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Missing Pathways to Self-Governance: Aboriginal Health Policy in British Columbia

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Missing Pathways to Self-Governance: Aboriginal Health Policy in British Columbia

Abstract

This article explores how current policy shifts in British Columbia, Canada highlight an important gap in Canadian self-government discussions to date. The analysis presented draws on insights gained from a larger study that explored the policy contexts influencing the evolving roles of two long-standing urban Aboriginal health centres in British Columbia. We apply a policy framework to analyze current discussions occurring in British Columbia and contrast these with Ontario, Canada and the New Zealand Māori health policy context. Our findings show that New Zealand and Ontario have mechanisms to engage both nation- or tribal-based and urban Indigenous communities in self-government discussions. These mechanisms contrast with the policies influencing discussions in the British Columbian context. We discuss policy implications relevant to other Indigenous policy contexts, jurisdictions, and groups.

Keywords

Aboriginal people, First Nations, Canada, New Zealand, jurisdiction, self-government, urban, health, health policy, non-governmental organizations

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Missing Pathways to Self-Governance: Aboriginal Health Policy in British Columbia

Despite Canada's constitutional commitment to Aboriginal¹ self-government, scholars studying Aboriginal-state relations agree that the implementation of self-government in Canada remains *unfinished business* (Abele & Prince, 2009, p. 568). Although jurisprudence has affirmed the legitimacy of urban Aboriginal communities as political communities entitled to the provision of services, and models of self-government that include Aboriginal peoples living in urban environments have been proposed (Abele & Prince, 2009; Peters, 2005; Walker, 2013), meaningful progress toward the actualization of such models has yet to be achieved.

In the province of British Columbia, a landmark agreement was struck that was unprecedented in Canada and elsewhere (Havemann, 1999). In November of 2005, the province of British Columbia (BC), the BC First Nations Leadership Council, and the federal Government of Canada signed the landmark tripartite *Transformative Change Accord* (TCA hereafter) (Canada, 2005). The focus of discussions prior to and emanating from the TCA has been on the development of a new relationship with First Nations and possibly, although this is less clear, with other Aboriginal peoples in BC. A number of milestones have been achieved since to realize this policy objective, including the adoption of a First Nations Health Plan in 2006 (British Columbia Assembly of First Nations, First Nations Summit, Union of British Columbia Indian Chiefs, & Government of British Columbia, 2007), the creation of a First Nations Health Council (FNHC) in 2007, and a First Nations Health Authority (FNHA) in 2010. The process of implementation has developed in an iterative manner, with expectations of meaningful engagement between the FNHA and either (a) all First Nation peoples living in BC (First Nations Health Council, British Columbia Ministry of Health, & Health Canada, 2012), (b) BC First Nation communities (The First Nations Leadership Council, Government of Canada, & Government of British Columbia, 2007), or (c) all Aboriginal peoples living in BC (British Columbia Assembly of First Nations, First Nations Summit, Union of British Columbia Indian Chiefs, & Government of British Columbia, 2007), depending on documents. These differences in foci and terminology likely reflect

- The iterative process these developments have followed, and the development of a clearer vision over time;
- The complexities and context of discussions; and
- The ever present transfer of federal functions to the FNHA, which includes the funding and delivery of health services exclusively to First Nations living on-reserve, and the delivery of a limited number of other health benefits (dental care and prescription drug coverage, for example), to all First Nations living on- and off-reserve.

¹In Canada, the term "Aboriginal peoples" refers to First Nations, Inuit, and Métis peoples. The federal government continues to use the colonial term Indian in its policy documents, and distinguishes between Registered and non-Registered Indians. A Registered Indian is a First Nations person registered under the terms of Canada's federal Indian Act. Registration ensures the right to live on-reserve and have access to policy-defined benefits (subsidized medication, eye care, etc.). Non-Registered Indians are a provincial jurisdiction. Métis are not eligible for registration.

These differences in foci also reflect the impact of missing mechanisms and pathways for engaging First Nations living in urban centres, as well as other Aboriginal peoples, in priority setting and decision-making over services delivered to them.

It is not the first time BC has recognized an obligation to actively engage Aboriginal peoples to redress persisting health inequities. In 1991, BC released the report *Closer to Home: The Report of the British Columbia Royal Commission on Health care and Costs* (British Columbia Royal Commission on Health Care and Costs, 1991). Interestingly, recommendations from this policy initiative focused almost exclusively on Aboriginal peoples living off-reserve in urban centres. The TCA, with its focus on a transfer of substantial responsibilities previously assumed by the federal government to First Nation peoples, signals a new era of engagement. However, given the historical lack of self-government pathways for Métis, Inuit, and Aboriginal peoples living in urban environments, the developments in BC are ostensibly fulfilling aspirations of First Nations, while possibly side-stepping the broader discussion of how to engage First Nations and other Aboriginal peoples living off-reserve.

The purpose of this article is to critically explore how the lack of pathways for implementing self-government in urban environments is linked to how Canadian and provincial policies have conceptualized and operationalized the concept of self-government as guaranteed by Section 35 of the Canadian Constitution Act, 1982 (Canada, 1982). Specifically, it explores how Aboriginal health policy, as it applies to the organization of health care, has shifted in BC policy over time; the reasons why this shift is significant; and possible alternate policy options. We suggest that meaningfully engaging all BC Aboriginal peoples may be unrealistic, given the lack of self-government pathways. In forming our analysis, we contrast the BC policy framework with two other frameworks that are used heuristically as examples of alternative approaches to policy. The first draws on Ontario's Aboriginal health policy framework because it is recognized as one of the most comprehensive in Canada (Lavoie, Gervais, Toner, Bergeron, & Thomas, 2013). We explore the strength of this policy framework and compare it to features of the 2005 BC TCA. Secondly, we draw on New Zealand's Māori health policy context. Māori-state relations are characterized by a unique socio-political context that has set the stage for an entirely different approach to recognizing the Crown's obligation to engage with Māori people. It includes both those who are still connected to their own traditional territory and nation and those living in urban environments regardless of whether or not they retain linkages with their traditional territory and identify with a specific *iwi* (tribal political organisations).

Our aim in this article is to contribute to an evolving national dialogue on the implications of missing pathways for self-government in urban contexts. The analysis we present is informed by insights gained from a larger study that explored the policy contexts influencing the evolving roles of two long-standing Urban Aboriginal Health Centres (UAHCs) in British Columbia, Canada. The research participants, who included provincial health policy and UAHC decision makers, discussed the shifting policy contexts that have shaped the evolution of the UAHCs; however, they were not asked to comment on any aspect of self-government in particular, nor was this issue an explicit focus of the UAHC study. Rather, the points related to self-government discussed here reflect the views of the authors' own analysis. The authors, in partnership with the UAHCs, realized that the current policy debates in Canada could be informed by insights gained from the UAHC study. Further, the analysis of self-government pathways discussed here are equally informed by the authors' synthesis of theoretical and international literature; these pathways are explored as possible avenues to consider in light of the policy and funding contexts

shaping the two UAHCs. Finally, although we draw on BC as a case in point, the issues we discuss are of national and international significance.

The next section describes this study and the dataset that informs this article. This section is followed by an overview of Aboriginal health policy in BC, to orient the reader to important contextual features. There, we provide an analysis of the *Closer to Home* report and the TCA, including opportunities and on-going challenges. We then contrast the current BC policy framework with alternative options implemented in Ontario and New Zealand. We conclude with a discussion of the role of Aboriginal organizations in the implementation of a form of self-government in urban contexts.

Overview of the Research

This article is informed by a larger study that aimed to (a) explore *how* health care services at two UAHCs are organized to explicitly address the needs of Aboriginal and non-Aboriginal peoples experiencing systemic marginalization and racialization, and (b) develop primary health care “performance” indicators that adequately reflect the impact of such services on peoples’ health and well-being (Browne et al., 2012; Wong et al., 2011). Both health centres have an explicit mandate to provide increased access to primary health care (PHC) services in two urban centres, and to make their services as accessible as possible to both Aboriginal and non-Aboriginal clients living with multiple health and social challenges. Many of the patients who self-identify as Aboriginal have been affected by the legacy of colonialism (in particular, economic marginalization, systemic discrimination and racism, intergenerational traumas associated with residential schools and more recent forms of colonialism such as child apprehension by the state (Benoit, Carroll, & Chaudhry, 2003; Browne et al., 2011)).

The dataset that we draw on is based on: (a) a document-based in-depth analysis of the BC Health Authorities and BC provincial government’s policy initiatives (for example, British Columbia Ministry of Health, 2004; British Columbia Ministry of Health Planning, 2003) that led to the emergence of the two UAHCs, and how those policies frame and constrain opportunities for Aboriginal engagement in policy discussions and health service delivery; and (b) in-depth interviews with provincial health policy and UAHC decision makers ($N = 8$). Interviews focused on the shifting policy contexts shaping UAHCs, the historical and current contractual relationships between the UAHC and funders, and how these policy and funding contexts influenced PHC service delivery in the two urban settings. All data were audio recorded, transcribed verbatim, and anonymized.

A thematic content analysis of policy documents was conducted. Interview data were analyzed using approaches for qualitatively derived data (Denzin & Lincoln, 2011; Thorne, 2008). The process included repeatedly reading interview transcripts to identify recurring and contradictory patterns in the data. Qualitative data analysis software (NVivo, QSR International, 2010) was used to assist with organizing and coding the interview data. As analysis proceeded, coding categories were refined, and the analysis shifted from a textual level to a deeper conceptual analysis of themes related to the policy contexts influencing the UAHCs. Credibility of the thematic analysis was continually evaluated by the members of our research team, which included experts in qualitative research and policy analysis, and executive directors and senior staff from the UAHCs. Triangulation of policy analysis and interview data also contributed to the rigor and trustworthiness of the analysis (Thorne, 2008).

Background and Context: The Jurisdictional Divide in Aboriginal Health Policy in Canada

When it comes to Aboriginal health care, the Canadian jurisdictional policy map is best described as a patchwork (Lavoie et al., 2013). For reasons described as historical and humanitarian (Waldram, Herring, & Young, 2006), the federal government has assumed primary responsibility for a complement of PHC services provided to First Nations registered under the federal Indian Act and living on-reserve, and to Inuit living in their traditional territories in Québec and Labrador. In contrast, provincial and territorial governments are responsible for the delivery of a number of health services, as defined by the *Canada Health Act 1984* (Canada Health Act, 1985). As discussed in more depth below, Ontario is the only province to have adopted a fairly comprehensive policy framework to address the health care needs of all Aboriginal peoples (Ontario Ministry of Community and Social Services, 1994). Although other provinces have included provisions addressing Aboriginal health in legislation, policies, or strategies, most of these focus on jurisdiction for legal, financial, or other reasons (Lavoie et al., 2013) that nevertheless fail to clarify areas of jurisdiction for service delivery (Lavoie & Forget, 2006).

Most provinces have developed regional health boards or health authorities to improve citizen participation, set priorities regionally, coordinate provision, and integrate service health care delivery (Kouri, 2002). Regionalization has added yet another level of complexity and variation in the complement of services accessible to Aboriginal peoples. The relationship between diverse and numerous Aboriginal nations in Canada and provincial health authorities varies across the country. With the exception of Ontario, regionalized systems do not require Aboriginal representation and, where they engage with Aboriginal communities, such engagement is based on relationships rather than policies (Lavoie et al., 2013; Lavoie et al., 2005; Smith & Lavoie, 2008).

Section 35 of the 1982 Canadian Constitution recognizes Aboriginal peoples' inherent right to self-government. Trends in self-government have improved opportunities for Aboriginal participation in service delivery. Agreements between federal and/or provincial health ministries, departments, or health authorities and Aboriginal communities have multiplied (Lavoie et al., 2013). These opportunities however have been largely limited to First Nations, Inuit, and some Métis groups still living in their traditional territories. Self-government agreements have their own geographical boundaries that may or may not coincide with provincial health authorities' own boundaries. In BC in particular, First Nations' self-government discussions were limited until the 1997 landmark *Delgamuukw* decision (Culhane, 1998). As a result of this decision, self-government discussions centred on issues of land and natural resources in traditional territories are proceeding, albeit with prudence. BC is thus an anomaly in Canada because, unlike other Canadian jurisdictions, self-government discussions are relatively recent (McKee, 2009). As in other jurisdictions, discussions of self-government in urban environments are lacking.

Across Canada, Aboriginal-controlled organizations have emerged in urban settings to fill service gaps and advocacy needs. Friendship Centres (over 100 across Canada) emerged in the 1950s to help Aboriginal peoples adjust to urban life and to provide bridging of social and health services (Graham & Kinmond, 2008). Walker has noted that Friendship Centres, and arguably other urban Aboriginal organizations such as the two UAHCs discussed in this article, have contributed to the emergence and nurturing of "associational Aboriginal communities" (in contrast to nation-based communities), whose

cultural heterogeneity neither undermines the coherence of this community nor its legitimacy as an Aboriginal community engaged in some level of self-governance (Peters, 2011a). Urban citizenship results in “the articulation of local-right claims and their substantiation through engagement with the state and other sectors of society” (Walker, 2006, p. 2349).

As others have (Peters, 2011a), we argue that in urban centres associational Aboriginal communities provide an opportunity for a form of urban self-government that neither competes with nor undermines other forms of self-governments (e.g., on-reserve governance structures), but rather complements these by providing opportunities for Aboriginal peoples living in urban environments to have their interests represented. Walker (2013) argued for increased engagement through the co-production of “future seeking and place making” (ie planning and policy making, Walker, 2013, p. 151). We notice important discussions in the literature on how associational Aboriginal communities might be engaged as a mechanism to enact urban self-government. To date, these discussions have remained theoretical (Peters, 2011b; Peters & Andersen, 2013). Further, there remain considerable differences in the understanding of urban Aboriginal governance within Aboriginal and First Nation communities. Tensions exist as to who has governing authority over urban Aboriginal communities (e.g., the provincial health authorities, local First Nations, provincial First Nations governance structures, etc.). Many urban Aboriginal organizations have publicly stated that their mandate is limited to services delivery. Interestingly, the FNHA has adopted the same stance, leaving the FNHC to shoulder political responsibilities. In Canada, these issues remain under discussion and no salient solution has emerged.

As will be discussed below, New Zealand has acknowledged the role of urban Māori organizations as an expression of self-government (*tino rangatiratanga*), without competing with or undermining *iwi*. In contrast, Canadian associational Aboriginal communities have yet to be recognized as a legitimate platform to represent Aboriginal peoples in ways that complement on-reserve governance structures, despite earlier federal commitments (Abele & Graham, 2011). The next sections explore Aboriginal health policy developments in BC and how these developments have narrowly defined the role urban Aboriginal health organizations play in the context of self-government.

Past Policy Approaches and Impact on the Present: The Case of Urban Aboriginal Health Centres in BC

In BC, the overall Aboriginal population is estimated at slightly under 200,000 (4.8% of the total BC population). Just slightly more than half (56.3%) of Aboriginal peoples in BC are First Nations registered as “Indians” under the Indian Act (Statistics Canada, 2006b). Further, the majority of Aboriginal peoples in BC live in urban areas (59.7%); 26% live on reserve and 14.3% live in rural areas (Statistics Canada, 2006a).

Early 1990s: Policy Directions

Although the above figures provide an important backdrop to the policy analysis that follows, it fails to explain the shift in focus between the 1991 *Closer to Home* report and more recent discussions. The *Closer to Home* (1991) report was a comprehensive review of the health status of British Columbians and of health services in BC. The report included a series of recommendations, two of which are relevant to this article. First, the report recommended the decentralization of the BC health care system, to “shift a portion of the decision-making power away from Victoria [the provincial capital city], [by]

substituting several regional authorities for one centralized authority” (British Columbia Royal Commission on Health Care and Costs, 1991, p. B37).

As noted earlier, a whole section of the *Closer to Home* report was also devoted to the health of “Native” (now Aboriginal) peoples, stating,

Currently, the health needs of Native communities are determined by outside agencies, usually without Native input or control. If British Columbians are to address these serious health issues, governments must relinquish much of the control over how and what services are delivered, and real partnerships must be forged between health care providers and Native communities. Culturally appropriate programs which meet the needs of the community and are controlled by the community must be funded, designed and implemented. (British Columbia Royal Commission on Health Care and Costs, 1991, pp. C-27)

The Commissioners were cognizant of the on- and off-reserve divide and the associated jurisdictional challenges, and recommended that provincial authorities

- Work with Aboriginal communities and federal authorities to develop community mental health programs;
- Negotiate agreements to fund physician services on-reserve; and
- Ensure that “full health services” are available to all communities. (British Columbia Royal Commission on Health Care and Costs, 1991, pp. C-31-32)

The bulk of the recommendations were however clearly focused on addressing the lack of Aboriginal health programs off-reserve: “Half of the province’s Native population lives off reserves, but services to meet this population’s needs are only beginning to develop” (British Columbia Royal Commission on Health Care and Costs, 1991, p. C-29).

Recommendations included the development of an information system to measure health determinants and health status; the development of alcohol and drug programs for youth, women, and people who use IV drugs; greater Aboriginal involvement in policy and program planning as well as implementation; the creation of an Aboriginal Health Division within the Ministry of Health, with its own Assistant Deputy Minister; and the development of Aboriginal-controlled health services, including services to Aboriginal people living in urban areas (British Columbia Royal Commission on Health Care and Costs, 1991, pp. C-28). One tangible outcome of these recommendations was the establishment of four urban Aboriginal health centres, two of which remain in existence today as established PHC centres. The 1991 report did not address how these PHC centres would relate to (a) the emerging regional health authorities, whose governance structures reflect dominant societal conceptualizations of health care priorities and strategies for operationalization, or (b) the growing urban Aboriginal population. Neither did it define the health service gaps these UAHCs were intended to address, nor how these UAHCs might articulate their services with other health service providers. Section 35 of the Constitution (Canada, 1982), the section that guarantees the right to self-government for Aboriginal peoples, was not mentioned. These initiatives were thus positioned outside Section 35, and therefore not framed as expression of self-

government but rather as Aboriginal non-government organizations tasked to deliver contractually defined health services.

Policy Directions in the New Millennium

The responsibility for Aboriginal health services delivered off-reserve was transferred from provincial coffers to BC's health authorities (HAs) in 2001 along with two directives: that existing contracts with UAHCs be maintained for a period of three years, and that the Aboriginal health budget transferred from the provincial government remain dedicated to Aboriginal health, rather than absorbed into provincial revenues (Government Decision-Maker Interview 35). HAs have since been given considerable autonomy in identifying strategies to address Aboriginal-specific health care needs, including ways of addressing urban population health priorities.

Since 2001, government policy documents (for examples, British Columbia Ministry of Health Services & Ministry of Children and Family Development, 2010; Woermke, 2011) have mentioned that there is a role for non-government organizations (NGOs) in addressing the health care needs of urban Aboriginal peoples. These same documents however fail to define or provide direction about the role of NGOs, articulate how the NGO sector should be supported, or identify the gaps in the health care system that the NGO sector is expected to address.

Individual NGOs have carved their own mandate, based on community input, needs, available funding, and activism. Our research clearly shows that the two UAHCs in BC play multiple roles: first, they are service delivery organizations that play an advocacy role in relation to the health needs of Aboriginal peoples in urban areas who are most impacted by social and systemic inequities (Browne et al., 2012; Wong et al., 2011). UAHCs advocate for better services both at the individual patient and at the system level. As this decision-maker describes:

Certainly the people who came together to form this Society understood . . . why people might not be accessing the health care system so they wrote a constitution which I think was very visionary . . . because I really think that they, they understood what might need to happen to do something really proactive around Aboriginal health. One was the opening of the health centre where Aboriginal people could come and feel safe and respected and honoured and it was really friendly to them and secondly was what needs to happen in our community to really make a difference so it was about not just looking at what happens within these four walls but how can the Society engage with the rest of the community in really making a difference. (UAHC Decision-Maker Interview 33)

Second, the UAHCs also provide community leadership that is politicized, yet whose political agenda is not linked to institutional development, or to formal political processes. For example, the two UAHCs are routinely engaged in consultations over the implementation of new initiatives such as the Off-Reserve Aboriginal Action Plan, which is focused on improving socio-economic outcomes for Aboriginal peoples living off-reserve (British Columbia Association of Friendship Centres, 2013). As noted before and in contrast to the reserve system, urban Aboriginal communities tend to lack a policy- or legislation-defined system of governance. This can pose challenges to creating organizational cohesion. Urban Aboriginal NGOs such as the UAHCs thus often provide a leadership role that may help achieving

community cohesion and advance an agenda addressing urban Aboriginal peoples' health in the absence of a common urban Aboriginal system of governance.

Let's not think of who owns what within the community, let's think along the lines that this belongs to every community member . . . It belongs to the god damn community, you know. And you know, it's been really really hard getting that across to people because of the way people have been, sort of conditioned to think, you know. (UAHC Decision-Maker Interview 25)

Findings from our study demonstrate that the UAHCs provide one model of what Walker (2006) calls "associational Aboriginal communities":

We have a totally different set-up in that we don't have any kind of boundaries, no definable boundaries . . . I don't think we've sat there and say kind of begun to talk amongst ourselves about, "given that we're not like a reserve," and yet we have all of the conditions of reserves in many cases. How are we going to make some decisions in a unified way, to bring about better conditions now? So that more of our kids go to school and graduate and become productive and so on and so forth. How are we going to house people in such a way that they can have those children go to school? And just so, it's not about self-government as much as it's about, how do we all cooperate amongst ourselves? And that's what I see, the whole thing about self-determination, I think if we can reach certain kinds of understandings amongst ourselves, we won't need to say, "Well we're self-governing," you know. (UAHC Decision-Maker Interview 25)

And I think we've made decisions about whether or not we're trying to be conscious about is this a community enterprise where we're going to be present and contribute or do we need to be present and be a leader? So it's about stepping up to the plate too often and saying, we should chair that. We have the ability, it's central enough to our concerns and what we should be doing in the community, that we should be playing a leadership role. And because we can. (UAHC Decision-Maker Interview 33b)

Solidifying UAHCs' role in representing urban Aboriginal peoples' interests to governments requires building relationships with governmental and non-governmental agencies, including funding agencies. Over time, and depending on shifting policy priorities, leadership style and context, funders' relationship with the UAHC may shift back and forth on a continuum characterized at one end as a flexible and responsive, partnership-based relationship, to the more limited role of an organization competing for contracts and delivering contractually-defined services at the other end. Opportunities for the UAHCs to engage with high-level decision-makers, or to have input into important debates, depends on and is defined by their relationship with the HA.

I think most of the time it's a comfortable relationship. I probably wouldn't be honest to say there's never any . . . tension or conflict there, that wouldn't be true. But I think for the most part, again as I say, we do have contracts, we do have schedule A's that spell out what we're providing money for and what our expectations are. If a contractor can't live with that, then we won't be giving them a contract or we'll be withdrawing that contract. And of course, all of our contracts have clauses for either party to get out of the contract if it's not working for either party. So I mean it's a business relationship. (Government Decision-Maker Interview 34)

Having NGO's being advocates is a challenge for them in terms of, should we fund it, what level of advocacy should we accept from an NGO that we're funding, when does it become a conflict of interest? (Government Decision-Maker Interview 35)

We're caring for the same people at one end of the spectrum or the other right? And if people aren't receiving good primary care they're ending up in acute care or ambulatory care with all the wrong reasons, for all the wrong reasons. And so in our primary care model of integrative accessible health services and strengthening those services at the community level it makes sense for us to work with not just [the HA] but NGOs as well and different, finding different ways to do that. And I don't think we draw enough on those supportive partnerships. (Government Decision-Maker Interview 36)

To date, as is the case for the FNHA, urban Aboriginal organizations (including the UAHCs discussed in this article) have framed their role as service delivery organizations that can advocate for the population they served, without representing them politically (Interviews 25, 33, 37).

Refocusing of Priorities: The New Transformative Change Accord

In November of 2005, the province of British Columbia, the First Nations Leadership Council, and the Government of Canada signed the landmark *Transformative Change Accord*. The TCA marks a major shift in health policy and politics in Canada, and is guided by three broad objectives: (a) close the gaps between First Nations and other British Columbians in the areas of education, health, housing and economic opportunities over the next 10 years; (b) reconcile Aboriginal rights and title with those of the Crown; and (c) establish a new relationship based on mutual respect and recognition (Canada, 2005; Kelly, 2011). This last objective echoes the Constitutional commitment to respect Aboriginal peoples' right to self-government. To close the gap in health inequities that exist between Aboriginal populations and their BC counterparts, the TCA proposes to prioritize investments in mental health and youth suicide prevention programs, chronic disease prevention, pilot projects integrating acute care and community health services for First Nations, the training of First Nations health care professionals, and telehealth. The TCA also commits to improving cross-jurisdictional coordination and to improving participation in planning and decision-making. By focusing on education, housing, workforce development and other areas, in addition to health care, the TCA offers concrete steps to address and redress a number of important inequities, including the creation of a FNHA mandated to manage and deliver services previously under the authority of the federal government (First Nations Health Council, Government of Canada, & Government of British Columbia, 2010).

The Tripartite Framework Agreement In-Principle (Her Majesty the Queen in Right of Canada, 2010), which operationalizes the Tripartite agreement in regards to health services, focuses on the transfer of services previously provided by the First Nations and Inuit Health Branch of Health Canada (FNIHB)² to "First Nations and their mandated health organizations [MHOs]" (The First Nations Leadership Council et al., 2007, p. 3). A MHO is defined as

² First Nations and Inuit Health Branch (FNIHB) of Health Canada supports the delivery of public health and health promotion services on-reserve and in Inuit communities, and the provision of primary care services in remote and isolated areas, where there are no provincial services readily available (Health Canada, 2013).

A health organization or agency with a defined mandate that is created and ratified through Band Council Resolutions or a motion passed at a duly convened meeting of representatives of the Chiefs and Councils and authorized for that purpose. Usually, but not always, such a mandated organization or agency will be legally incorporated. (The First Nations Leadership Council et al., 2007)

This transfer occurred on October 1, 2013. The language used in the First Nations Health Plan suggests that, at this point, only First Nations recognized by the federal government through the registry and those nations who have MHOs are included in the new policy framework. MHOs refer specifically to health organizations that operate on-reserve, or in a few cases off-reserve, under the leadership of a First Nation community, a consortium of communities, or a tribal council. Although some may access funding from their health authority, the main source of funding for these organizations was FNIHB and is now the FNHA. By definition, Métis, Inuit, First Nations peoples who are not registered under the Indian Act and those who are not formally affiliated with a specific First Nation, however, cannot be represented by MHOs (90,000 Aboriginal peoples in BC).

The implicit features of these policy documents position First Nations and their MHOs as self-government mechanisms within a federal-provincial-First Nations decision-making process. For example, First Nations are provided the opportunity to sign agreements with Canada and BC “as nations.” Other Aboriginal groups (e.g., non-registered First Nations, Métis), including the diverse groups residing in urban centres, do not have access to a similar mechanism or pathway to participate in decision-making. Unmet needs and missing alternative pathways can put pressure on urban Aboriginal organizations to speak on behalf of the population they serve, without having an explicit mandate to do so. We argue that this issue reflects the broader context of self-government discussions in Canada.

Extending Opportunities for Expression of Self-Government

Canada, and therefore BC, has yet to adopt a policy framework that gives shape to Section 35 of the Constitution, which promises the right to self-government to all Aboriginal peoples. While mechanisms for self-government have been extended to First Nations, and some Métis and Inuit who remain connected to their traditional territories, pathways for Aboriginal peoples who do not have a specific nation affiliation remain undefined.

Operationalizing Section 35 for those who no longer are affiliated to a specific First Nation, or living outside of their traditional territory (primarily in urban areas), is complex. Ontario and New Zealand have both attempted to tackle this issue in different ways. Examples from Ontario and New Zealand provide interesting counterpoints to the BC context. Ontario was the first province to have developed an Aboriginal Healing and Wellness Strategy (AHWS) in 1990, and to have developed an overarching Aboriginal Health Policy in 1994 (Ontario Aboriginal Health Advocacy Health Initiative, 1999). The strategy led to the creation of 10 Aboriginal health access centres, six healing lodges, seven family shelters, two family violence healing programs, two outpatient hostels, and crisis intervention teams in 47 northern communities (Ontario Ministry of Community and Social Services, 2011). The AHWS is the most comprehensive policy framework currently in place in Canada (Lavoie et al., 2013), and may serve as a model for other provinces including BC.

Until recently, the implementation of the AHWS was directed by a Joint Management Committee (JMC) with representation from key Aboriginal political bodies, including Métis, First Nations, and provincial non-Aboriginal ministries and departments. Collectively, these organizations represented the interests of urban, rural, and remote First Nations, Métis, and Inuit. This high-level oversight committee may have resulted in too much standardization:

The [AHWS] has standardized and streamlined its processes to effectively manage a diverse group of programs province-wide. But in doing so, it may have curtailed some of the local autonomy that is the fundamental strength of the community-based programs it supports. (Minore & Katt, 2007)

In 2010, Ontario renewed its commitment to the AHWS, but noted that the JMC was expected to wind down its operations (Meilleur, 2010). This shift may be associated with the creations of Local Health Integration Networks (LHIN) in 2007, tasked with regional health priority setting and resource allocation. Each LHIN is expected to be advised by an Aboriginal Health Council, thereby increasing flexibility and responsiveness to regional priorities (Ontario Public Appointment Secretariat, 2007). This level of urban Aboriginal engagement, which is entrenched in policy, is unprecedented in Canada (Lavoie et al., 2013) and offers some guarantees of representation for all Aboriginal peoples living in Ontario.

New Zealand has tackled the issue of representation in the context of the implementation of their 2001 health policy, *He Korowai Oranga* (New Zealand Ministry of Health, 2002). The policy reiterated the 1988 commitment that all policies in New Zealand should reflect the principles of the 1840 Treaty of Waitangi:

- Partnership: working together with *iwi* (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).

The principle of partnership has led the District Health Boards (DHBs) to enter into formal agreements with two very distinct Māori populations: *Manawhenua* and *Mataawaka*. Manawhenua includes local *iwi* (nations) whose traditional territory coincides with the territory covered by the DHB. Mataawaka groups are predominantly found in large urban settings. Manawhenua and Mataawaka are not necessarily mutually exclusive since some Mataawaka are cognizant of their *whakapapa* (lineage) and of their tribal affiliation(s).

Implementation efforts have resulted in a multiplicity of governance arrangements between DHBs and local Manawhenua and Mataawaka Māori groups. In some cases, the policy led to the creation of new Mataawaka groups to fulfill the need for a consultative or advisory body for the DHB Board (Pere,

Boulton, Smiler, Walker, & Kingi, 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.

Conclusions

New Zealand and Ontario have developed mechanisms to engage both nation or tribal and associational Aboriginal communities in self-government discussions. In Ontario, policy options have formalized the relationship between Aboriginal peoples and regional planning processes. In New Zealand, policies have gone further and created obligations to ensure representation. This is not the case in BC, where the focus of Aboriginal health policy shifted: by first focusing on the health of Aboriginal peoples living off-reserve, and then shifting focus to the development of a tripartite discussion which to date has been focused on the transfer of FNIHB to the FNHA and the engagement of First Nation communities. The reasons for this shift are pragmatic: addressing pressing inequalities the early 1990s, and in 2005, creating a more coherent health care system in BC by creating partnerships between the federal government, HAs and First Nations. But this shift is also highlighting a policy weakness in the conceptualization of self-government which limits the political space some First Nations, Métis, and Inuit have in the BC and the Canadian political landscapes. BC is the last jurisdiction in Canada to enter into self-government discussions with First Nations living on-reserve, and is now doing so as the result of a Supreme Court ruling that impacts title to land and resources for First Nations only. This exclusionary shift is unlikely purposeful, but rather reflects the Canadian national conceptualization of self-government. The current federal jurisdictional structure necessitates that the current focus on transferring FNIHB obligations to the FNHA requires the engagement of First Nations communities. Future plans related to closing the health equity gap will however require the engagement of all Aboriginal peoples and clear pathways are missing.

We note that Canada and the provinces have yet to explore, define, and act on obligations entrenched in the Canadian Constitution for those Aboriginal peoples no longer affiliated with a First Nation or other Aboriginal nation, and/or living outside of their traditional territory such as urban environments. New Zealand has tackled this obligation to Manawhenua and Mataawaka with pragmatic solutions. Canadian policy debates have yet to extend the same opportunities. As a result, those affiliated to their nations are being extended self-government or self-determination opportunities. In contrast, those who do not connect with a specific nation or with their traditional territory depend on the NGO sector to extend services and advocacy. As described by this research participant:

That to me is what self-determination really is all about, you know. It's not about us proclaiming ourselves as some sort of sovereign group of people, it's saying, "We have in place agreements that we ourselves have reached amongst ourselves." (UAHC Decision-Maker Interview 25)

In BC, UAHCs are located at the heart of associational Aboriginal communities and might become mechanisms of urban citizenship, which centres on an active civil society that develops a capacity to engage the state as a partner in its locally driven citizenship agenda. The organizations with which we engaged did not see this as part of their role. We suggest that associational Aboriginal communities could offer an opportunity to engage Aboriginal peoples in a form of self-governance that complements other forms such as the role of First Nations governments. Realizing this potential, or generating options

more suitable to urban Aboriginal organizations, requires national discussions supported by resources and an adequate timeframe. In BC, expecting these discussions to take place as a “side project” of the FNHA is unlikely to yield to the outcome sought and could possibly undermine the work of the FNHA.

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