

Canada's Designs for Aboriginal Participation

The forum opened with a sweet grass ceremony. An elder led a prayer on behalf of First Nations, Inuit, Metis and Urban Aboriginal Peoples. A small plume of smoke wafted above the conference hall as she walked between the neatly arranged rows of tables and chairs to say a blessing for the event.

This day was especially reserved for the Aboriginal perspective in Canada's largest-ever public consultation on how to reform its health system. In the year and a half it existed, the Romanow Commission facilitated 26 public hearings, hosted twelve one-day Citizens' Dialogues, published forty expert accounts and convened nine expert panels, among many other activities. The consultation cost nearly Can\$20 million.

Including Aboriginal voices in this nationwide deliberation, however, proved more challenging than anticipated, so the Romanow Commission took extraordinary measures, which included this forum.

Seated behind a table on a small stage, Commission Chairman Roy Romanow faced the crowd of more than 100 Aboriginal leaders: religious figures, nurses, teachers and other community representatives. With television cameras rolling, the participants took the short walk into the spotlight of the podium and had their say.

A study supported by the Development Research Centre on Citizenship, Participation and Accountability looked at the role of Aboriginal people in the deliberative aspects of the Romanow Commission, established in April 2001 by the Canadian government to deliberate with citizens on the future of healthcare in Canada. While some Aboriginal people participated in the dialogues, the outcomes did not fully reflect Aboriginal health issues. The difficulties of engaging and empowering members of marginalised groups within official government-led meetings are widely documented. How can we improve the design of participatory institutions so that they can cope with the complex politics of representation and inclusion? This case study explores the value of separate participatory spaces for severely marginalised groups

like Aboriginal people, some of the costs of this separated participation, and new ways of thinking about including the marginalised in large scale deliberations.

The colonial legacy

In Canada, the complex legacies of colonisation have left Aboriginal people – *First Nations, Metis and Inuit* – at the bottom in a range of indicators such as well-being, economic status, education, housing quality and health outcomes. Complicating matters, many Aboriginal people claim self-government rights, often based in centuries-old treaties. There are conflicting views of what political units are involved on the territory called 'Canada' and whether Aboriginal people are properly subject to the rule of the Canadian state.

The Romanow Commission's mandate was to review Canada's healthcare system, engaging Canadians in a national dialogue on its future and making recommendations to enhance the system's quality and sustainability. Extensive consultations took place with forty expert reports, nine expert panels, partnerships with broadcasters, universities, business and advocacy groups and the health policy community. The Commission, with a staff of 47 people, tried to find out Canadians' views through Citizen's Dialogues. It sought to go beyond conventional forms of citizen input to one where citizens were encouraged to move from their preconceived understandings and interests to positions informed by careful exchanges of perspectives and reasons. This was real deliberation: engaging citizens and stakeholders in ways that challenged their understandings, confronting them with the sorts of trade-offs called for in health policy. But serious issues of engaging marginalised groups such as Aboriginal people were overlooked.

Inclusion Errors

The Romanow Commission engaged with Aboriginal people's health and inclusion in complex and

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contradictory ways. The Commission used a 'ChoiceWorks' methodology based on the principle that participants are individuals and speak for themselves and not as representatives of special interests. Though the process did include Aboriginal people, it did not focus on questions of Aboriginal health or build in devices to allow Aboriginal participants to overcome the dynamics of marginalisation. The final report devoted a chapter to questions of Aboriginal health based on careful consultation with Aboriginal people. But the explicitly deliberative elements of the Commission's work were with statistically representative groups of 'unaffiliated citizens'.

The consultation process was considered a success overall with the final report of the Commission clarifying Canadian values around healthcare, including demands for transparency and accountability and entrenching an active role for citizens in healthcare policy making. Yet when considering the inclusion of the perspectives of marginalised groups, particularly Aboriginal people, success is questionable. Some Aboriginal people were included in the dialogues, but neither their design nor their outcomes include even a whisper about Aboriginal health issues. Though Aboriginal people did participate in all sessions, organisers were disappointed in the degree to which the dialogue was able to engage them. Aboriginal people often did not turn up to sessions once recruited, and were typically were very quiet in the dialogue sessions. Two localised ad hoc attempts to hear more Aboriginal voices – though creating a small separate group and recruiting additional Aboriginal people to sessions – had little effect. These experiences point to the difficulty of engaging and empowering members of marginalised groups within invited deliberative spaces and to the limitations of piecemeal innovations in surmounting these difficulties.

This was a failure to overtly engage with the complex politics of representation. Who needs to be at the table and in what numbers? Who is typically marginalised in political dialogues? How do dynamics of exclusion and marginalisation get managed within

the process? Serious engagement with these politics of representation would have required changes in the structure of the deliberation. Giving Aboriginal people a more influential voice would have required changes to the basic structure of the dialogue, thus challenging the individualistic premises of the method.

Critical design choices

The study suggests that the successes and shortcomings of the Romanow Commission in including Aboriginal people are tied to three key features of deliberative design. These design choices are critical in enabling marginalised groups to negotiate the complex politics of recognition and representation.

1) The extent to which the process is reflexive: how far the participants are allowed to define the terms in which they participate, the issues they address and the form the deliberation takes. If there had been greater reflexivity in the Citizens Dialogues, Aboriginal participants would have been able to deliberate together about the terms of their conversation.

2) The extent to which public involvement is iterative: participants being involved from the start. *Iterative* refers to how much deliberation is treated as ongoing. The Citizen's Dialogues were single, bounded, eight-hour events, which were non-iterative. Elites decided the structure of the dialogue and how to assimilate outcomes into the commission's reports.

3) The existence of separate spaces: in which members of marginalised groups can reflect on dynamics of power and exclusion and negotiate questions of common agendas, strategies and identities. Separate spaces were not created for marginalised groups yet they allow for culturally specific modes of communication and self-representation; and provide room for the internal complexities of perspectives to be dealt with democratically and deliberatively. They may also allow for a greater reflexivity on how issues are framed.