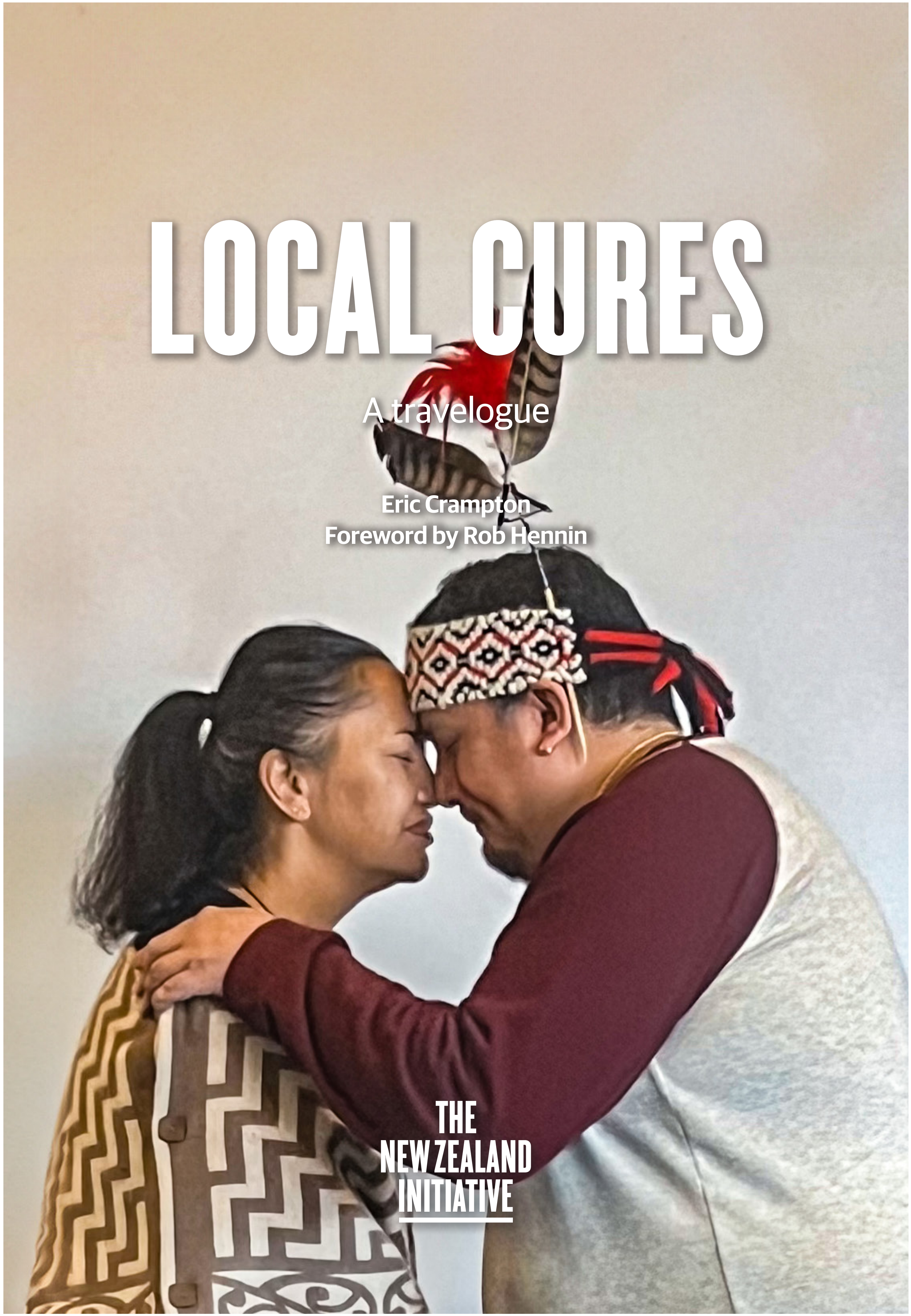
LOCAL CURES

A travelogue

Eric Crampton

Foreword by Rob Hennin



THE NEW ZEALAND INITIATIVE

ABOUT THE AUTHOR

Dr Eric Crampton is Chief Economist with the New Zealand Initiative in Wellington and Adjunct Senior Fellow with the Department of Economics and Finance at the University of Canterbury. Eric covers policy areas ranging from local government and infrastructure funding and financing, to earthquake preparedness and climate policy. His economic policy commentary features regularly across New Zealand's major media outlets.

ABOUT THE NEW ZEALAND INITIATIVE

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Our mission is to help build a better, stronger New Zealand. We are taking the initiative to promote a prosperous, free and fair society with a competitive, open and dynamic economy. We develop and contribute bold ideas that will have a profound, positive, long-term impact.

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FOREWORD

BY ROB HENNIN
CHIEF EXECUTIVE OFFICER, nib

For many years now, nib has been developing and enhancing models of care to do a better job of meeting the health needs of iwi populations, a programme we call "Toi Ora".

It's tempting to think that our constant focus on creating better solutions means we are ahead of the curve, but inevitably, we can learn from other countries where innovative thinking has improved health outcomes for their indigenous populations.

For this reason, in March 2024, nib took a group of stakeholders to visit the First Nations Health Authority in Canada to examine their health delivery programmes. We invited The New Zealand Initiative's Chief Economist, Dr Eric Crampton, to join us to provide an independent and objective review of what we saw. This report is the result of that review, and we are delighted to be the recipient of Eric's typically sharp analysis expressed in a helpfully concise form.

Our collaboration with the Initiative continues to provide nib with opportunities to do better for our customers, our stakeholders and for New Zealand. We also value highly the relationship we have with Oliver Hartwich and his team.

Thank you, Eric, for capturing the essence of our findings in your report.

Rob Hennin

Kiwis on tour: the nib study group.

INTRODUCTION

British Columbia, Canada, has pioneered a more localist approach to indigenous health care.

Health services for members of the province's First Nations are delivered through the First Nations Health Authority.

The system maintains a strong emphasis on local voice in determining health priorities and in finding solutions that work for each community. At the same time, the system is embedded within an overall healthcare system far more constraining than New Zealand's.

Understanding the context of Canada's health system, First Nations' place as a third tier of government in Canada, and Indigenous Services Canada's[1] provision of healthcare services for First Nations overall matters when drawing lessons from British Columbia's experience.

In March 2024, nib insurance led and funded a study tour to British Columbia to learn about health service devolution to First Nations. nib has partnered with North Island rōpū[2] for health insurance and health services for whānau and kaimahi[3]. The study group included nib's Rob Hennin, Sarah McBride and Ros Toms; Te Runanga o Ngāti Porou's George Reedy, Ngāti Whātua Ōrākei's Tom Irvine and Rangimarie Hunia, and Ngāti Awa Social and Health Service's Enid Ratahi-Pryor.

I was invited to join the tour to see what I might learn and perhaps to help translate between Canadian and New Zealand contexts.

This short report is a combination of a travelogue and a report on health system devolution. It will provide institutional context as it becomes important for understanding along the journey. But it is very much my impression from the trip.

Some aspects would be inappropriate to provide in detail.

First Nations communities shared their stories with iwi representatives in confidence and shared understanding as colonised peoples.

When representatives from the First Nations Health Authority shared their experiences with the study tour, it was to help other

1 From 1966 until 2011, the department was called the Department of Indian Affairs. It underwent a name change in 2011, again in 2015, finally becoming Indigenous Services Canada in 2017.
2 "Group", in this case encompassing iwi, hapū, and businesses.
3 Families and employees – those covered by the agreements.

indigenous communities achieve better health outcomes – not to contribute to a public report that might draw strong conclusions, friendly or otherwise, about how that system works.

British Columbia's First Nations Health Authority is simultaneously thoroughly indigenous and entirely a part of Canada's overall health care system. The latter imposes constraints both on structure and on thinking about health services.

I hope I do no disservice in sharing what I learned on that tour. Things New Zealand could do differently are no critique of what Canada's First Nations have found appropriate within the context of Canada's system.

Overall, I think it makes a good case for localism in health service delivery, partnership with iwi and hapū in service provision, and private-public partnerships in achieving better outcomes.

It also makes a case for not waiting for governments to move first or for governments to decide on structures.

As we left for Canada, at least some on our tour were disheartened by the recent disestablishment of Te Aka Whai Ora, the Māori Health Authority. As we rode back to Vancouver airport, the mood had shifted. There is potential for localism and iwi-led health services without a large centralised separate bureaucratic structure.

PACIFIC BLUE CROSS AND PARTNERSHIP IN HEALTH DELIVERY

In New Zealand, nib partners with a small number of rōpū for health insurance and health service delivery to whānau and kaimahi.

In British Columbia, payment for many services that are funded by the First Nations Health Authority but that are delivered outside of the public healthcare system is facilitated by Pacific Blue Cross.

But explaining what that means in Canada requires a fair bit of institutional context.

The Canada Health Act

Provincial governments receive payments from central government through the Canada Health Transfer, with potential reductions in those payments if they do not meet the principles established under the Canada Health Act.

The Act sets out five principles applying to insured health services[4].

1. Public Administration: A public authority must administer and operate public health care insurance plans on a non-profit basis.

2. Comprehensiveness: A province's health care insurance plan must cover all insured health services provided by hospitals, physicians or dentists (i.e. surgical-dental services that require a hospital setting). Dental services more generally are not included.

3. Universality: All insured residents of a province are eligible on uniform terms.

4. Portability: Residents can move between provinces without loss of coverage. They are covered by a home-province's plan during any waiting period imposed by the province to which they move.

5. Accessibility: Insured persons have reasonable access to insured services on uniform terms unimpeded by user charges or extra billing.

The Accessibility provision precludes co-payments for services covered by public insurance, which is often referred to as Medicare. This provision is a cultural touchstone that forms an unfortunate part of Canada's constructed national identity. Canadians look across their border to America and recoil when they see problems facing the uninsured.

Kiwis may remember Roger Beattie's reception when he suggested farming threatened weka for the feather and restaurant trade while promoting conservation. He very plausibly did a better job in breeding weka on his farm than the Department of Conservation had ever managed. Farming weka for conservation and culinary purposes has a lot of merit.

If Beattie had proposed farming kiwi instead of weka, it would be comparable to proposing private health care in Canada or even mixed systems like New Zealand's.

It is not entirely unmentionable. An important subplot in *Les Invasion Barbares* (The Barbarian Invasions), one of Canada's better films, featured angst over private healthcare as an important theme. The aging Québécois social-democrat protagonists agonised over whether one of them should betray life-long principles by seeking cancer treatment in nearby Vermont when Québec's public

4 I here summarise and sometimes exactly follow the phrasing used in Health Canada's 2014-15 Annual Report, available here: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/hcs-sss/alt_formats/pdf/pubs/cha-ics/2015-cha-lcs-ar-ra-eng.pdf

hospital system could not provide any reasonable care.

But it is generally impolite to suggest potential roles for private payment to augment public health services.

Patients receiving funded services at private clinics cannot pay or co-pay for those services. Instead, the clinic bills the province's health insurance plan. To the extent that private clinics can deliver services at lower cost than public clinics, they are incentivised to set up shop and do so. If encouraging greater provision of the service would require greater payment than is available through the provincial monopoly government-run health insurer, then it will be difficult.

Services falling outside of Medicare can be charged. And provinces vary in what is allowed.

British Columbia has private surgical centres; their services are contracted by the provincial government. Alberta has a broader range of private clinics; my father, who lives on Vancouver Island, travelled there for knee surgery that would only be legally available in British Columbia after lengthy queuing in the public system.

The Province is defensive even about publicly-funded services provided through private clinics. When asked about the growth in private service delivery, British Columbia's Minister of Health Adrian Dix said, "To be clear, when we talk about private surgery, just as we talk about how primary care offices are effectively privately held, it's public insurance. We strongly support public health care and we've expanded public surgeries."[5]

This context matters when considering the flexibility that any localist version of health services might enjoy in Canada, whether within a First Nations community or otherwise.

In British Columbia, Pacific Blue Cross offers private insurance covering vision, mental wellness, hearing aids, prescription drugs, virtual care, dental services, hospital accommodation for better rooms, medical equipment and supplies not covered by the province's PharmaCare, and practitioner services. Practitioner services include naturopaths, massage therapists, physiotherapists and more[6] – but not general practitioners. Your family doctor would be covered under the public system.

In New Zealand, health insurance, whether private or through the Accident Compensation Corporation (ACC), can cover surgeries and other procedures that would otherwise face longer waiting lists in the public system. You might even choose an insurance policy that covers visits to the G.P.

Canada's system features lengthy queues for service but little ability for individuals with greater resources to provide extra payment to shorten the queue for others by selecting a private provider. Canadians would consider it a "two-tier" health system, and the term is very much used as an epithet.

Publicly funded services may be privately delivered but only publicly funded.

The federal government also funds additional services for members of First Nations communities because of the Medicine Chest.

The Medicine Chest

Nothing in Te Tiriti, the Treaty of Waitangi, explicitly sets a right to government-funded health services – but such a right can be read into Article 2 of the Treaty. The Waitangi Tribunal's 2023 Hauora Report found that inequities in health outcomes facing Māori constitutes a breach of Treaty obligations. The Treaty's guarantee of tino rangatiratanga was found to have been breached[7]. Interpretations of the Treaty are contentious and I take no view of the merits of different readings. Canada's Treaty 6, and practice during other treaty negotiations, make Canada's obligation more explicit.

Treaty 6 included many First Nations in Alberta, Saskatchewan, and two from Manitoba. The signing process began in 1876 and continued until the 1950s.

5 Penny Daflos. 2023. "'It's a big concern': Private delivery of public health care grows yet again in B.C." CTV News Vancouver. 2 February. Available at https://bc.ctvnews.ca/it-s-a-big-concern-private-delivery-of-public-health-care-grows-yet-again-in-b-c-1.6256468

6 See Pacific Blue Cross, "Personal Health and Dental Insurance Plan". Website accessed July 2024. https://www.pac.bluecross.ca/personal-health/plan-finder#phi

7 Waitangi Tribunal. 2023. Hauora: Report on Stage One of the Health Services and outcomes Kaupapa Inquiry. Available at https://waitangitribunal.govt.nz/news/report-on-stage-one-of-health-services-and-outcomes-released/

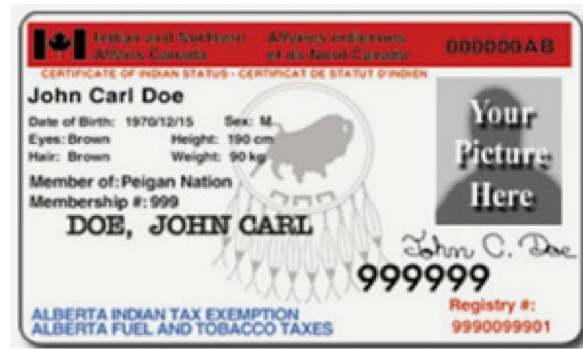

Figure 1: Examples of certificates of Indian status.Indigenous Services Canada.

The medicine chest clause of Treaty 6 reads as follows:

That a medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians at the direction of such agent.... That in the event hereafter of the Indians comprised within this Treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by Her Indian Agent or Agents, will grant ... assistance of such character or to such extent as the Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians of the calumet that shall have befallen them.[8]

The Crown explicitly took on an obligation to provide health services to indigenous communities in times of need in Treaty 6. The clause has been read as requiring a more comprehensive provision of health services than that provided under the Canada Health Act.

While the Medicine Chest clause is only explicitly noted in Treaty 6, it is argued to have been included in oral versions of other treaties.[9]

The provision also extends to British Columbia, where James Douglas, Chief Factor of the Hudson's Bay Company at Fort Victoria, negotiated land purchases from First Nations in some parts of the province, but where most land is considered unceded.

Non-Medicare services provided by private clinics funded through insurance payments or private payment in other cases may consequently be funded by the Canadian government for those with Indian status.[10]

Proof of eligibility is provided through an Indian Status card, which also provides proof of eligibility for certain tax exemptions and other targeted programmes.

And with that background, we can return to Pacific Blue Cross – the first stop on our tour.

Partnership and claims-administration

In principle, those with Indian Status are eligible for a wide array of government-funded benefits not covered by provincial health schemes. These include dental care, vision care, mental health counselling, drugs and pharmacy products, and medical transportation.[11]

In practice, uptake was poor.

And much of it was obviously a claims administration problem.

8 As cited by Aimée Craft and Alice Lebihan. 2021. The treaty right to health: A sacred obligation. National Collaborating Centre for Indigenous Health. Available at https://www.nccih.ca/Publications/Lists/Publications/Attachments/10361/Treaty-Right-to-Health_EN_Web_2021-02-02.pdf

9 See discussion in Craft and Lebihan at p.15.

10 At this point, I will quote footnote 1 from Craft and Lebihan, because terminology becomes important when distinguishing between status Indians eligible for government-funded services, and others. They write: "Most of the language surrounding Indigenous identity, especially that of the legally recognized "Indian" under the Indian Act is problematic, to say the least; however, it continues to be the legal technical term used for First Nations peoples under the Indian Act and in the Canadian Constitution. When referring to Indigenous Peoples today outside of the technical legal context, either First Nations (more restrictive and generally reserved for people with Indian Status under the Indian Act) or Indigenous (more inclusive) is used. As well, the term Aboriginal Peoples of Canada may be referenced, pursuant to Section 35 of the Constitution Act, 1982, and includes "Indian, Inuit and Métis." However, most Indigenous Peoples and nations prefer to refer to themselves in their particular languages (ex. Anishinaabe)". See Craft and Lebihan, p. 5.

11 See Government of Canada. "Benefits and services under the Non-Insured Health Benefits program". Available at https://www.sac-isc.gc.ca/eng/1572545056418/1572545109296

nib study group with Pacific Blue Cross.

Before the establishment of the First Nations Health Authority [FNHA], and during an initial transition period after the FNHA was established, health service providers in British Columbia billed Indigenous Services Canada for funded services provided to First Nations members.

Health service providers did not like dealing with Indigenous Services Canada for claims reimbursement. Complicated paperwork for a relatively small number of patients, in some areas, combined with delays, made First Nations patients more administratively difficult.

Services to other clients from health benefit companies like Pacific Blue Cross were more straightforward and preferred.

First Nations peoples experienced that difference as discrimination. They were less preferred as patients because the system run by Ottawa was far from ideal.

The government-funded non-Medicare services available to First Nations coincided with the kinds of medical services that can be provided privately.

Consequently, most health service providers would already have had an existing billing relationship with Pacific Blue Cross.

The First Nations Health Authority partnered with Pacific Blue Cross to learn about the barriers band members faced in accessing services and to come up with solutions – made easier by the FNHA's strong community presence.

The solution was reasonably obvious.

Residents of British Columbia who present an Indian Status Card at a clinic providing funded health services would be treated.

nib study group with Pacific Blue Cross.

The clinic would send the claim to Pacific Blue Cross, which would bill the FNHA for the service and claims administration.

From the patient's perspective, the process was seamless; Pacific Blue Cross worked only in the background unless a dispute about coverage arose. Pacific Blue Cross's call centre would help in trickier cases; they also learned that their representatives needed to be trained in cultural safety and indigenous awareness. As FNHA would fund culturally-relevant services not traditionally covered under health plans, Pacific Blue Cross had to learn how to handle those kinds of claims.

Pacific Blue Cross explained that they work in partnership with the FNHA, with frequent discussions of what is working and what could be improved; a representative from the FNHA also sits on their Board.

The work is ongoing, with continued efforts to improve systems in remote communities. They also noted that they had initially underestimated the speed of uptake of dental services. Since those services had always been funded, the rapid uptake of those services under the new administrative arrangement is a mark of success in removing barriers to care.

THE FIRST NATIONS HEALTH AUTHORITY

British Columbia is home to Canada's first and only First Nations Health Authority. However, First Nations in other provinces also have different forms of autonomy over health services.

One Government of Canada website trying to explain how health services are provided to First Nations peoples in general notes that "the Canadian health system is a complex patchwork of policies, legislation and relationships"[12] – with funding for services provided to First Nations adding an additional layer of complexity.

The Canada Health Act, previously discussed, requires that provincial health insurance plans cover all eligible residents, including First Nations.

Indigenous Services Canada funds or directly provides additional services covered by the Medicine Chest provisions. Health Canada and the Public Health Agency of Canada provide funding for other programmes for urban and remote indigenous people.

As First Nations have a constitutionally recognised inherent right of self-government, individual indigenous governments can negotiate self-government agreements with central and provincial governments which can include health.

At this point, we probably need to note First Nations' status as a third tier of government in Canada.

Tino Rangatiratanga, Canadian-style

Canada's federal structure has a relatively weak central government with relatively powerful provinces. Municipalities have powers similar to New Zealand's local councils.

If Canada's provinces disappeared and their authorities centralised into Ottawa, Canada would be a lot more like New Zealand.

With an important exception.

First Nations have autonomy on Indian Reserves, forming a third tier of government with powers exceeding those normally held by Canadian municipalities.

Amendments to the Indian Act in 1951 began more formal recognition of that autonomy. In 1988, the Kamloops Amendment to the Indian Act enabled First Nations to set property taxes on reserve land to fund themselves. In 2005, the First Nations Fiscal Management Act allowed First Nations to take up greater autonomy. It also created the First Nations Tax Commission, the First Nations Fiscal Management Board and the First Nations Finance Authority.

By 2021, 209 of some 634 First Nations across Canada had opted into greater autonomy through the First Nations Fiscal Management Act.[13]

First Nations governments can set property taxes on their reserves, use those taxes to back debt that finances infrastructure, and decide on their own zoning and building rules. However, funding from central government remains the predominant source of income for First Nations governments.

We later visited with Sḵwx̱ wú7mesh Úxwumixw, the Squamish Nation, who are using that autonomy to build apartment towers at Seńáḵw near downtown Vancouver. Autonomy there meant they did not need the city's permission to build. However, they did need to

12 Government of Canada. "Indigenous Health Care in Canada". Available at https://www.sac-isc.gc.ca/eng/1626810177053/1626810219482
13 See extensive and fascinating discussion in Donn. L. Feir and David Scoones, 2023. "Leading the Way: First Nations in Canadian Fiscal Federalism". Chapter 11 in Lecours, André et al. 2023. Fiscal Federalism in Canada: Analysis, Evaluation, and Prescription. University of Toronto Press.

negotiate an extensive service agreement with the city.[14]

First Nations can also take up self-government in health.

Indigenous Services Canada explains that self-government in health can include making laws and having jurisdiction over health services and traditional healing services, as well as administration of health services[15]. These services can be co-funded by central and provincial governments, reflecting that those levels of governments would otherwise have had responsibility for funding those services.

British Columbia's First Nations built Canada's institutions for fiscal autonomy on reserves and were first to take up fiscal authority. Feir, Jones and Scoones document the diffusion of First Nations tax authority outwards from Kamloops, British Columbia, where the Tulo Institute provided training in First Nations governance and tax administration.[16]

British Columbia's First Nations Health Authority is Canada's first and only such agency. But First Nations in other provinces have been taking up authority over health in different ways (see Box 1).

14 Seṅáḵw Services Agreement. Available at https://vancouver.ca/files/cov/senakw-services-agreement.pdf
15 Government of Canada. "Indigenous Health Care in Canada". Available at https://www.sac-isc.gc.ca/eng/1626810177053/1626810219482
16 Feir, Donn., M. Jones and D Scoones. 2023. "When do nations tax? The adoption of property tax codes by First Nations in Canada." Public Choice. https://doi.org/10.1007/s11127-022-01039-4

Box 1: Models of health transformation

- In 2018, Manitoba Keewatinowi Okimakanak (MKO) signed a Memorandum of Understanding with Canada committing to First Nation-led health care transformation in MKO territory. In 2020, MKO established the Keewatinohk Inniniw Minoayawin, a northern First Nations led-health organization that is exploring innovative primary care services models tailored specifically for northern Manitoba First Nations communities and preparing to assume the responsibility for service delivery.
- In 2019, the First Nations of Quebec and Labrador Health and Social Services Commission signed a tripartite Memorandum of Understanding with Canada and the province of Quebec, which committed the partners to work towards a new health and social services governance model.
- In 2020, the Southern Chiefs' Organization signed a Memorandum of Understanding with Canada to establish a new health governance model focused on equitable and culturally appropriate health care for First Nations in southern Manitoba.
- In 2021, the Nishnawbe Aski Nation (NAN) signed a trilateral statement with Canada and the province of Ontario, committing to work together in partnership to support the establishment of a First Nations health services delivery system in NAN Territory. NAN has actively worked with their communities to identify key health priorities requiring immediate action in conjunction with exploring new models of health service delivery that will bring services closer to home and build capacity in northern communities to access and deliver more culturally responsive services.
- In 2022, Canada committed support to a partnership with Tajikeimɨk, a newly formed health and wellness organization working on behalf of Mi'kmaw communities in Nova Scotia.
- In 2023, Tajikeimɨk signed a trilateral memorandum of understanding with Canada and the province of Nova Scotia declaring ongoing partnership and mutual support toward transforming the design and delivery of health services serving the Mi'kmaq in Nova Scotia.

Source: Models of health transformation. Indigenous health care in Canada: Roles, responsibilities and legislation for federal, provincial, territorial and indigenous governments.[17]

17 Government of Canada. "Indigenous Health Care in Canada". Available at https://www.sac-isc.gc.ca/eng/1626810177053/1626810219482

The First Nations Health Authority

As noted earlier, these are my impressions from two days of extensive discussion where First Nations communities shared their experiences in a spirit of cooperation and shared understanding with iwi representatives working to improve health in their communities.

We learned that the process toward self-governance in health began in 2001 with a report on substantial health disparities. First Nations communities then began working together to think about better solutions, and then collectively asked for the establishment of the FNHA.

This kind of collaboration was facilitated by prior collaboration across dispersed First Nations. The Squamish Nation itself was built by a set of separate villages that pulled together a century earlier to push back against provincial encroachment.

In 2007, tripartite agreements between First Nations, the Government of Canada, and the Province of British Columbia set a path toward the First Nations Health Authority – following the Transformative Change Accord in 2005.

In October 2013, the FNHA took responsibility for administering programmes and services previously delivered by Health Canada's First Nations Inuit Health Branch – Pacific Region.[18]

The province of British Columbia has five regional health authorities. The First Nations Health Authority sits alongside that structure, with responsibility for the health and wellbeing of First Nations people.

The FNHA "plans, designs, manages, and funds the delivery of First Nations health programmes and services".[19] Alongside the FNHA, the First Nations Health Council [FNHC] provides "political representation, leadership, and advocacy", and the First Nations Health Directors Association [FNHDA] provides "technical advice and capacity development".

The system is accountable to local Chiefs and leaders across some two hundred communities spanning 26 cultural groups and 34 languages. Managing local approaches within Canada's single-payer model is not straightforward.

We were helpfully provided with a diagram (Figure 2) explaining the governance structure. The regions denoted by colour in the diagram below do not reflect different First Nations communities but rather follow the boundaries of existing British Columbia Regional Health Authorities. Those regional health authorities continue to provide services to First Nations peoples, including hospital services.

Our knowledge exchange sessions included the FNHC Chair, the FNHDA Board President, and seventeen senior officials from the FNHA.

We learned that from 2013 on, the FNHA took over programmes and services as they were. It then started to rebuild those services to reflect First Nations aspirations and priorities.

The shift to the FNHA also meant that locals could find better ways around bureaucratic problems.

For example, rules for funded patient transport required patients to be transported to the geographically closest treatment centre. But in places with complicated topography, getting to the closest treatment centre might require a connecting flight in Victoria. Treatment in Victoria would make more sense. Similarly, processes had made it easy to get funding to fly every band member from a community out for a dental visit, but hard to hire a local dentist even when that would have been far more cost-effective.

The shift to greater community voice and community-based solutions enabled better outcomes.

We also heard that remote communities are visited by primary care teams, complemented by virtual doctors available seven days a week, one doctor for each region. This approach for remote health services may be worth considering more broadly.

18 First Nations Health Authority: About Us. Available at https://web.archive.org/web/20240407042539/https://www.fnha.ca/Documents/FNHA_AboutUS.pdf

19 Province of British Columbia. 2017. "First Nations Health Authority". https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities/first-nations-health-authority

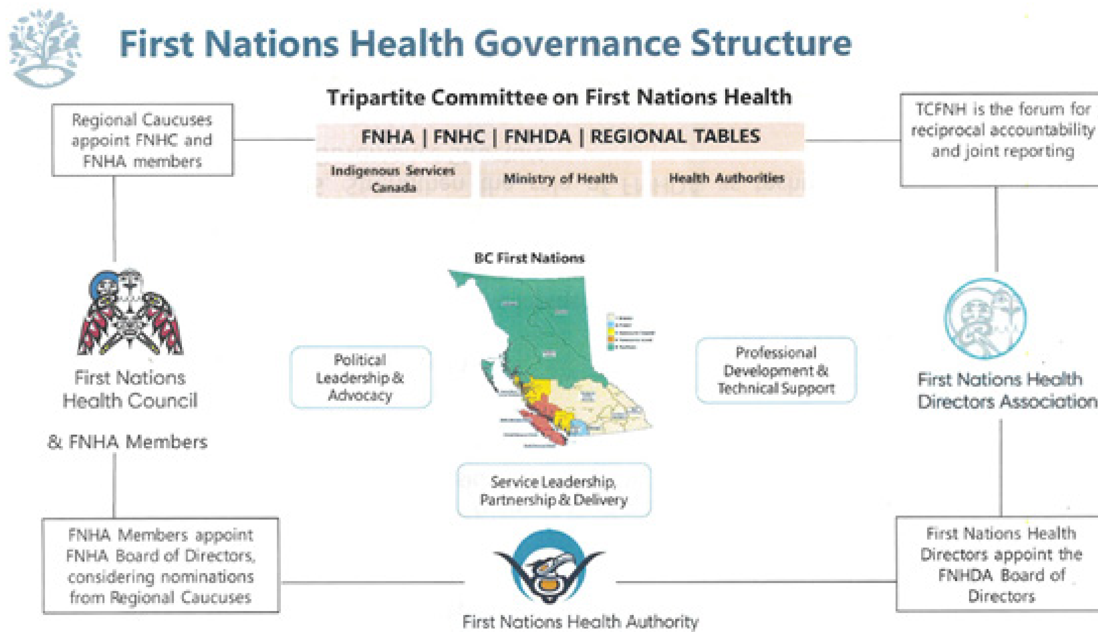

Figure 2: First Nations Health Governance Structure.

Funding and Scale

British Columbia has roughly the same overall population as New Zealand: 5.6 million people as of April 2024 to New Zealand's 5.3 million.

We heard that First Nations, Métis and Inuit make up some 5.9% of British Columbia's population, with some 180,000 First Nations members spread across over 200 Bands speaking 34 languages. Census 2021 put the number of First Nations peoples with Registered or Treaty Status at 125,000.

As of 2023, New Zealand's estimated Māori population was just over 900,000, or about 17% of the total population.

The Māori Health Authority's 2022-23 Annual Report noted 237 employees as of 1 July 2023; the organisation was still in development. Its complement was reported to have grown to 400 full-time equivalent staff in 2023 before being abolished with a change in government.

The 2022-23 Annual Report noted an appropriation of NZD$217.6 million to deliver Hauora Māori services, $350 million for delivering Primary, Community, Public and Population Health Services (where Te Whatu Ora is the lead agency), and $5.6 million for delivering problem gambling services (again where Te Whatu Ora is lead).

Budget 2023 allocated $616 million, 2% of the health budget, to enable the Māori Health Authority to deliver Hauora Māori services. Or just under $700 per person, using the 2023 estimate of the Māori population.

The First Nations Health Authority's 2022/23 Annual Report noted CAD$791 million in expenses, which included $724 million on programme services, $53.8 million on corporate operations, and $13.9 million on governance and First Nations Engagement.

Programme services include expenditures on extended health benefits of $248 million; direct community services funding of $300 million on community health and wellness services and programmes; health services and programmes expenses of $165 million on nursing services, environmental services, public health response, policy and planning, and the Chief Medical Officer's portfolio; and, regional operations spending of $10 million to support regional operations, programmes and projects.

The FNHA budget amounted to almost $4,400 per person of First Nations, Métis or Inuit background, or over $6,000 per person of Registered or Treaty Status.

While the FNHA's Annual Report does not provide a staff count, a

2020 evaluation report tallied 748 employees as of 2019.[20]

In April 2023, a ten-year $8.2 billion funding agreement for the FNHA was set.[21]

Overall, the FNHA is substantially larger than New Zealand's Māori Health Authority in terms of staffing and funding. However, it has been in place since 2013; the Māori Health Authority may have grown over time. The difference between $700 per person and at least $4,400 per person seems substantial, even without accounting for differences in currency value.

Governance and localism

With authority comes responsibility. Or, to paraphrase FNHA Board Chair Colleen Erickson, 'we can't pound the table and complain because we're the ones who are supposed to fix it.'

Real responsibility matters.

Within a context of substantial funding from the Canadian government and co-funding from the province, that can bring substantial governance requirements when incorporating local objectives.

Effectively, the task requires learning from each community what the community's goals and aspirations are for health within an indigenous framework, bringing those lessons up to a regional level to coordinate, up further again to set FNHA priorities, and then back down.

One of the regions explained the meeting sequence that ensures local voices are represented within the broader governance structure, on a regular annual schedule.

Initial working groups, including Chiefs, Health Directors, and service providers, would engage with local networks and committees. The results of their discussions would feed up to Family Health Director Tables providing technical advice. That discussion would set the stage for family caucuses[22] setting local priorities to bring through to regional caucuses of all of the region's First Nations. At the regional caucus, they would also hear updates from the FNHC, FNHA, FNHDA, and the regional partnership accords. The Partnership Accords are agreements between the First Nations Regional Caucus, the FNHA, and the relevant provincial Regional Health Authority.[23] FNHC, FNHA, and FNHDA representatives would meet biweekly as working extensions of the regional caucus. A Partnership Accord Steering Committee would have FNHC and FNHA representatives meet with the province's regional health authority twice-annually. A Tripartite Committee, including the FNHA, health authorities, and the provincial Ministry of Health and Health Canada, provides a forum for coordinating and aligning programming and planning across the partners. An Executive Committee of FNHA and regional health authority executives provides operational oversight, and regular meetings of the FNHA CE and the regional health authority's CE would discuss issues identified as priorities.

The governance task is not small.

A November 2023 evaluation of the First Nations Health Council still considered the FNHC's structure as needing stronger regional representation and to "go beyond reporting and engagement at these [Sub-Regional Assemblies, Regional Caucuses, and Gathering Wisdom for a Shared Journey province-wide forums] forums to ensure all communities are being heard." The evaluation also noted conflicting feedback where some Nations were inadequately represented but having fifteen members on the FNHC "lends to ineffectiveness and unproductive meetings (e.g. long meetings without enough tasks getting done)."[24]

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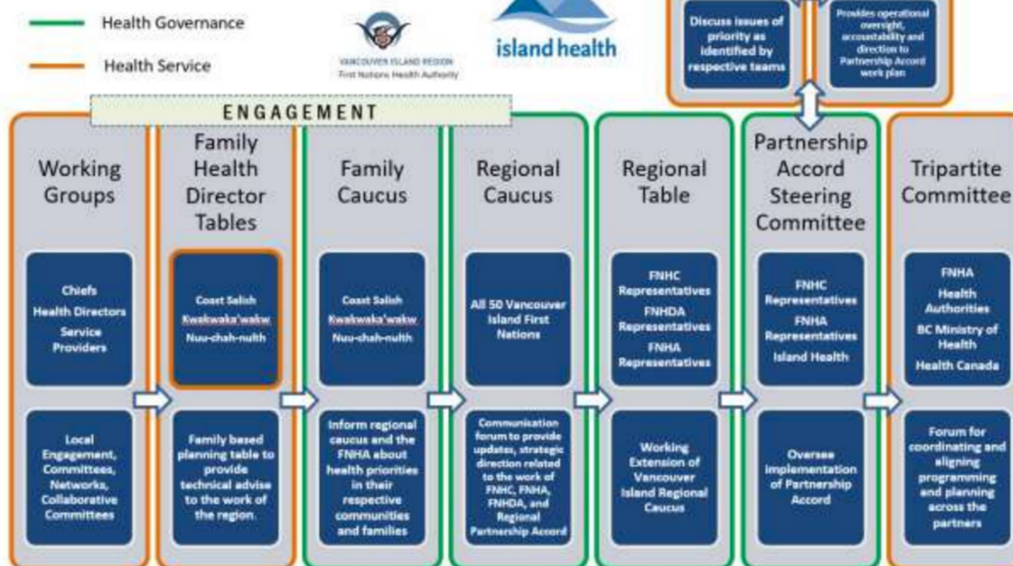
20 The evaluation report notes that "In 2018/19, 67% of the FNHA's staff were employed in roles related to delivering programmes and services to the communities, supporting direct community engagement, direct service delivery, programme and service support services, and funding relations with First Nations communities and mandated health services." Goss Gilroy Inc. 2020. "Evaluation of First Nations Health Authority: Case Study Technical Report." https://web.archive.org/web/20240308222820/https://www.fnha.ca/Documents/FNHA-Evaluation-Case-Study-Technical-Report.pdf

21 https://fnhc.ca/wp-content/uploads/2023/04/News-Release_First-Nations-Health-Authority_EN.pdf

22 To translate across contexts, you could understand a 'family' in this instance as akin to a small iwi.

23 See, for example, https://web.archive.org/web/20220301222516/https://www.fnha.ca/Documents/FNHA-Island-Health-Partnership-Accord.pdf

24 Ference & Company Consulting. 2023. "Exploring the journey of the First Nations Health Council (FNHC): What We Heard Report". An evaluation of the FNHC prepared for Chiefs and leaders in BC. Available at https://fnhc.ca/wp-content/uploads/2023/11/Exploring-the-Journey-of-the-FNHC-What-We-Heard-Report-2023.pdf



Vancouver Island Partnership Accord Evaluation Report, 2019.

The governance task is not simple, but the problem is hardly unique to the FNHC or Canada.

Some governance complexity is set by the mix of legal and political agreements under which the FNHA operates.

Cultural safety

We heard that, in response to the 2020 In Plain Sight report on discrimination experienced by First Nations in British Columbia's health care system[25], the FNHA and the province have put a strong emphasis on cultural safety.[26] They have worked to set a standard enabling cultural safety through cultural humility and indigenous-specific anti-racism efforts.

To that end, each regional provincial health authority also now has a vice-president for indigenous health and teams supporting cultural safety and humility (CSH). There are workstreams for FNHA and for the Province in promoting CSH, an Indigenous-Specific Anti-Racism Policy Framework, monthly all-staff Communities of Practice gathering spaces to learn and develop cultural humility, and an action plan and regional engagement strategy. Provincial health authorities and the Association of Doctors of BC also entered into a memorandum of agreement toward eliminating indigenous-specific racism and discrimination in health care.[27]

Evaluation

While we did not hear about evaluation work on the FNHA's first decade, we learned about evaluation plans going forward about regional and sub-regional health reports provided annually to communities, and about systems for enabling culturally-safe access to First Nations data.

After the sessions, I was able to read prior evaluation work

25 https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf

26 The FNHA's emphasis on cultural safety and humility predated the In Plain Sight report; the Vancouver Island Partnership Accord Evaluation Report of 2019 cited ongoing work and recommended further promotion as part of health care professional education. See Vancouver Island Partnership Accord Evaluation Report, https://web.archive.org/web/20211103211256/https://www.fnha.ca/Documents/Vancouver-Island-Partnership-Accord-Evaluation-Report.pdf

27 British Columbia Ministry of Health, Health Authorities, and Association of Doctors of BC. 2022. Memorandum of Agreement. Available at: https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/health/moa_2022_-_declaration_and_isar.pdf

that is publicly available. That qualitative work suggested success in advancing a First Nations perspective on health and wellness, in helping to improve community and regional planning, and in identifying community and client needs before developing and implementing policies and strategies to address those identified needs. It noted increased service access for urban clients and those away from home who had been more poorly served before the FNHA. It pointed to successes in partnering with Pacific Blue Cross for claims administration and improving effective access to services. And to improvements in nursing services.

It also suggested that the FNHA's access to First Nations health data through partnership with the Provincial government, and improvements to that data, aided in programme development and assisted in making informed decisions.[28] For example, the Indigenous Cancer Strategy in 2017 depended on cancer patient journeys mapped through better data access and on identified disparities in cancer outcomes.

But, while the FNHA is set to enable greater localism in indigenous health, the evaluation reports did not discuss opportunities for learning from those different approaches when combined with better data.

During our meetings, we learned that the FNHA takes evaluation work seriously. Its central evaluation team is headed by a Director of Evaluation; other FNHA departments and regional offices also undertake evaluation work. Some reporting work is part of mandatory evaluations and reviews; other evaluation work is undertaken to support other initiatives. They also provide evaluation and performance monitoring advice to communities.

We heard that data and evaluation were important in support, but they did not trump other kinds of knowledge. Participants often referred to "two-eyed seeing", meaning combining an indigenous lens with other (including statistical) ways of seeing the world. An economist of an academic bent might want to test which approaches were successful in which places and why, using statistically rigorous methods. FNHA emphasised co-creating evaluation frameworks through processes that build trust and relationships and integrating more indigenous methodologies.

We also heard that prior culturally insensitive research had shaped data access provisions for other academic research using First Nations data. As in New Zealand, access to administrative data with potential implications for indigenous people comes with restrictions. However, unlike in New Zealand, substantial research grants are available to encourage quantitative academics to take on that kind of data work despite the restrictions.

Greater data access has also helped communities in deciding on priorities. We heard that one band's elders had enquired about pre-term births, received the perinatal data, and collaborative efforts then began to set a plan around the issue. It seemed exemplar of a co-development process in which traditional statistical methods and traditional knowledge work together to identify problems, come up with solutions, and then check what works through both eyes.

But most scheduled evaluation in the five-year evaluation plan was set at a broader policy and delivery level. It seems to remain an opportunity for further development.

Cultural exchange and learning

The agenda included a lot of time for cultural exchange and sharing to build mutual understanding. Nevertheless, culture shock seemed occasionally evident on both sides.

To Kiwis, Canada's systems can seem very bureaucratic. It was surprising that it had been possible to run a system that would require patients to do the equivalent of flying from Haast to Westport for treatment via Christchurch rather than just stop in Christchurch. However, the FNHA's ability to secure an $8.2 billion ten-year guaranteed funding arrangement with an automatic escalator, was a very sharp contrast to more short-term arrangements in New Zealand.

28 See Goss Gilroy Inc, 2020. Evaluation of the First Nations Health Authority: Final Evaluation Report. https://web.archive.org/web/20230325013933/https://www.fnha.ca/Documents/FNHA-Evaluation-Report.pdf and Evaluation of the First Nations Health Authority Case Study Technical Report. https://web.archive.org/web/20240308222820/https://www.fnha.ca/Documents/FNHA-Evaluation-Case-Study-Technical-Report.pdf

Enid Ratahi-Pryor and Colleen Erickson, Board Chair, FNHA.

nib study tour group with FNHA, FNHC, and FNHDA knowledge exchange session participants.

At the same time, while some of Canada's toxic drug crisis was obvious simply by being in and around Vancouver, the scale of it was harder to appreciate without hearing about the work trying to address it. The problem goes well beyond fentanyl. New Zealand has thus far been lucky.

For their part, the Canadians seemed surprised by some of the initiatives taken on by iwi. Iwi participants described using iwi resources to fund the delivery of better services to iwi members – including services that are otherwise available through New Zealand's public health system and other services that in Canada would be covered by Medicine Chest provisions.

Such initiatives would be surprising in Canada for two reasons. Private payment to improve the quality or speed of Medicare-funded services is considered two-tiered and violates the accessibility principles of the Canada Health Act. One participant asked whether iwi working to deliver better service accessibility might be considered as contributing to a two-tiered system. To some Canadians, the question itself is implicit condemnation. The iwi representative explaining her work in improving health outcomes for her community simply noted that the public system does not meet Māori access needs.

At the same time, in Canada, the Crown is understood to have an explicit treaty obligation to fund services covered by the Medicine Chest provisions. A First Nations community using its own resources to ensure the timely delivery of services covered by those provisions could be seen as letting the Crown get away with not meeting its treaty obligations. By contrast, iwi learned not to wait but to get on with the job.

Enid Ratahi-Pryor and Aaron Williams, Elder and Knowledge Holder, who welcomed us to the Musqueam, Squamish, and Tsleil-Waututh Nations.

CONCLUSION

Our trip did not end with the First Nations Health Authority.

We visited Kamloops, where Tk'emlúps te Secwépemc Chief Manny Jules told us about his work in building First Nations fiscal institutions and his father's work in setting the country's first on-reserve industrial park. His Band is now building subdivisions where homes sell for millions of dollars and the Reserve provides infrastructure services.

We also saw the orchard at the Kamloops Indian Residential School. The Band is collecting stories from the families of the missing children believed to lie in the suspicious ground depressions. And the school now serves a better purpose as home to the First Nations Tax Authority.

We met with Sḵwx̱ wú7mesh Úxwumixw, the Squamish Nation, who told us some of their health experience – and of their experience in building at Seṅ áḵw. An important aspect I had not adequately appreciated was that their setting of a Service Agreement with the City of Vancouver built on decades of prior similar agreements between the Department of Indian Affairs and adjacent municipalities for on-reserve services. Their agreement is theirs, but it did not emerge from nowhere.

But those are stories for another time.

The Decentralisation Theorem in public finance tells us that we are better off when local communities can tailor services to suit local needs – especially when local needs vary from the average.

Canada's increasing devolution of healthcare services to First Nations is an important example of local approaches. But it is very much a part of Canada's overall healthcare policy context, and of Canada's Treaty context that recognises far greater self-governance for First Nations communities.

Opportunities for localism in healthcare are constrained when the overarching funding framework prohibits co-payment for government-funded services and consequently restricts private healthcare services. Localist approaches already being undertaken in New Zealand would be anathema in the Canadian context.

And while there is work that can most easily be facilitated through larger organisations, like rigorous evaluation work, the funding environments are very different. The First Nations Health Authority's budget per First Nations person was in the thousands of Canadian dollars. Before its abolition, the Māori Health Authority's budget was in the hundreds of New Zealand dollars per Māori person.

British Columbia's First Nations Health Authority seems on track to enable better health outcomes for the people it serves. It continues to have opportunities to harness its local base for mutual learning about delivering better outcomes.

The mood as we left British Columbia was sharply different from the mood when we boarded for Vancouver. In leaving for Vancouver, iwi participants keenly felt the loss of the abolition of the Māori Health Authority. In returning home, we were thinking more about opportunities for localist approaches without a centralised government bureaucracy and instead building up local and regional collaboration as and where needed, when warranted.

When we met with Sḵwx̱wú7mesh Úxwumixw, Ngāti Whātua Ōrākei's Tom Irvine explained the traditional proverb that, for Māori, the most important thing in the world is people: he tangata, he tangata, he tangata. But Irvine has a slightly different take on it:

> He aha te mea nui o tēnei ao, he tangata, he takiwā, he kaupapa.

What is the most important thing in the world? It is people, it is place, it is purpose.

It's hard for me to think of a better way of expressing a localist ideal – whether in health services or otherwise. When the people of a place have a peaceful purpose, central government should enable rather than stand opposed.

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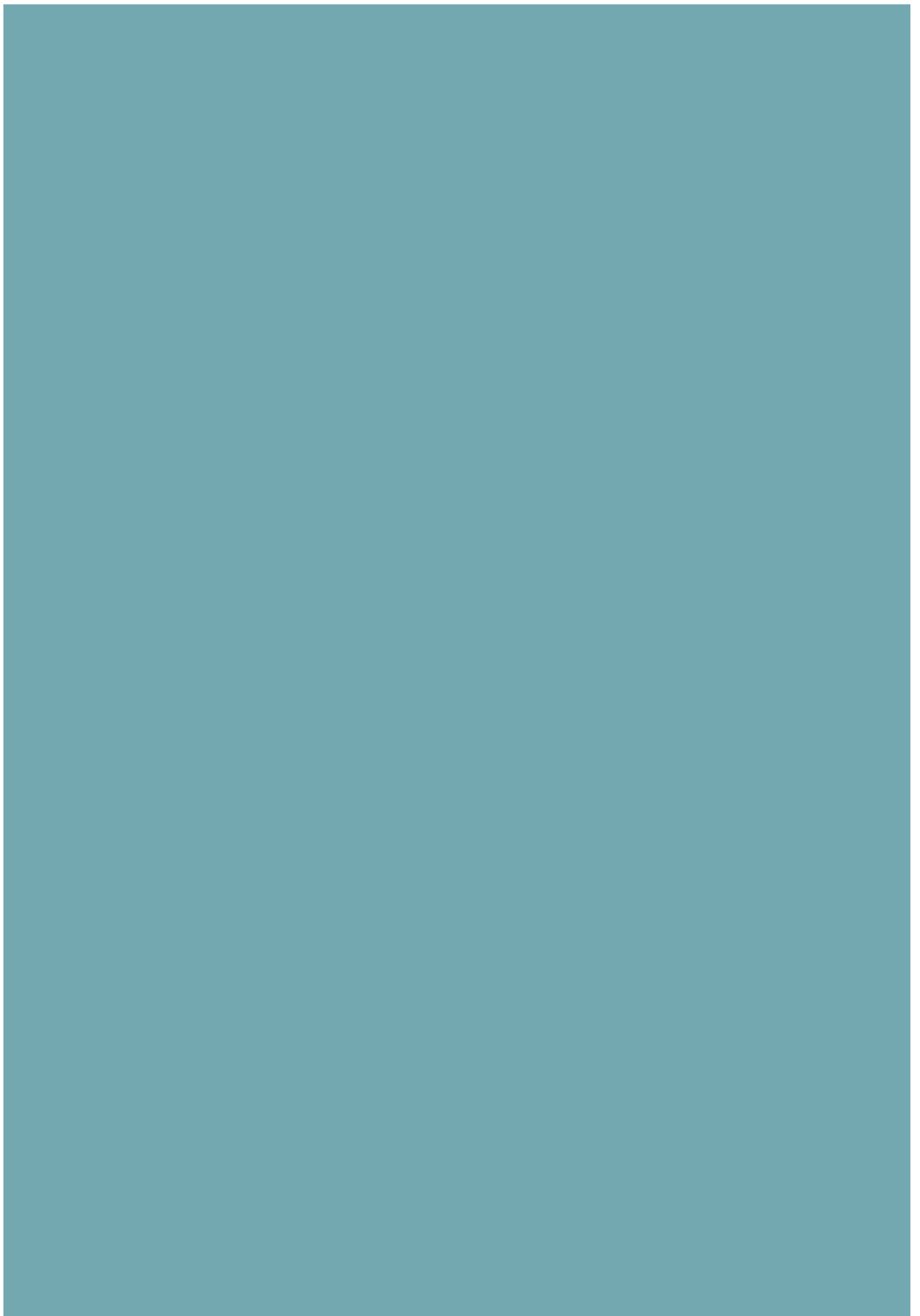

"It's tempting to think that our constant focus on creating better solutions means we are ahead of the curve, but inevitably, we can learn from other countries where innovative thinking has improved health outcomes for their indigenous populations."

Rob Hennin
Chief Executive Officer, nib

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The New Zealand Initiative
PO Box 10147
Wellington 6143