpac.org.nz/BPJ/2008/May/rongoa.aspx> - see complete reference in list.)

Whānau Ora - Extended Family Wellbeing Program

What it is: *Whānau Ora* is a key cross-government work programme jointly implemented by the Ministry of Health, *Te Puni Kōkiri* (the Ministry of Māori Development), and the Ministry of Social Development. It is an approach that places *whānau* (families) at the centre of service delivery, requiring the integration of health, education and social services.

(For more information on *Whānau Ora* from the Ministry of Health:

<http://www.health.govt.nz/our-work/populations/maori-health/whanau-ora-programme>)

Whānau Ora is an innovative approach to improve *whānau* wellbeing. It aims to empower *whānau* to be more self-managing and to achieve better outcomes in areas such as health, education, housing, employment and income levels.

- *Whānau Ora* works with *whānau* as a whole, rather than focusing separately on individuals and their problems.
- It is about empowering *whānau* to identify their needs and aspirations to improve their lives, and helping them to build their capacity to achieve their goals in a sustainable way.

How it works: *Whānau Ora* works in a range of ways, which is influenced by the approach the *whānau* wishes to take.

- Some *whānau* will want to come up with ways of improving their own lives and may want to work on this with a *hapū*, *iwi* or another organisation.
- *Whānau* may use the services of a navigator, a practitioner who helps them work together to identify their needs and aspirations and develop a plan for the future. The navigator then supports the *whānau* to access co-ordinated services in areas such as education, primary health and employment, to carry out the plan.

Whānau Ora was introduced as a result of the **2009 Taskforce on Whānau-Centred**

Initiatives. The government set up the Taskforce in recognition that current approaches to social and health services were not serving Māori *whānau* well enough. This was seen in the poorer outcomes for Māori overall in areas like health, education, intergenerational unemployment, offending and marginalisation in society. The Taskforce carried out research and extensive community consultation around the country. It found widespread support for the government to adopt a strong *whānau ora* approach, and recommended a detailed framework for implementing this.

The ***Whānau Ora Partnership Group*** is the Crown/*Iwi* partnership responsible for the strategic leadership of *Whānau Ora*. Chaired by the Minister for *Whānau Ora*, it consists of six representatives of the National *Iwi* Chairs Forum and six Ministers representing the Crown. The Group decides direction and priorities for *Whānau Ora*.

The **outcomes** agreed by the *Whānau Ora* Partnership Group are:

- *Whānau* are self-managing and empowered leaders;
- *Whānau* are leading healthy lifestyles;
- *Whānau* are participating fully in society;
- *Whānau* and families are participating confidently in *Te Ao Māori* (the Māori world);
- *Whānau* and families are economically secure and successfully involved in wealth creation;
- *Whānau* are cohesive, resilient and nurturing;
- *Whānau* and families are responsible stewards of their living and natural environments.

Whānau Ora is not just for Māori families. From November 2014 to June 2015, for example, **35% of *Whānau Ora* support and services went to *whānau* of ethnicities other than Māori.**

(For more information from the *Te Puni Kōkiri* :

<http://www.tpk.govt.nz/en/whakamahia/whanau-ora/frequently-asked-questions/>)

Mahere Information System

Mahere (Chart, plan) is an information system designed to assist health and social service providers with *whānau* planning and tracking the achievement of *whānau* goals and outcomes. *Mahere* is provided by the Ministry of Health on behalf of *Te Puni Kōkiri* (the Ministry of Māori Development), with support from the Ministries of Social Development and Education. Health and social service providers are supported to use *Mahere* if they are part of *Whānau Ora*.

Capabilities provided by *Mahere* include:

- a client (person or *whānau*) database;

- a planning tool that **supports staff working collaboratively with individuals or whānau**;
- the ability to record progress in different ways e.g. activities and objective against the outcomes;
- a needs assessment tool to support staff to work with whānau or an individual to help identify strengths and areas of need;
- the ability to generate reports to support business decisions;
- electronic referral for services between providers using *Mahere*;
- **the ability for whānau/clients to access and update** some of their own information and the actions they are working on;
- the ability to support **whānau or individuals to manage their own plan(s)** without relying on assistance from staff in providers.

(For more information on Mahere:

<http://www.health.govt.nz/our-work/populations/maori-health/whanau-ora-programme/mahere>)

Kia Ora Hauora (National Māori health workforce development program)

Kia Ora Hauora (Supporting Māori into Health) is a national programme that was established in 2008 to increase the overall number of Māori working in the health and disability sector. The programme has been developed in response to the national and international shortage of health sector workers - and the demand for more Māori health professionals in the sector.

The *Kia Ora Hauora* website contains a range of helpful **information** targeted at Māori secondary school and tertiary *tauirā* (students) and people within the community considering a career change. Students can access health careers information and support aimed at encouraging a health career, staying in study and understanding the variety of employment opportunities in health.

There is also information on what support is available with study and finances. The site enables access to **Māori mentors**, and **information and updates of regional initiatives**.

(For more information : <http://kiaorahauora.co.nz/programme-info>)

Hauora Māori Scholarships in Health and Disability Studies

Hauora Māori Scholarships provide **financial assistance** to students who are undertaking or completing a course (level seven or above) in health and disability studies that has been accredited by the New Zealand Qualifications Authority (NZQA).

The scholarships are open to any person who:

- is enrolled and attending a university, polytechnic, *wānanga* (tertiary institution that caters for Māori learning needs, established under the Education Act 1990) or private training establishment based in New Zealand;
- has *whakapapa* (lineage, descent) and/or cultural links with *Te ao Māori* (the Māori world) or Māori communities;
- can demonstrate a commitment to and/or competence in Māori health and wellbeing studies;
- is studying a health or disability-related, NZQA-accredited course.

(For more information :

[http://www.health.govt.nz/our-work/populations/maori-health/hauora-maori-scholarships-2016\)](http://www.health.govt.nz/our-work/populations/maori-health/hauora-maori-scholarships-2016)

Te Pātaka Auahatanga Hauora Māori (The Storehouse of Māori Health Innovation), financed by the *Te Ao Auahatanga Hauora Māori* Innovation Fund

Te Pātaka Auahatanga Hauora Māori (The Storehouse of Māori Health Innovation) is an **online resource** to showcase successful Māori health innovations that were developed and trialled from funding provided by the 2009-2013 *Te Ao Auahatanga Hauora Māori* innovation fund.

(To access the Storehouse:

[http://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers/te-ao-auahatanga-hauora-maori-maori-health-innovation-fund-2013-2017/te-pataka\)](http://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers/te-ao-auahatanga-hauora-maori-maori-health-innovation-fund-2013-2017/te-pataka)

Te Ao Auahatanga Hauora Māori: the Māori Health Innovation Fund 2013–2017

The overall goal of the Fund for 2013–2017 is to advance *Whānau Ora* by affirming Māori approaches that improve Māori health outcomes focusing on improved *whānau* and child health outcomes. The key objectives of *Te Ao Auahatanga Hauora Māori* are to:

- advance *Whānau Ora* and affirm positive Māori approaches that improve Māori health outcomes;
- promote Māori service delivery systems that value health and social service collaboration and employ *whānau*-centred interventions;
- recognize service models that address the needs of *whānau*, *hapū* (kinship group, sub-tribe), *iwi* and Māori communities;
- enhance physical, spiritual, mental and emotional health, giving *whānau* control over their own destinies.

(For more information on the 2013-2017 Fund:

<http://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers/te>

As this brief review demonstrate, *He Korowai Oranga* really aims at increasing Māori contribution and control :

- **as individuals partnering in their own care;**
- **as a key part of the health workforce, and;**
- **as contributors to DHB decision-making and service delivery.**

(Ministry of Health, 2014, p.7)

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Complement - Additional research and evaluation documents:

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Promising initiatives in Indigenous Health - Australia

National Initiative

- *Closing the Gap* commitment, additional funding and prioritizing partnership

Aboriginal Community-Controlled Health Services

- Delivering holistic, comprehensive, and culturally appropriate health care to the community which controls it

Anangu Ngangkari Tjutaku Aboriginal Corporation

- Coordination, administration, and delivery of *ngangkari* (traditional healers) services

- Ngangkari clinics
- Educational workshops
- Training
- Individual Consultations and treatments
- Cleansing buildings, healthcare facilities, houses, outdoor areas

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PROMISING INITIATIVES IN INDIGENOUS HEALTH - AUSTRALIA

National Initiative

Closing the Gap framework appears hopeful in that :

- it places Indigenous health improvement and equality as a more central priority;
- it has created a collective commitment throughout all levels of government;
- it has allocated greater funding towards health programming;
- it has also listed community control and engagement as well as partnership as priorities;
- it also incorporates the social determinants of health into “closing this gap”, which is viewed as a more appropriate method for addressing the complex factors of Indigenous health and life outcomes, and reflects more holistic Indigenous models of health and well-being (WHO, 2008)

(To access current Closing the Gap report:

http://closingthegap.dpmc.gov.au/assets/pdfs/closing_the_gap_report_2016.pdf)

There are still significant health disparities (Vos et al., 2009), and; there is a recognition that Indigenous **participation and ownership** of planning and delivering

health services, are of central importance (Couzos et al., 2005).

Aboriginal Community-Controlled Health Services

The failure of the states to provide adequate services led to the emergence of the Aboriginal Community-Controlled Health Services (ACCHS) movement. It shifted Aboriginal health from states to the Commonwealth Government in the early 1970s, and finally to the Commonwealth Department of Health in 1995 (Lavoie, 2004).

National Aboriginal Community-Controlled Health Organizations (NACCHO)

allow for a community-controlled model of health research that is more community-based and participatory, shifting the balance of control towards those being researched. This participatory approach is more ethical and democratic in nature and is increasingly responsive to the needs of the communities. The Aboriginal community-control of services is also an expression of Indigenous peoples right to self-determination (Couzos et al., 2005).

Traditional Healing

Anangu Ngangkari Tjutaku Aboriginal Corporation (Ngangkari = traditional healers) : central body for coordination, administration and delivery of ngangkari services.

(For more information: <http://antac.org.au/>)

Hand-In-Hand: Report Aboriginal Traditional Medicine (Panzironi & Anangu Ngangkari Tjutaku Aboriginal Corporation, 2013)

(To access the report :

<http://antac.org.au/wp-content/uploads/2016/04/Hand-in-Hand.pdf>)

Positive health outcomes for patients:

- provision of a holistic two-way health care model and a collaborative team-based approach to Aboriginal health;
- building community trust in the Western health care system;
- increasing cost effectiveness of health care;
- reducing cases of misdiagnosis;
- enhancement of quality health care;
- calming effects on patients;
- enhancing compliance with Western medical treatments.

United Nations Declaration on the Rights of Indigenous Peoples recognises that 'Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals' (art. 24.1).

The World Health Organization (WHO) acknowledges that traditional medicine (TM) has played a fundamental role in primary health care for thousands of years and continues to be an essential component of public health around the world. Also promotes the usage of traditional medicine worldwide, recognizing the additional health benefits to certain populations, including Indigenous communities (WHO, 2013).

Definition: Traditional medicine is the sum total of knowledge, skills and practices on holistic health care, which is recognised and accepted by the community for its role in the maintenance of health and the treatment of diseases. Traditional medicine is based on the theories, beliefs and experiences that are indigenous to the different cultures, and that is developed and handed down from generation to generation (WHO/WPRO 2000a: 29)

The legal and policy analysis identifies a foundational flaw: the neglect of Aboriginal traditional medicine in the current national Aboriginal and Torres Strait Islander health policy agenda. This flaw requires investigation of the root causes which underlie the neglect of Aboriginal traditional medicine. The report provides an in-depth analysis of the conceptual underpinnings on which the COAG's Closing the Gap health policy agenda rests and it identifies **two root causes:**

- a limited application of the *human rights approach* to the Closing the Gap Indigenous health policy agenda, and;
- the predominance of the epistemological foundations of *western medicine vis-à-vis Aboriginal traditional medicine* ****two-way health care model**

RECOMMENDATIONS

Closing the Gap and Aboriginal Traditional Medicine

Recommendation 1: It is recommended that Aboriginal Traditional Medicine be included in Australia's national Closing the Gap health policy agenda pursuant to articles 24.1 and 31 of the United Nations Declaration on the Rights of Indigenous Peoples.

Recommendation 2: It is recommended that Aboriginal Traditional Medicine be

recognised as a legitimate system of traditional medicine based on its own traditional knowledge system, philosophical underpinnings, educational and training model. The legitimacy of Aboriginal traditional medicine should not be assessed against the criteria, conceptual underpinnings, educational and training model of western medicine.

National Aboriginal and Torres Strait Islander Health Plan and Aboriginal Traditional Medicine

Recommendation 3: It is recommended that Aboriginal Traditional Medicine be included in the National Aboriginal and Torres Strait Islander Health Plan. The integration of Aboriginal Traditional Medicine aligns with the fundamental principles of the National Aboriginal and Torres Strait Islander Health Plan. National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well-Being and Aboriginal Traditional Medicine

Recommendation 4: It is recommended that the review of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009 includes Aboriginal Traditional Medicine and Aboriginal traditional healers in the new national policy framework, strategies and implementation plans.

Commonwealth funding

Recommendation 5: It is recommended that the Commonwealth government strengthen funding agreements in partnership with the South Australian government to support the systematic provision of Aboriginal traditional healers interventions in the South Australian health care system.

South Australia: Policy development on Aboriginal Traditional Medicine Accreditation, qualification and registration

Recommendation 6: It is recommended that Aboriginal traditional healers themselves determine the process of accreditation, qualification and registration according to their traditional medical knowledge system. Qualification, accreditation and registration standards should align with their traditional educational and training model, rather than the western biomedical model. Rates and payment schedule

Recommendation 7: It is recommended that a consistent fee-for-service payment schedule for ngangkari services be established and applied within the South Australian health care system. The fee-for-service payment schedule should be negotiated in partnership with the ngangkari, Aboriginal community controlled health services and mainstream health services.

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Promising initiatives in Indigenous Health - Canada

British Columbia Tripartite Framework Agreement, 2013

- *Transformative Change Accord: First Nations Health Plan, 2006*
- Design, management, and delivery of First Nations health programming in BC transferred to the new **First Nations Health Authority**
- First Nations ownership and decision-making
 - Healthy living
 - Communicable disease control
 - Nursing Services
 - Maternal, Child and Family Health
 - Mental Wellness and Substance Use
 - Environmental Health
 - Research, Knowledge Exchange, Evaluation
 - eHealth
 - Health Human Resources
 - Funding Arrangements
 - Health and Wellness
 - Health and Wellness Planning
 - Traditional Healing

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PROMISING INITIATIVES IN INDIGENOUS HEALTH - CANADA

British Columbia Tripartite Framework Agreement

- The Parties have agreed to develop a *Health Partnership Accord* that will capture the vision of the Parties for a better, more responsive and integrated health system for First Nations in British Columbia and will build on the *Transformative Change Accord: First Nations Health Plan (2006)*, the *First Nations Health Plan MOU (2006)* and the *Tripartite First Nations Health Plan (2007)*.
- The British Columbia Tripartite Framework Agreement on First Nation Health Governance was signed on October 13th, 2011.
- As part of the Agreement, on October 1st, 2013, **Health Canada transferred its role in the design, management, and delivery of First Nations health programming in British Columbia to the new First Nations Health Authority (FNHA).**

(To consult the British Columbia Tripartite Framework Agreement on First Nation Health Governance :

<http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/tripartite/framework-accord-cadre-en-g.php>)

Tripartite Committee on First Nations Health Annual Report 2014-2015 :

http://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/aboriginal-health-directorate/final_2015_togetherinwellness_web.pdf

First Nations Health Authority

The First Nations Health Authority (FNHA) is the **first province-wide health authority of its kind in Canada**. In 2013, the FNHA assumed the programs, services, and responsibilities formerly handled by Health Canada's First Nations Inuit Health Branch – Pacific Region. Its vision is to transform the health and well-being of BC's First Nations and Aboriginal people by dramatically changing health care for the better.

The FNHA is responsible for planning, management, service delivery and funding of health programs, in partnership with First Nations communities in BC. Guided by the vision of embedding **cultural safety and humility** into health service delivery, the FNHA works to reform the way health care is delivered to BC First Nations through direct services, provincial partnership collaboration, and health systems innovation.

The First Nations Health Authority is part of a **unique health governance structure** that includes political representation and advocacy through the First Nations Health Council, and technical support and capacity development through the First Nations Health Directors Association. Collectively, this First Nations health governing structure works in partnership with BC First Nations to achieve a shared vision.

Their work does not replace the role or services of the Ministry of Health and Regional Health Authorities. The First Nations Health Authority will collaborate, coordinate, and integrate their respective health programs and services to achieve better health outcomes for BC First Nations.

(For more information : <http://www.fnha.ca/about/fnha-overview>)

Programs and Services

Services provided under the Agreement are largely focused on health promotion and disease prevention.

Overview of programs and services: <http://www.fnha.ca/what-we-do>)

FNHA Programs Compendium (January 2016) :
http://www.fnha.ca/Documents/FNHA_Programs_Compendium.pdf

Complement - Other similar agreements (smaller scale)

- Emergence of provincially supported Aboriginal health authorities in Quebec (James Bay Cree and Nunavik Inuit), Saskatchewan (Athabasca Health Authority) and British Columbia (Nisga'a) (Lavoie, 2011).

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Conclusions and Key Findings

Key attributes for successful Indigenous health initiatives

- Context-specific
- Indigenous Vision of Health - Holism
- Social Determinants of Health and Health Equity
- Self-determination

“[There is great] diversity of language, culture and practice across Indigenous peoples within the [...] countries. While this is a major source of strength and pride, it poses administratively the challenge that **"one size doesn't fit all"** – what works for one Indigenous group, may not work for another”. - WHO, 2010

CONCLUSIONS AND KEY FINDINGS

Key Findings of this Research

- To conclude, all three countries face similar health disparities between Indigenous and non-Indigenous populations. The most promising paths to equity combine elements from :
 - the **social determinants of health**;
 - the Indigenous **perspectives on well-being, as well as**;
 - the **incorporation of Indigenous voices** into the decision-making process.
- However, we acknowledge that the **contexts** vary across countries and that there is no ‘one size fits all’ approach to improve Indigenous health.
- Indeed, the context in **New Zealand** is somewhat favourable, as the Indigenous population accounts for a larger share of the population, is quite homogenous, and does not face challenges related to remoteness. Yet, the lesson to take away from the New Zealand case is that the policy-makers actually **listen, value and integrate** Maori’s perspective and knowledge.
- As for **Australia**, the government has just started to recognize and act upon the Indigenous health issues. Still, it remains done through a top-down approach.
- Here in **Canada**, the Government is making efforts to bridge the divide between the State and the Indigenous groups. These efforts are beginning to

- be translated into meaningful actions and changes in policy, as demonstrated by the British Columbia Tripartite Agreement.

Critic of this point of view:

- In Canada, Australia and New Zealand, Indigenous primary health care services emerged at the juncture between an Indigenous commitment to self-determination and ideological influences in national health care systems. Despite this apparent convergence of interest, governments carefully continue to define, with or without an official policy, the sphere over which Indigenous People can exercise some influence despite paying lip service to Indigenous self-government (Canada), Aboriginal self-determination (Australia) or the Treaty of Waitangi (New Zealand). (Lavoie, 2004, p.19)

Call to Action

- Much work has been done in the past 20 years to improve Indigenous peoples' living conditions worldwide. The two International Decades of the World's Indigenous Peoples (1995-2004 & 2005-2014) helped foster international cooperation to solve problems faced by indigenous peoples in areas such as human rights, the environment, development, education, health, economic and social development.
(<http://www.ohchr.org/EN/Issues/IPeoples/Pages/InternationalDecade.aspx>)
 - The UN Declaration on the Rights of Indigenous Peoples is one example (produced in 2007 - signed by 4 countries in 2010).
 - Several national initiatives took place too (for instance: recent national apologies in Canada and Australia in 2008).
- However, there is still a lot of work to do. In the aftermath of the 2014 World Conference on Indigenous Peoples, a UN System-Wide Action Plan on the rights of indigenous peoples was developed, calling for the sustained involvement of its Member states in addressing Indigenous peoples' issues (UN, 2015).
- In addition, the Indigenous population in all three studied countries tends to be young and increasing, which reaffirms the urgency to address health disparities sooner rather than later.
 - The maturing of this youth cohort combined with increases in life expectancy suggests that Aboriginal population aging will have a greater impact on the health system than what is anticipated for the general population (Lemchuck-Favel & Jock, 2004, p.36).

Other Challenges to be Addressed in the Future

- Racism/Discrimination while accessing health services.
 - When services are available, Indigenous peoples are often reluctant or afraid to use them because staff can be insensitive, discriminatory and unfriendly.
 - There is a need for better training for non-Indigenous health workers in cultural competency.
 (Stephens *et al.*, 2006, p.2025).

- Recognition in the Constitution and further participation in decision-making.
 - Whether that be in mainstream political processes, in the health system planning and delivery, or in research.
 - Risk related to greater transfer of responsibility and self-government: all three governments may be capitalizing on the discourse of self-determination to off-load services onto the shoulders of poorly-resourced Indigenous health services (Lavoie, 2004, p.19).
 - All groups highlight the key mechanism for implementing solutions is through partnerships, collaboration, respect and relationships that are based on trust and multiple dimensions, one of which includes reciprocity (Pulver *et. al*, 2010, p.12).
 - It is hard to claim national voice based on numerical representation alone (for Indigenous groups) (Pulver *et. al*, 2010, p.11).
 - The voices of non-Indigenous peoples are represented through a process known as Parliament. The expectation of the mainstream, that the Indigenous community will speak with one voice only, is not something that the mainstream holds itself to (indeed the mainstream is made up of different sub-views). The extent to which Indigenous peoples are represented in mainstream processes is not the focus of this paper, yet it is an important consideration in the development of health policies, including health financing policies, that require leadership across many sectors (Pulver *et. al*, 2010, p.11).
 - There is a need for capacity building of Indigenous peoples in research.
 - Indigenous people have been seen purely as objects of scientific study, providing ethnographic accounts (Stephens *et al.*, 2006, p.2024).
 - Indigenous peoples should fully participate as equal partners, in all stages of data collection.
 - Research must also respond to the priorities and aims of the Indigenous communities themselves.
 - Developing a capacity to generate their own research projects, and creating supportive relationships with other researchers to

- co-produce locally relevant knowledge. The creation of knowledge is critical to the self-determination of Aboriginal peoples (Anderson *et al.*, 2011, p.43-44).
 - Ensuring that Aboriginal knowledge is considered equal to the science-based perspective (Anderson *et al.*, 2011, p.50).
- Lack of accurate and updated data on Indigenous peoples to support the policy-making process.
 - There are significant problems in the collection of accurate data on Indigenous peoples as a whole, and on health in particular. Consequently, it makes it harder to implement policies when there is no data to base them on (Pulver *et. al*, 2010, p.8).
 - Improved data for health and living conditions are needed to help create policies that lead to access to comprehensive, culturally appropriate health care services, health education, nutrition, and housing.
 - Another challenge is the difficulty to assess trends over time due to frequent changes of government.
- Chronic underfunding in Indigenous health programs.
 - Higher per capita Indigenous health expenditures will be needed for some time to correct for the unacceptably high burden of disease and mortality currently being experienced by Indigenous peoples (Pulver *et. al*, 2010, p.12).
 - Greater support for Indigenous health programs, both at the state/federal level and at the regional/provincial/territorial level, is needed.
 - Removal of financial barriers to access health services (UN, 2016).
- Mental health issues in Indigenous communities.
 - Related amongst other things to the colonial past, lack of self-determination and lack of importance granted to the spiritual dimension of health as well as loss of traditional medicine and practices (healers, elders, etc).
- Sensitivity for Indigenous peoples' issues on the international health agenda.
 - There is a risk that Indigenous peoples might continue to be ignored by the international health policy simply because they do not fit into the top-down and utilitarian approach to health policy-making (Stephens *et al.*, 2006, p.2026).
 - A key priority is the inclusion of Indigenous peoples onto the international health and development agenda. This is essential in terms of securing international visibility and fund allocation (Stephens *et al.*, 2006, p.2026).
 - The sharing of best practice methods, approaches and experiences

- between countries as well as work on the international level with organizations on Indigenous health issues are of great importance (ex: Inter-Agency Support Group on Indigenous Peoples' Issues - IASG) (Pulver *et. al*, 2010, pp.12-13).

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