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Aboriginal Participation in Health Planning: Representation, Reconciliation, and Relationship-Building with an Aboriginal Advisory Committee

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Introduction

Both within British Columbia and Canada-wide, Aboriginal peoples consistently suffer poorer health than their non-Aboriginal counterparts (Canadian Institute for Health Information 2004; Commission on the Future of Health Care in Canada 2002; Foster et al. 1995; Ministry of Health Planning 2002; Royal Commission on Aboriginal Peoples 1996b). The gap in health status between Aboriginal and non-Aboriginal populations is an enduring legacy of colonialism, sustained by the continuing political, social, and economic marginalization of Aboriginal peoples (Hackett 2005; Kelm 1998; Kirmayer Simpson, and Cargo 2003). Given these broad and deeply rooted determinants of Aboriginal health, the health-care system is only one avenue to Aboriginal health improvement, but it remains a crucial one.

Both the federal and British Columbian governments have acknowledged that Aboriginal participation in health-care decision making contributes to overall Aboriginal health improvement. Federally, the goal of the 1979 Indian Health Policy is to “achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves” (Health Canada 2001a). In their guidelines for Aboriginal health planning in regional health authorities, the BC Ministry of Health states: “Involving Aboriginal people at all levels of the [health] planning and development process is integral to successfully being able to create and implement service options that are required to meet Aboriginal community health needs” (Ministry of Health Planning 2001, 2).

Despite the fact that it is endorsed in government policy, there is a dearth of research and literature on Aboriginal participation in health planning, and little guidance for regional health authorities on how to engage Aboriginal peoples in this process. An examination of the extensive literature on citizen participation in health planning reveals that Aboriginal people have not generally been considered in this field. Studies that refer to Aboriginal participation in health planning are

mostly limited to Aboriginal participation in health programming (e.g., Griffin et al. 2000), and participatory research (e.g., Dickson 2000; Dickson and Green 2001; Kaufert et al. 1999; Kaufert and Kaufert 1998). Even the application of the term “citizen” has different connotations for Aboriginal peoples than it does for other Canadians in the existing literature on citizen participation (Wood 2003).

This article explores meaningful participation in Aboriginal health planning using the findings of case study research on the Aboriginal Health and Wellness Advisory Committee (AHAWAC) of the Interior Health Authority. Interviews, direct observations, and document review methods were used to gather data that provide rich accounts of the challenges that committee members face in establishing meaningful working relationships between Interior Health officials and local Aboriginal communities. Recommendations based on the analysis of these data are provided.

Aboriginal Health Within the Interior Health Authority

Interior Health was established in 2001 as one of five newly consolidated regional health authorities in British Columbia. Geographically, the Interior Health Service Area includes over 200,000 square kilometers in the southern interior of the province. Interior Health serves approximately 700,000 residents with an annual budget of \$1.2 billion.

The service area contains the traditional territory of many culturally distinct First Nations: Shuswap; Okanagan; Ktunaxa; T’silhoqot’in; Nlaka’pamux; St’Wixt; Carrier; and Sl’t’atl’imx (Interior Health Authority 2003). The Interior Health region is also home to many Aboriginal people originating from other parts of the province, country, and continent. In 2001, there were 36,700 Aboriginal people residing in the Interior Health service area, comprising 5.7% of the overall population of the region, Aboriginal peoples comprise 4.4% of BC’s population overall (BC Stats 2004b). There are 54 reserves within Interior Health’s service boundaries, yet, only half of the Aboriginal population in the area lives on reserve (BC Stats 2004a). There is a great deal of diversity among the Aboriginal population in this area, and Aboriginal residents do not necessarily share the same culture, history, or health issues.

Despite this diversity, the Aboriginal population commonly experiences health inequities relative to the experiences of non-Aboriginal residents. For instance, the age-standardized mortality rate for status Indians in the Interior Health region ranges from 84.6 to 163.7 per 10,000 (spread across Interior Health’s Health Service Areas), while the rate for other residents ranges from 56.2 to 68.9 per 10,000 (1991–99 data. Interior Health Authority 2003). The infant mortality rate, another indicator of population health, reveals a similar trend: The upper range of the infant mortality rate is 10.6/1000 births for status Indians, and 5.6/1000 for other residents (Interior Health Authority 2003).

Mapping the Territory: Guidance from the Literature

This study is informed by the literature and administrative trends in three conceptual areas: citizen engagement in health planning, regionalization and participation, and Aboriginal participation in health-care decision making.

Citizen Engagement in Health Planning

The term “participation” may be used to describe a wide variety of types of public involvement. As demonstrated in Arnstein’s (1969) well-known paper “A Ladder of Citizen Participation,” participation can range in practice from forms of “non-participation” (at the lowest rungs of the ladder), to degrees of “citizen power” and “citizen control” (at the top of the ladder). Understanding the situation-specific meaning of participation is clearly important.

The term “citizen engagement” implies a particular type of public participation. Its central tenets include “greater emphasis on information and power sharing, and mutual respect and reciprocity between citizens and ... governors” (Abelson and Gauvin 2004, 2). Citizen engagement is a key aspect of the “new public management” that has been widely adopted by governments of Western industrialized countries in the last twenty years and is characterized by decentralization, devolution of responsibilities to other government jurisdictions or third parties, and restructured accountability relationships. This redesign of governance systems is intended to permit more active communication between government and stakeholders and a direct connection between citizens and the policy process, as well as (perhaps paradoxically) a greater market orientation (Pal 2001).

While citizen engagement has become a buzzword in public administration, the popularization of public participation in health care may largely be attributed to the World Health Organization (WHO), which, in the 1978 Alma-Ata declaration, forwarded community participation as a cornerstone of the strategy to achieve the goals stated in the policy statement, “Health For All by the Year 2000” (Zakus and Lysack 1998). Public participation is also consistent with the approaches to health promotion and population health espoused by health researchers and Canadian health care organizations. According to Health Canada, the population health approach “ensures appropriate opportunities for Canadians to have meaningful input into the development of health priorities, strategies, and the review of outcomes” (Health Canada 2001a). Still, even with apparent government endorsement, “the use of citizen engagement mechanisms in the Canadian health system is in its infancy” (Abelson and Gauvin 2004, 3).

The principle of affected interests states that everyone who is affected by the decision of a government should have a right to participate in that government (Wharf and McKenzie 2004). Beyond this basic political right, one of the main stated goals of public participation is to include the concerns and desires of those who utilize the system in the decision-making process, thereby improving

decisions and empowering individuals and communities (Perlstadt et al. 1998). Citizen participation in health planning is also purported to increase the accountability of health service providers, improve networking between those providers and community members, to make more efficient use of scarce resources, and to encourage creative problem solving (Pivik 2002). However, several commentators have noted that there is little empirical evidence to support these professed benefits (Blue et al. 1999; Zakus and Lysack 1998). Public participation “in health system planning and decision making remains a largely untested concept” (MacKean and Thurston 2000, 19). Evidence gathering in this area may be plagued by a lack of critical research analysis as well as conceptual ambiguity (Zakus and Lysack 1998).

While citizen participation in health planning is intuitively appropriate, the strategies for and evaluation of participation are decidedly complex. Labonte and Laverack’s (2001) caution is useful when appraising citizen participation: “Whenever the term ‘participation’ is encountered, it should always be followed by the specifications, ‘by whom,’ ‘in what,’ ‘why’ and ‘for whose benefits’ ” (Labonte and Laverack 2001, 127).

Regionalization and Public Participation

The regionalization of health services “generally means an organizational arrangement involving the creation of an intermediary administrative and governance structure to carry out functions or exercise authority previously assigned to either central or local structures” (Church and Barker 1998, 467). Regional health authorities embody the tension inherent in new public management between local participation and accountability, and concerns with economies of scale in service delivery. However, regional health authorities are uniquely positioned with respect to public participation. It is generally surmised that the “decentralization of the [health care] system [has] opened up more opportunities for public input because decision making ... occurs closer to the community” (Maloff, Bilan, and Thurston 2000, 68). Indeed, “more meaningful public participation” is cited as one of the objectives of the transition to the regional model (Kouri 2002, 20), but the extent to which public participation appears a priority for regional health authorities varies (Flood and Archibald 2005).

Regional health authorities have significant responsibilities in Aboriginal health. In British Columbia, they have been given the task of providing acute care, continuing care, prevention services, and some environmental health services to Aboriginal residents in the province, regardless of their legal status or place of residence. However, some of these public services may be offered on reserve by Health Canada or by Aboriginal service organizations, which begets jurisdictional confusion. Aboriginal board members of regional authorities have stated, “The regionalized approach to health appears to many Aboriginal British Columbians to be no more effective in meeting their needs than the previous ministry-centred system” (Aboriginal Governors Working Group 1999, 1). The implications of

regionalization for Aboriginal health care have not been significantly addressed in the literature.

Aboriginal Participation in Health-care Decision Making

Prior to European contact, Aboriginal communities in what is now British Columbia had regionally specific, locally controlled, and often sophisticated systems of health care (Kelm 1998). Through the process of colonization, these systems were displaced, de-legitimated, and challenged by new diseases. The history of Aboriginal participation in Western health care has been marked largely by exclusion and paternalism on the side of past governments (Kelm 1998) and the contemporary notion of participation cannot be divorced from this legacy (O'Neil, Reading, and Leader 1998).

In order to understand the contemporary participation of Aboriginal peoples in health-care decision making, it is important first to grasp the basic elements of Aboriginal health care. This involves tracing the complex system of funding relationships and multiple accountabilities (Abele 2004) as they have evolved into the current scheme, in which the government of Canada has responsibility for ensuring the provision of health-care services to status Indians and the Inuit, which are then provided to Aboriginal peoples through a combination of federal, provincial, and Aboriginal-run services. What is given here is a greatly abbreviated version of history that may, at the very least, point to the political influences, competing assumptions, and fragmented service delivery that characterize Aboriginal health care (Commission on the Future of Health Care in Canada 2002). This context profoundly shapes the ability of Aboriginal peoples to participate in health-care decision making.

When British Columbia joined Confederation in 1871, jurisdiction for Aboriginal peoples' health and welfare passed from the local to the federal level. In 1874, the Canadian government passed the Indian Act, effectively cementing federal trusteeship over Aboriginal peoples. Several treaties were signed between First Nations and the Canadian government, but only one (Treaty no. 6, signed in 1876 with the Cree of central Alberta and Saskatchewan) contained any explicit provisions for health care. This treaty contains the infamous "medicine chest" clause that has been subject to differing interpretations regarding the health-care obligations of the Canadian state to Aboriginal peoples. Notwithstanding this, the Canadian government has been formally involved in health service delivery to Aboriginal people since establishing the first nursing stations on reserves in the early 1900s. Rather than viewing this service provision as an Aboriginal right, the federal department of health considers such involvement "a matter of custom and moral duty" (Elliot and Foster 1995, 114).

In the early to mid-1900s, Aboriginal health policy was shaped by colonial notions of racial superiority, the concept of the "white man's burden," and fears of infectious diseases localized in Aboriginal communities (e.g., tuberculosis due to the poor living conditions on reserves) (Kelm 1998). Within this agenda,

Aboriginal peoples “participated” insofar as they were the recipients of this system of care, or were involved in resistance to colonial systems of medicine.

In 1969, Prime Minister Trudeau’s White Paper called for the repeal of the Indian Act in order to encourage the greater assimilation of Aboriginal peoples into mainstream Canadian society (Indian and Northern Affairs Canada 2004). Aboriginal peoples resoundingly rejected this plan as an attack on their sovereignty. The plan was withdrawn, but these events marked the beginning of a new phase in Aboriginal/non-Aboriginal relations, and opened the door to discussions of Aboriginal self-government.

In 1979, the federal government adopted the Indian Health Policy. The stated goal of the policy was “to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves” (Health Canada 2001a). Following the intention of this policy, in 1986, the federal government announced the opportunity for eligible Aboriginal communities south of the 60th parallel to assume administrative control of federal on-reserve health services. The federal cabinet approved the Indian Health Transfer Policy in order to fulfill this commitment. Many Aboriginal communities are currently involved in Health Transfer. In the Pacific Region (British Columbia), as of June 2004, 41 transfer agreements have been signed, affecting 55% of on-reserve First Nations communities in the province (Health Canada 2004).

While Health Transfer has significantly increased Aboriginal participation in health-care decision making, the policy does not encompass all types of health services, and does not apply to all Aboriginal peoples; only those who are status, First Nations, on-reserve communities qualify. Moreover, Health Transfer is not a panacea for Aboriginal self-determination in health. Some Aboriginal communities view Health Transfer as a withdrawal of the federal government’s historical duty to protect Aboriginal peoples’ health, and thus refuse to participate in it (Culhane Speck 1989). Other communities do not have the capacity to participate (Sommerfield and Payne 2001). All of these factors mean that Aboriginal peoples and communities, both with Health Transfer arrangements and without, still rely to a great extent on services delivered by regional health authorities.

Each province has chosen its own policies and practices in Aboriginal health care with varying forms of Aboriginal participation. In British Columbia in 1991, the government formed six Aboriginal Health Councils across the province. The Health Councils were comprised of Aboriginal representatives from the community and included ex officio government representatives. The Health Councils engaged in strategic planning and setting priorities for funding provided by the provincial government. When the province of British Columbia regionalized its health services in 1997, it was mandated that all regional health boards and community health councils include one Aboriginal governor. However, when the province restructured regionalization in 2001, the requirement for Aboriginal

participation in health authority governance was eliminated, along with the entire Aboriginal Health Council structure. Interior Health and the four other newly formed regional health authorities assumed the responsibilities for Aboriginal health planning and resource allocation.

Aboriginal health plans are a ministry-mandated requirement of each BC regional health authority. According to the Provincial Health Officer, Aboriginal health plans must demonstrate “increased Aboriginal involvement in decision making and planning for their population, and ... show establishment of a meaningful working relationship with the Aboriginal community” (Ministry of Health Planning 2002, 87). While the Ministry provides final approval of all regional health authority Aboriginal health plans, to date there has been no formal assessment of the extent to which Aboriginal people are meaningful participants in health planning.

Methods

Participants and Setting

The Aboriginal Health and Wellness Advisory Committee (AHAWAC) was formed on May 6, 2002, when Aboriginal community members and Interior Health staff met to discuss the province’s transfer of Aboriginal health responsibilities to the regional health authority. The AHAWAC is comprised of 14 Aboriginal community members, seven Interior Health staff (ex officio) and two Interior Health Board members (ex officio). With two exceptions, all members of the AHAWAC are Aboriginal.

Data Collection

The research relied on interviews, direct observations, and document review. Interview participants were purposefully selected from a list of the 23 members of the AHAWAC, using quota selection to provide geographic coverage and balance between urban and reserve-based research participants. Eleven in-person interviews were conducted in geographically dispersed locations within the southern interior of British Columbia; two interviews were conducted by telephone. Interviews were semi-structured and interview transcripts were central to data analysis.

Additional data collection occurred through direct observations of two types of meetings. Four community consultation meetings offered a significant look at the relationship between Interior Health and Aboriginal communities. At an AHWAC meeting, interview respondents voiced many of the same views and anecdotal stories that they shared with the researcher during personal interviews. This apparent “duplication” served the purpose of data triangulation. Data collected from each of the meetings included descriptive notes (reconstruction of some

dialogue and particular events) as well as reflective notes (personal impressions and interpretations). Descriptive notes were subject to the same coding scheme as interview transcripts.

The documents reviewed included the Interior Health Aboriginal Health Plan, Committee meeting minutes, organizational charts, and other relevant organizational documents. Documents were used to understand the activities, goals, and mandate of the Aboriginal Health division in Interior Health. By contributing this additional vantage point, document review complemented personal observations and interviews.

Data Analysis

Data analysis relied both on direct interpretation and categorical aggregation. Various techniques were used for data analysis, including text searches for recurring words, identifying internal inconsistencies, and colour-coding of “issues.” In order to define and distinguish themes from the data, the researcher used recorded audiotape to “talk out” the analysis, and played back the tapes to define a logical interpretive path. These recordings document some of the iterative coding procedure in action. Through the analysis, overarching themes of the findings emerged—representation and reconciliation—which identify the tensions that radiate throughout this investigation of Aboriginal participation in health planning.

Emergent Themes

Representation and reconciliation both underscore the challenges that committee members face in establishing meaningful working relationships between Interior Health—a bureaucratic organization accustomed to Western medicine—and local Aboriginal communities that are enduring the effects of historic disenfranchisement, continuing marginalization, and poor health status. In this context, representation is a multifaceted concept. It points to the representational role that committee members each play with respect to “the community” and/or governmental health authority. Representation implies the power to survey, define, and categorize the represented. The committee itself is also a representation—it is not just a working body, but also a symbol of the relationship between Aboriginal peoples and “the government.” Representation offers dilemmas that committee members must resolve in carrying out their work. Reconciliation implies the rebuilding of damaged relationships. Integral to the concept of reconciliation is the redefining of a balance of power between parties. Reconciliation is also the process of creating correspondences between competing agendas and conflicting world views.

Findings: Common Aim, Divergent Perspectives

Some of the findings of this investigation are illustrated here by quotes from Advisory Committee members.

Lost in Translation: Defining the Purpose of the Committee

According to the Committee's terms of reference, the committee's purpose is to "provid[e] advice to Interior Health on matters pertinent to the improvement of health and health services for Aboriginal People" (Interior Health Authority 2004, 1). However, this advisory role was not uniformly envisioned by committee members, who variously construe the purpose of the committee. Some of the factors implicated in this role confusion are:

- Division of power

There's that element of "this is an Interior Health committee, and Interior Health has the last say," that this is "an advisory to." So there's still a bit of that power struggle, still that tension.

- Various interpretations of the relationship between advice and implementation

I think that because they are asking for our advice as an Advisory Committee, they should take our advice.

It's not as if we can come and say "we want this and we want that, so give us that."

Similarly, committee members provided a spectrum of views on one of the major roles of the committee: allocating funds that are provided to the health authority by the Ministry of Health through the Aboriginal Health Initiatives Program (AHIP). These funds offer a vital source of revenue to Aboriginal community programs that promote health improvement. A subcommittee of AHAWAC judges community proposals and decides on funding allocation. Funding allocation is unsatisfactory to many committee members, however, because:

- There is real or perceived bias in the subcommittee's funding allocation;

I hear locally, "As long as such and such sits on the [sub] committee, we'll never get any money." So I know it's a sore point.

- Resource scarcity begets conflict;

There's only so many dollars and they've got us all fighting over them. It's typical.

In addition to allocating funds, committee members note that a great deal of the work of the committee is focused on an umbrella of activities that could be termed "education." Committee members depict this educating role in a variety of ways:

- Educating Interior Health about Aboriginal people

[The] number one [role of the committee] was to assist in the education of Interior Health as a new entity with very little history with respect to working with Aboriginal people.

- Information gathering and Aboriginal community capacity building

[A positive experience I've had with the committee] has been having the opportunity to be at a table where I'm able to collect information that's going to help us as [an Aboriginal community] organization run better.

Widening the Circle: The Challenge of Community Representation

According to the committee's terms of reference accountability statement, "AHAWAC is the link between IH [Interior Health] and Aboriginal communities. Committee members are accountable to the communities they represent and should ensure the provision of communication to Aboriginal people. IH acknowledges the committee as representing the Aboriginal People within the First Nations territories served by IH" (Interior Health Authority 2004b, 1).

While the Advisory Committee is intended to be a representational body, community representation is not a linear extrapolation from Aboriginal communities to the Advisory Committee table. Community representation is complicated by the following factors:

- Interior Health Aboriginal Liaisons describe dual representation and dual accountability (to Interior Health and Aboriginal communities);

I'm being pulled in a lot of directions, I guess ... It's hard to meet in the middle and be that one person for everybody.

- Constituent-based representation must be reconciled with regional Aboriginal representation.

We have to represent the interests that we come to the table with, and that's very important because we have such diverse interests ... But at the end of the day, when a decision is being made, the interests are for all Aboriginal people and the well-being of Aboriginal people as a collective.

In addition, despite the fact that many committee members initially equated community representation with committee composition, it is clear that membership itself is not indicative of adequate representation. Community representation also requires:

- Listening to community members

To be truly representing, you have to hear what people are saying if you're going to be at the table speaking on people's behalf.

- Communicating back to community members

So, have we got the representation? Yes. Do we have all of the issues on the table? No. I don't believe that all of the committee members are as diligent in performing their functions of representing and reporting back to their constituencies.

- Formal consultation

I really think that representatives like this on the committee, if they're serious about their position and their role and making plans, they would make it a priority to set up consultations within their areas.

Some members express concern about the committee's ability to represent all Aboriginal peoples for Aboriginal health planning. They identify specific representation that should be included in committee membership or wider Aboriginal health planning:

- "Under-represented" demographics

[On] the committee, I would include people from the communities, some young people from the communities, at least a couple of elders from the communities.

- Aboriginal clients

Engagement of the population that's going to be a recipient of the service—I think that's an indicator of success in planning in Aboriginal communities.

But committee members also identify barriers to wider participation:

- Community lack of interest

Even though we put the questions out there, or we give them the information, you don't get a lot of feedback back. The basic kind of feeling I get from the people is "just take care of it." That kind of apathy thing.

- Complexity of Aboriginal health-care system creates confusion about the health authority's role

You hear the complaint [from Aboriginal community members], "Well, we don't get services from the province" ... They're so confused; they don't know who's paying for what or who should be giving them what. It's too complicated.

- Difficulty of reaching marginalized people

To get information out from here to the average person, it takes more than posting it at the Band Office, at the Friendship Centre, emailing folks, whatever ... Most of our people live at or below the poverty line, so going online somewhere is not a priority ... It's that group of people that we need to reach ... And who has time to do that? Who's willing to do that?

Consultation poses additional challenges to the Advisory Committee in terms of timely decision making and progress:

People, I don't think, are comfortable making decisions because they have to go back to the community. But you know what? The community put you there, so they're saying make the decision, move us forward.

Square Peg, Round Hole? Reconciling Aboriginal Health and Health Care

Committee members identify various determinants of Aboriginal health, including:

- Colonization

How did we get this way? It didn't happen overnight. [We are] still feeling the impact of two hundred-some years of colonization.

- Social and economic determinants of health

Health is interconnected and linked with socio-economic status, education, general well-being.

Some committee members believe that the committee is employing an “Aboriginal approach” to health planning through the following means:

- Education of mainstream health-care providers and administrators
- Funding allocation

I think the characteristic of [an Aboriginal approach to health planning] ... is just looking at some of the [AHIP] projects that have been supported and the reason why.

But not all committee members are convinced that the committee is employing an Aboriginal approach, or developing a holistic health system. Barriers to this approach are:

- Conceptual opposition of the medical model

When we're doing health planning, we're looking at the absence of disease, that's the medical model. That does not meet with an Aboriginal perspective.

- Ministry “silos” that isolate the various determinants of health

If we're going to be effective ... [health planning] has to become more holistic and integrated. That won't happen because Interior Health has that mandate, MCFD [Ministry of Child and Family Development] has that mandate.

Despite the uneasy relationship between holistic Aboriginal determinants of health and Western notions of health care, most committee members define successful Aboriginal health planning with reference to improved health statistics:

[Success in Aboriginal health planning is] when statistics show that we're meeting the goal [of improved health]. And it is going to be statistic-driven in order to prove that.

But Committee members commonly communicated a sense of frustration relative to the progress of the committee in affecting Aboriginal health:

I've been very frustrated mostly for two years because I just felt like we weren't doing anything, that nothing was changing.

Elements identified as slowing the progress of the committee include:

- Turnover of Interior Health's staff members
- Lack of implementation
- Lack of resources for implementation
- Racism towards non-Aboriginal people at the Advisory committee

There's been some pretty heated discussions, some pretty nasty things said. A lot of racial slurs made. The people on our committee, some of them have some strong feelings about

non-Native people and White people and they'll say things, and it's gotten ugly at a couple of meetings.

- Racism of the health authority towards Aboriginal people (associated with inadequate funds)

Interior Health said, "Oh my god, a million and a half dollars over three years? Oh my god! That's far too much money for those Indians, so cut it back." So to me it's like trinkets again: "Give those Indians a few trinkets and they'll be quiet and happy for a while and fight amongst themselves and we're okay, we can carry on with business as usual."

Despite the challenges to progress, committee members consistently stressed the positive aspects of the committee. Commonly, it is the very existence of the committee as a vehicle for Aboriginal health planning that engenders this conviction. A committee member sums up the importance of the committee in this way, and provides a reminder of the recent establishment of this working relationship:

Can [the committee] really affect change? I think so, and I think that is more evident in some areas as opposed to others, but we have to remind ourselves that just because the process is flawed at times, the outcome is worth the challenges, and that Aboriginal voice speaks, maybe too loud at times, maybe not loud enough at others, maybe in the wrong context or the wrong venue ... but speaks nonetheless, and somebody is listening and for a long, long time nobody heard us at all. So both sides will learn.

Meaningful Participation: Accountability, Power, and Validation

Meaningful representation and meaningful reconciliation (the suggested basis of meaningful participation) can be explored through this discussion of accountability, power, and validation of Aboriginal health approaches.

Multi-directional Accountability

Given the committee's position as an intermediary body between Aboriginal communities and Interior Health, meaningful representation implies multi-directional accountability relationships. This includes accountability between Interior Health and Aboriginal communities (vertical accountability), and between the community-based committee members and Aboriginal peoples in the region (horizontal accountability). Intersecting accountability describes converging responsibility for meaningful participation, and conflicting accountability refers to the tension inherent in multidirectional accountability relationships. Mutual engagement describes a relationship that promises to support meaningful participation.

Vertical accountability. Accountability between Interior Health and the committee is founded upon the provision of sufficient support for meaningful Aboriginal health planning and implementation. In this context, meaningful representation requires clear articulation and expectations about the link between

the Committee's advice and the health authority's actions; that is, *answerability* (Abelson and Gauvin 2004).

Abelson and Gauvin contend that regional health authorities can sidestep answerability if the participatory process is not based on trusting relationships. They explain:

RHA [regional health authority] decision making can find superficial, non-binding ways to demonstrate through their business plans that they have responded to community health committee advice. Without the key elements of relationship-building that include a trusting, open exchange between the RHA and community health advisory committee, the answerability criterion may be easily undermined. (26)

Horizontal accountability. It is not merely the link to constituency organizations that determines appropriate accountability; rather, accountability refers to the quality of the interactions between representatives, constituent organizations, and the Aboriginal population. Viewed in this way, meaningful representation implies that community members are aware that they are being represented, and that the representation is credible and responsive (Frankish et al. 2002; Maloff, Bilan, and Thurston 2000; Perlstadt et al. 1998).

Intersecting accountability. For nearly all committee members, relying solely on the Advisory Committee for Aboriginal health planning is not adequate representation. The meaningful representation of communities implies health planning that is informed by knowledge and appreciation of the unique character, needs, and abilities of individual Aboriginal communities and is supported by channels of communication and accountability to and from the committee setting. According to the findings, both community-based members and the health authority have responsibility for gathering knowledge and cultivating relationships with communities.

Conflicting accountability. Conflicting accountability challenges meaningful participation. For community-based committee members, the structure of representation requires them to be accountable to their constituents by supporting the community's interests at the committee table. They must also balance the wishes of their constituents with an overall agenda for Aboriginal health that may or may not meet with their community's vision. Liaisons are similarly challenged in their dual allegiance to Aboriginal communities and Interior Health.

Mutual engagement. Citizen engagement typically refers to processes in which governments take the initiative to involve citizens in policy development; a broader view of engagement includes "mutual engagement." Abelson and Gauvin (2004) contend that mutual engagement is the most robust form of participation, as it implies both strong accountability relationships and community empowerment. All actors in public participation have important parts to play in mutual engagement, but not identical roles.

As Interior Health receives funds for Aboriginal health planning and holds the final place of authority in the advisory relationship, the organization is respon-

sible for providing support (resources, staff, supportive environment) for meaningful participation within the committee. Interior Health must also willingly share decision-making power, as “participation without redistribution of power is an empty and frustrating process for the powerless” (Arnstein 1969, 216).

Meaningful participation extends beyond the Advisory Committee, however. Interior Health plays an important role in Aboriginal community engagement through episodic and ongoing engagement efforts. Initiating these relationships is clearly challenging for the organization, as this work goes well beyond the boundaries of service provision, yet it is not Interior Health alone that determines meaningful participation. Mutual engagement supports Aboriginal self-determination by acknowledging the critical role of proactive community leadership. Community-based committee members are far from passive in shaping the relationship between Interior Health and Aboriginal communities. Through their bridging role as community representatives, community-based committee members can encourage and facilitate or, alternatively, inhibit engagement.

In identifying elements of meaningful participation, the preceding discussion suggests that meaningful participation may be supported and developed. Still, surmounting some barriers to meaningful participation will be more difficult than clearing others, such as low community capacity, lack of implementation, and inadequate resources. A problem that seems even more immutable than these is that of reconciling the conflict between Aboriginal conceptions of health and the biomedical foundation of the health-care organization. The research findings and the literature have suggested a place to achieve some resolution of this latter tension and thereby to facilitate more meaningful participation.

A Meeting Place: Population Health and Aboriginal Health Planning

The population health approach. Population health is “an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups” (Health Canada 2001b), by focusing on the importance of broad social, environmental, and biological determinants of health on health status. The population health approach is espoused by population health divisions at the federal, provincial, and regional health authority levels, but the necessity of such “special” departments point to the difficulty in reorienting the entire health care system towards the population health approach.

Applying a population health perspective to health planning involves the following five planning principles: holistic view of health, evidence-based decision making, focus on equity, use of partnerships, and empowerment and public participation (Canadian Institute for Health Information 2005). Acting as an educator, resource broker, community developer, partnership developer, and advocate, the health authority can support community empowerment, participation, and inter-sectoral approaches towards addressing the determinants of health (Labonte 2002).

Figure 2.1: Conceptual Intersection for Aboriginal Population Health Approaches

Despite the uncontroversial nature of these principles, population health has not been implemented extensively. Even when supportive research and information is available, “health officials ... seem unable to apply recent developments in social epidemiological theory and population health research findings” (Raphael 2004, slide 99). This inability stems from the difficulty of implementing policies that require inter-sectoral action and a longer time frame to assess effectiveness, as well as political ideologies and medical culture that favour individual, biomedical approaches to health. Thus, despite the implications of a sea change in health policy, population health has, as of yet, been limited to a marginal movement within health care (Evans and Stoddart 1994; Lindbladh, Lyttkens, Hanson, and Ostergren 1998; Raphael 2003; Raphael 2000).

Aboriginal approaches to population health. Aboriginal peoples “do not see themselves as a pan-Aboriginal population because they come from diverse nations, heterogeneous cultures, linguistic groups, and geographies where there is no ‘one perspective’” (National Aboriginal Health Organization 2001, 7). There are, however, some shared philosophies regarding health across Aboriginal cultures that could be termed “Aboriginal approaches” (Kinnon 2002).

As expressed by many committee members, the causes and impacts of health and disease extend beyond individuals and reverberate throughout families and communities. Accordingly, “individual behaviours are [recognized as] important,

but they are related to a much broader community health approach” (Armstrong 2005, 5). This community-based approach to well-being has led some commentators to characterize Aboriginal health improvement as an aspect of overall community healing (Warry 1998). Community healing implies a quality of community engagement consistent with the higher rungs of Arnstein’s (1969) ladder of citizen participation, where the community itself identifies and is engaged in strategies to improve its own well-being. Community healing implies that a health authority takes on supportive (rather than leadership) roles that are consistent with the population health approach.

Commentators on Aboriginal health have suggested that “population health, health promotion, disease prevention, and health protection are principles and approaches that are compatible with an Aboriginal world view” (Kinnon 2002, 4). In fact, Ball (2005) refers to “Aboriginal ways” as “the original population health conceptual framework,” stating, “it would seem that Aboriginal ideas about how to support the survival, healthy growth, and optimal development of their own peoples have long embodied the assumptions, aims, and approaches that society is now calling population health” (Ball 2005, 37).

While there are clear commonalities between these two health frameworks, the population health approach best known in mainstream health care must be adapted for its application to Aboriginal health. Scott (2005) discusses both the commonalities and the divergence in the two perspectives, but emphasizes the relevance of population health to Aboriginal health:

Both Aboriginal views and population health frameworks recognize that well-being is the result of a complex interplay between environment and person ... However, there are key areas where subtle differences between western notions of human need and Aboriginal ideas ... exist ... Soulful dimensions are only ever incidentally recognized within ... the health determinants discussion. Secondly ... culture is important in the restoration of balance and harmony from a contemporary Aboriginal perspective ... Nonetheless, with its focus on the reduction of social inequities, environmental integrity, and self-determination, the population health approach has particular relevance for Aboriginal people in Canada. (Scott 2005, 2)

Despite the affinity between population health and Aboriginal health, there are challenges to the acceptance of Aboriginal population health approaches within health care. Prominent among these is “evidence-based decision making,” in which where evidence is restricted to “scientific” peer-reviewed studies that comply with Euro-Western notions of research and knowledge. Since the acceptable knowledge base in this area is nearly non-existent (particularly with respect to “best practice” interventions), there is little impetus for health authorities to alter their approach to Aboriginal health.

The application of Aboriginal population health approaches will require validation within the health authority, especially through leadership support; this, in turn, will determine access to resources. The health authority will also need to build skills and the capacity to employ Aboriginal population health approaches.

Table 2.1: Benefits of Relationship-building Between the Health Authority and Aboriginal Communities

Build awareness, understanding, trust, interpersonal relationships	Establish basis for vertical accountability
Improve clients' access to services by improving awareness and referrals	Gain community input for evidence-based decision making
Improve suitability of services for Aboriginal client group	Develop partnerships for addressing social/political/environmental determinants of health
Establish channels for information flow between the community and health authority	Build capacity of Aboriginal health policy community
Increase knowledge of local communities' health issues and of Aboriginal health approaches	Support community-based efforts for community healing

Source: 2001 Census of Canada

Applying such a framework to health planning is an important point from which to build the shared understandings necessary for trust and true engagement.

The preceding discussion has merely indicated the potential to modify the population health approach for Aboriginal health planning; a fully articulated Aboriginal population health framework is beyond the scope of this research. However, based on the interconnections between participation, population health, and Aboriginal community-based healing (**Figure 2.1** – page 32), an Aboriginal population health framework would be grounded in the elements of meaningful participation elucidated in this research.

Conclusions

The findings presented here illustrate not only the divergent perspectives on Aboriginal health planning held by Advisory Committee members, but also the value placed on the Advisory Committee as a vehicle for meaningful Aboriginal participation. Strengthening accountability relationships and employing Aboriginal population health approaches are two suggested means by which to resolve some of the tensions that inhibit meaningful participation in health planning. This study emphasizes the importance of genuine relationship-building between the Health Authority and Aboriginal communities for achieving gains in Aboriginal health.

It also reveals an intricate understanding of participation featuring representation and reconciliation as key themes, but this understanding of participation is not just a highly localized construct; representation and reconciliation have some parallels in the mainstream participation literature through concepts such as accountability, power sharing, and trusting relationships.

Similarly, the mainstream population health framework offers promising concepts applicable to Aboriginal health, such as participation and social determinants of health. The research suggests that the mainstream population health approach, while valuable in many respects, should be elaborated upon, stretched,

and challenged by Aboriginal population health approaches. Such approaches are a means through which to build the relationships integral to meaningful participation in Aboriginal health planning.

This research emphasizes that not all participation is necessarily meaningful, and meaningful participation is not the entire responsibility of any one party. Mutual engagement indicates the combined responsibilities of the health authority, the AHAWAC, and Aboriginal communities in engaging in effective relationships for Aboriginal health improvement. As relevant today as ten years ago, the Royal Commission on Aboriginal Peoples (1996a) reinforces the need for a comprehensive approach to Aboriginal health that involves mutual engagement:

[Aboriginal people] need to work with non-Aboriginal health and social services agencies to transform relations with them. Mainstream services and agencies need to become more welcoming and more sensitive to cultural difference. And they need to start seeing Aboriginal people as partners in the design, development and delivery of services. (Royal Commission on Aboriginal Peoples 1996a)

Clearly, relationship building through special projects, as well as ongoing, formal, and informal connections, offers benefits to Interior Health and Aboriginal community organizations—some benefits for the health authority are summarized in **Table 2.1**.

True commitment to Aboriginal health will require stretching the boundaries of comfort for the organization. The Royal Commission similarly underscores the need to work beyond the traditional boundaries of the Euro-Western health-care system to improve Aboriginal health. The commission's report states:

The pattern of causality for a specific illness includes factors outside the boundaries of ordinary medicine—social, emotional and economic conditions that in turn lead back to the complex, destabilizing and demoralizing legacy of colonialism. Obviously, then, more of the same—more illness care services—will not turn the tide. What is needed is a new strategy for Aboriginal health and healing. (Royal Commission on Aboriginal Peoples, 1996a)

According to the Royal Commission, this new strategy involves Aboriginal self-determination in an integrated system of health and social services. But, the Commission acknowledges the critical importance of supportive mainstream organizations in facilitating the progression towards Aboriginal control. Regional health authorities can contribute to this vision by supporting meaningful participation in Aboriginal health planning.

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