

DISCUSSION PAPER No. 13

**COMPARING AUSTRALIAN
WITH CANADIAN AND
NEW ZEALAND PRIMARY CARE
HEALTH SYSTEMS
IN RELATION TO
INDIGENOUS POPULATIONS:
LITERATURE REVIEW
AND ANALYSIS**

Katrina Alford

Onemda VicHealth Koori Health Unit

Discussion Paper No. 13

July 2005

ISBN 0 7340 3089 4



© Katrina Alford* and *Onewda* VicHealth Koori Health Unit (formerly VicHealth Koori Health Research and Community Development Unit) 2005

ISBN 0 7340 3089 4

First printed in July 2005

This work is joint copyright. It may be reproduced in whole or in part for study or training purposes, or by Aboriginal and Torres Strait Islander community organisations subject to an acknowledgment of the source and no commercial use or sale. Reproduction for other purposes or by other organisations requires the written permission of the copyright holder(s).

Additional copies of this publication can be obtained from:

Onewda VicHealth Koori Health Unit

Centre for Health and Society

4/207 Bouverie Street

The University of Melbourne

Vic. 3010 AUSTRALIA

T: +61 3 8344 0813

F: +61 3 8344 0824

E: koori@cshs.unimelb.edu.au

W: www.cshs.unimelb.edu.au/koori/

Copy Editor: Cristina Liley

Production Editor: Jane Yule

Cover Artwork: Michelle Smith & Kevin Murray

Design: University of Melbourne Design & Print Centre

Printed by University of Melbourne Design & Print Centre

* Dr Katrina Alford is a Senior Research Fellow in the Centre for Health and Society, School of Population Health at The University of Melbourne.

This Discussion Paper was produced with the assistance and financial support of the Cooperative Research Centre for Aboriginal Health.

Table of Contents

Discussion Paper Series	ii
Indigenous References and Acknowledgments	iv
Glossary	v
Executive Summary	1
Introduction	5
Method	6
Basis for Comparisons	8
Focus 1 Structure, Funding and Resource Allocations	13
1.1 Structure	13
1.2 Funding and resource allocations	16
Issue 1.1 Definitions	25
Issue 1.2 Indigenous/community versus ‘mainstream’ health service preference and use	25
Issue 1.3 Jurisdictional issues and imbalances	26
Issue 1.4 Funding deficits, geographical and sectoral resource allocations	26
Focus 2 Population and Data Issues	28
Issue 2.1 Population-based funding	28
Issue 2.2 Data quality—Census and administrative population/health data	29
Issue 2.3 Weighting health resource allocations	31
Focus 3 Barriers	33
Issue 3.1 General barriers	33
Issue 3.2 Geographical location	34
Issue 3.3 Price barriers	34
Issue 3.4 Attitudes and culture	35
Issue 3.5 Treaties and native title	35
Issue 3.6 Health workforce	36
Conclusions	38
Appendix 1: References	41

OneMDa VicHealth Koori Health Unit: Discussion Paper Series

The *OneMDa* VicHealth Koori Health Unit (formerly VicHealth Koori Health Research and Community Development Unit), launched in June 1999, has been developed in partnership with Aboriginal communities and organisations, in particular the Victorian Aboriginal Community Controlled Health Organisation. Core funding is provided by the Victorian Health Promotion Foundation, the University of Melbourne through the Centre for Health and Society where the Unit is located, and the Commonwealth Department of Health and Ageing.

At the core of the Unit's work is a commitment to undertaking, collaborating in and supporting research that directly benefits the Koori community. The work of the Unit spans academic and applied research, community development, and medical education. The combination of these activities is a central and innovative aspect of the Unit's function, as is the identification and use of mechanisms to link research with the improvement of health care practices and policy reform. Overall, these tasks are guided both by a strategic oversight committee.

In relation to the research program, five key areas govern the inquiry undertaken within the Unit. These comprise: historical research into Koori health policy and practice; historical and contemporary research into health research practice, ethics and capacity building; applied research on the social and cultural experience of Koori health, well-being and health care delivery; health economics research on the factors and processes that impact on the provision and use of Koori health care; and the evaluation of Koori primary health care and related health promotion programs.

The Discussion Paper Series (DPS) is directly linked to this diverse program of research and provides a forum for the Unit's work. The DPS also includes papers by researchers working outside the Unit or in collaboration with Unit staff. Individual papers aim to summarise current work and debate on key issues in Indigenous health, discuss aspects of Indigenous health research practice and process, or review interim findings of larger research projects. It is assumed that the readership for the series is a broad one, and each paper is closely edited for clarity and accessibility. Additionally, draft papers are 'refereed' so as to ensure a high standard of content.

More information on the series, on the preparation of draft papers, and on the work of the Unit can be obtained by directly contacting the Unit. Copies of all discussion papers are available from the Unit, or can be downloaded as pdfs from the *OneMDa* website.

Discussion Paper Titles

Discussion Paper No. 1: Ian Anderson, Harriet Young, Milica Markovic & Lenore Manderson, *Aboriginal Primary Health Care in Victoria: Issues for Policy and Regional Planning* (December 2000).

Discussion Paper No. 2: Kim Humphery, *Indigenous Health and 'Western Research'* (December 2000).

Discussion Paper No. 3: David Thomas, *The Beginnings of Aboriginal Health Research in Australia* (September 2001).

Discussion Paper No. 4: Michael Otim, *Indigenous Health Economics and Policy Research* (November 2001).

Discussion Paper No. 5: Daniel McAullay, Robert Griew & Ian Anderson, *The Ethics of Aboriginal Health Research: An Annotated Bibliography* (January 2002).

Discussion Paper No. 6: Ian Anderson, *National Strategy in Aboriginal and Torres Strait Islander Health: A Framework for Health Gain?* (March 2002).

Discussion Paper No. 7: Anke van der Sterren & Ian Anderson, *Building Responses to Blood-Borne Virus Infection among Kooris Using Injecting Drugs—Improving the Link between Policy and Service Delivery* (December 2002).

Discussion Paper No. 8: Kim Humphery, *The Development of the National Health and Medical Research Council Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research: A Brief Documentary and Oral History* (December 2002).

Discussion Paper No. 9: Michael Otim, Ian Anderson & Russell Renhard, *Aboriginal and Torres Strait Islander Hospital Accreditation Project: A Literature Review* (November 2002).

Discussion Paper No. 10: Nili Kaplan-Myrth, *Political Visions: Blindness Prevention Policy as a Case Study of Community–Government Relations in Aboriginal Health* (June 2004).

Discussion Paper No. 11: Gregory Phillips & the Project Steering Committee, Committee of Deans of Australian Medical Schools, *CDAMS Indigenous Health Curriculum Development Project: National Audit and Consultations Report* (August 2004).

Discussion Paper No. 12: Ian Anderson, Wendy Brabham, Bill Genat, Helen Keleher, Janice Jessen, Di Fitzgerald & Bernie Marshall, *National Indigenous Public Health Curriculum Audit and Workshop: Project Report* (October 2004).

Onewda VicHealth Koori Health Unit
Centre for Health and Society
Level 4/207 Bouverie Street
The University of Melbourne
Vic. 3010 AUSTRALIA
Tel: +61 3 8344 0813 Fax: +61 3 8344 0824
E: koori@cshs.unimelb.edu.au
W: www.cshs.unimelb.edu.au/koori/

Indigenous References

The following typology will be used in this review:

* *Indigenous:*

Cross-national references to Indigenous populations.

Comparisons with non-Indigenous populations within each country.

Australian Aboriginal and Torres Strait Islanders (some reference to 'Aboriginal' or Aboriginal and Torres Strait Islanders/ATSI in areas of health, workforce, policy and organisational names).

* *Aboriginal/Aborigines:*

Canadian First Nations, Inuit and Métis Indigenous populations.

* *Māori:*

Māori and Pacific Islanders New Zealand.

Acknowledgments

Funding for this project was provided by the Cooperative Research Centre for Aboriginal Health (CRCAH). Critical feedback on a draft of this paper was given to the author by Alison Larkins, Commonwealth Department of Health and Ageing.

Glossary

ABS	Australian Bureau of Statistics
ACCHOs/ ACCHS	Aboriginal Community Controlled Health Organisations/ Services
AHSs	Aboriginal Health/Medical Services (short for ACCHS)
AHMAC	Australian Health Ministers' Advisory Council
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMSANT	Aboriginal Medical Services Alliance Northern Territory
ATSI	Aboriginal and Torres Strait Islanders
ATSIC	Aboriginal and Torres Strait Islander Commission
CAEPR	Centre for Aboriginal Economic Policy Research
CCT	Coordinated Care Trials
CDHAC	Commonwealth Department of Health and Aged Care (now Department of Health and Ageing)
CGC	Commonwealth Grants Commission
COAG	Council of Australian Governments
CRCAH	Cooperative Research Centre for Aboriginal Health
GPs	General Practitioners (family physicians)
HIC	Health Insurance Commission
HREOC	Human Rights and Equal Opportunity Commission
HTP	Health Transfer Policy (Canada)
IHSs	Indigenous Community Controlled Health Services (AHSs in Australia)
KWHB	Katherine West Health Board
MBS	Medical Benefits Scheme
NACCHO	National Aboriginal Community Controlled Health Organisation
NCEPH	National Centre for Epidemiology and Population Health
NIHB	Non-Insured Health Benefits Program (Canada)
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OECD	Organisation for Economic Cooperation and Development
PBS	Pharmaceutical Benefits Scheme

PHCAP	Primary Health Care Access Program
RAC	Rumbalara Aboriginal Co-operative
RMC	Rumbalara Medical Centre
SAR	Service Activity Reporting
SCRCSSP	Steering Committee for the Review of Commonwealth/State Service Provision
VACCHO	Victorian Aboriginal Community Controlled Health Organisation

Executive Summary

Background

This is a literature review and analysis (hereafter the ‘review’) of the primary health care system for Indigenous people in Australia, as compared with those operating in Canada and New Zealand. Largely confined to services within the health sector, the review signposts sources and documents to enable readers to access all material cited. The review has three main focuses: structure; funding and resource allocation; population and data issues; and barriers to accessing culturally informed and adequate primary health care services. The most significant issues affecting Indigenous health services are identified along with some basic analysis.

Findings

Comparisons

In **all three countries**—Australia, New Zealand and Canada—the health (and the more general social and economic) status of Indigenous populations is significantly poorer than that of their non-Indigenous counterparts. In **Australia**, in particular, there has been little or no progress in Indigenous health over the past decade or more (Ring & Brown 2002; AMA 2002, 2004), and it could be argued that there has been no improvement at all in the past three decades. The gap in socio-economic status between Indigenous and non-Indigenous Australians is also greater. The **Canadian** and **New Zealand** education systems and public policies are generally more culturally and linguistically diverse than in **Australia**. Several factors have been cited as contributing to the relatively poorer health status of Indigenous Australians, and its lack of improvement compared with Canada and New Zealand. These include

- *Demographics*: Indigenous Australians comprise a smaller proportion of the total population than in Canada or New Zealand.
- *Treaties*: the formal recognition of Indigenous populations through treaties in both Canada and New Zealand (and in the US), unlike Australia.
- *Workforce deficiencies*: a scarcity of Indigenous doctors and health workers in Australia (whether more so than in Canada is difficult to establish).
- *Funding inadequacies*: the ratio of Indigenous to non-Indigenous total health expenditure from all sources in Australia is only 1.22:1 (1.27:1 for primary care services only). This is substantially less than required given the relative health status of Indigenous compared with non-Indigenous Australians.

Focus 1: Structure, funding and resource allocations

1.1 Structure

The **Canadian** and **Australian** federal systems engender continuing conflict regarding processes that are put in place to meet national obligations toward Indigenous peoples. These processes include cost-shifting, administrative complexity and fragmentation of health service funding arrangements, particularly in Australia.

The provision of health care for Indigenous people in **Canada** and **New Zealand** has been profoundly affected by the existence of treaties, which have provided a basis for the recognition of Indigenous people's specific health (and other) needs and cultural differences. Australian Indigenous people lack such recognition.

The **Canadian** primary health care system is limited by its bureaucratic registration requirements regarding 'Indians', and its exclusion of specific provision for non-reserve First Nation and Métis populations.

All three countries have a dual system in relation to Indigenous people: mainstream or 'non-Indigenous' primary health service providers, and Indigenous-specific health service providers (AHSs). It is difficult to establish precise utilisation patterns and comparisons between the three regarding mainstream versus Indigenous primary health service use. Reports from all three countries suggest inadequate provision of primary health care services for Indigenous populations.

Australian government policy assumes that AHSs merely 'supplement' mainstream health services, which may further contribute to inadequate primary health care provision for Indigenous people.

Australian Indigenous people's demands for greater independence, including control over health services, may meet more political and government resistance in the future following the abolition in 2004 of the national politically representative Indigenous body Aboriginal and Torres Strait Islander Commission (ATSIC).

1.2 Funding and resource allocations

In all three countries, funding and resource allocations to Indigenous health services are inadequate, particularly in view of the poor health status of Indigenous compared with non-Indigenous populations.

Canadian and **Australian** literature suggest that the quest for greater Indigenous control over health service provision and funding may have been used to offload fiscal responsibility onto poorly resourced Indigenous communities. (Although not apparent from the evidence, this may also apply to New Zealand).

Health service reform proposals in **all three countries** include conversion of historically based health expenditures based on utilisation patterns to a capitation model, weighted for Aboriginality, greater health need and locality. Recent reforms in **Australia** include the Primary Health Care Access Program (PHCAP) pilot.

In **Australia**, most Commonwealth Indigenous-specific primary health expenditure funds the ongoing operations of Aboriginal Community Controlled Health Organisations (ACCHOs). Funding increases are considered inadequate as they are based largely on current utilisation patterns, adjusted for various factors, and may perpetuate inequalities in health service provision. Data limitations prevent more quantitative estimates of the gap between 'core' government funding and current needs.

Four main funding and resource allocation problems persist regarding AHSs in **Australia**, with some evidence of similar problems both in **Canada** and **New Zealand**:

- access to secure and stable funding;
- limitations in population-based data, notably under-enumeration and variable data quality, impede effective resource allocations, particularly to rural and remote regions;
- funding bases are insufficiently weighted to reflect the substantially poorer health status of Indigenous people;
- in Australia, Commonwealth policy and funding levels assume that AHSs are supplementary to mainstream health services. This may be a questionable assumption in view of utilisation patterns, even in non-remote regions with a mainstream supplier;
- the recently established PHCAP program in **Australia** presents an alternative primary health service provision and funding model to the current 'history + add-on' current model of funding AHSs. Its potential benefits outweigh possible problems and address some of the many weaknesses in the existing model.

1.3 Issues in Focus 1

These include:

- definitional issues regarding 'Aboriginality', related to legislative and regulatory controls;
- preference for Indigenous versus mainstream primary health services;
- jurisdictional issues including cost-shifting; and
- funding deficits and within this constraint further sectoral and geographical imbalances in resource allocations.

Focus 2: Population and data issues

- The potential for population-based funding of primary health services for Indigenous people in **all three countries** is limited by the lack of accurate population data. Census enumeration issues are particularly evident in Australia, where there is no alternative, comprehensive and reliable health administrative data available to compare with Census data.
- Weighting health resource allocations is widely commended, in view of the health status gap between Indigenous and non-Indigenous populations.

Focus 3: Barriers

The literature in **all three countries** indicates multiple and mutually reinforcing barriers to Indigenous people's access to culturally informed and adequate primary health care services, including:

- geographic barriers, notably in Australia;
- price-based barriers, particularly in Australia and New Zealand;
- attitudinal and cultural barriers, including poor attitudes in the non-Indigenous health care sector, a lack of cultural awareness among non-Indigenous health professionals, and Indigenous suspicion, and perhaps rejection, of the health systems of 'colonisers';
- workforce issues, namely a lack of qualified Indigenous health professionals, particularly in remote regions; and
- the absence in Australia of treaty-based or formal recognition and codification of Indigenous rights, including those regarding traditionally owned land (native title).

Introduction

This is a literature review and analysis of the primary health care system for Indigenous people in Australia, as compared with those operating in Canada and New Zealand. The World Health Organization regards an adequately resourced primary health care system as vital to improving overall population health, and recommends that efforts be made to bolster its role in overall health care systems (Rosser & Weel 2004). The term ‘primary health care’ includes health care services in mainstream general practice, Indigenous/Aboriginal health services, as well as community health centres staffed by GPs, health workers, and allied health, social welfare and nursing professionals.

While this review also looks at services outside the health sector—such as education, employment and housing (Anderson *et al.* 2001)—it largely confines itself to services within it. Nor is it directly concerned with Indigenous health status *per se*, but rather summarises the Australian provision of Indigenous people’s primary health care needs on a comparative basis. A comprehensive appraisal of relevant literature, with some basic analysis of significant issues. the review signposts sources and documents to enable readers to access material cited.

The review has three main focuses: structure, funding and resource allocation; population and data issues; and barriers to accessing culturally informed and adequate primary health care services. Within each focal area the most significant issues affecting Indigenous health services are identified, with some basic analysis within the constraints of a Cooperative Research Centre review-length paper.

Method

Main themes

- * structure, funding and resource allocation;
- * population issues: enumeration, data quality, weighting Aboriginal/Indigenous health expenditure; and
- * barriers to accessing primary care: geography, treaties, native title, prices/cost, attitudes/culture, workforce issues.

Key words

- * Australia, Canada, New Zealand, Indigenous, Māori, Aboriginal and Torres Strait Islander, First Nations.
- * Indigenous/Aboriginal health systems, primary health care services, health care policy, health outcomes, equity, barriers, access and health care services, census and enumeration, population, resource allocation and weighting, health funding/expenditure.

Database search

- * PUBMED at the National Library of Medicine 'PubMed' facility:
<<http://www.ncbi.nlm.nih.gov/PubMed>>.

Keywords were entered into this database in various combinations. Relevant citations, author and article names from within the database were then used to find further information.

- * Statistical, enumeration and census searches focused on each country's respective statistical lead agency:

Statistics Canada <<http://www.statcan.ca>>

Statistics New Zealand <<http://www.stats.govt.nz>>

Australian Bureau of Statistics <<http://www.abs.gov.au>>

- * Government policy and formal legal document/agreement searches began with government and Aboriginal departments, both relating to Indigenous people and to health.

Canada

Health Canada <<http://www.hc-sc.gc.ca/english/index.html>>

Indian and Northern Affairs Canada <http://www.ainc-inac.gc.ca/index_e.html>

New Zealand

Ministry of Health <<http://www.moh.govt.nz/moh.nsf>>

Ministry of Māori Development <<http://www.tpk.govt.nz>>

Australia

Commonwealth Government Department of Health and Ageing
<<http://www.health.gov.au/>>

Office for Aboriginal and Torres Strait Islander Health
<<http://www.health.gov.au/oatsih>>

Basis for Comparisons

In **all three countries** the health (and more general social and economic) status of Indigenous populations is significantly poorer than that of their non-Indigenous counterparts. In **Australia**, where there have been few improvements at all in the past three decades, an increase in the gap in life expectancy between Indigenous and non-Indigenous people occurred in 2003 (Dow & Gardiner-Garden 1998; Ring & Firman 1998; Anderson 2000; Duckett 2000; Thompson *et al.* 2000: 55–6; Ring & Brown 2002; AMA 2002; ATSI Social Justice Commissioner 2003: 1.7). As measured by life expectancy, the gap between Indigenous and non-Indigenous populations is seven years in **Canada**, more than nine years in **New Zealand**, and in excess of nineteen years in **Australia** (AIHW 2003a; New Zealand Director General 2003).

Several factors have been cited as contributing to both the poorer health status of Indigenous Australians and its lack of improvement, compared to Canada and New Zealand. These include:

- *Treaties*: the formal recognition of Indigenous populations in treaties in both Canada and New Zealand, unlike Australia, may have ‘play(ed) a significant and useful role in the development of health services, and in social and economic issues’ (Ring & Firman 1998; see also Dow & Gardiner-Garden 1998; Havermann 1999; Miller 2000; Hays 2001).
- *Workforce deficiencies*: a scarcity of Indigenous doctors and health workers in Australia (whether more so than in Canada is difficult to establish).
- *Funding inadequacies*: the ratio of Indigenous to non-Indigenous total health expenditure from all sources in Australia is only 1.22:1 (1.27:1 for primary care services only). This is substantially less than required given the relative health status of Indigenous compared with non-Indigenous Australians (AIHW 2001; CGC 2001: Ch. 6).

In **all three countries**, however, Indigenous people under-utilise primary health care services relative to their population and health needs. They also rely heavily on government sources of funding, as do low-income people in general (CGC 2001; ABS 1996 & 2004; Lavoie 2003a & 2003b; Gauld 2001; Health Canada 2003; Scott *et al.* 2003; New Zealand Director General 2003).

In 2002, all three countries’ National Medical Research Councils signed a precedent-setting Memorandum of Understanding, to cooperate on research on and with their respective Indigenous populations (Redding 2003). This may facilitate more comparative and collaborative health research in future. At present, however, comparative literature and data searches have to be conducted largely on a country-by-country basis.

The three countries are historically and economically comparable. European colonisation in all three resulted in Indigenous populations experiencing ‘dispossession, deprivation, and at least until recent times, demographic decline’ (Kunitz 1990 cited in Ross 2002).

Physically, **Canada** and **Australia** are geographically large continents with dispersed populations, particularly the former. Both have sizeable rural and remote populations, and proportionately more Indigenous than non-Indigenous people live in rural or remote areas. Average population densities in both are low by international standards. These geographical and demographic factors create additional difficulties in accessing and providing health care services. Summary demographic information is provided in Table 1.

Table 1: Population Data for Australia, Canada and New Zealand (2001 Census)*

	Australia	Canada	New Zealand
Total pop'n	18,972,350	29,639,030	3,820,749
Indig. pop'n	458,520	976,305	526,281
Indig. pop'n (% of total pop'n)	2.4%	3.3% (2)	13.8%
Pop'n density of country (persons per KM ²)	2.3	2.9	13.6
% Indig. pop'n in rural/remote regions (1)	27% (remote only)	57% First Nations 73% Inuit	16%
% non-Indig. pop'n in rural/remote regions	2.0% (remote only)	NA (3)	NA
% total pop'n in rural/remote regions	2.6% (remote only)	21–30%	12.5%

Sources: 2001 census for each country; Shoranick 2003; AIHW 2004 see websites census and AIHW 2003a, 2003b & 2004. Geographic information from *Encyclopaedia of World Geography*, 1994, Anromeda Oxford, Oxfordshire, and New Zealand government statistics.

Notes:

⁽¹⁾ Definition of rural:

Canada: all territory outside major urban centres, constitutes 95 per cent of Canada's land mass.

New Zealand: outside urban areas, i.e. outside concentrated settlements of 1000 people or more; rural population includes offshore islands.

Australia: Five ABS geographical classifications of population centres, ranging from capital cities to very remote regions (known as ARIA), with regions classified according to average road distance to these centres; AIHW 2004.

⁽²⁾ Of total Canadian Aboriginal population, 62.4 per cent are First Nations (North American Indians), 29.9 per cent Métis, 4.6 per cent Inuit and 3.1 per cent not classified.

⁽³⁾ NA: not available.

* For discussion of Census and data issues, see Issue 2.2: Data quality—Census and administrative population/health data.

Other similarities between **all three countries** include:

- Similar legal *bases* derived from British law, and similar types of *economic development* as capital-based mixed market economies.
- Similar *stages of development in Indigenous policy*. *Assimilation* policies from the early nineteenth century until the 1960s included passive as well as more aggressive forms of assimilation, which in Australia included forced relocation to missions, suppression of traditional culture and languages, ‘assimilation’ of half-caste peoples, and removal of children from families (HREOC 1997; Havermann 1999; Alford & Muir 2004).
- The postwar development of a *welfare state* in each country was based on similar assumptions governing social policy (equity, access, etc.). Much of it did not extend to Indigenous people, however, who were still expected to ‘assimilate’ and express similar, if not identical, customs and behaviour to non-Indigenous people (McMahon *et al.* 1996: 104–5).
- Since the 1960s, heightened *Indigenous political activism* and demands for greater rights and independence, including in the health sector, resulting in Australia in the establishment of the first (urban) Aboriginal Health Service in the early 1970s (McMahon 1996: 105; Anderson 2000; Alford & Muir 2004).
- Similar *gaps in health status* compared with non-Indigenous populations.
- Increased trend to defining *State–Indigenous relationships* via land claims and service contracts (Lavoie 2004).

These similarities should not, however, overshadow the substantial differences between the three in the historical, legal, political and social developments that may have directly or indirectly influenced the health care systems of each. These differences include:

- The establishment of *federal political systems* in Australia and Canada, and a unitary system in New Zealand. Differences between the Australian and Canadian systems are nonetheless marked. In Australia, principal taxation powers are vested in the Commonwealth but with considerable State responsibilities for health care. By contrast, taxation powers and jurisdiction over health care are a provincial responsibility in Canada, with some health care provision further devolved to regional health boards. As a result, there is considerable variation in the wealth of provinces and the quality of their health services.
- Differences in *constitutional and judicial forms of recognition of Indigenous people’s rights and citizenship*. The process of colonisation in all three countries varied, but one common feature until the twentieth century, was the imposition of substantial restrictions on Indigenous people’s civil rights, residence, mobility and employment (Armitage 1995). The timing and nature of colonisation differed significantly, with Indigenous Australians arguably being the most enduringly disadvantaged in terms of legal recognition of rights and citizenship.

In Canada, the 1763 Royal Proclamation and associated policies prohibited colonists from dealing directly with ‘Indians’ for land (unlike in Australia), and set the scene for

a succession of land and rights treaties (Havermann 1999; Miller 2000). In New Zealand, the 1840 Treaty of Waitangi formally guaranteed Māori citizenship rights, followed by political rights through legislation in 1863 and limited social welfare rights in the 1920s and 1930s (Armitage 1995). Colonial Australia, in contrast to both Canada and New Zealand, adhered to the legal doctrine of *terra nullius*, which was associated with, and justified, the dispossession of traditional lands on a large scale, as well as a persistent refusal to engage with Indigenous people in negotiations over traditional lands and rights (Reynolds 1989; Links to Aboriginal Resources; Langton *et al.* 2004). Australia failed to recognise Indigenous people in its Constitution until 1967. By the 1970s, the principle (if not practice) of equality of services for Indigenous peoples had been recognised in all three countries (Armitage 1995: 235).

- *Treaties.* Unlike Australia, governments in both Canada and New Zealand established treaties with Indigenous peoples following colonisation. These treaties provided a political mechanism for codifying Indigenous rights and may have contributed to the development of (health) services and to the recent social and economic gains of Indigenous people in both countries (Durie 1989; Ring & Firman 1998; Havermann 1999; Hays 2001; Langton *et al.* 2004).
- *Native title rights.* All three countries experienced severe, prolonged and, at times, violent Indigenous–European conflict over land ownership and use, but different developments and outcomes followed the initial dispossession and dispersal. In Canada, First Nations people were confined to reserves. In colonial New Zealand, the Treaty of Waitangi was effectively ignored as formal Māori control over their lands diminished throughout the nineteenth century. In Australia, the Aborigines had no recognition of land rights at all. By the end of the nineteenth century, Indigenous peoples in all three countries had been reduced to holding less than 5 per cent of their traditional land (Armitage 1995; Havermann 1999; Monture-Angus 2000).

In the 1960s, negotiations between Indigenous people and government in Canada and New Zealand resulted in the return of land, and the restoration of traditional rights to hunt and fish, and to access Crown land (Armitage 1995; Havermann 1999; Monture-Angus 2000; Links to Aboriginal Resources). No such recognition occurred in Australia until a 1992 High Court judgment (Mabo), which facilitated the return of land in remote areas but made it difficult for native title successes in more established, economically viable parts of the continent, notably in south-east Australia (Alford 1999a & 1999b; Toussaint 2004).

- *Health care access costs.* The Canadian system may be generally more equitable than Australia's or New Zealand's. While a form of public national health insurance or Medicare system exists in all three countries, free health care is not guaranteed in Australia or New Zealand, where variable co-payments to medical practitioners are required and may be increasing (Elliot 2003; Young & Dobson 2003; Scott *et al.* 2003). By contrast, under the (1984) *Canada Health Act*, federal government transfer payments require the provinces to guarantee equal access to all with no discrimination on the basis of income or need (or gender, religion and race) (Lavoie 2003a & 2003b).

On a comparative basis overall, and without denying the severity of health-related and health-system issues affecting Indigenous populations in all three countries, there seems to be *greater marginalisation of Indigenous people in Australia*. Comprising a smaller proportion of the population than in either Canada (although only slightly) or New Zealand, they lack constitutional or treaty recognition of their rights and sovereignty, and the gap in socio-economic and health status between Indigenous and non-Indigenous populations is greater. In addition, Canadian and New Zealand education systems and public policies are generally more culturally and linguistically diverse than in Australia (Dow & Gardiner-Garden 1998; Hunter & Schwab 1998; Ring & Brown 2002; AIHW 2003a).

Focus 1: Structure, Funding and Resource Allocations

1.1 Structure

Both **Canada and Australia** have federal political and health systems, and **New Zealand** a unitary political system. The division between federal and State/provincial jurisdictions in Australia and Canada has resulted in continual conflict regarding obligations to Indigenous people (Monture-Angus 2000; Anderson 2000a, 2000b & 2002).

In both the Canadian and New Zealand health care system, responsibility is more devolved than in Australia—to provincial authorities in **Canada** (except for Aboriginal primary health care) and, increasingly, to district/regional authorities in **New Zealand**. In **Australia** the federal government has taxation powers and the States responsibility for most health care, with a resulting mismatch between taxation and service delivery. In all three countries, however, national or Commonwealth policy is the dominant influence in the health system: all have both a private and public system, and all experience varying degrees of tension or division between primary and secondary care (Gauld 2001; Lavoie 2003a & 2003b).

In **New Zealand**, long-standing institutional problems led to substantial reform of the national health care system in the 1980s. Since then, the trend has been to decentralise health service funding and management, most recently to District Health Boards, including for most Māori health providers (New Zealand Director General 2003). The impact of these reforms is yet to be fully felt with some suggestion of persistent institutional problems with the fragmentation of the system overall (Health Funding Authority 2000; Gauld 2001; Lavoie 2003a & 2004).

Australia's health care system performs well by Organisation for Economic Cooperation and Development (OECD) standards in terms of overall efficiency and effectiveness, but poorly in relation to Aboriginal people (Commonwealth of Australia 2001; OECD 2004; AIHW 2004a & 2004b). The system is complex owing in part to the structure of health financing, which derives from federal government taxes alone, with States, Territories and regions prohibited from raising revenue by taxation. The Commonwealth makes allocations to the States, which are responsible for most health care provision and (re)allocate federal funds on a geographical basis. These are topped up with conditional or tied Commonwealth grants (Donato & Scotton 1998; AIHW 2004).

All three countries have publicly administered, and at least partially privately delivered, national health care systems. Only **Canada's** Medicare system guarantees free public health, doctor, specialist and hospital care, as 'co-payments' or 'extra payments' were made illegal in 1984 (Lavoie 2003a). While Australia's national insurance scheme, Medicare, provides

for bulk-billing, a method whereby clients face no direct payments if the cost of services is the same as that recommended by government, most GPs and specialists charge higher fees; hence clients bear direct costs in the form of co-payments. These have increased as bulk-billing rates have fallen (Elliot 2003; Young & Dobson 2003). The New Zealand primary care system also involves user part-charges for GP care. As a result, Indigenous peoples in both **Australia** and **New Zealand** face price-based barriers to primary health care in the mainstream health system (Duckett 2000; Scott *et al.* 2003), unless they can access Indigenous controlled health services where access fees are usually waived (Lavoie 2003a & 2003b).

From an Indigenous perspective, all three countries have a dual health care system, in which Indigenous people may access primary health care services through Indigenous community controlled health services (IHSs) and cooperatives, if these are available, and/or through non-Indigenous health care providers, who are largely private. It is difficult, however, to establish precise utilisation patterns of IHSs compared with other 'mainstream' health primary health care services in any of the three countries.

In **Canada**, Aboriginal health care has been influenced by historical treaty recognition of First Nations' rights and associated Indian Acts and amendments that require registration as 'Indian'. The Inuit, known as Eskimos, were recognised under the Indian Act more recently (1940s), while the Métis Canadians, historically regarded as more 'European', have no specific treaty-based rights.

Primary health care for on-reserve First Nations is under federal jurisdiction, while for other Canadians it is a provincial responsibility along with secondary and tertiary services (Lavoie 2004). The Canadian Health Transfer Policy (HTP), announced in 1989, provides the basis for transferring administration and control of community-based health services to on-reserve First Nations. By 2001, 71 per cent of First Nation communities, representing nearly half of the eligible First Nation population, were engaged in delivering on-reserve primary health care services funded by the federal government, and another 13 per cent were exploring the possibility of doing so (Health Canada 2002). General practitioners/physicians are funded by the provinces to attend these centres regularly. By contrast, off-reserve Aboriginal Canadians are expected to utilise non-Aboriginal ('mainstream') health services, or one of a small number (eleven) of urban IHSs (Lavoie 2003b & 2004).

In **New Zealand** the 1840 Treaty of Waitangi should have afforded Māori people more potential to influence health policy development than in Australia, but this seems not to have occurred until the increasing Māori political activism of the 1970s and 1980s. After a change of government in 1984, the incoming Labour administration formally acknowledged Crown obligations under the Treaty of Waitangi and embraced biculturalism (Gauld 2001). The establishment in 1993 of a Māori Health Directorate within the Ministry of Health has been associated with a substantial increase in the number of Māori health service providers—twenty-five in 1992 to 233 in 2003 (New Zealand Director General 2003). Māori are potentially in a stronger political position to influence health (and other policy) developments than Aboriginal Australians, owing to their relatively larger demographic presence and higher level of education (Dow & Gardiner-Garden 1998).

The New Zealand primary health care system for Māori people may be more advanced than in Australia, although this is difficult to prove conclusively. However, there is a network of community-based comprehensive primary care, with additional services developed to provide for specific groups such as women and children. Moreover, all New Zealand health providers are expected to show how their services will meet the participation and service needs of Māori (New Zealand Ministry of Health 2001 & 2002). These primary health care services may still be inadequate, in view of higher Māori hospitalisation rates per head of population compared with other New Zealanders (New Zealand Director General 2003). Additionally, although the 'special relationship' between Māori people and the Crown is formally acknowledged in health care policy, their participation in overall health policy development remains limited (Durie 1998; Cunningham & Durie 1999; Gauld 2001; Lavoie 2004).

In **Australia**, policy leadership in general is limited in a federation with no constitutional or treaty recognition of Aboriginal people (Anderson 2002). Historically, Australian Indigenous people have lacked the political infrastructure and formal recognition that First Nations people in Canada and the Māori in New Zealand have had. This, and the tripartite structure of government in Australia have led to a slower and less coherent development of AHSs. Staffed initially by volunteer health personnel, AHSs emerged (the first in 1971) following a successful referendum in 1967 that enabled the Commonwealth to count Aborigines in official censuses and removed the States' exclusive power to legislate for them. With some delay, Commonwealth funding followed. By the mid 1970s, a national Aboriginal and Torres Strait Islander health peak council had been established, renamed as the National Aboriginal Community Controlled Health Organisation (NACCHO) in 1992 (Anderson & Brady 1999).

In **Australia**, the main means of accessing primary health services, through general practitioners (GPs), is more difficult in rural and remote areas because of the relative shortage of doctors and nurses, and, for Indigenous people, low levels of Medicare registration (Anderson & Thomson 2002; Leeder 2003; Lavoie 2003a; AIHW 2004a). In addition to private GPs, there are state health services, hospital non-admitted patient services and Aboriginal Community Controlled Health Services (ACCHSs), with Flying Doctor Services in some more remote areas (CGC 2001: Ch. 6). By 2003–04, 124 AHSs were operating throughout Australia, with more than 40 per cent located in remote regions (SCRCSSP 2004). Data are not readily available to assess the adequacy of this provision, but the number and distribution would suggest that non-remote Indigenous Australians are not well served by AHSs. The Commonwealth Grants Commission (CGC) and other bodies have highlighted the need to expand the current network of ACCHOs in Australia (CGC 2001: xx; OATSIH 2004a & 2004b).

Rural doctor shortages are compounded by a long-term and persistent reluctance by Indigenous Australians to access mainstream services. This is reflected in their low utilisation of general practitioner services compared with non-Indigenous people in all geographical regions, even where mainstream services are available (see below under 1.2 Funding; CGC 2001: Ch. 6; OATSIH 2004a & 2004b). Mainstream primary health care

services have been generally regarded as less capable of meeting the health needs of Indigenous people (ATSIC 1999). As a result, many go without primary health care (OATSIH 2004a). The Commonwealth maintains, however, that Indigenous health needs 'are largely met through the funding and delivery of mainstream health services', and that AHSs are 'complementary' to those provided by the mainstream (CGC 2001: Ch. 6).

Although in the past decade there has been some improvement in Indigenous access to mainstream primary health services in Australia, there are still areas without a GP, and where access to Medicare funded services is impossible. Access is also limited by GP co-payment charges, as well as Medicare's requirement for unique identification of individuals, a relatively recent measure with which the majority of Indigenous people have not been able to comply due to transience, homelessness and identification problems. The CGC report on Indigenous health (and other) service funding emphasises that 'it is critical for the Commonwealth to increase Indigenous people's access to Medicare and the Pharmaceutical Benefits Scheme (PBS) (PBS 2001: xx).

Indigenous aspirations for greater 'self-government' (Canada), 'self-determination' (Australia) or 'tino rangatiratanga' (New Zealand) have been reflected in changes to the health care system in **all three countries**. Since the 1960s, Indigenous people have sought greater control over community-based primary health care services for their population, with varying degrees of success. Official and government policy documents now invariably refer to the need for increasing Indigenous community control over the health services provided for them (Lavoie 2003a, 2003b & 2004; CGC 2001: Ch. 6).

1.2 Funding and resource allocations

The health systems in **all three countries** provide both mainstream and Indigenous-specific primary health care services, depending on demographic, geographic and economic/public finance factors. Notwithstanding the fact that overall health expenditure in all three is at or above the OECD average, there are concerns that funding and resource allocations to Indigenous health services are inadequate, and grossly so given the poor health status of the three Indigenous populations compared with the non-Indigenous populations (Mooney *et al.* 1998; Commonwealth of Australia 2001; Mooney 2000 & 2003; Duckett 2000; Ring & Eiston 2000; Gauld 2001; AMA 2002; Ring & Brown 2002; Lavoie 2003a & 2003b; Murray 2003; New Zealand Director General 2003; OECD 2004). Moreover, Indigenous populations in all three countries have expressed concerns that governments may be capitalising on their quest for self-determination to offload funding (and management) responsibility to a population that is not adequately resourced to provide comprehensive health services (Anderson & Brady 1995; Lavoie 2003a & 2003b).

The key feature of the **Canadian** health care system, from an Aboriginal perspective, is the on-reserve, off-reserve distinction and associated exclusion of specific provision for non-reserve First Nation and Métis populations.

Resource allocations to on-reserve communities under the Health Transfer Policy is one of several issues of concern, as they are based on historical expenditures, without reference to

either current population, population growth or needs (Lavoie 2003b). Appropriate financing that reflects needs and geographical contingencies remains a contentious issue (Lavoie 2003a & 2004). Further, funding based on calculation of First Nations living on-reserve fails to consider the impact and utilisation of services by others living on reserves such as spouses, professionals working within the community and those not registered under the Indian Act, as well as adjacent off-reserve communities. First Nations people living off-reserve are expected to utilise mainstream services, with a few exceptions, and are caught up in federal–provincial cost-shifting tendencies as a result (Lavoie 2003b).

Lavoie (2003a & 2003b) concludes that health services for Canadian First Nations are not equitably funded compared to provincial services, particularly given the inferior health status of First Nations people compared with other Canadians. Data collected in 1993 indicated health service under-funding by 45 per cent in one First Nation community compared to provincial ‘mainstream’ health services (Eyles *et al.* 1994). First Nations do not receive funding allocations that reflect the actual population being served, access to funding is difficult, and competitive rather than needs-based or efficient. Government cost-shifting leaves First Nations with little or no care in some situations, especially in public health. The system is further weakened by the on-off reserve distinction. The current structure limits First Nations’ abilities to provide services that are holistic or responsive to their own priorities (Lavoie 2003b).

Lavoie (2003b & 2004) concludes that a capitation model adjusted for demography, remoteness and needs may provide a better funding basis than funding based on bureaucratically constructed differentiations between categories of ‘Indians’ according to on-off reserve categorisations.

In **New Zealand**, inconsistencies in funding and access to health care remain an issue, notwithstanding substantial reforms in recent decades (Gauld 2001). The New Zealand primary care system involves user part-charges for GP care (Gauld 2001; Scott *et al.* 2003).

New Zealand health sector reforms since the 1980s have followed a model of contracting services out and increasing competition between providers, with some movement away from the competitive market model from the late 1990s. Māori health service providers were also expected to follow the competitive model, although a specific fund was established for promoting Māori provider development and health improvement programs, following advice from the Māori Health Commission (Gauld 2001). Currently, Māori health service funding is a combination of existing competitive contract funding and more recent population-based funding, replacing the prior needs and volume-based contract system (Gauld 2001). District Health Boards are funded on a per capita basis, weighted for various categories of need and population type, e.g., gender. The impact of these reforms is yet to be fully felt (Gauld 2001; Lavoie 2003a).

Notwithstanding these reforms, Māori health service funding issues persist, including under-resourcing relative to health need, the short-term nature of funding and the costs to providers involved in the competitive funding model (see Australian case studies below; New Zealand Director General 2003). Also, Māori (and other low-income) groups continue to have significantly higher levels of cost-related unmet needs.

Current low-income targeted government subsidies reduce, but do not fully compensate for, the barrier posed by doctors' fees. Moreover, there appear to be barriers other than income for Māori and Pacific Islanders (see below under Focus 3: Barriers; Scott *et al.* 2003; New Zealand Director General 2003).

In **Australia**, fiscal responsibility for Indigenous health services has shifted several times, including to the Indigenous organisation ATSIC from the early 1990s until 1995 when the Commonwealth health portfolio resumed control (Anderson 2000a & 2000b). Since then, the movement for greater Indigenous control over health expenditure and related policy has failed to progress, notwithstanding a succession of inter-governmental agreements and framework documents that include reference to increasing Indigenous participation and control over health services (Anderson 2000a & 2000b).

The abolition of ATSIC by the federal government in 2004, and the apparent bipartisan political indifference to the need for politically independent, representative Indigenous organizations, might suggest that the chances of Indigenous Australians obtaining greater control over their health services are not strong (ATSI Social Justice Commissioner 2003; Alford & Muir 2004). The most recent annual report of Australia's Social Justice Commissioner notes that the (federal) government appears reluctant to change its ways in relation to Aboriginal policy, decision-making or resource allocation: 'The primary focus of the government is not on transforming the current approach... or on recognising Indigenous jurisdictions... sharing power... (or changing) existing financial commitments' (ATSI Social Justice Commissioner 2003: Ch 1).

Per capita expenditure on Indigenous health and welfare from all sources is barely higher than for non-Indigenous people, notwithstanding substantially poorer health status (CGC 2001; SCRCSSP 2004; AMA 2004). Two-thirds (64.5 per cent) of all Australian primary health care expenditure for the population as a whole is on Medicare-funded GP services through the Medical Benefits Scheme (MBS) and for pharmaceutical services prescribed by medical practitioners through the PBS.

It is difficult to establish the proportion of total Indigenous primary health care funding in Australia that is directed towards mainstream services and that which is directed towards Indigenous-specific services, notably those provided by AHSs. The most recent national triennial report on health expenditure (AIHW 2001) for 1998–99 estimated that less than 10 per cent (9.7 per cent) of all health expenditure in Australia went on Indigenous-specific programs. This does not, however, include mainstream provider payments from Indigenous-specific funding (e.g., hospital specialist care in an Indigenous clinic) or Indigenous provider payments through mainstream funding programs (e.g., GPs in AHSs billing Medicare) (OATSIH 2004a & 2004b).

In general, health service funding is complex and fragmented, consisting of multiple funders and programs. This has led to calls for funding reforms to improve efficiency, equity and accountability of the health system. Proposals include a national capitation model weighted for Aboriginality and fund pooling (Peacock & Segal 2000).

Divisions of General Practice, the coordinating body for GPs in Australia, receives substantial funding to cater for Indigenous clients, without a commensurate, comprehensive uptake of Indigenous clients (Sibthorpe & Meihubers 1999). The mainstream agencies that service rural and remote areas, such as Rural Workforce Agencies and the Rural and Remote General Practice Program, also receive substantial funding that includes an indeterminate component for Indigenous clients (CDHAC 2000 to CGC 2001: App. D). Any funding reform program should include these expenditures in devising, by way of example, a population-based and/or pooled funding arrangement.

Health expenditure patterns indicate three main differences between Indigenous and non-Indigenous primary health care utilisation in Australia:

- Indigenous use of primary health care services is extremely low compared with non-Indigenous utilisation rates. The ratio of Indigenous compared to all Australians' use of medical (MBS) services was 0.41 in 1998–99, and 0.33 for pharmaceutical (PBS) services. GPs are the gatekeepers to specialist medical services and Indigenous use of the latter is lower again (0.21) (AIHW 2001).
- A marked preference by the Indigenous community for ACCHOs, with a much higher proportion of total Indigenous health expenditure on community and public health services than in the overall population.
- Relatively higher Indigenous use of hospital accident and emergency facilities.

Table 2 summarises the differences between Indigenous and non-Indigenous Australians' primary health service use based on expenditure patterns.

Table 2: Comparisons of Indigenous and non-Indigenous Australians' patterns of primary health service use 1998–99

	Indigenous %	non-Indigenous %	Total expenditure %
Acute care-non-admitted patient services	20.1	13.8	14.0
Community and public health	57.2	16.9	18.2
Patient transport	6.9	3.1	3.2
Medicare and other medical	11.8	46.6	45.5
PBS drugs and appliances	4.0	19.5	19.0
Total	100	100	100

Source: CGC 2001: 116

In short, Commonwealth expenditure on Medicare (MBS) and on the PBS is biased against people who most need these services. To raise direct Commonwealth expenditure on Indigenous people's health services to the Australian average would require a significant increase in both MBS and PBS funding (CGC 2001: xx). Various recommendations to improve Indigenous access to Medicare have been made, including streamlining enrolment and claims procedures, and alternative arrangements such as the cashing out of notional levels of Medicare funding, as tested during the Coordinated Care Trials (CCTs) since the late 1990s in remote areas of Australia (CGC 2001: Ch 6). The bulk of Commonwealth expenditure on Indigenous-specific primary health is spent on funding the ongoing operations of ACCHOs (60 per cent in 1998–99), with additional Commonwealth Indigenous-specific funds to a number of State health services. AHSs are funded by the Commonwealth body Office of Aboriginal and Torres Strait Islander Health (OATSIH) or by a mix of Commonwealth and State funds (Anderson & Brady 1999). Although the Commonwealth has significantly expanded the Indigenous community health sector over the past decade (CGC 2001: Ch. 6), responses by key stakeholders suggest that this is grossly inadequate to meet current expressed primary health needs (e.g., AMA 2002; Ring & Brown 2002; Mooney 2003; Murray 2003). Funding is based largely on current utilisation patterns, adjusted for various factors. Using this as a funding base may be inappropriate and potentially perpetuate inequalities in health service provision (Peacock & Segal 2000). Government (OATSIH) funding shortfalls have led AHSs to apply for competitive grants and tenders (see case study below of Rumbalara Medical Centre). Data limitations prevent more quantitative estimates of the gap between 'core' government funding and current operating income need.

While ACCHOs are now embedded in the legislative and policy complexities of the Australian health care system, they are marginalised from shaping the health care environment. Four main funding and resource allocation problems persist:

- Access to secure and stable funding. A considerable proportion of Indigenous health funding is short-term, for projects or programs secured on a competitive basis, which perpetuates problems with adequately resourcing health care infrastructure and services on a longer term, sustainable basis (Anderson 2000a; Lavoie 2004). Interest continues in reforming financing and funding of Indigenous primary health care in Australia, but with few results to date (Anderson *et al.* 2001). The establishment of a number of Council of Australian Governments (COAG) community trials in 2002–03 were intended to improve administrative arrangements to overcome traditional structural barriers to Indigenous access to health and other services. Progress to date has been limited, which has led to the claim that all levels of government are lacking the political commitment to facilitate this (ATSI Social Justice Commissioner 2003).
- Population-based data limitations, notably under-enumeration and variable quality of data, impede more effective resource allocations particularly to rural and remote regions (Warchivker *et al.* 2000; Cunningham 2002a & 2002b; Murray 2003; AIHW 2003a, 2004a & 2004b; ATSI Social Justice Commissioner 2003: Ch. 1).

- Commonwealth policy and funding levels assume that AHSs are supplementary to mainstream health services (CGC 2001: Ch. 6). This is a questionable assumption in view of utilisation patterns (indicated above), even in non-remote regions with a mainstream supplier.
- Funding bases (utilisation trends) are insufficiently weighted to reflect the substantially poorer health status of Indigenous people (Mooney 2000; Mooney *et al.* 1998, 2003; Peacock & Segal 2000; CGC 2001; Ring & Brown 2002; AMA 2002; Murray 2003).

Australian Indigenous health service (and funding) models

In an attempt to increase Indigenous access and control over primary health services in Australia, the Primary Health Care Access Program (PHCAP) was established by the Commonwealth in 2001 as a potential prototype for national implementation. The PHCAP followed the CCTs, which addressed issues caused by fragmented funding from multiple sources by pooling government and some non-government funding, as well as the cashing out of Medicare funds which are then allocated to a single body charged with planning and purchasing services on behalf of Indigenous clients. Evaluations have been generally positive (CGC 2001: Ch. 6; Robinson *et al.* 2003; OATSIH website).

PHCAP is a regional primary health care service model that plans to build on existing regional and local health plans to improve primary health care services, including for non-Indigenous Australians. PHCAP provides a framework for estimating needs-based funding and allocation between mainstream and Indigenous providers (OATSIH 2004a).

In the PHCAP framework, Indigenous communities are defined by health regions, each having a Regional Aboriginal Health Board that may promote Indigenous control within the constraints of legislation and performance indicators, as well as the limits imposed by the difficulty of recruiting and retaining qualified Indigenous health professionals and workers. Funding is based on yearly average health care expenditure rates per capita, multiplied by two for Aboriginality and again by two if the region is remote. Funding may include both mainstream and Indigenous-specific health services, but is currently focused on the latter in a pilot in two remote areas. Regional Aboriginal Health Boards may operate either as fund holders or as direct providers of primary health care services (OATSIH 2003–04; Lavoie 2003a). Funding does not rely on (demand-driven) Medicare utilisation rates but is a capitation model, with expenditure benchmarks for each service based on population data, weighted to reflect higher Indigenous health needs and higher costs of meeting them in rural and remote areas. (CGC 2001: Ch. 6).

The emergence of the PHCAP service and funding model means that there are now two different models of funding AHSs in Australia:

- 1) A two-tiered model, comprising core, non-competitive funding from the Commonwealth (OATSIH) based on historical expenditures plus adjustments for inflation and various health indicators (eg., MBS utilisation), with a second tier or source of funding based on competitive grants for specific programs and projects. Examples include the Danila Dilba Health Clinic in Darwin and the Rumbalara Medical Centre in northern rural Victoria (see case studies below).

- 2) A capitation model, based on geographically defined Indigenous populations with AHSs, with funding weighted for Aboriginality and locality. An example is the Katherine West Health Board (KWHB) in the Northern Territory.

The boxes below represent case studies of the two different funding models.

Australian Case Study 1: Historical two-tiered funding model

Danila Dilba Health Clinic

Darwin

- serves an Indigenous population of about 5700 (8.5% of total regional population)
- 11,000+ client contacts in 1999–2000
- 69 staff (51 EFT), 70% of whom are Indigenous
- all GPs, medical specialists and nurses are non-Indigenous
- two fixed locations and one mobile
- complex funding arrangements—18 different contracts with many government funding sources
- main funder—Commonwealth OATSIH and competitive grants/tenders

Source: Lavoie 2003a: 38–42; direct contact with Clinic.

Australian Case Study 2: Historical two-tiered funding model

Rumbalara Medical Centre (RMC)

Shepparton/ Goulburn Valley, rural northern Victoria

- serves an Indigenous population of about 5000 (about 10% of total regional population)
- 20,763 client contacts in 2002–03
- 25 staff (EFT), 65% of whom are Indigenous
- all GPs and medical specialists are non-Indigenous
- two fixed locations (medical and dental) and limited outreach services
- main funder—Commonwealth OATSIH and competitive grants/tenders mainly to government/public sector

Source: RAC Annual Reports and Service Activity Reporting to OATSIH.

Australian Case Study 3: Full capitation funding model

Katherine West Health Board (KWHB)

Northern Territory

- serves a population of about 3200 (about 90% Indigenous)
- about 80 staff (mainly full-time), 61% of whom are Indigenous
- all GPs, medical specialists and nurses are non-Indigenous
- nine clinics and a mobile service
- sole provider of regional Indigenous health services
- site of (1 of 4) Aboriginal Coordinated Care Trials in 1998
- transferred funding under the PHCAP in December 2001
- jointly funded by Northern Territory Government and Commonwealth; funding pooled and weighted for Aboriginality (x 2) and remoteness (further x 2); additional ability to access Medicare (Commonwealth)

Sources: PHCAP 2003–04; Lavoie 2003a: 55–6; KWHB Annual Report 2003; direct contact with KWHB.

The historical two-tiered model of funding AHSs has several problems, including:

- core OATSIH funding is based on utilisation patterns rather than population data and may, as a result, lead to unmet demand for AHSs and inadequate basic health infrastructure (Peacock & Segal 2000);
- funding based on current utilisation patterns assumes non-AHS clients can and will access mainstream primary health services, which is unlikely, particularly in regions with a shortage of GPs;
- core funding relies on census-derived population estimates that may under-enumerate the real Indigenous population (see below under Issue 2.1 and 2.2). Goulburn Valley Indigenous agencies have expressed concern about the accuracy of Census-derived regional data and that this may partly account for deficient funding of health (and other) services (McKendrick & Christie 1978; Alford 2002);
- multiple funding sources entail onerous, fragmented reporting requirements to as many as thirty different funders of program grants to many AHSs;
- administrative and operational costs imposed by competitive tendering and time and personnel diverted from core business providing health care services;
- complex, fragmented and short-term funding arrangements adversely affect AHS operations;
- the lack of a population-based approach to health service needs; and
- the lack of fund pooling arrangements or weighting of funding to reflect health needs (Peacock & Segal 2000; CGC 2001: Ch. 6; Lavoie 2004).

The emerging full capitation model, including the pilot PHCAP, has a number of potential strengths including:

- overcoming under-funding of AHSs based on Medicare data (see above);
- funding is pooled, overcoming fragmentation problems arising from previous multiple contracts with funders (eleven in the case of KWHB);
- funding is based on a capitation model which, if adjusted appropriately for demography, remoteness and needs may provide a better funding basis than historically based funding (Peacock & Segal);
- the funding formula is more generous than under the CCTs, which funded the trials at the average Australian utilisation rate, whereas under PHCAP, KWHB will receive four times the average expenditure (OATSIH 2003–04; Lavoie 2003a: 55–6); and
- focusing on primary health care may or will reduce Indigenous hospitalisation rates (early evidence suggests this), with an agreement that PHCAPs (at least KWHB) will be refunded the hospitalisation savings (Lavoie 2003a).

The downside of the PHCAP model includes:

- administrative and reporting requirements;
- the need for a secure (multi-year) funding base; and
- the need in a capitation model for accurate population data. Problems with poor Census identification and under-enumeration of Indigenous people are endemic in Australia, in all regions (see below; Cunningham 1998, 2002a & 2002b; Briscoe & Smith 2002).

In both models, the existence of Indigenous health providers has led to some fragmentation of health services for Indigenous people, and a shifting of responsibility for Indigenous health inequalities away from government onto Indigenous health providers (Lavoie 2003a & 2004). Additionally, while the PHCAP model will hopefully improve Indigenous access to primary health care, the long-term lack of government investment in Indigenous education and community infrastructure may create considerable obstacles to achieving improved outcomes (Lavoie 2004).

Issue 1.1 Definitions

Canada has ongoing bureaucratic problems regarding the definition, description and associated legislative and regulatory treatment of Indigenous people. The *Indian Act* (1976) requires registration as Aboriginal as Treaty rights and benefits, including some health benefits, are awarded to registered individuals (free medication, eye and dental care, glasses, the right to have a house on-reserve, and so on). Amendments in 1985 resulted in additional registrations, but an increasing proportion of Aboriginal children will not be eligible for registration under the Act owing to the status of their parents. This will reduce the Aboriginal population base entitled to (non-insured) health benefits. Government attempts to narrow eligibility and definition have ensured that the term 'Indian' has become a 'bureaucratic construct' rather than a meaningful reference to Aboriginal ancestry (Lavoie 2003b & 2004).

In **Australia**, Aboriginality has been defined, redefined and classified more than sixty times since European settlement, often by gradations of definitions of colour (*'black-ness'*) for the purposes of discriminatory regulation and/or oversight (McCorquodale 1997). The current and now conventional three-part definition includes descent/ancestry, self-identification and community acceptance. This is still not without problems, particularly in Tasmania (Sanders 2004). Indigenous identifiers are increasingly common in health data sets, with varying degrees of accuracy and coverage of the relevant population or community (ABS 1997; AIHW 1999). One of the many ongoing identification issues in Australia is the increasing self-identification by Indigenous people in censuses and, proportionally, of children and of Indigenous–non-Indigenous (*mixed race*) partnerships in Australia (Briscoe & Smith 2002).

Issue 1.2 Indigenous/community versus 'mainstream' health service preference and use

In **Canada**, primary health care access issues exist for off-reserve Aboriginal Canadians, including for the 42 per cent of First Nation people who do not have access to reserves (Smith 2000). Indigenous populations adjacent to reserves and off-reserve are expected to utilise non-IHS services (or the few urban IHSs; Lavoie 2004). The HTP policy focuses on on-reserve primary health care services and does not address broader Aboriginal health access and equity issues.

In **Australia**, Commonwealth policy is based on the assumption that most Indigenous people will access mainstream GPs and that AHSs are supplementary to mainstream services. The evidence indicates otherwise, namely, an under-utilisation of mainstream primary (private) health services and an implicit preference for AHSs. More generally, Indigenous communities prefer community-based health services, unlike non-Indigenous people who generally opt for private consultations (Nelson 2004; SCRCSSP 2004: 81–4).

A review of government funding of Indigenous health (and other) services by the Commonwealth Grants Commission indicates the need for substantially more funding for Indigenous health, with both mainstream and AHS services needing to be expanded significantly to cater for Indigenous primary health care needs (CGC 2001: Ch. 6).

Issue 1.3 Jurisdictional issues and imbalances

The scope for cost-shifting between geographical jurisdictions appears to be significantly greater in federal political systems. In **Canada**, the dual provincial and federal government jurisdiction in health policy has resulted in cost-shifting between the two in the provision of Indigenous health services (Lavoie 2003b). This is partly the cause of inequitable financing of Aboriginal health services (a federal responsibility) compared with non-IHS provincial services. First Nations people living off-reserve are not entitled to use on-reserve IHSs, and are effectively caught in a federal–provincial cost-shifting exercise. As a result, the HTP may leave some First Nations people without any health care service access, thereby aggravating the on-reserve off-reserve dichotomy (Lavoie 2004).

In **Australia**, the health care system is characterised by State-based health care responsibilities that are not matched by financial clout, which belongs with the Commonwealth through its taxation powers. This has resulted in a ‘vertical fiscal imbalance’ (Mooney & Scotton 1998: 36). Partly for this reason, funding of health services for Indigenous people derives from multiple funders, particularly in the competitive and hybrid models (see above), in which AHSs report not only to government (OATSIH) but to all additional funders (CGC 2001: Ch. 6).

Issue 1.4 Funding deficits, geographical and sectoral resource allocations

1.4.1 Funding deficits

Indigenous health service funding in **all three countries** is inadequate, particularly in view of the differentials in health status compared with non-Indigenous populations (Mooney *et al.* 1998; CGC 2001; Ring & Brown 2002; Mooney 2003; Lavoie 2003a, 2003b & 2004; New Zealand Director General 2003; SCRCSSP 2004; AMA 2004). Concerns have been expressed that the quest for Indigenous control over their health services may be double-edged, in causing governments to offload fiscal responsibility onto already poorly resourced communities (Lavoie 2003a, 2003b & 2004). In Australia, the medical peak council the Australian Medical Association (AMA) regularly reports on Indigenous people’s parlous health status, the latest report in 2004 noting that Indigenous health care needs at least an extra \$450 million a year (AMA 2004).

1.4.2 Geographical issues

In **Canada**, Indigenous health funding appears inequitably financed when judged against funding for provincial services. Additionally, off-reserve and urban Aborigines’ specific health needs are poorly addressed. As nearly 40 per cent of First Nations people live in urban centres, Canadian health policy is limited geographically and demographically (Lavoie 2004). **New Zealand** evidence on this point indicates general under-resourcing issues, with Māori health expenditure per head of population barely higher than that of other New Zealanders, notwithstanding significantly poorer health status (New Zealand Director General 2003).

In **Australia**, a geographical bias in funding compounds problems arising from overall low per capita health expenditure on Indigenous people's health and welfare relative to need. Government expenditure is weighted more towards urban than rural or remote areas. This does not match the geographical pattern of needs for Indigenous health services (CGC 2001: Ch. 6). However, it would appear that AHSs are disproportionately located in remote areas (41.1 per cent of 124 total AHSs) (SCRCSSP 2004: 81), which highlights shortages in urban and rural areas in view of the low overall numbers of AHSs relative to the Indigenous population and its distribution.

1.4.3 Sectoral allocations

In **Australia**, the single largest category (25 per cent in 2000–01) of Australian health expenditure is on public hospitals (AIHW 2003a). Government allocations in the health care system are generally weighted towards acute care rather than to the primary care sector (CGC 2001: Ch. 6; Anderson 2001; SCRCSSP 2004: 81–2). Indigenous access to primary health care services is relatively low compared with non-Indigenous people, and extremely low rates of government expenditure on Indigenous primary health care are evident (SCRCSSP 2004: 82).

By contrast, the above-average Indigenous use of acute care services is partly the result of a lack of access to primary services, as well as late presentation of illnesses (CGC 2001: xix; SCRCSSP 2004: 81–2). There is some evidence from one PHCAP pilot study (Katherine West) that an increased focus on primary care has led to a drop in Indigenous hospitalisation rates (Lavoie 2003a). Policy recommendations to improve primary health care access include improving access to Medicare and pharmaceutical benefits, and greater Indigenous involvement in the delivery of health services (CGC 2001: xix; Gruen *et al.* 2002; Couzos 2003).

Focus 2: Population and Data Issues

Issue 2.1 Population-based funding

The central focus of data collections in all three countries is the census. Studies indicate a number of census enumeration problems in accurately identifying Indigenous populations in the three countries. This is discussed in the next section (Issue 2.2).

Canada

Enumeration issues affect resource allocation in providing health services in Canada (Lavoie 2003b). Health Transfer Policy (HTP) resource allocations to Indigenous communities that have undergone a transfer policy issue are inadequate to meet population-based needs. HTP funding is based on historical expenditures plus 15 per cent for administration with no consideration for increases in population, as opposed to a capitation model adjusted for demography, remoteness, etc. It is, moreover, only available for on-reserve communities. Given high rates of mobility within Indigenous communities (including on/off reserves) and an annual population growth of 3 per cent, funding does not adequately meet existing on-reserve health needs (Lavoie 2003b).

Australia

Most government primary health care funding is provided on a subsidy basis to individual general practices, rather than being population based. In 2004, the federal Opposition flagged moving towards a more integrated population-focused approach to funding, and possibly devolving and pooling funding for health care at a regional level (Allen Consulting Group 2002).

Regarding Indigenous funding, one central issue is that health (and other) funding allocations are based on census enumerations and/or estimates of Indigenous people, which substantially understate or underestimate the Indigenous population (see next section). In an attempt to measure Indigenous health needs accurately on a geographical and demographic basis, the CGC initiated efforts by the ABS to develop a multi-dimensional index of Indigenous socio-economic disadvantage by ATSI region, which will include health status. It is hoped that this will more tightly link population-based identification of needs to resource allocation (CGC 2001: xix, 14, 41–51). The task is a difficult one owing to Indigenous census enumeration issues see below under Issue 2.2.

The emerging PHCAP model described above should provide a mechanism to improve local Indigenous health systems, including both mainstream and Indigenous-specific health services, on a population basis (OATSIH site). Identification of needs and gaps requires accurate regional population data to estimate the relevant service population, a persistent

problem in Australia (and Canada and possibly New Zealand). Without precise population data it is not possible to monitor or evaluate accurately health service access, or health service funding adequacy (AHMAC 1997). According to the ABS, Indigenous population estimates 'are important in determining the distribution of government resources and are essential in calculating a range of key Indigenous social indicators' (ABS 2000: item 14). From an Indigenous health service perspective, accurate population counts and other population information are imperative, particularly given the likelihood of a shift to per capita funding in Indigenous health service funding in Australia and elsewhere (CGC 2001: xii).

Issue 2.2 Data quality—Census and administrative population/health data

One of the difficulties in assessing the comparative health status of Indigenous people and its progress across countries is the lack of high-quality data for comparative purposes (Ross in 2002; Bauert *et al.* 2003). There are census enumeration problems in all three countries. In both **Australia** and **New Zealand** the census has 100 per cent coverage, but in **Canada** participation is elective and First Nations/Aboriginal participation is low, making the data less reliable (Briscoe & Smith 2002; Lavoie 2003a & 2003b). Identification as Aboriginal in Canada may not be as much of a problem as in Australia, however, given the treaty-based benefits resulting from registration as 'Indian' (Lavoie 2003a & 2003b).

While participation in the Australian census is legally mandatory, Indigenous participation and/or identification as Indigenous is incomplete and variable (ABS 1999 & 2000; Martin *et al.* 2002; Briscoe & Smith 2002; Taylor & Bell 2003; Lavoie 2003a & 2003b). This, together with a lack of alternative, accurate administrative data sets with which to compare census derived data, results in a comparison of Australian Indigenous health status across regions that is 'a numerical example of uncertainty' (Cunningham 1998, 2002a & 2002b). Whether the lack of comprehensive population-based data in all three countries is a significant contributing factor to the issues that affect primary health care services for Indigenous populations obviously cannot be ascertained (Atkinson *et al.* 2002).

In both **Canada** and **Australia**, the multi-jurisdictional delivery of health care services compounds apparently inherent problems of obtaining accurate Indigenous population counts, including political, administrative and cultural factors (Briscoe & Smith 2002; Taylor & Bell 2003).

In **Australia**, Indigenous health care is not focused on population-based needs, partly due to a lack of good quality population-based data on Indigenous health and health care (CDHAC2000 submission to CGC 2001: xvi; AIHW 2004a: 195–6). There is a need for improved data collection 'as a matter of urgency' for policy, planning and program delivery (ATSI Social Justice Commissioner 2003). One vehicle for achieving this may be the Council of Australian Governments, which in 2003 established a number of community trials for a more coordinated approach to Indigenous communities and a reporting framework on key indicators of Indigenous disadvantage. However, to date COAG has not achieved a significant amount of progress (ATSI Social Justice Commissioner 2003: Ch. 1.8).

Despite efforts by the ABS to improve the accuracy of Census and administrative data information about Indigenous people, a significant gap between Census and alternative Indigenous population records and estimates persists, both over time and between and within Census geographical boundaries (Briscoe & Smith 2002). Problems persist in accommodating new Indigenous identification in Censuses, notwithstanding policy and methodological reviews and reforms to census enumerations (Young 2002). Moreover, the lack of reliable smaller area population and health data makes regional health status comparisons difficult (Cunningham 2002a & 2002b).

Census enumeration issues affecting Indigenous identification are well documented in **Australia** (Briscoe & Smith 2002). These have been summarised as ‘the turmoil of Aboriginal enumeration’ (Warchivker, Tjapangati & Wakerman 2000) and Indigenous population counting as ‘political geography’, with political, administrative and cultural processes all influencing government attempts to enumerate the Indigenous population and Indigenous responses (Gray cited by Taylor 2002). Moreover, while geographical isolation has been identified as a key problem (Taylor 1993; Martin & Taylor 1995), apparently endemic enumeration problems exist in all regions. This may suggest that social isolation or alienation is also likely to contribute to Indigenous under-enumeration and/or incomplete identification as Indigenous (Alford 2003; Taylor 2002).

Generic Census enumeration problems include:

- Wording of questions regarding Indigenous status. These have varied over time and may affect the propensity of people to identify as Indigenous (Briscoe & Smith 2002).
- Changes in people’s inclination to identify as Indigenous over time, for whatever reasons (Briscoe & Smith 2002).
- Low and various Indigenous response rates to censuses in general, including for reasons of mobility, transience, education and literacy factors, and historically based suspicion, mistrust and avoidance of government/bureaucratic officials and forms (O’Donoghue 1997; CGC 2001; Young 2002; Taylor 2002; Alford 2003; Alford & Muir 2004).
- Census geographical boundaries differ from alternative administrative boundaries (e.g., State health departments, ATSIC councils), and they bear a poor relationship to the actual linguistic or family groupings of different Indigenous communities. There are numerous reasons for these mismatches, reflecting past and present circumstances (Altman & Gaminiratne 1992; Young 2002).
- Census assumptions about households, including that there is one discrete, stable household (to respond to the Census questionnaire) rather than a number of interlinked, fluid households (Briscoe & Smith 2002).
- The lack of an independent and valid check against the accuracy of census counts, and of a rigorous model that might predict changes in the propensity of people to identify as Indigenous on censuses (Taylor 2002).

These problems limit the collection of useful meaningful population data. Alternative administrative data sets exist, but are of variable quality and often incomplete (Cunningham 2002a & 2002b; Taylor 2002). A voluntary Indigenous identifier has recently been included in Medicare registrations. This may lead to an improved picture of Indigenous primary health service utilisation in future, but, to date, registrations are still low (an estimated 12 per cent in late 2004) and are an unrepresentative sample of the overall Indigenous population (OATSIH 2004a; HIC website).

An alternative approach to relying on population data may be to measure Indigenous health care needs, establish performance indicators for funding purposes and identify desired outcomes. All three tasks are difficult, with the last particularly hard to achieve and evaluate owing to the multiple influences on Indigenous (and all) people's health status. In Australia, caution has been expressed about tying measured outcomes to funding, especially at a micro level (Anderson & Brady 1999).

Issue 2.3 Weighting health resource allocations

In **Canada**, HTP resource allocations in relation to Indigenous communities that have undergone a transfer policy are considered inadequate because they are formulae-based funding, not necessarily based on health care need (Lavoie 2003a, 2003b & 2004).

In **New Zealand**, Māori health and disability expenditure in 2003 was 14.7 per cent of total expenditure, which is barely higher than the Māori proportion of the total population, notwithstanding a significantly poorer health status (New Zealand Director General 2003).

In **Australia**, clinicians and health experts urge that proportionately more money should be spent on Indigenous people's health given their greater health needs (Mooney & Jan 1997; Ring & Firman 1998; Wiseman & Jan 2000; Mooney 2000 & 2003; Duckett 2000; Leeder 2003; AMA 2002 & 2004). Public expenditure on Indigenous health (and all other welfare, infrastructure and education services) falls well short of that required to redress the substantial inequalities of Indigenous Australians compared with their non-Indigenous counterparts (Neutze *et al.* 1999; CGC 2001; Alford & Muir 2004). One estimate is that reallocating a mere 1 per cent of Australia's health care budget would increase Indigenous health spending by 50 per cent (Mooney *et al.* 1998).

This raises the question of how to identify and measure the need for primary health care. The CGC considers two approaches to measuring health needs:

- 1) a multi-factor approach that focuses on measuring needs in terms of specified outcomes and associated priorities for funding (factors including population, relative socio-economic disadvantage, geographical remoteness); and
- 2) a population approach that focuses on resource inputs matched against an agreed standard.

Progress towards the development of either approach is impeded by a lack of accurate regional population and other social and health data (CGC 2001: Ch. 6).

The issue of what weighting to place on Indigenous health care expenditure and what criteria and measurements to use (e.g., mortality, morbidity rates, etc.) affects **all three countries**. The Australian literature is summarised below.

It has been suggested that between 2.5 and 7.3 times the average per capita expenditure on non-Indigenous health services be allocated for Indigenous health, with higher weighting in regions of greater need and with greater access difficulties (Mooney *et al.* 1998; Mooney 2003; CGC 2001: Ch. 6; OATSIH 2004a & 2004b). The Commonwealth Department of Health and Ageing has considered this issue in implementing the PHCAP program, concluding that Indigenous health expenditure should be at least twice the national average per capita expenditure on primary health care, and up to four times the national average in rural and remote areas. The Aboriginal Medical Services Alliance Northern Territory (AMSANT) has suggested a higher weighting (2.5 times that for non-Indigenous people, plus location-based add-ons). The CGC's review of Indigenous funding concludes that:

[O]n the evidence presented to us, the poorer health status of indigenous people, and their greater reliance in the public health system, would justify at least a doubling of the average per capita government expenditure on non- Indigenous people (CGC 2001: 127).

Focus 3: Barriers

3.1 General barriers

In **Canada**, barriers to accessing health care services were highlighted in the Health Transition Fund pilot program evaluation in 2002:

Aboriginal people have been ill-served by the country's health system. They frequently come up against barriers when attempting to access services, and the care they do receive is often of a poorer quality than that enjoyed by other Canadians.

Barriers include geographical and cultural/knowledge-based barriers, cultural insensitivity and a lack of health staff able to speak Aboriginal languages. Mitigation of these through outreach activities in order to ensure that services are provided in a less threatening environment, as well as the introduction of liaison workers to act as facilitators and mediators, have proved largely successful in increasing Aboriginal access to health services (Health Transition Fund 2002).

Indigenous people in northern Ontario have insufficient and/or ineffective primary health care, according to one recent quantitative report based on hospitalisation data for various indicators (Shan *et al.* 2003). The study did not attempt to generalise the results to other Indigenous populations in Canada.

A similar pattern exists in **New Zealand**. Barriers to accessing primary health care services for Māori people include possible supply shortages, a lack of Māori GPs, allied health and nursing personnel relative to the population and possibly also mainstream GP attitudes (New Zealand Director General 2003).

In **Australia**, Indigenous people face multiple interrelated barriers to accessing care, particularly in the primary care sector, including (beside location factors discussed below):

- cultural and social factors;
- financial and cost-related barriers;
- workforce issues (lack of an Indigenous presence);
- poor linkages between services; and
- a lack of a population focus (CDHAC submission to CGC 2001: ix; OATSIH 2004a).

Issue 3.2 Geographical location

In **Australia**, a relative shortage of GPs in rural and remote areas of Australia is an access issue for both Indigenous and non-Indigenous people (AIHW 2004). Geographical remoteness is considered a leading cause of Indigenous poor health status, which on average worsens with increasing distance from population centres (Deeble *et al.* 1998; AIHW 2001, 2003a, 2003b & 2004). Indigenous access to Medicare-funded primary health care services and to pharmaceutical benefits is relatively poor everywhere, but worsens again in more remote regions (CGC 2001: Ch. 6; AIHW 2004). The geographical remoteness factor has been considered in the health economics literature on weighting of government health expenditures. There is clearly a need to develop better regionally based health and health cost weights in Australia, and for more discussion about what the benchmark(s) should be (CGC 2001: Ch. 6).

The 'problems' of Indigenous people, including poor health status, are often assumed to be attributed to 'locational disadvantage' (Taylor & Hunter 1998: 4), that is, geographical remoteness from (predominantly non-Indigenous) population centres. Indigenous status is, however, a stronger predictor of low MBS/PBS usage than remoteness (OATSIH 2004a). Moreover, three out of every four Indigenous Australians do not live in remote regions of Australia and still have poor health status (AIHW 2003b). For example, Victoria is one of the least rural/remote States in Australia but standardised death rates per head of its Indigenous population are higher than the national average (CGC 2001: Ch. 6). Focusing on geographical remoteness may also lead to the neglect of other factors and, in particular, to social isolation and exclusion (Alford 2003; Alford & Muir 2004).

Issue 3.3 Price barriers

In **all three countries**, data limitations prevent detailed analysis of price-based barriers to accessing primary health care services by Indigenous people. OECD evidence indicates that in 2001, out-of-pocket payments per capita for health care in Australia were the third highest among (thirty) OECD countries, surpassed only by the US and Switzerland, and were more than twice those in New Zealand and 15 per cent higher than in Canada (OECD 2004).

In **New Zealand**, price barriers to GP services for Māori people have been reduced, but not eliminated, by government subsidies. Factors such as income and cost continue to impede Māori access to primary health care services and to GPs (Scott *et al.* 2003; New Zealand Director General 2003).

In **Australia**, the overall decline in bulk-billing and increasing co-payments for mainstream GP services in the past few years may have impacted on Indigenous primary health care utilisation. Research gaps prevent further analysis.

Issue 3.4 Attitudes and culture

In **Canada**, holistic approaches to Aboriginal health initiatives—rather than simply providing (generic) services without reference to culture, overall well-being or environment—have been more successful (Stout & Kipling 2002).

In **New Zealand**, the impact of culture on Māori health service system issues may be variable according to age (Houghton 2001). Younger Māori (under forty-five) conceptions of health are closer to the Western (Cartesian) mind–body dualism, whereas older Māori tend to have a more traditional, cultural approach, conceiving of health as holistic, comprising physical, spiritual, emotional and familial influences (depicted by Durie in Houghton 2001). This has implications in all three countries for ensuring that cultural frameworks in organisations supplying Indigenous health care are dynamic, rather than prescriptive or traditionally rigid (Houghton 2001).

In **Australia**, a study in the late 1990s found lower than previously assumed Indigenous utilisation of primary health care services, and that one contributing factor was cultural differences (Deeble *et al.* 1998). A key cause of Indigenous Australians' poor health status compared with Indigenous populations in Canada and New Zealand may be cultural—namely, the rejection of the colonists' health system, with an increasing rather than declining lack of trust in it (Mooney 2000; Caldwell 2002; Henry *et al.* 2004).

Emotional and cultural barriers are two of five main risk factors identified for Indigenous ill-health in Australia, resulting in high rates of mental health problems and an inability or unwillingness to access primary health care services. These are compounded by 'a historical legacy of barriers to access to health services' (CGC 2001: 109; see also O'Donoghue 1999; Leeder 2002). A report to OATSIH identifies the need for cultural safety for Indigenous health service clients, including imparting culturally safe knowledge to non-Indigenous doctors and health workers (Curtin Indigenous Research Centre 1998; see also Baum 1998).

Issue 3.5 Treaties and native title

Treaties have contributed to the improved health status of Indigenous populations in **Canada** and **New Zealand**, according to Ring and Firman (1998): 'Treaties, no matter how loosely worded, have appeared to play a significant and useful role in the development of health services, and in social and economic issues'. In **Australia**, the lack of distinctive legal recognition of Indigenous people's autonomy and culture may compound the effects of being a small demographic minority in a large continent in contributing to the poor health, welfare and more general socio-economic outcomes of Indigenous Australians (AIHW 2001, 2003a, 2003b & 2004a; ATSI Social Justice Commissioner 2003; Bauert *et al.* 2003; Murray 2003).

Australia, unlike both Canada and New Zealand, lacks treaty recognition of native title (Havermann 1999; Langton *et al.* 2004). The link between this and the relatively poor health status of Indigenous Australians has been asserted but not explored in any detail (Ring & Firman 1998). The Australian anthropologist W. E. H. Stanner suggests that the

impact of colonisation and dispossession in Australia did, and would continue to, damage the general health and well-being of Indigenous Australians:

Our word 'home'... does not match the aboriginal word that may mean 'everlasting home', 'totem place', 'life source', 'spirit centre'. As a result, contemporary Aborigines may experience 'vertigo in living... no stable base of life... every group structure... put out of kilter; no social network has a point of fixture left. (Stanner 1969)

The relationship between traditional land and health is described well in research by one Indigenous Elder and scholar in Australia, Wayne Atkinson: 'Take away land as Indigenous people often assert, and you take away our soul, and identity and our well being as a people' (Atkinson 2000).

More generally, some clinical and academic experts in Australia regard the recognition of Indigenous peoples' prior ownership of land as central to their achieving greater social and economic justice (Baum 1998; Alford 1999a & 1999b; Eades 2000; ATSI Social Justice Commissioner 2003; Alford & Muir 2004). The prospects for a treaty or some formal codification of Indigenous rights in Australia remain a distant prospect at this point (Alford & Muir 2004).

Issue 3.6 Health workforce

In **Canada**, Aboriginal health and liaison workers have been important as facilitators and mediators in the provision of health services. There has also been a need for appropriate cultural sensitivity training, in view of evidence of racism in the health sector (Health Transition Fund 2002).

New Zealand's Māori health workforce is larger, relative to the overall population, than the Indigenous health workforce in Australia, but is still well below what their proportion in the overall population would warrant (13.8 per cent). Only 2.3 per cent of GPs are Māori, with higher proportions of allied health and nursing personnel, but still less than 10 per cent in all disciplines. As in Australia, government strategies and frameworks are in place regarding promoting growth in the Māori health workforce (New Zealand Director General 2003).

In **Australia**, workforce issues may also be relevant in explaining the relatively poorer (again) health status of Indigenous Australians compared with their Canadian and New Zealand counterparts. The paucity of Indigenous doctors and health workers in Australia persists, as do general rural health workforce shortages (AIHW 2004), despite many government declarations and strategies designed to redress these shortages over the years (summary in AHMAC 2002).

In 1999, a major review of Aboriginal Health Worker (AHW) training in Australia was commissioned by OATSIH. It identified a lack of specifically Indigenous health workers in Australia, that most are middle-aged females (average forty years), that workforce turnover is high, and that in some regions up to 60 per cent lack formal training. The case studies in Section 1.2 (Funding, etc.) illustrate the difficulties of attracting and retaining Indigenous

medical and health staff to rural and remote areas in particular. The lack of, and the need for, a planned and coordinated approach to AHW training has been emphasised (Curtin Indigenous Research Centre 1999).

In 2001, the CGC noted a continuing lack of trained Indigenous health professionals, with difficulties in recruiting them, and a lack of training and recognition of AHWs across the States and their integration into other vocational education and training. Mainstream health professional training in the cultural and social circumstances of Indigenous clients was also deemed deficient (CGC 2001: 131–2; Wakerman *et al.* 2000).

Notwithstanding a succession of national policies directed at increasing the Indigenous health professional workforce, it remains overwhelmingly non-Indigenous, with the exception of Aboriginal Health Workers. Matched against the 2.4 per cent Indigenous proportion of the total Australian population, the proportion of Indigenous medical staff (2001 data) was 0.3 per cent, nurses 0.8 per cent, dentists and dental workers 0.6 per cent, pharmacists 0.1 per cent and allied health professionals 0.3 per cent (OATSIH 2004a).

In 2002, the Australian Health Ministers endorsed a five- to ten-year ‘national strategic’ framework to increase the Indigenous (and non-Indigenous) health workforce in both mainstream and community-controlled AHSs. The framework did not include reference to the funding and resources required to implement this agenda (AHMAC 2002). The Australian Medical Association estimates that the Indigenous health care sector is substantially under-funded—facing a shortfall of 430 doctors and 450 other health professionals—and has called for more funding of training places, including for Indigenous people (AMA 2004).

The role of AHWs is regarded as crucial in promoting better communication between non-Indigenous medical staff and Indigenous clients, and as vital in providing for more effective service delivery (CGC 2001: Ch. 6; AHMAC 2002). Health workforce deficits—and, in particular, the paucity of Aboriginal doctors, nurses, and other health professionals—is one of many barriers to Indigenous people accessing primary health care services. AHSs currently have more Indigenous medical, nursing and allied health staff than in the mainstream (67 per cent Indigenous staff), but still a relatively small proportion of doctors (2.5 per cent) and nurses (12.5 per cent) (SCRCSSP 2004: 81). Increasing Indigenous staff and providing cultural awareness to staff has led to large increases in Indigenous access to mainstream health services in one regional location studied (Hayman 2003).

Conclusions

Indigenous health status

Indigenous health status is poor in **all three countries**, with the greatest gap between non-Indigenous and Indigenous populations being in **Australia**, which has shown the least improvement. Possible reasons for this include: the timing and impact of colonisation, notably the lack of native title or treaty recognition; geographic and demographic factors; funding issues; the relative lack of development of Indigenous-specific health services; and workforce deficits.

Funding and resource allocations

Deficient funding levels in relation to health needs are highlighted in the literature on **all three countries**, as are allocation and distribution problems occurring within those funding constraints. Aligning funding to health needs, particularly at a local level, is considered desirable but fraught with problems. One issue is whether it is possible or desirable to use health indicators as financial accounting tools in resource allocations. Another is attribution, that is, whether improved health outcomes are or can be attributable to financial and resource inputs (Anderson & Brady 1999).

The on/off reserve issue in Canada, allocations between mainstream and Indigenous-specific health care services in all three countries, and cost-shifting in federal systems (**Canada** and **Australia**) are all unresolved issues. Federalism is not the only structural and sectoral issue, however. Fragmentation and inefficiencies in New Zealand's unitary system continue to cause concern in the health sector.

Funding issues regarding population bases, weighting for greater health need and Aboriginal participation in health care system funding issues and outcomes remain unresolved. The abolition of ATSIC in **Australia** (in 2004) foreshadows greater mainstreaming of Indigenous health and welfare service provision and funding. The effects of this on the primary health care system for Indigenous people in Australia are yet to be identified.

Pooling primary health service funding at a regional or local level is commended in the literature. This appears to have made more headway in **Canada** and **New Zealand** than in **Australia**, but with some movement towards this in Australia's recently established PHCAP program. As yet, this still applies only to Indigenous people in remote regions and while it may become a national prototype in future, at present funding remains largely based on (inadequate) population data, delivered via multiple funding sources in many jurisdictions, on either a competitive or non-competitive basis. Australia's CGC has recommended a

multi-jurisdictional and cross-functional approach to Indigenous service delivery in health and welfare, with greater provision for pooling, ‘cashing out’ notional Medicare (and pharmaceutical) funding and allocating this to ACCHOs (CGC 2001).

Policy issues regarding structure, funding and resource allocation issues

All three countries have relatively well-developed policies and frameworks for delivering improved (primary) health care to Indigenous people, although population and health data deficiencies may impede greater development. **Australia** may be relatively disadvantaged in one key respect, however, as the Commonwealth does not adequately recognise the need/desirability of increasing Indigenous-specific health services, including in non-remote regions.

In **all three countries** there appears to be a considerable gap between policy formation and reform, and practical outcomes such as more funding (a clear deficit), more attention to policy implementation and improved service provision and delivery for Indigenous populations. As a result, there remains a significant, if imprecisely measured, gap between recognition of Indigenous health-related problems and meaningful, feasible policy development and implementation to redress these problems.

These problems may be greater and more politically intractable in **Australia**. Ian Ring, internationally respected Professor of Public Health at James Cook University in Queensland, has recently emphasised that the lack of resources allocated towards improving Indigenous health in Australia reflects a lack of political commitment: ‘If you’re 2 per cent of the population, you don’t have a treaty and you’re not a potent political force, then commitment just isn’t a priority’ (cited in Murray 2003).

Data quality issues

Poor, incomplete and variable data on Indigenous population and population-based health issues and measures may partly account for deficiencies in (primary) health care service provision and access. Data issues also make comparisons difficult between and within **all three countries**.

Barriers

Indigenous access to primary health care remains an issue in **all three countries**. Barriers include

- geographical and location issues, particularly in Australia;
- financial costs, notably private co-payments for mainstream GP services, particularly in Australia;
- lack of Indigenous-specific health services (AHSs);
- resource allocations weighted towards the acute care sector rather than, and perhaps at the expense of, primary health care, which aggravates primary health care service supply deficits;

- attitudinal and cultural barriers, including racism in the health care sector, historical attitudes of suspicion and/or avoidance of government-linked primary health care services, and culturally inappropriate forms of health care service delivery;
- (lack of)political recognition of traditional lands and Indigenous rights. This appears to be a greater and persistent problem in Australia, with specific impacts on health status likely but not scientifically established; and
- workforce deficits, notably the lack of Indigenous medical, allied health and AHW personnel.

The biggest barrier?

Funding? Inadequate provision of Indigenous-specific health care services? Demographics? Geography? Political insensitivity? Lack of agency and political power of colonised populations? Other?

Readers may choose from this menu or select their own. Hopefully this review provides signposts to evidence and resources that will enable more informed opinions and policy decisions on these and all Indigenous health and welfare issues. The need is great given the gaps in health status between Indigenous and non-Indigenous populations in all three countries. Perhaps the last, if not final, word, comes from the esteemed Australian health economist Professor Stephen Duckett (2000):

Broader issues of dignity, identity, and justice need to be taken into account (as well as) the need for further progress on reconciliation.

Appendix 1: References

Most health/medical journals can be accessed via PubMed:
<<http://www.ncbi.nlm.nih.gov/PubMed>>.

Comparative

General Websites

Association for Canadian Studies in Australia New Zealand,
<<http://powerop.com.au/acsanz>>.

Links to Aboriginal Resources (Australia, Canada, New Zealand, US),
<<http://bloorstreet.com/300block/aborl.htm>>.

General

Armitage, A. 1995, *Comparing the Policy of Aboriginal Assimilation: Australia, Canada & New Zealand*, University of British Columbia Press, Vancouver.

Dow, C. & Gardiner-Garden, J. 1998, *Indigenous Affairs in Australia, New Zealand, Canada, U.S., Norway & Sweden*, Parliamentary Library, Parliament of Australia, Canberra.

Havermann, P. (ed.) 1999, *Indigenous Peoples' Rights in Australia, Canada and New Zealand*, Oxford University Press, Auckland.

Langton, M., Tehan, M., Palmer, L. & Shain, K. (eds) 2004, *Honour among Nations? Treaties and Agreements with Indigenous People*, Melbourne University Press, Melbourne, E-Book: <<http://www.mup.unimelb.edu.auebooks>>.

Lavoie, J. 2003a, *Indigenous Primary Health Care Services in Australia, Canada and New Zealand: Policy and Financing Issues*, Centre for Aboriginal Health Research, Darwin, <http://www.umanitoba.ca/centres/centre_aboriginal_health_research/researchreports/Indigenous_Primary_HealthCare_Services>.

Lavoie, J. 2004, 'Governed by Contracts: The development of Indigenous primary health services in Canada, Australia & New Zealand', *Journal of Aboriginal Health*, vol. 1, no.1, pp. 6–22.

Organisation for Economic Cooperation and Development (OECD) 2004, *OECD Health Data 2004: A Comparative Analysis of 30 Countries*, OECD, <<http://www.aihw.gov.au/international/oced/ocdhd04.html>>.

- Redding, J. 2003, 'A Global Model and National Network for Aboriginal Health Research Excellence', *Canadian Journal of Public Health*, vol. 94, no. 3, p. 185.
- Ring, I. & Firman D. 1998, 'Reducing Indigenous Mortality in Australia: Lessons from other countries', *Medical Journal of Australia*, vol. 169, no. 10, pp. 528–33.
- Rosser, W. & Weel, C. 2004, 'Research in Family/General Practice is Essential for Improving Health Globally', *Annals of Family Medicine*, vol. 2:s2–s4.
- Shoranick, T. 2003, Comparative Health Status Indicators for Indigenous Populations, Paper to 10th Canadian Conference on International Health, Ottawa, <http://www.ainc-inac.gc.ca/pr/ra/ipf_e.pdf>.
- Stout, M. & Kipling, G. 2002, *Synthesis Series—Aboriginal Health*, Health Canada, Health Transition Fund, <<http://www.hc-sc.gc.ca/htf-fass/english>>.
- Thompson, N., Murray, R., Ring, I. & Garrow, S. 2000, 'Aboriginal Health Status', in S. Couzos & R. Murray (eds), *Aboriginal Primary Health Care. An Evidence-based Approach*, Oxford University Press, Melbourne, pp. 38–60.

Canada

General Websites

- Census material, <<http://www.statcan.ca/english/census>>.
- Health Canada, <<http://www.hc.gc.ca>>.
- Health Canada, Non-Insured Health Benefits Program (NIHB), <<http://www.hc-sc.gc.ca>>.
- Indian and Northern Affairs Canada, <<http://www.ainc.inac.gc.ca/pr>>.
- National Aboriginal Health Organization, <<http://www.naho.ca>>.

General

- Eyles, J., Birch, S. & Chambers, S. 1994, 'Fair Shares for the Zone: Allocating health-care resources for the native populations of the Sioux Lookout zone, Northern Ontario', *Canadian Geographer*, vol. 38, no. 2, pp. 134–50.
- Health Canada 2002, *Annual Report First Nations and Inuit Control*, Program Policy Transfer Secretariat & Planning Directorate, Health Funding Arrangements, Minister of Public Works and Government Services Canada, <<http://www.hc.gc.ca>>.
- Health Canada 2003, *A Statistical Profile on the Health of First Nations in Canada*, <<http://www.hc.gc.ca>>.
- Lavoie, J. 2003b, 'The Value and Challenges of Separate Services: First Nation in Canada', in J. Healy & M. McKee (eds), *Health Care: Responding to Diversity*, Oxford University Press, Oxford.

Miller, J. 2000, *Skyscrapers Hide the Heavens. A History of Indian–White Relations in Canada*, 3rd edn, University of Toronto Press, Toronto.

Monture-Angus, P. 2000, *Journeying Forward. Dream Aboriginal Peoples' Independence*, Pluto Press, Sydney.

Shan, B., Gunraj, N. & Hux, J. 2003, 'Markers to Access to & Quality of Primary Care for Aboriginal People in Ontario, Canada', *American Journal of Public Health*, vol. 93, no. 5, p. 798.

Smith, M. 2000, 'Looking Out for our Indigenous People: The Canadian experience', *Australian Journal of Public Administration*, vol. 59, no. 3, pp. 79–86.

Australia

General Websites

Aboriginal Community Controlled Health Organisations (ACCHO), National body NACCHO, <<http://naccho.org.au>> and State bodies, e.g., Victoria <<http://vacchho.com.au>>.

Australian Bureau of Statistics (ABS), <<http://www.abs.gov.au>>.

Australian Institute of Health and Welfare (AIHW), <<http://www.aihw.gov.au>>.

Aboriginal and Torres Strait Islander Commission (ATSIC), <<http://www.atsic.gov.au>>.

Australian Indigenous HealthInfoNet, <<http://www.healthinfonet.ecu.edu.au>>.

Centre for Aboriginal Economic Policy Research (CAEPR), Australian National University, Canberra, <<http://www.anu.edu.au/caepr>>.

Cooperative Research Centre for Aboriginal Health (CRCAH), <<http://www.crcah.org.au>>.

Health Insurance Commission (HIC), <<http://www.hic.gov.au>>.

Human Rights and Equal Opportunity Commission (HREOC), Social Justice Commission, *Annual Reports 1993–2003*, <http://www.hreoc.gov.au/social_justice/sjreport> Indigenous Law Resources, <http://www.austlii.edu.au/other/IndigLRes>>.

National Library of Medicine, searchable medical journal database, <<http://www.ncbi.nlm.nih.gov/entrez/query.fcgi>>.

Office for National Aboriginal and Torres Strait Islander Health (OATSIH), <<http://www.health.gov.au/oatsih/cont.htm>>.

Primary Health Care Research and Information Service, <<http://www.phris.org.au>>.

Australia – General

- Australian Bureau of Statistics (ABS) 1996, *National Aboriginal and Torres Strait Islander Survey 1994. Australia & by ATSI Region*, <<http://www.abs.gov.au>>.
- Australian Bureau of Statistics (ABS) 2004, *National Aboriginal and Torres Strait Islander Survey 2002. Australia*, <<http://www.abs.gov.au>>.
- Australian Health Ministers' Advisory Council (AHMAC) 1997, *The Aboriginal & Torres Strait Islander Health Information Plan*. AIHW, Canberra.
- AHMAC 2002, *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, AHMAC, Canberra, <<http://www.health.gov.au/oatsih/cont.htm>>.
- Australian Institute of Health and Welfare (AIHW) 2001, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, <<http://www.aihw.gov.au>>.
- AIHW 2003a, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, <<http://www.aihw.gov.au>>.
- AIHW 2003b, *Rural, Regional and Remote Health. A Study on Mortality*, AIHW, Cat. No. PHE 49, Canberra.
- AIHW 2004, *Australia's Health. 9th Biennial Report of the AIHW*, AIHW, Cat. No. 44, Canberra, <<http://www.aihw.gov.au>>.
- Alford, K. 1999a, Native Title Developments in South-East Australia: From 'terra nullius' to 'the tide of history', *Journal of Economic and Social Policy*, vol. 3, no. 2, pp. 157–66.
- Alford, K. 1999b, 'Whitewashing Away Native Title Rights', *Arena Journal*, vol. 13, pp. 67–83.
- Alford, K. 2002, *Shepparton Indigenous Community Employment Strategies*, Report to Commonwealth of Australia Departments of Employment & Workplace Relations and Transport & Regional Services, (Ganbina) Koori Economic & Employment Training Agency, Shepparton, <www.dewr.gov.au and www.ganbina.com.au>.
- Alford, K. 2003, 'Denying Aboriginal Identity in South-East Australia: The failure of the assimilation model in schools', *International Journal of Learning*, vol. 10, <<http://LearningConference.Publisher-Site.com>>.
- Alford, K. & Muir, J. 2004, 'Dealing with Unfinished Indigenous Business: The need for historical reflection', *Australian Journal of Public Administration*, <<http://www.ipaa.org.au>>.
- Australian Medical Association (AMA) 2000, *Public Report Card. Aboriginal and Torres Strait Islander Health. No More Excuses*, AMA, Canberra, <<http://www.ama.com.au/web.nsf/topic/publications>>.
- AMA 2004, *Healing Hands-Aboriginal and Torres Strait Islander Workforce Requirements*, Discussion Paper, AMA.
- Anderson, I. 2000a, Australian Indigenous Health, paper presented to 2nd International Conference Primary Health Care, Melbourne, <<http://www.dhs.vic.gov.au/acmh/ph>>.

Anderson, I. 2000b, 'Evidence and Aboriginal Primary Health Care', in S. Couzos, & R. Murray (eds), *Aboriginal Primary Health Care. An Evidence-based Approach*, Oxford University Press, Melbourne, pp. 631–37.

Anderson, I. 2001, 'Aboriginal Health, Policy and Modelling in Social Epidemiology', in R. Eckersley, J. Dixon & B. Douglas (eds), *The Social Origins of Health and Well-Being*, Cambridge University Press, Cambridge, pp. 247–58.

Anderson, I. 2002, 'Critical Issues in National Aboriginal Health Strategy: A framework for health gain', *VicHealth Koori Health Research and Community Development Unit, Discussion Paper 6*, University of Melbourne, Melbourne, <<http://www.cshs.unimelb.edu.au/koori>>.

Anderson, I. 2004, 'The Framework Agreements: Intergovernmental agreements and Aboriginal and Torres Strait Islander health', in M. Langton, M. Tehan, L. Palmer & K. Shain (eds), *Honour Among Nations? Treaties and Agreements with Indigenous People*, Melbourne University Press, Melbourne, e-Book: <<http://www.mup.unimelb.edu.au/ebooks>>.

Anderson, I. & Brady, M. 1995, 'Performance Indicators for Aboriginal Health Services', Centre for Aboriginal Economic Policy Research (CAEPR), Discussion Paper 81, 1995, abstract only, <<http://www.anu.edu.au/caepr>>.

Anderson, I. & Brady, M. 1999, 'Performance Indicators for Aboriginal Health Services', in L. Hancock (ed.), *Health Policy in the Market State*, Allen & Unwin, Sydney, pp. 187–209.

Anderson, I. & Thomson, N. 2002, 'Health of Indigenous Australians: A rural perspective', in D. Wilkinson & I. Blue (eds), *The New Rural Health*, Oxford University Press, Melbourne, pp. 115–8.

Anderson, I., Young, H., Markovic, M. & Manderson, L. 2001, 'Aboriginal Primary Health Care in Victoria: Issues for policy and regional planning', *VicHealth Koori Health Research and Community Development Unit, Discussion Paper 1*, University of Melbourne, Melbourne, <<http://www.cshs.unimelb.edu.au/koori>>.

Atkinson, V., Graham, J., Pettit, G. & Lewis, L. 2002, 'Broadening the Focus of Research into Indigenous Health', *Medical Journal of Australia*, vol. 177, no. 6, pp. 286–7.

Atkinson, W. 2000, *Not One Iota: The Yorta Yorta Struggle for Land Justice*, PhD Thesis, LaTrobe University (copies in University Library and Goulburn Valley Regional Library, Shepparton).

Aboriginal and Torres Strait Islander Commission (ATSIC) 1999, *There's no Need for Indigenous People to Have their own Medical Services. As a Matter of Fact: Answering the Myths and Misconceptions about Indigenous Australians*, 2nd edn, ATSIC, <<http://www.atsic.gov.au>>.

Aboriginal and Torres Strait Islanders (ATSI) Social Justice Commissioner 2003, *Native Title Report*, <http://www.humanrights.gov.au/social_justice/ntreport03>.

Bauert, P., McMaugh, E., Martin, C. & Smylie, J. 2003, 'Indigenous Health: Chronically inadequate responses to damning statistics', *Medical Journal of Australia*, vol. 178, no. 5, p. 246.

Baum, F. 1998, *The New Public Health: An Australian Perspective*, Oxford University Press, Melbourne.

Commonwealth of Australia 2001, House of Representatives Standing Committee on Family and Community Affairs, 'Health is Life, Report on the inquiry into Indigenous Health', Parliament of the Commonwealth of Australia, Canberra, <<http://www.aph.gov.au/house/committee/fca/indhea/reportfinal.pdf>>. Plus Government Response to the House of Representatives Inquiry into Indigenous Health 2001, *Health is Life*, <<http://www.health.gov.au/oatsih/healthlife/pdf/hisl.pdf>>.

Couzos, S. 2003, 'The Health and Welfare of Territorians; Better Health Care: Studies in the successful delivery of primary health care services for Aboriginal and Torres Strait Islander Australians', *Australian and New Zealand Journal of Public Health*, vol. 27, no. 1, p. 93.

Curtin Indigenous Research Centre 1999, *A National Review of Aboriginal and Torres Strait Islander Health Worker Training*, Office of Aboriginal and Torres Strait Islander Health (OATSIH), Canberra, <<http://health.gov.au/oatsih/cont.htm>>.

Donato, R. & Scotton, R. 1998, 'The Australian Health Care System', in G. Mooney & R. Scotton (eds), *Economics and Australian Health Policy*, Allen & Unwin, Sydney, pp. 20–39.

Duckett, S. 2000, *The Australian Health Care System*, Oxford University Press, Melbourne.

Eades, S. 2000, 'Reconciliation, Social Equity and Indigenous Health', *Medical Journal of Australia*, vol. 172, pp. 468–9.

Elliot, A. 2003, *The Decline in Bulk Billing: Explanations and Implications*, Current Issues Brief No. 3 2002–03, Parliamentary Library, Parliament of Australia, Canberra, <<http://www.aph.gov.au/library/pubs/cib/2002-03/03cib03.htm>>.

Gruen, R., Weeramanthri, T. & Bailie, R. 2002, 'Outreach and Improved Access to Specialist Services for Indigenous People in Remote Australia: The requirements for sustainability', *Journal of Epidemiology and Community Health*, vol. 56, pp. 517–21.

Hayman, N. 2003, Improving Indigenous Access to a Mainstream General Practice, Paper to 7th National Rural Health Conference, <<http://www.nrha.net.au/nrhpublic/publicdocs/conferences/7thNRHC/Papers/general>>.

Hays, R. 2001, 'Rural Practice in Australia', in J. Geyman, T. Norris, & L. Gary Hart (eds), *Textbook of Rural Medicine*, McGraw-Hill, New York, pp. 411–22.

Henry, B., Houston, S. & Mooney, G. 2004, 'Institutional Racism in Australian Healthcare: A plea for decency', *Medical Journal of Australia*, vol. 180, no. 10, pp. 517–20.

Human Rights and Equal Opportunity Commission (HREOC) 1997, *Bringing Them Home. National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*, Sterling Press, Canberra.

HREOC 2003a, *Annual Report*, <http://www.hreoc.gov.au/social_justice/sjreport03>.

HREOC 2003b, Native Title Report, <http://www.humanrights.gov.au/social_justice/ntreport03>.

Hunter, B. & Schwab, R. 1998, *The Determinants of Indigenous Educational Outcomes*, Centre for Aboriginal Economic Policy Research Discussion Paper 160, Australian National University, Canberra, <<http://www.anu.edu.au/caepr>>.

Leeder, S. 2003, 'Achieving Equity in the Australian Healthcare System', *Medical Journal of Australia*, vol. 179, no. 9, pp. 475–8.

McCorquodale, J. 1997, 'Aboriginal Identity: Legislative, judicial and administrative definitions', *Australian Aboriginal Studies*, vol. 2, pp. 24–35.

McMahon, A., Thomson, J. & Williams, C. (eds) 1996, *Understanding the Australian Welfare State*, 2nd edn, Macmillan, Melbourne.

Miller, J. 2000, *Skyscrapers Hide the Heavens. A History of Indian–White Relations in Canada*, 3rd edn, University of Toronto Press, Toronto.

Mooney, G. 2003, 'Inequity in Australian Health Care. How do we progress from here?', *Australian and New Zealand Journal of Public Health*, vol. 27, no. 3, pp. 267–70.

Mooney, G. & Scotton, R. (eds) 1998, *Economics and Australian Health Policy*, Allen & Unwin, Sydney.

Murray, S. 2003, 'Australia's MDs Decry Poor State of Aboriginal Health', *Canadian Medical Association Journal*, vol. 168, no. 2, p. 1583.

Nelson, M. 2004, *Report on the 2004 General Practice and Primary Health Care Research Conference*, <<http://www.racgp.org.au/afp/downloads/pdf/july2004>>.

O'Donoghue, L. 1997, 'In Indigenous Affairs, Nothing Is New, Just Forgotten', *Australian Journal of Public Administration*, vol. 56, no. 4.

O'Donoghue, L. 1999, 'Towards a Culture of Improving Indigenous Health in Australia', *Australian Journal of Rural Health*, vol. 7, pp. 64–9.

Reynolds, H. 1989, *Dispossession. Black Australians and White Invaders*, Allen & Unwin, Sydney.

Ring, T. & Brown, N. 2002, 'Indigenous Health: Chronically inadequate responses to damning statistics', *Medical Journal of Australia*, vol. 177, no. 11, pp. 629–31.

Robinson, G., d'Abbs, P., Togni, S. & Baille, R. 2003, 'Aboriginal Participation in Health Service Delivery: Coordinated care trials in the Northern Territory of Australia', *International Journal of Health Care Technology and Management*, vol. 5, nos 1 & 2, p. 45.

Steering Committee for the Review of Commonwealth/State Service Provision (SCRCSSP) 2004, *Report on Government Services-Indigenous Compendium*, Productivity Commission, Canberra, <<http://www.pc.gov.au/gsp/reports/rogs/compendium2004>>.

Sibthorpe, B. & Meihubers, S. 1999, *Aboriginal Health Initiatives in Divisions of General Practice*, National Centre for Epidemiology and Population Health (NCEPH), Discussion Paper 17, Australian National University, Canberra, <http://www.nceph.anu.edu.au/publications/discussion_papers>.

Stanner, W. 1969, *1968 Boyer Lectures: After the Dreaming*, Australian Broadcasting Commission, Sydney.

Taylor, J. & Hunter, B. 1998, *The Job Still Ahead: Economic Costs of Continuing Indigenous Employment Disparity*, Report for Aboriginal and Torres Strait Islander Commission, Commonwealth of Australia, Canberra, <<http://www.atsic.gov.au>>.

Toussaint, S. (ed.) 2004, *Crossing Boundaries: Cultural, Legal, Historical and Practice Issues in Native Title*, Melbourne University Press, Melbourne.

Wakerman, J., Matthews, S., Hill, P. & Gibson, O. 2000, “Beyond Charcoal Lane”. Aboriginal and Torres Strait Islander Health Managers: Issues and strategies to assist recruitment, retention and professional development’, University of Queensland, Brisbane.

Young, A. & Dobson, A. 2003, ‘The Decline in Bulk-billing and Increase of Out-of-pocket Cost for General Practice Consultations in Rural Areas of Australia, 1995–2001’, *Medical Journal of Australia*, vol. 178, no. 3, pp. 122–6.

Australia – Funding

Allen Consulting Group 2002, *Australian Healthcare System: Directions for Reform*. Forum at Melbourne Business School, <<http://www.allenconsult.com.au/papers/ReformHealthCareFinance>>.

Australian Institute of Health and Welfare (AIHW) 2001, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People 1998–99*, AIHW, Canberra, <<http://www.aihw.gov.au>>.

AIHW 2004a, *National Public Health Expenditure Report 2000–01*, Series No. 18, AIHW, Canberra.

AIHW 2004b, *Health System Expenditure on Disease and Injury in Australia 2000–01*, Series 19, Cat. No. HWE 26, AIHW, Canberra.

Commonwealth Department of Health and Aged Care [now Ageing] (CDHAC) 2001, *Submission to the Commonwealth Grants Commissions Inquiry into Indigenous Funding*, <<http://www.health.gov.au/oatsih/pdf/grntcomm.pdf>>.

Commonwealth Grants Commission (CGC) 2001, Report on Indigenous Funding, CGC, <<http://www.cgc.gov.au>>.

Deeble, J., Mathers, C., Smith, I., Goss, J., Webb, R. & Smith, V. 1998 & 2001, *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, AIHW, Canberra, <<http://www.aihw.gov.au>>.

- Mooney, G. 2000, 'What's Fair in Funding Indigenous Health Care? We don't know but isn't it time we did?', *The Drawing Board: An Australian Review of Public Affairs*, vol. 1, no. 2, pp. 75–85, <<http://www.econ.usyd.edu.au/drawingboard/journal/00111/mooney.pdf>>.
- Mooney, G. & Jan, S. 1997, 'Vertical Equity: Weighting outcomes? or establishing procedures?', *Health Policy*, vol. 39, no. 1, pp. 79–87 (abstract only).
- Mooney, G., Wiseman, V. & Jan, S. 1998, 'How Much Should We Be Spending on Health Services for Aboriginal and Torres Strait Islander People?', *Medical Journal of Australia*, vol. 169, pp. 508–9.
- Mooney, G., Jan, S. & Wiseman, V. 2002, 'Staking a Claim for Claims: A case study of resource allocation in Australian Aboriginal health care', *Social Science and Medicine*, vol. 54, no. 11, pp. 1657–67 (abstract only).
- Neutze, M., Sanders, W. & Jones, G. 1999, 'Public Expenditure on Services for Indigenous People—Education, Employment, Health and Housing', Discussion Paper 24, Australian Institute, Canberra.
- Office of Aboriginal and Torres Strait Islander Health (OATSIH) 2003–04, Primary Health Care Access Program (PHCAP), <<http://www.health.gov.au/oatsih/cont.htm>>.
- OATSIH 2004a, 'Aboriginal and Torres Strait Islander Primary Health Care Review, Consultant Report 1', J. Dwyer, K. Silburn & G. Wilson, *National Strategies for Improving Indigenous Health and Health Care*, OATSIH, Canberra.
- OATSIH 2004b, 'Aboriginal and Torres Strait Islander Primary Health Care Review, Consultant Report 2', C. Beaver & Y. Zhao, *Investment Analysis of the Aboriginal and Torres Strait Islander Primary Health Care Program in the Northern Territory*, OATSIH, Canberra.
- Peacock, S. & Segal, L. 2000, 'Capitation Funding in Australia', *Health Care Management Science*, vol. 3, pp. 77–88.
- Rumbalara Aboriginal Co-operative Ltd (RAC) including Rumbalara Medical Centre 2000–03, *Annual Reports 2000–03*. Contact: <rac@limited.com.au> or Toolambah Rd, Mooroopna, Vic. 3629 Australia. AHSs Service Activity Reporting (SAR) format to OATSIH is available at OATSIH, <<http://www.health.gov.au/oatsih/cont.htm>>.
- Ring, I. & Brown, N. 2002, 'Indigenous Health: Chronically inadequate responses to damming statistics', *Medical Journal of Australia*, vol. 177, no. 11, pp. 629–31.
- Ring, I. & Eiston, J. 2000, 'Health, History and Reconciliation', *Australian and New Zealand Journal of Public Health*, vol. 23, no. 3, pp. 228–31.
- Wiseman, V. & Jan, S. 2000, 'Resource Allocation within Australian Indigenous Communities: A program for implementing vertical equity', *Health Care Analysis*, vol. 8, no. 3, pp. 217–33 (abstract only).

Australia – Enumeration/data

ABS1993, *Census Working Paper: Aboriginal/Torres Strait Islander Counts—1991 Census Data Quality: Aboriginal and Torres Strait Islander Counts*, J. Evans, D. Kahles & C. Bate, ABS, Canberra, <<http://www.abs.gov.au>>.

ABS 1996, *National Aboriginal and Torres Strait Islander Survey 1994*, ABS, Canberra.

ABS 1997, *Indigenous Identification in Administrative Data Collections. Best Practice and Quality Assurance*, ABS/AIHW, Canberra.

ABS 1999, *Population Issues, Indigenous Australians, 1996*, ABS, Cat. No. 4708.0, Canberra.

ABS 2000, *Directions in Australia's Aboriginal and Torres Strait Islander Statistics*, ABS, Canberra.

ABS 2003, *Australian Census 2001*, ABS, Canberra.

ABS & AIHW 1997, *Aboriginal and Torres Strait Islander Health Information: Quality Data through National Commitment*, Final Report to Australian Health Ministers' Advisory Council, ABS & AIHW, Canberra.

AIHW 1999, *Assessing the Quality of Identification of Aboriginal and Torres Strait Islander People in Hospital Data*, IHW4, AIHW, Canberra, <<http://www.aihw.gov.au>>.

Altman, J. & Gaminiratne, K. 1992, 'Establishing Trends in ATSI Regional Council Populations Using Census Data: A cautionary note', Centre for Aboriginal Economic Policy Research (CAEPR) Discussion Paper No. 20, 1992, abstract only, <<http://www.anu.edu.au/caepr>>.

Briscoe, G. & Smith, L. (eds) 2002, *The Aboriginal Population Revisited. 70,000 Years to the Present*, Aboriginal History Monograph 10, Aboriginal History Inc., Canberra.

Caldwell, J. 2002, 'Aboriginal Society and the Global Demographic Transition', in G. Briscoe & L. Smith (eds), *The Aboriginal Population Revisited. 70,000 Years to the Present*, Aboriginal History Monograph 10, Aboriginal History Inc., Canberra, pp. 160–9.

Cunningham, J. 1998, 'Implications of Changing Indigenous Population Estimates for Monitoring Health Trends', *Australasian Epidemiologist*, vol. 5, no. 1, pp. 6–8.

Cunningham, J. 2002a, 'Regional Variations in Health Data Quality on Australian Indigenous People Make Comparisons Hazardous', *Australian and New Zealand Journal of Public Health*, vol. 26, no. 6, p. 497.

Cunningham, J. 2002b, 'Comparing Indigenous Health Status Across Regions: a numerical example of uncertainty', *Australian and New Zealand Journal of Public Health*, vol. 26, nos 6, p.497.

Gray, A. 2002, 'The Future History of Australian Families', in G. Briscoe & L. Smith (eds), *The Aboriginal Population Revisited. 70,000 Years to the Present*, Aboriginal History Monograph 10, Aboriginal History Inc., Canberra, pp. 109–31.

Martin, D., Morphy, F., Sanders, W. & Taylor, J. 2002, *Making Sense of the Census: Enumeration in Remote Australia*, Centre for Aboriginal Economic Policy Research (CAEPR) Research Monograph No. 22, Australian National University, Canberra, <<http://www.anu.edu.au/caepr>>.

Martin, D. & Taylor, J. 1995, 'Enumerating the Aboriginal Population of Remote Australia: methodological and conceptual issues', CAEPR Discussion Paper No. 91, Canberra, abstract only, <<http://www.anu.edu.au/caepr>>.

McKendrick, J. & Christie, D. 1978, 'The Aboriginal Population of Victoria', *Medical Journal of Australia*, vol. 1, pp. 319–20.

Ross, K. 2002, 'Recent Trends in the Demography of Indigenous Populations of Australia, NZ, Canada and the United States of America', in G. Briscoe & L. Smith (eds), *The Aboriginal Population Revisited. 70,000 Years to the Present*, Aboriginal History Monograph 10, Aboriginal History Inc., Canberra, pp. 132–59.

Sanders, W. 2004, 'The Tasmanian Electoral Roll Trial in the 2002 ATSIC Elections', *Australian Journal of Public Administration*, vol. 63, no. 1, pp. 51–65.

Taylor, J. 1993, 'Census Enumeration in Remote Australia: Issues for Aboriginal data analysis', *Journal of Australian Population Association*, vol. 10, no. 1, pp. 53–67 (excerpt only).

Taylor, J. 2002, 'Indigenous Enumeration in the Late Twentieth century: Emerging issues for population analysis', in G. Briscoe & L. Smith (eds), *The Aboriginal Population Revisited. 70,000 Years to the Present*, Aboriginal History Monograph 10, Aboriginal History Inc., Canberra, pp. 93–108.

Taylor, J. & Bell, M. 2003, 'Options for Benchmarking ABS Population Estimates for Indigenous Communities in Queensland', CAEPR Discussion Paper No 24, <<http://www.anu.edu.au/caepr>>.

Warchivker, I., Tjapangati, T. & Wakerman, J. 2000, 'The Turmoil of Aboriginal Enumeration: Mobility and service population analysis in a central Australian community', *Australian and New Zealand Journal of Public Health*, vol. 24, no. 4, pp. 444–9 (abstract only).

Young, E. 2002, 'Indigenous Demographic Issues at Australia's Millennium: Population mobility', in G. Briscoe & L. Smith (eds), *The Aboriginal Population Revisited. 70,000 Years to the Present*, Aboriginal History Monograph 10, Aboriginal History Inc., Canberra, pp. 81–92.

New Zealand

General Websites

He Korowai Oranga: Māori Health Strategy, Ministry of Health, <<http://www.moh.govt.nz/mhs.html>>.

Ministry of Health Māori Health, <<http://www.moh.govt.nz/maori.html>>.

New Zealand Consultations with Māori 1990–2001: A Selective Annotated Bibliography, <http://www.tpk.govt.nz/publications/docs/bib_Health.pdf>.

New Zealand Government, <<http://www.govt.nz>>.

New Zealand Māori Workforce site: Hauora.com, <<http://www.hauora.com/>>.

New Zealand Parliament, <<http://www.parliament.govt.nz>>.

Tikanga Oranga Hauora = Health Trends: Whakapakari No. 4 2000, *Te Puni K_kiri—Ministry of Maori Development*, <<http://www.tpk.govt.nz/maori/education/tohtrend.pdf>>.

New Zealand—General

Cunningham, C. & Durie, M. 1999, 'Te Rerenga Hauora', in P. Davis & K. Dew (eds), *Health and Society in Aotearoa/New Zealand*, Oxford University Press, Auckland.

Durie, M. 1989, 'The Treaty of Waitangi and Health Care', *New Zealand Medical Journal*, vol. 102, no. 869, pp. 283–5.

Durie, M. 1998. *Whaiora: Maori Health Development*, 2nd edn, Oxford University Press, Auckland.

Gauld, R. 2001, *Revolving Doors: New Zealand's Health Reforms*. Institute of Policy Studies and Health Services Research Centre, University of Wellington.

Health Funding Authority 2000, *Striking a Better Balance: A Health Funding Response to Reducing Inequalities in Health*, Health Funding Authority, Ministry of Health, <<http://www.moh.govt.nz/>>.

Houghton, F. 2001, 'Maori Health Services, Maori Conceptions of Health and Cultural Assimilation', *Australian and New Zealand Journal of Public Health*, vol. 25, no. 4, p. 379.

New Zealand Director General 2003, *Annual Report State of Public Health*, Ministry of Health, <<http://www.moh.govt.nz/>>.

New Zealand Ministry of Health 2001, *The Primary Health Care Strategy*, New Zealand Ministry of Health, Wellington, <<http://www.moh.govt.nz/>>.

New Zealand Ministry of Health 2002, *He Korowai Oranga, Maori Health Strategy: Discussion Document*, New Zealand Ministry of Health, Wellington, <<http://www.moh.govt.nz/mhs.html>>.

Scott, K., Marwick, J. & Crampton, P. 2003, 'Utilization of General Practitioner Services in New Zealand and its Relationship with Income, Ethnicity and Government Subsidy', *Health Services Management Research*, vol. 16, no. 1, pp. 45–55 (abstract only).

New Zealand—Enumeration/Data

Census of Population of Dwellings 2001, *Statistics New Zealand*. <<http://www.stats.govt.nz/census.htm>>.

Māori Population Summary 1858–2001, <<http://www.stats.govt.nz/domino/external/pasfull/pasfull.nsf/0/4c2567ef00247c6acc256bf900106d23/SFILE/Table%201.xls>>.