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Regionalization as an Opportunity for Meaningful Indigenous Participation in Healthcare: Comparing Canada and New Zealand

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Abstract

In Canada and New Zealand, policies support Indigenous participation in the planning and delivery of community-based primary health services. However, these services represent only a fraction of the health services accessed by Indigenous peoples. In New Zealand, legislation enacted in 2000 introduced mechanisms to ensure that Māori have a voice in the decisions made by health boards. In Canada, neither policies nor legislation currently ensure that Aboriginal communities are represented in provincial health systems or regional health boards. The New Zealand experience shows that adding mechanisms of participation to legislation and policies creates opportunities for Māori and health boards to engage in discussions about how to best allocate resources to reduce disparities between Māori and non-Māori health outcomes. In Canada, this dialogue may not occur. Requiring that such mechanisms be created in all Canadian jurisdictions would establish meeting places for dialogue, and assist in closing policy and access gaps that remain.

Keywords

Indigenous, health care, Canada, New Zealand, governance, participation

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Regionalization as an Opportunity for Meaningful Indigenous Participation in Healthcare: Comparing Canada and New Zealand

Recent reports on the health of Indigenous peoples have shown that inequalities remain worldwide (Bristow, Stephens, & Nettleton, 2003). In recognition of the importance of cultural safety (Ramsden, 2002), cultural appropriateness (Wilson, 2008), and participation by Indigenous peoples in primary healthcare, both Canada and New Zealand have adopted policies supporting Indigenous participation as one key mechanism to address health inequalities. This has resulted in the emergence of Indigenous health providers, who contribute a broad range of valuable community-based, culturally appropriate, primary healthcare services (Boulton, 2005; Lavoie, 2003). These community-based services nevertheless represent only part of the health services accessed by Indigenous people in both Canada and New Zealand (Crengle, Lay-Yee, & Davis, 2004; Lavoie & Forget, 2006). Further, numerous studies have shown that so-called “mainstream” services demonstrate limited responsiveness to Indigenous needs and that racism continues to limit their effectiveness (Browne, 2005, 2007; Culhane, 2003; Harris et al., 2006; Smith, Edwards, Varcoe, Martens, & Davies, 2006; Varcoe & Dick, 2008).

Although provincial variations exist in Canada, both Canada and New Zealand have adopted a regionalized health system with health boards responsible for functions previously assigned to local (municipal, regional, or provincial) or central (provincial or national) structures. The health authorities or boards that resulted share a number of characteristics. They are responsible for the health of a population in a geographically defined area and provide a broad range of services, from community-based healthcare to small regional hospitals and specialized care in larger hospitals. Finally, they have been created with the objective of consolidating the authority previously distributed to multiple providers and organizations (Lewis & Kouri, 2004). In New Zealand, legislation introduced in 2000 contained requirements to ensure Māori have a voice in regional and local healthcare planning and decision-making with a view to improving Māori health outcomes (Boulton, Simonsen, Walker, Cumming, & Cunningham, 2004). These innovations align with the literature on public engagement (Bruni, Laupacis, & Martin, 2008). In contrast, regionalized systems in Canada have been implemented without assurances of Aboriginal participation.

This paper explores opportunities for Indigenous participation in regionalized healthcare structures in both Canada and New Zealand. Specifically, the paper answers three broad questions: a) What mechanisms has New Zealand embedded in its legislative and policy framework to facilitate Māori engagement, and what have been the benefits of these? b) What opportunities to have a voice in provincial healthcare systems have been extended to Canadian Aboriginal peoples? and finally c) What lessons may Canada and other countries learn from the New Zealand experience?

A Note on Terminology

The word *Māori* came to be used as a collective noun to distinguish the Indigenous population of New Zealand after the period of colonisation by the English, French, and others from the late 1700s. The term was adopted by missionaries, tasked with translating the Treaty of Waitangi in 1840 (described below), to designate the more than 70 distinct tribes of Indigenous residents at the time of colonisation. The term Māori has since come to mean the Indigenous people of New Zealand. While recognizing that this suggests cultural and experiential uniformity that does not in fact exist, this paper nevertheless utilizes the collective Māori for simplicity.

In Canada, the collective *Aboriginal people* is an umbrella term encompassing First Nations, Inuit, and Métis, and is entrenched in the Constitution as amended in 1982. The term, however, glosses over cultural, legislative, and administrative complexities. *First Nations* is the preferred self-referent used by the peoples of Canada who were historically known as *Indians*. The collective term First Nations veils a multiplicity of nations; for administrative purposes, there are currently over 700 First Nations recognised by the federal government. *Inuit* is also a collective self-referent that refers to the Arctic people who were historically known as Eskimos. Inuit, themselves, recognise local groups with different names (Pallurmiut, Inuvialuit, etc.), reflecting the complexity of Arctic history and a subtlety in cultural differences of which outsiders are often unaware. Finally, *Métis* refers to the descendants of French or Scottish traders and Cree and Ojibway women who settled in the Red River area, north of what is now Winnipeg, Manitoba. They developed their own blended culture and language, Metchif. After Confederation, the Métis were not entitled to sign treaties and do not benefit from the special provisions made by the federal government for a number of programs, including community-based health services.

Throughout this paper, the term *Aboriginal* will be used when statements apply to First Nations living on- and off-reserve, Inuit, and Métis. Elsewhere, the terms First Nations, Inuit, and Métis will be used. Finally, the term *Indigenous* will only be used when speaking in international terms.

Framework

Over the past decades, health policies in Canada and New Zealand have spoken to the need to support Indigenous engagement in health policy design, primary healthcare planning, and delivery. Participation by Indigenous people is promoted in the hope that this will necessarily yield more responsive and accessible services and, in the long run, improve health outcomes. This commitment echoes principles initially entrenched in the Alma-Ata Declaration on primary healthcare (World Health Organisation & UNICEF, 1978), and subsequent World Health Organization-endorsed resolutions and reports (People's Health Movement, 2000; World Health Organisation, 1986, 2008). Researchers involved in Indigenous health research have wholeheartedly endorsed this principle (Adelson, 2005; Harris et al., 2006; Howden Chapman & Tobias, 2000; Kunitz, 1994; Robson & Harris, 2007), which echoes current debates on the importance of broader community engagement in the pursuit of equity (Mitton, Smith, Peacock, Evoy, & Abelson, 2009). For Indigenous people, securing increased control over the delivery of services to their constituency is also a crucial step towards self-determination (Durie, 1998b; O'Neil, Reading, & Leader, 1998). A recent study showed that increased Indigenous control over primary healthcare services results in lower rates of avoidable hospitalization (Lavoie et al., 2010a).

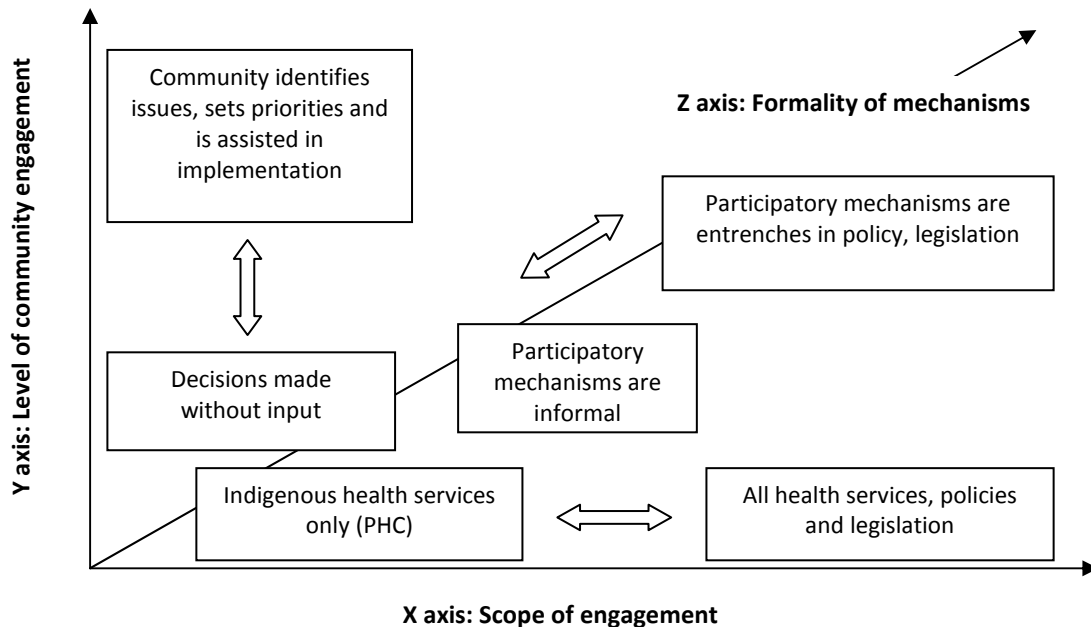
According to Bruni and colleagues (2008), there are at least four reasons that public participation in setting healthcare priorities has value. First, as funders (through taxation and payment) and users, citizens are the most important stakeholders of the healthcare system. Thus, legitimacy and fairness demand that users be represented at the priority-setting table. Second, greater public involvement in policy-making is in keeping with the principles of democracy. Third, empowering people to provide input in decisions that affect their lives encourages support for those decisions, which, in turn, improves the public's trust and confidence in the healthcare system. Fourth, public involvement provides a crucial perspective about the values and priorities of the community, which should lead to higher quality, or at least greater acceptance of priority-setting decisions. Similar arguments can be made for increasing Indigenous participation in policy and priority setting.

In the Indigenous context, a history of oppressive policies (Havemann, 1999; Reid & Robson, 2007), continued reports of racism and discrimination in both comparator countries (Browne, 2007; Browne & Varcoe, 2006; Harris et al., 2006; Paradies, Harris, & Anderson, 2008; Walker, Signal, Russell, Smiler, & Tuhiwai-Ruru, 2008), and documented health inequities (Adelson, 2005; Harris et al., 2006; Howden-Chapman & Tobias, 2000; Kunitz, 1994; Robson & Harris, 2007) not only add weight to the argument for greater participation, but also a sense of urgency among Indigenous communities that such participation must occur.

Building on the continuum of community participation developed by Brager and Specht (1973), we suggest that mechanisms of community participation in healthcare are best represented by a tri-dimensional diagram (Figure 1), where:

- the x axis reflects the scope of community participation with health promotion and community services at one end of the spectrum, and all health services, policies, and legislation at the other end;
- the y axis relates to the level of community participation, with decisions being made without Indigenous input at one end of the spectrum, and engagement at all levels at the other; and
- the z axis reflects the extent to which the mechanisms in place are ad hoc or institutionalized.

Figure 1. Tri-dimensional Framework for Community Engagement in Health



Canada's focus so far has been almost exclusively on the implementation of formal mechanisms focused on improving the responsiveness of community-based primary healthcare delivered to (and by) Indigenous peoples living in their traditional territory (or its current proxy: on-reserve for First

Nations and the Far North for Inuit) with little attention paid to ensuring that the overall healthcare system is responsive and culturally safe. Neither policies nor legislation currently ensure that Aboriginal communities are represented in provincial health systems or Regional Health Authorities (RHAs) (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2010b). This stands in sharp contrast to New Zealand where legislated provisions require the District Health Boards (DHBs) to: negotiate formal agreements with Māori communities, have Māori representation on the board, and ensure all providers within the healthcare system demonstrate responsiveness to Māori clients.

Methods

This paper highlights selected findings from two large and independent policy review studies. The first study, *The Health Reforms 2001 Research Project*, was undertaken to monitor the progress of, and evaluate, the impact of the health reforms enacted by the New Zealand Public Health and Disability Act 2000 (NZPHD Act), as they were implemented (Boulton et al., 2004). The research was conducted between 2001 and 2005 and investigated themes such as governance in DHBs; strategic decision-making; financing, purchasing, and contracting for health services; devolution; workforce capacity and capability; Māori health; and Pacific health (Mays, Cumming, & Tenbenschel, 2007).

All of New Zealand's then 21 DHBs participated in the study with detailed case studies undertaken in five DHBs. There were two rounds of interviews and postal surveys in 2002 and 2003, and 2004 and 2005. The DHB-wide data collection covered the expectations and experiences of those involved in implementing and working with the NZPHD Act 2000 model, and data was collected through: documentary analyses; key informant interviews with Ministers, ministerial advisors, officials, and national stakeholders; a postal survey of DHB members; interviews with DHB Chief Executive Officers and Chairs; and interviews with DHB Planning and Funding Managers. The experiences and expectations of Māori was a particular feature of the research (Mays et al., 2007).

The second study was a review of Aboriginal Health Policies and Legislation in Canada. This study was conducted on behalf of the National Collaborating Centre for Aboriginal Health between March 2007 and April 2008 (Lavoie et al., 2010b). The overall objective was to develop a comparative inventory of public and community health policies and legislation impacting or relevant to Aboriginal health in Canada from the late 1960s onward. For each jurisdiction (Aboriginal, federal, provincial, and territorial), internet searches were used to locate primary documents (legislation, policies, regulations) produced by Ministries or Departments of Health. We acknowledge that the Canadian data is not as in-depth as the New Zealand; however, we contend that both datasets are sufficiently robust to support the objectives of this paper.

Māori Engagement in New Zealand Health Services

As the last colony to be settled, New Zealand followed a different path from that of other “new world” countries with a colonial heritage. The colonial government was committed to avoiding the complexities of the reserve system established in Canada and the United States, and the violence experienced in Australia. Integration, rather than marginalization and containment, became the objective. As a result, the colonial government required that a treaty, the Treaty of Waitangi, be signed in 1840 between the Crown and around 500 Māori Chiefs as a condition for home rule. From then on, the government adopted a policy of “racial amalgamation” (Ward, 1995) and assimilation. Māori received some tangible benefits, such as the guarantee of four Māori seats in Parliament, forums for

Māori participation in healthcare, and educational opportunities (Durie, 1998a, 1998b). These provisions have no real equivalent in Canada. Critiques have suggested that the provisions nevertheless fell short of Māori expectations because they were policy-based rather than treaty-based (Ward, 1999).

The Treaty of Waitangi remained largely ignored for many years. Then in 1975, the Treaty of Waitangi Act was adopted by Parliament, thereby removing the implementation of the Treaty from the realm of policy and providing a formal mechanism to resolve disputes. At the time, Māori were becoming increasingly more vocal about the need to link culture and health. While Māori argued that health could be described as *taonga* [treasure], and therefore protected under Article Two of the Treaty, this interpretation was rejected by the New Zealand government, which argued that its responsibility in matters of healthcare was the same for all citizens. Following the refocused attention on the Treaty of Waitangi, the 1988 Royal Commission on Social Policy recommended that three treaty-based principles become the basis of all social policy dealing with Māori. In the health sector, these principles are articulated in the following manner:

- Partnership: Working together with *imi* [tribe], *hapū* [sub-tribe], *whānau* [family], and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- Participation: Involving Māori at all levels of the sector in planning, development, and delivery of health and disability services.
- Protection: Ensuring Māori enjoy at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values, and practices (New Zealand National Health Committee on Health and Disability, 2002).

In the last two decades, the New Zealand health system has undergone a series of reforms (Gauld, 2001). The latest of these reforms, instituted with the passing of the NZPHD Act 2000, has sought to improve the planning, funding, and organization of health services. The NZPHD Act 2000 model is based on overarching health strategies reflecting national priorities. The 20¹ DHBs purchase and/or provide services for geographically defined populations. Local communities provide input into DHB decisions through elected representation and consultation in the development of health needs assessments. The current NZPHD Act 2000 requires the DHBs to: (1) establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement; (2) continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori; and (3) provide relevant information to Māori for the above purposes (New Zealand Government, 2000). These three requirements reflect the Treaty of Waitangi principles. However, the interpretation of these provisions and ability to give effect to the requirements varies considerably across the DHBs.

Enabling Māori Participation

At the governance level, the legislation requires that each board consist of seven elected members and up to four members appointed by the minister. When appointing, the Minister of Health must ensure that the Māori membership of the board is proportional to the number of Māori in the DHB's resident population, and there are at least two Māori members on the board. The experience of Māori board members on DHBs has been varied. For many, their experience was influenced by the degree to which

¹ Two DHBs, Southland and Otago, were merged forming Southern DHB on May 1, 2010.

they were able to negotiate the issues of representation and accountability. The legislation creating the DHB structure does not distinguish between, on the one hand, *Māori* board members and, on the other, board members who *happen to be Māori*. Respondents in the Health Reforms 2001 study noted that the distinction was very real and problematic. It gave members cause to carefully consider the decisions and advice offered at the Board table since it could be regarded as partisan and, therefore, easily discounted or ignored. A number of respondents in the Health Reforms 2001 study commented on the unease they felt with regard to whether the views of all *Māori* were adequately represented at the Board table. Further, they noted the subtle distinction between whether a board's *Māori* members comprised those who identified as a "Māori board member" or board members who "happened to be *Māori*" had implications in terms of whether the public regarded the board to be truly representative of its *Māori* constituents and able to provide an effective *Māori* voice at the decision-making table.

Despite the legislative silence on the issue of *Māori* representation, *Māori* board members identified a range of ways in which they, as board members, were able to contribute to the work of the DHB in considering *Māori* health. *Māori* board members: provided strategic advice and input into strategic documents; acted as advocates on behalf of *Māori*, *Māori* communities, and *Māori* units within the DHB itself; articulated community concerns at a strategic level; monitored the work programme of the DHB; and acted to uphold the relationship between the Crown and *Imi* [tribes]. In acting in these various roles, *Māori* board members were cognisant of the multiple accountabilities they had to manage (Pere, Boulton, Smiler, Walker, & Kingi, 2007).

In addition to ensuring adequate *Māori* membership, DHBs must ensure that all their members, not only those who identify as *Māori*, "are skilled and knowledgeable about the Treaty of Waitangi and *Māori* health issues and about their local communities" (New Zealand Ministry of Health, 2002b, p. 6). From the Crown's perspective, the responsibility for improving the health status of *Māori* in their geographically defined area clearly rests with the board as a whole, not simply the few *Māori* board members. The view that improvements in *Māori* health are the responsibility of all those who participate in the health sector, not simply *Māori*, is reiterated again and again in the government's health policies and strategy documents requiring greater levels of collaboration, cooperation, and integration from the health sector than ever before.

Partnership Arrangements

Most DHBs have interpreted the act to mean that alongside the board, a *Māori* governance group is required to advise on how proposed funding and planning decisions may affect the *Māori* population and the achievement of *Māori* health outcomes. Giving effect to the principle of partnership has compelled the DHBs to consider how they work with two very distinct *Māori* populations: *Manawhenua* and *Mataawaka*. *Manawhenua* comprise local *ivi* whose traditional territory coincides with the territory covered by the DHB. *Mataawaka* groups are predominantly found in large urban settings and comprise *Māori* who hail from other tribal areas. The *Māori* Health Policy, *He Korowai Oranga*, states that DHBs should work together with "*Iwi, hapū, whanau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services*" (New Zealand Ministry of Health, 2002a, p. 2). Implementation efforts have resulted in a multiplicity of governance arrangements between DHBs and local *Māori* who represent both *Manawhenua* and *Mataawaka*. Often entities that were already in existence prior to the reforms were adapted to fulfill the need for a consultative or advisory body for the DHB Board. In other instances, new entities were created (Pere et al., 2007). The establishment and composition of these groups is as varied as the DHBs in which

they reside; however, all have the function of representing the Māori population in decisions affecting health and health services to that population.

Māori representation in decision-making at the regional level (i.e. on DHB Boards) is mirrored in primary health, at the level of the Primary Healthcare Organisations (PHOs). PHOs are funded by DHBs to provide essential primary healthcare services in the community to an enrolled population. The range of services provided varies from PHO to PHO but may include doctors, nurses, and other health professionals (such as Māori health workers, health promotion workers, dietitians, pharmacists, physiotherapists, psychologists, and midwives).

PHOs are not-for-profit organisations, providing services either directly by employing staff or through their provider members and vary widely in size and scope. A set of minimum requirements guided the establishment of PHOs, setting out the standards that PHOs must meet. While not overly prescriptive, the minimum standards do include the provision that PHOs will give communities, *imi*, and enrolled people the opportunity to have their say about the services PHOs provide (New Zealand Minister of Health, 2001). Consequently, most PHOs, if not already so-called Māori-led PHOs, will also include Māori representation at the governance level.

The Protection Principle

The NZPHD Act charges DHBs with improving, promoting, and protecting the health of all New Zealanders and, in recognition of the principles of the Treaty of Waitangi, improving Māori health outcomes. The two key aims driving *He Korowai Oranga* are: to affirm Māori models, approaches, and initiatives to improve the health of *wāhānau*, *hapū*, and *imi*; and to improve Māori health outcomes through the gradual reorientation of the way that Māori health and disability services are planned, funded, and delivered (New Zealand Ministry of Health, 2002a). The protection principle as articulated requires the health sector to consolidate the gains achieved to date in Māori health service provision (particularly in the field of traditional healing) and in workforce development. Comparatively, Māori capacity in the health sector has reached a strong point in “by Māori for Māori” health services, which deliver predominantly primary care services and have grown from 20 in 1993 to 240 in 2005. *Rongoa* or traditional healing services that employ the use of traditional practices, such as *mirimiri* (a form of massage) and traditional medicines, are a unique feature of the New Zealand healthcare sector. DHBs have a responsibility to ensure that the gains that have been made in providing alternative and culturally appropriate service provision are not lost.

Summary

On the whole, formal policy innovations in New Zealand have created opportunities for Māori and DHBs to cooperate in the pursuit of improved Māori health outcomes (z axis in Figure 1). Although some mechanisms facilitating active engagement predated the *He Korowai Oranga* policy, the policy itself provided an impetus to strengthen existing mechanisms and create new ones. While a policy-driven approach may not necessarily translate into consensus over the process, and in terms of outcomes, at least in the short term (y axis), it nevertheless provides Māori with a broader range of opportunities to ensure responsiveness (x axis) and provides DHBs with opportunities to dialogue on how to best plan and deliver health, medical, and hospital services to achieve health gains.

Policies Supporting Aboriginal Engagement in Mainstream Health Systems in Canada

The Canadian context is considerably more complex, involving ten provincial and three territorial healthcare systems that all dovetail with a federally-funded community-based healthcare system for First Nations and Inuit if living in their traditional territory and their current proxy (the reserves, the North). First Nations and Inuit living outside of these areas and Métis are considered a provincial responsibility, and remain largely invisible. The following section broadly summarizes the situation.

Table 1 provides a demographic breakdown of the Aboriginal population in Canada. Roughly speaking, First Nations are found in the Yukon Territory and the provinces. The Inuit inhabit the territories of the Far North: Nunavut, the Northwest Territories, Nunavik in the province of Quebec, and Nunatsiavut in Labrador. The majority of Métis are found in Ontario, Manitoba, Saskatchewan, and Alberta. In the Canadian context, primary healthcare services for on-reserve First Nations are a matter of federal jurisdiction; whereas primary healthcare for other Canadians, as well as secondary and tertiary health services, are a matter of provincial jurisdiction. This historical separation, which is based on two documents, the Royal Proclamation of 1763 and the Constitutional Act of 1867, was reaffirmed in the Constitution Act 1982. This continues to create challenges in the coordination of primary, secondary, and tertiary care, public health, and discharge planning between on- and off-reserve services (Hawthorn, 1966; Romanow, 2002; National Advisory Committee on SARS and Public Health, 2003; Lavoie et al., 2005; Assembly of First Nations, 2006).

Currently, most on-reserve health funding comes from federal public funding. Some First Nations may secure funding through agreements with their respective provincial health services or Regional Health Authority (RHA) (for example, diabetes prevention or urban health services); but this is still public funding and minor in terms of total investments (Lavoie et al., 2005). Services accessed on-reserve are largely under some measure of control by First Nation communities, thus ensuring responsiveness to local needs and culturally appropriate interventions. The commitment to First Nations' participation in the planning and delivery of on-reserve primary healthcare services is entrenched in the 1979 Indian Health Policy (Health Canada, 1979). Services accessed off-reserve operate outside the reach of this policy. They are delivered by the provinces or funded by the provinces and delivered by practitioners in private practice under the purview of RHAs. Although service agreements have been struck between First Nations and some RHAs, no province has developed a policy framework to facilitate First Nations participation in provincial services planning (Lavoie et al., 2010b). Two provinces, British Columbia and Nova Scotia, appear to be moving in that direction (British Columbia Assembly of First Nations et al., 2007; Mi'Kmaq et al., 2005).

Canada recognizes four Inuit regions: Inuvialuit in the Northwest Territories; the territory of Nunavut; Nunavik, which is the northern third of the province of Québec; and Nunatsiavut in the province of Newfoundland and Labrador. Health services for Inuit, if delivered in the Northwest Territories or Nunavut, are provided by departments with meaningful Inuit participation in governance. This is largely the result of history, isolation, and demographics that ensure a prominence of Inuit voices in government. Services provided to Inuit living in Quebec and Labrador are co-funded by federal and provincial governments. In Nunatsiavut and Nunavik, modern treaties (land claim agreements) have been signed by Inuit and both levels of government to clarify issues of jurisdiction.

Services for Métis, First Nations living off-reserve, and Inuit living outside of their traditional areas are provided by the provinces or territories. In the territories, the Yukon, Northwest Territories, and Nunavut, the predominance of Aboriginal peoples ensures representation. This is not the case in the

Table 1*Canadian Aboriginal Population per Provinces and Territories 2006 (Statistics Canada 2008)*

		Total population	Aboriginal identity population	Aboriginal population as % of the national, provincial, or territorial population	North American Indian	Métis	Inuit
	Canada	31,241,030	1,172,785	3.8%	698,025	389,780	50,480
Provinces	Newfoundland and Labrador	500,610	23,455	4.7%	7,765	6,470	4,715
	Prince Edward Island	134,205	1,730	1.3%	1,225	385	30
	Nova Scotia	903,090	24,175	2.7%	15,240	7,680	325
	New Brunswick	719,650	17,650	2.5%	12,385	4,270	185
	Quebec	7,435,905	108,425	1.5%	65,085	27,980	10,950
	Ontario	12,028,895	242,495	2.0%	158,395	73,605	2,035
	Manitoba	1,133,515	175,395	15.5%	100,640	71,805	565
	Saskatchewan	953,850	141,890	14.9%	91,400	48,120	215
	Alberta	3,256,355	188,365	5.8%	97,275	85,495	1,610
	British Columbia	4,074,385	196,075	4.8%	129,580	59,445	795
Territories	Yukon Territory	30,190	7,580	25.1%	6,280	800	255
	Northwest Territories	41,060	20,635	50.3%	12,640	3,580	4,160
	Nunavut	29,325	24,915	85.0%	100	130	24,635

Provinces where Aboriginal groups remain largely invisible in the provincial healthcare landscape (Lavoie, O'Neil, & Reading, 2007). Only Ontario and British Columbia have developed policies to fund urban health centres to serve the unique needs of urban Aboriginal peoples. These centres are generally managed by an Aboriginal board and offer a range of primary healthcare services.

The invisibility of Aboriginal peoples in provincial healthcare systems is the result of two inter-related factors. First, with the exception of the Territories and the North, the Aboriginal population is relatively small and sparsely distributed. Second, and perhaps more importantly, entrenched in the Canadian policy landscape are practices rooted in the past that positioned Aboriginal peoples at the margin of the settler society. Until 1956, full citizenship was to be secured only through enfranchisement afforded through:

- An individual being forced or choosing to enfranchise (examples include First Nations who opted to serve in the Canadian army in both World Wars, secured higher education, wanted access to hospital care, women who married non-Aboriginal men);
- Non-admission, as in the case of the Métis who were denied the opportunity to sign treaties and other benefits extended to First Nations and Inuit because they were, historically, deemed “westernized” enough to be enfranchised. This is now slowly changing (Lavoie et al., 2010b).

Although enfranchisement came with the right of full citizenship, including the right to vote, it did not guarantee full participation in Canadian society (Royal Commission on Aboriginal Peoples, 1996).

Today, policies provide entrenched mechanisms to ensure that First Nations and Inuit living in their traditional territories or their proxies have a voice in shaping the delivery of primary healthcare services in their communities and territories. First Nations living on-reserve also have a policy-entrenched mechanism to ensure that local services are responsive. Provincial healthcare systems that serve all Aboriginal groups have not entrenched mechanisms to ensure representation. Only British Columbia, Ontario, and Nova Scotia have policies that stipulate the make-up of the Board of Directors must reflect the population the RHAs it is set up to serve. Aboriginal peoples are not specifically mentioned. Ontario is the only province to have established a council composed of Aboriginal peoples to advise on regional priority setting in healthcare, which is provided through the Local Health Integration Networks (Lavoie et al., 2010b).

Kelly (2011) has argued that the *Transformative Change Accord*, which was signed in 2005 between the Government of British Columbia, the Government of Canada, and the Leadership Council Representing the First Nations of British Columbia, may be signalling a new era in Aboriginal health policy. An offspring of the Kelowna Accord discussions, this Accord is a commitment to close the gap that exists between British Columbia First Nations and other British Columbia residents in health, education, and housing, and to settle issues of Aboriginal rights and title. To close the health gap, the Accord proposes the transfer of the policy and service delivery role currently undertaken by the Federal Government to BC First Nations (First Nations Health Council et al., 2010). Although operational details lie beyond the scope of this paper, current discussions suggest the formation of a First Nations Health Authority to fulfill this mandate. While the plan holds promises, this project remains largely at the planning stage and sizable challenges remain (Kelly, 2011).

Summary

In the Canadian context, policies have focused on Aboriginal participation in the planning and delivery of community-based primary healthcare services located in First Nations and Inuit territories (Figure 1, x and y axes). Aboriginal peoples who do not live in the North or on-reserve, approximately one half of the overall Aboriginal population (Statistics Canada, 2008), remain largely unaffected by these innovations. As a result, few health services accessed by Aboriginal peoples actually include Aboriginal input into decision-making, service planning, or service configuration. Policies and legislation (z axis) are silent on this issue (Lavoie et al., 2010b).

Discussion: Policy Lessons

While New Zealand has opted to formalize its commitment to engaging Māori through legislation and policy (the z axis in Figure 1), Canada and the provinces continue to favour ad hoc and informal approaches. The question then is: *What might be gained by adopting national and provincial legislation and policies that provide clear direction on, at least, minimal levels of engagement?*

Mitton and colleagues recently completed a scoping review of the literature on public participation and priority setting in healthcare. They concluded that there is a lack of evaluation of public participation engagement processes (Mitton et al., 2009; World Health Organisation, 2008). We argue that an appropriate framework has been lacking and propose a tri-dimensional framework to assist in reflections on the focus of engagement mechanisms.

We recognize that legislation and policies do not necessarily end debates related to governance and participation, nor does a commitment to include Indigenous people at the decision-making table automatically lead to a greater investment in Indigenous people's health. In the New Zealand context, at least, pressure remains to ensure adequate funding for improving Māori health is allocated in the central government's annual budget to support efforts being undertaken by DHBs to reduce health inequalities (Health budget, 2011). Our analysis of the New Zealand context clearly shows that a "cookie cutter" approach to engagement may be counter-productive. The benefit of adopting a formalized approach is that it has created an impetus for Māori, DHBs, and even PHOs to meet and engage in discussions on how to best allocate resources to close the health gap that remains, thereby potentially increasing transparency and the credibility and quality of decision-making processes. In the context of competing demands and priorities, this dialogue may not otherwise occur.

In the Canadian context, opportunities for dialogue between Aboriginal communities and the healthcare system is ad hoc. Dialogue occurs in some provinces or parts of provinces, but it is often inadequately resourced and subject to shifting priorities and personalities. Entrenching a requirement to create these mechanisms in all jurisdictions would, as it did in New Zealand, establish space for an evolving dialogue that aligns with the principles of democracy and transparent decision-making, and promotes confidence and trust. From such discussion, opportunities and practical solutions for addressing the inequalities that continue to exist for Aboriginal peoples may be identified. At the very least, a level of engagement may emerge that will assist in making healthcare systems more seamless for Aboriginal peoples and address both systemic barriers and institutional racism. This, in itself, is a worthwhile pursuit.

References

- Adelson, N. (2005). The embodiment of inequity. *Canadian Journal of Public Health, 96*, S45-S61.
- Assembly of First Nations. (2006). *First Nations public health: A framework for improving the health of our people and our communities*. Ottawa: Assembly of First Nations.
- Boulton, A. (2005). *Provision at the interface: The Māori mental health contracting experience*. Unpublished doctoral dissertation, Massey University, New Zealand.
- Boulton, A., Simonsen, K., Walker, T., Cumming, J., & Cunningham, C. (2004). Indigenous participation in the 'new' New Zealand health structure. *Journal of Health Services Research and Policy, Supplement 2*, 35-40.
- Brager, G., & Specht, H. (1973). *Community organizing*. New York: Columbia University Press.
- Bristow, F., Stephens, C., & Nettleton, C. (2003). *Utā W'āchil: Health and wellbeing among Indigenous peoples*. London: Health Unlimited and the London School of Hygiene & Tropical Medicine.
- British Columbia Assembly of First Nations, First Nations Summit, Union of British Columbia Indian Chiefs, & Government of British Columbia. (2007). *The transformative change accord: First Nations health plan, supporting the health and wellness of First Nations in British Columbia*. Vancouver: Government of British Columbia.
- Browne, A. J. (2005). Discourses influencing nurses' perceptions of First Nations patients. *Canadian Journal of Nursing Research, 37*, 62-87.
- Browne, A. J. (2007). Clinical encounters between nurses and First Nations women in a Western Canadian hospital. *Social Science & Medicine, 64*, 2165-2176.
- Browne, A. J., & Varcoe, C. (2006). Critical cultural perspectives and health care involving Aboriginal peoples. *Contemporary Nurse, 22*, 155-167.
- Bruni, R. A., Laupacis, A., & Martin, D. K. (2008). Public engagement in setting priorities in health care. *Canadian Medical Association Journal, 179*, 15-18.
- Crengle, S., Lay-Yee, R., & Davis, P. (2004). *Māori providers: Primary health care delivered by doctors and nurses: The National Primary Health Care Survey (NatMedCa): 2001/02 (Report 3)*. Wellington: Ministry of Health.
- Culhane, D. (2003). Their spirits live within us: Aboriginal women in Downtown Eastside Vancouver emerging into visibility. *American Indian Quarterly, 27*, 593-606.
- Durie, M. (1998a). *Te Mana Te Kawanatanga: The politics of Māori self-determination*. Oxford: Oxford University Press.
- Durie, M. (1998b). *Whaiora: Māori health development*. (2 ed.). Auckland: Oxford University Press.
- First Nations Health Council, Government of Canada, & Government of British Columbia. (2010). *British Columbia Tripartite First Nations Health: Basis for a framework agreement on health governance*. Victoria: Government of British Columbia.
- Gauld, R. (2001). *Revolving doors: New Zealand's health reforms (2001)*. Wellington, New Zealand: Victoria University of Wellington, Institute of Policy Studies and Health Services Research Centre.
- Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: Cross-sectional study. *Lancet, 367*, 2005-2009.
- Havemann, P. (1999). *Indigenous peoples' rights in Australia, Canada & New Zealand*. Oxford: Oxford University Press.
- Hawthorn, H. B. (Ed.) (1966). *A survey of the contemporary Indians of Canada: Economic, political, educational needs and policies (The Hawthorn Report)*. Ottawa: Indian Affairs Branch.

- Health budget: Mind the \$127 million gap. (2011, June 3). *Scoop Independent News*. Retrieved November 10, 2011, from <http://www.scoop.co.nz/stories/PO1106/S00041/health-budget-mind-the-127-million-gap.htm>
- Health Canada. (1979). *Indian health policy 1979*. Retrieved November 10, 2011, from www.hc-sc.gc.ca/msb/pptsp/hfa/publications/poli79_e.htm
- Howden-Chapman, P., & Tobias, M. (2000). *Social inequalities in health: New Zealand 1999*. Wellington: Ministry of Health.
- Kelly, M. D. (2011). Toward a new era of policy: Health care service delivery to First Nations. *The International Indigenous Policy Journal*, 2, 1-12.
- Kunitz, S. J. (1994). *Disease and social diversity: The European impact on the health of Non-Europeans*. New York: Oxford University Press.
- Lavoie, J. G. (2003). The value and challenges of separate services: First Nations in Canada. In J. Healy, & M. McKee (Eds.), *Health care: Responding to diversity* (pp. 325-349). London: Oxford University Press.
- Lavoie, J. G., & Forget, E. (2006). *A financial analysis of the current and prospective health care expenditures for First Nations in Manitoba*. Manitoba: Centre for Aboriginal Health Research.
- Lavoie, J. G., Forget, E., Prakash, T., Dahl, M., Martens, P., & O'Neil, J. D. (2010a). Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba? *Social Science & Medicine*, 71, 717-724.
- Lavoie, J. G., Gervais, L., Toner, J., Bergeron, O., & Thomas, G. (2010b). *Aboriginal health policies in Canada: The policy synthesis project*. Prince George, BC: National Collaborating Centre for Aboriginal Health.
- Lavoie, J. G., O'Neil, J., Sanderson, L., Elias, B., Mignone, J., Bartlett, J., et al. (2005). *The national evaluation of the health transfer policy: Final report*. Winnipeg: Manitoba First Nations Centre for Aboriginal Health Research.
- Lavoie, J. G., O'Neil, J. D., & Reading, J. (2007). Community healing and Aboriginal self-government. In J. H. Hylton (Ed.), *Aboriginal self-government in Canada: Current trends and issues* (3rd ed.). Saskatoon: Purish Publishing.
- Lewis, S., & Kouri, D. (2004). Regionalization: Making sense of the Canadian experience. *Healthcare Papers*, 5, 12-31.
- Mays, N., Cumming, J., & Tenbensen, T. (2007). *Health reforms 2001* (Research Report No. 1: Overview). Wellington, New Zealand: Health Services Research Centre, Victoria University of Wellington.
- Mi'Kmaq, Nova Scotia, & Canada Tripartite Forum. (2005). *Providing health care and achieving health* Halifax, NS: Health Working Group Subcommittee.
- Mitton, C., Smith, N., Peacock, S., Evoy, B., & Abelson, J. (2009). Public participation in health care priority setting: A scoping review. *Health Policy* 91(3), 219-28.
- National Advisory Committee on SARS and Public Health. (2003). *Learning from SARS: Renewal of public health in Canada: A report of the National Advisory Committee on SARS and public health October 2003*. Ottawa: Health Canada.
- New Zealand Government (2000). *New Zealand Public Health and disability Act 2000*. (p.Section 2).
- New Zealand Minister of Health. (2001). *The primary health care strategy*. Wellington, New Zealand: New Zealand Ministry of Health.
- New Zealand Ministry of Health (2002a). *He Korowai Oranga: Māori health strategy*. Wellington, New Zealand: New Zealand Ministry of Health.
- New Zealand Ministry of Health (2002b). *Whakatataka: Māori health Action Plan 2002-2005*. Wellington, New Zealand: New Zealand Ministry of Health.

- New Zealand National Health Committee on Health and Disability. (2002). *Tena te ngaru whati, tena te ngaru puku, there is a wave that breaks, there is a wave that swells: A framework to improve Māori health policy*. Wellington, New Zealand: National Health Committee on Health and Disability.
- New Zealand Public Health and Disability Act 2000, Public act 2000 No 91, Section 2 (2000).
- O'Neil, J. D., Reading, J. R., & Leader, A. (1998). Changing the relations of surveillance: The development of a discourse of resistance in Aboriginal epidemiology. *Human Organization*, 57, 230-237.
- Paradies, Y., Harris, R., & Anderson, I. (2008). *The impact of racism on Indigenous health in Australia and Aotearoa: Towards a research agenda* (Discussion Paper No 4.). Darwin, Australia: Cooperative Research Centre for Aboriginal Health.
- People's Health Movement. (2000). *People's charter for health*. Retrieved November 10, 2011, from <http://www.phmovement.org/en/resources/charters/peopleshealth>
- Pere, L., Boulton, A., Smiler, K., Walker, T., & Kingi, L. (2007). *Health reforms 2001 research project: Māori health and the 2001 health reforms* (Rep. No. 6). Wellington, New Zealand: Health Services Research Centre.
- Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu*. Unpublished Doctoral dissertation. Wellington, New Zealand: Victoria University of Wellington.
- Reid, P. & Robson, B. (2007). Understanding health inequities. In B. Robson, & B. Harris (Eds.), *Hauora: Māori standards of health IV. A study of the years 2000-2005* (pp. 3-10). Wellington, New Zealand: Te Ropu Rangahau a Eru Pomare.
- Robson, B. & Harris, R. (Eds.) (2007). *Hauora: Māori standards of health IV. A study of the years 2000-2005*. Wellington, New Zealand: Te Ropu Rangahau a Eru Pomare.
- Romanow, C. R. J. (2002). *Building on values: The future of health care in Canada (Final Report)*. Ottawa, ON: Commission on the Future of Health Care in Canada: The Romanow Commission.
- Royal Commission on Aboriginal Peoples. (1996). *People to people, nation to nation: Highlights from the report of the Royal Commission on Aboriginal Peoples*. Ottawa, ON: Minister of Supply and Services Canada.
- Smith, D., Edwards, N., Varcoe, C., Martens, P. J., & Davies, B. (2006). Bringing safety and responsiveness into the forefront of care for pregnant and parenting aboriginal people. *Advances in Nursing Science*, 29, E27-E44.
- Statistics Canada. (2008, January 15). Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 Census. *The Daily*.
- Varcoe, C., & Dick, S. (2008). Intersecting risks of violence and HIV for rural and Aboriginal women in a neocolonial Canadian context. *Journal of Aboriginal Health*, 4, 42-52.
- Walker, T., Signal, L., Russell, M., Smiler, K., & Tuhiwai-Ruru, R. (2008). The road we travel: *Māori* experience of cancer. *New Zealand Medical Journal*, 121, 27-35.
- Ward, A. (1995). *A show of justice: Racial 'amalgamation' in nineteenth century New Zealand*. Auckland, New Zealand: Auckland University Press.
- Ward, A. (1999). *An unsettled history: Treaty claims in New Zealand today*. Wellington: Bridget Williams Books.
- Wilson, D. (2008). The significance of a culturally appropriate health service for Indigenous Māori women. *Contemporary Nurse*, 28, 173-188.
- World Health Organisation. (1986, November 21). *Ottawa charter for health promotion*. Adopted at the First International Conference on Health Promotion, Ottawa, ON.
- World Health Organisation. (2008). *Primary health care: Now more than ever*. Retrieved November 10, 2011, from http://www.who.int/topics/primary_health_care/en/
- World Health Organisation & UNICEF. (1978). *Primary health care: International Conference on Primary Health Care 1978 Alma-Ata, Kazakhstan*. Geneva, Switzerland.