First Nation/State Relationships and First Nation Health: An Exploratory Analysis of Linkage Social Capital as a Determinant of Health

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Introduction

This research is an exploratory analysis of relationships developed between First Nations and the Canadian governments and First Nation health status. Health transfer, the British Columbia Treaty Commission (BCTC) and First Nation organizations and services identified in the *Guide to First Nation Organizations and Services* (2002) are utilized as indicators of First Nation relationships with the Canadian governments. This study incorporates a holistic concept of health with the methods and theory used in population health. The research adds to the current dialogue in First Nation health by directly addressing the interactions between First Nation communities, services and organizations and the state.[1] Current dialogues on First Nation/state relationships are based in legal discourse, exploring the constitutionality and precedence of First Nation rights and title. Current discussions on relationships developing resources are limited to individual interactions within and between communities (Mignone 2003). This research project is not meant to imply that it is necessary to have a relationship with the state to improve well-being of the First Nation population. But, in cases where it is unavoidable, evaluating relationships and First Nation health status together may explain variations in health status between different First Nation populations. First Nation populations strive to increase their active engagement in determining their own social systems as a matter of self-determination/self-governance. Populations with active engagement in their social setting have better health than those with little or no involvement (Wilkinson 1996, Kawachi et al. 1997). Since active engagement extends beyond individual interactions, it must include the groups we belong to. We must compare relationships that First Nation groups participate in with their health status to understand the influence of active engagement. Further case study investigations will provide a guide for best practices or culturally appropriate relationships between First Nations and the Canadian governments.

This paper's focus is on health status variations between First Nations, and current explanations for these variations. It suggests that the relationships developed in health transfer — the BCTC and First Nation communities, groups, services, and organizations and the state — may account for variations in health status between First Nations within different health regions of British Columbia. It is assumed that these relationships increase First Nation participation in the development and maintenance of social services. Health

1 The state includes the federal and provincial governments and their representatives.

transfer and the BCTC process are relationships/interactions between First Nations and Canadian governments that are meant to increase First Nation control, authority, and active involvement in their communities.

Setting the Stage: Colonialism Defined

First Nations' relationships with the Canadian government have influenced their health (Kelm 1998, Lux 2001). These relationships, primarily characterized by colonial governance, led to epidemics of infectious diseases, removal of First Nation governing systems, and degradation of First Nation social systems, including health care. As described by Kelm (1998: xviii, italics added), colonialism is

> … geographical incursion, *socio-cultural dislocation, the establishment of external political control,* and economic dispossession, *the provision of low level social services*, and finally, the creation of ideological formulations around race and skin colour, which position the colonizers at a higher evolutionary level than the colonized.

Of particular interest in this study concerning the removal of colonial structures is the establishment of external political control, socio-cultural dislocation, and the provision of low level social services. Modern relationships between First Nations and the Canadian governments continue to affect their health but are not included as a social determinant in First Nation health discourse. Developing indicators of social relationships to be included within First Nation health analysis requires an investigation of contemporary relationships and an understanding of First Nation sovereignty issues. Incorporating this knowledge with theories on social capital in health analysis will provide a method to identify indicators of relationships that contribute to the health of the First Nation populations. The resulting analysis will identify First Nation communities, organizations, and services with the ability to meet their constituents' needs and goals through positive relationships with the Canadian government and demonstrate how increased equity in civil society participation improves health. This analysis may also explain variations in health status between First Nation groups and the general population of Canada.

> The wellness of our people, including their social, economic, and spiritual well-being, crosses the separate terms [of reference of the Royal Commission]. Wellness is a community issue, a national issue, a women's issue. It touches youth concerns, family considerations, even self-governance and historical concerns.

> Tom Iron, 4th Vice-Chief, Federation of Saskatchewan Indian Nations, Saskatchewan, 26 May, 1992 (*Report of the Royal Commission on First Nation Peoples* 1996).

This quote by Tom Iron alludes to a concept of health that is intimately related to the relationships people participate in. This concept of health resonates amongst many First Nation populations throughout Canada, and must be realized throughout research, policy, and delivery of social services.

Measuring Well-Being

First Nation health status varies among First Nation populations; variations exist between First Nations, on or off reserve; Status or non-Status Indians; Inuit; and Métis, and between the total First Nation population and the general population of Canada. These variations are reported in mortality and morbidity statistics collected by various Canadian governing agencies and First Nation organizations. For example, in 1991 First Nations, as a single population, lived 7.3 years less as males and 5.9 years less as females than the general population (*Report of the Royal Commission on First Nation Peoples* 1996).

Morbidity statistics also report variations within and between the First Nation populations and the general population of Canada. Generally speaking, First Nations experience more illness than their general population peers and some diseases are more prevalent amongst specific First Nation groups (First Nation, Inuit, or Métis).

Explaining Variations in Health

Variations in health status are commonly distributed across social characteristics. For instance, high levels of education, individual income, employment and labour force participation are positively correlated to improved health status (Berkman and Kawachi 2000). This general correlation holds true with variations in health status within and between the First Nation populations and the general population. First Nations as a single population have lower educational attainment, individual income, employment, and labour force participation (RRCAP 1996).

First Nation groups within the British Columbia health regions, as reported by the British Columbia Provincial Health Officer (2002) do not conform to this positive correlation (Figure 1). Utilizing seven indicators of socioeconomic status (SES) the British Columbia Provincial Health Officer (2002)

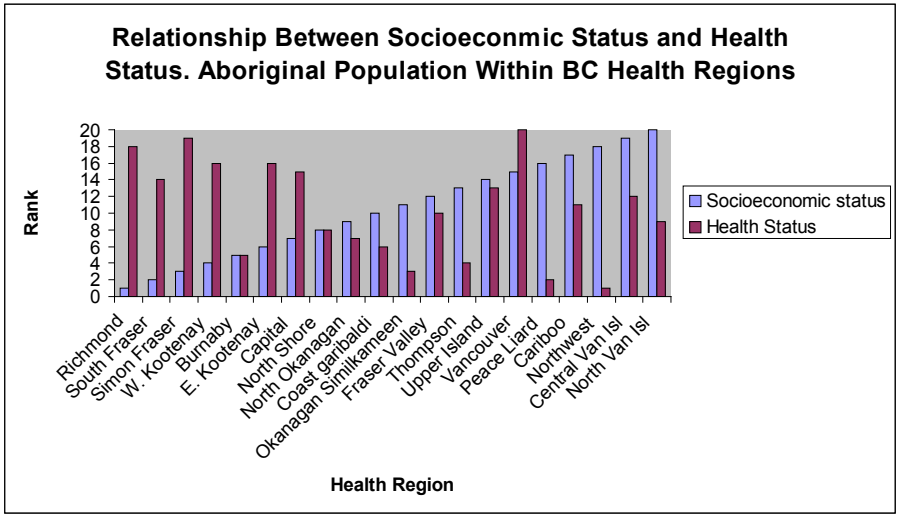


Figure 1. First Nation health status rank and SES rank by British Columbia health regions.

reported that health regions with the highest SES indicators also reported the poorest health status while First Nations in health regions with the lowest socioeconomic status had the highest health status. The socioeconomic status indicators include employment, income, and educational attainment. The health indicators included are infant mortality, life expectancy of men and women, potential years of life lost.

The indicators utilized to measure socioeconomic status amongst the First Nation population in British Columbia, as a single index, do not conform to the volumes of research demonstrating a positive correlation with health status. The *British Columbia First Nations Regional Health Survey* (2000) also reports a lack of positive correlation between socioeconomic status and health status indicators. The authors of this report suggest that this discrepancy is a result of poor indicators that do not accurately reflect the social context that promotes health in these regions (First Nations Chiefs' Health Committee 2000). For instance, First Nations in the northern interior health regions may require an education that meets a natural resource based economy, occupations that may not necessitate a grade 12 or higher education. And, incomes may be less because they are supplemented by traditional forms of resource acquisition. Another source for variations in health between First Nations in different health regions may be the differences in the social relationships that

these First Nation populations participate with the state.

First Nation/State Social Relationships

Social relationships that result in the development of social services (education, health care, justice, etcetera) are considered social capital. These relationships extend throughout society, occurring between individuals, groups, and the state. Relationships between groups and the state are considered linkage social capital because they extend beyond the community the group is directly involved with in the production of social services. The relationships described by linkage social capital are commonly conceptualized as hierarchical or vertical in nature. Relationships within and between communities are considered bonding and bridging social capital, respectively and are considered to be horizontal in nature.

Social Capital Theory

Social capital has become very prevalent in academic, policy, and government discussions. As with any popular theory, there are several concepts reflecting different standpoints. Each standpoint incorporates three main elements: interaction; inclusiveness; and the production of a shared good, service, or commodity. Whether people interact formally or informally, through institutions or as acquaintances; how many people interact; representatives; level of involvement; and how the resulting good, social service, institution, or commodity, is shared, acquired, or utilized differs for each concept. Some concepts of social capital have been refined to a "definitive" level and adopted by international and national organizations; this does not mean that they reflect how the elements of social capital are realized within colonial relationships between First Nations and the Canadian governments. In the hope of continuing the debate on the theoretical aspects of social capital I have co-opted several theories into a hybrid theory of social capital to describe First Nation and Canadian state relationships. This theory incorporates the three main elements but does not presuppose how each influences the other or what qualities are required to develop or maintain these elements. How these elements are realized in First Nation/state relationships varies in each relationship. Incorporating the three main elements of social capital theory with indigenous theory on state relationships, sovereignty, self-governance, and self-determination informs a thematic analysis of policy documents describing relationships between First Nations and the Canadian state.

Linkage social capital may affect population health by increasing acces-

sibility to health services, through leveraging resources, developing a common understanding (needs and goals) and by developing responsive policies (Veenstra 2002). The ability of a group to develop linkage social capital is also implicated in the maintenance of cultural continuity. Cultural continuity is the realization of a population's culture within a social service. Chandler and Lalonde (1998) have demonstrated the importance of cultural continuity in reducing suicidal ideation amongst First Nation youth. They found that First Nation communities with governing and social systems that were under First Nation control had less suicide amongst their youth. Chandler and Lalonde (1998) do not utilize social capital as a theoretical framework and do not theoretically address how cultural continuity is realized in social services. Mignone and O'Neil (2005) have proposed mechanisms that link First Nation youth suicide and social capital partially derived from the research of Chandler and Lalonde (1998).

Bonding and bridging social capital have also been implicated in the maintenance and production of population health. The majority of this research is individually focused, describing relationships between individuals and the society at large. They describe how membership in groups, unions, and professional associations as well as trusting others, reciprocating, and maintaining norms of behaviour improves health (Berkman and Kawachi 2000, Kawachi et al. 1997, Kawachi et al. 1999).

Recognizing First Nations

Linkage social capital, with its focus on the state and First Nation relationships, implicates the entire First Nation population as noted by the Canadian Charter of Rights and Freedoms (1985).

> Canadian Charter of Rights and Freedoms, section 35:
> (2) In this Act, *"aboriginal peoples of Canada" includes the Indian, Inuit and Métis peoples of Canada.*
> Indian Act (R.S. 1985, c. I-5)
> **4.** (1) *A reference in this Act to an Indian does not include any person of the race of aborigines commonly referred to as Inuit.*

But how these diverse populations are implicated in this general statement is realized in other documents that set the stage for relationships resulting in social services. For instance, health transfer relationships are developed between the Canadian government and First Nations south of the 60th parallel who have managerial experience and who wish to assume control over health resources within their community (First Nations and Inuit Health

Branch 1999). So, every First Nation group that is included in the Canadian Charter of Rights and Freedoms is not included in every relationship with the state that produces a social service. And, some relationships, such as those developed with the British Columbia Treaty Commission (BCTC), are broader in scope as they produce multiple social services within one comprehensive relationship with specific First Nation groups (BCTC 2004).

First Nations who do not fit neatly into an established relationship with the Canadian government who wish to influence social service development may need to develop relationships with municipal or provincial governments. Recognizing the need to incorporate these populations into social service production the British Columbia government publishes the *Guide to Aboriginal Organizations and Services.* This document is intended to identify First Nations with whom the provincial government may develop relationships, in order to produce a social service accessed by the First Nation population (British Columbia, Personal communication 2003).

Developing Indicators of Relationships

Health transfer was developed primarily by the federal government with minimal consultation with First Nations. The process of health transfer is meant to increase capacity amongst First Nations in order to deliver mandatory programs and permit First Nations to determine their own program delivery and development. This, in turn, increases the level of First Nations inclusion in social service development and delivery.

The federal government has determined what information will be shared and what knowledge must be transferred for accountability, program implementation, and evaluation. The resulting social services include seven mandatory programs. The federal government primarily determines when a First Nation is able to develop community based programs.

The BCTC is a comprehensive program that allows a First Nation to bring anything to the table for negotiations. Treaty talks result in a variety of programs administered by the First Nation and increases their inclusion in social services development substantially.

Results

After identifying the common themes in social capital theories and indigenous theories on self-government, self-determination, and sovereignty a thematic analysis was applied to documents describing relationships between

First Nations and the Canadian state. This analysis identified three indicators of relationships, including the number of communities in health transfer, the British Columbia Treaty Commission process, and the number of First Nation organizations and services in *Guide to Aboriginal Organizations and Services* (2002). In order to identify the role of linkage social capital as a determinant of First Nation health and to suggest an explanation of variations in health status among health regions of British Columbia, linkage social capital indicators were correlated to First Nation health indicators and health region ranking in a graphical interpretation based on exploratory data analysis.

Depending on each relationship, different First Nation populations are included or excluded. For instance, health transfer primarily targets on-reserve populations, while the BCTC process is more likely to include off-reserve populations. *The Guide to Aboriginal Organizations and Services* listings include non-status and off-reserve populations.

There are several gaps in the available data for a complete analysis of how many First Nations are included in these relationships. Health data is not discrete enough to identify populations that are directly affected by or involved in these relationships. For these reasons, the research utilizes exploratory data analysis to identify trends and correlations.

The Vancouver health region has the largest off-reserve population of all health regions and only one First Nation community, which also participates in health transfer programs and is negotiating within the British Columbia Treaty Commission process. The on-reserve population in the Vancouver health region is the second smallest of all health regions in British Columbia. This means that the number of First Nations people able to participate in health transfer and the British Columbia Treaty Commission process in

Table 1. Vancouver health region off reserve population, health and SES rank[1, 2] and linkage social capital indicators.

Health region	Vancouver
Off reserve population	11,140
Number of communities	1
Number of communities in health transfer	1
Number of communities in BCTC process	1
Number of First Nation organizations and services	82
Health rank	20
SES rank	15

1. Source: British Columbia Ministry of Health Services, Vital Statistics Agency. British Columbia Provincial Health Officers Report, 2002
2. Rank 20 is the lowest health and SES status of all health regions while rank 1 is the highest health and SES status.

the Vancouver health region is minuscule considering the number of First Nations people living off reserve. The Vancouver health region also has the lowest health rank of all health regions, leaving to question the efficiency of 82 organizations and services. (Table 1).

Table 2. Northwest health region on reserve population, health and SES rank[1] and linkage social capital indicators.

Health region	North West
On reserve population	9745
Number of communities	33
Number of communities in Health Transfer	14
Number of communities in BCTC process	20
Number of First Nation organizations and services	29
Health rank	1
SES rank	18

1. Source: British Columbia Ministry of Health Services, Vital Statistics Agency. British Columbia Provincial Health Officers Report, 2002.

The health region with the largest on-reserve population has the best health and plenty of opportunity for First Nation participation in social service development through health transfer and the BCTC process, but few participate in First Nation organizations and services identified in the *Guide to Aboriginal Organizations and Services* (2002) listings (Table 2).

Table 3. Thompson Cariboo First Nation population, health and SES rank[1] and linkage social capital indicators.

Health Region	Thompson Cariboo
First Nation population	21,600
Number of communities	38
Number of communities in Health Transfer	20
Number of communities in BCTC process	7
Number of First Nation organizations and services	33
Health rank	7.5
SES rank	15

1. Source: British Columbia Ministry of Health Services, Vital Statistics Agency. British Columbia Provincial Health Officers Report, 2002

The health region with the most First Nations has a higher health status than most other health regions (Table 3). This health region has few opportunities for First Nation participation in social service development. Within this health region, a number of First Nations are pursuing alternative routes, outside of the BCTC process, for treaty and land claim settlement.

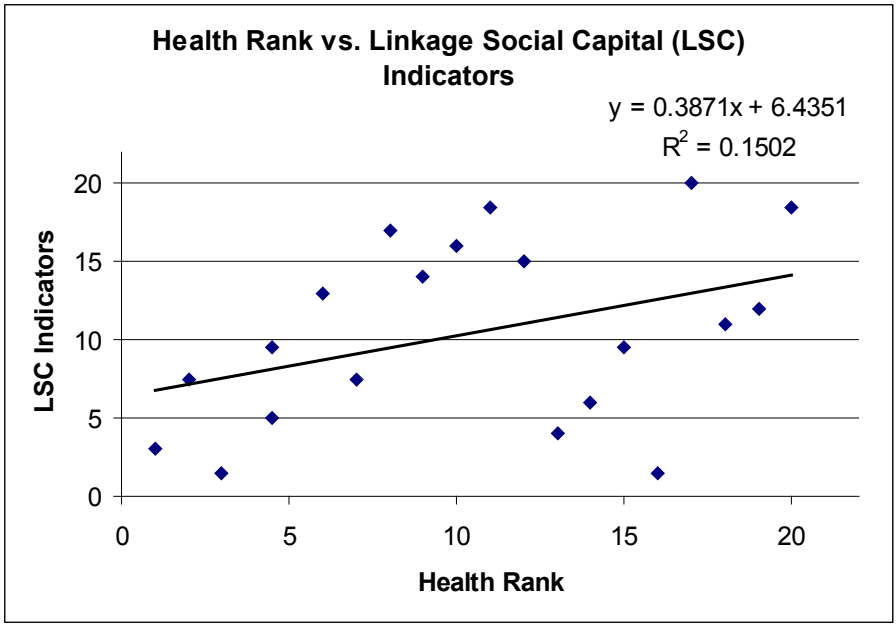
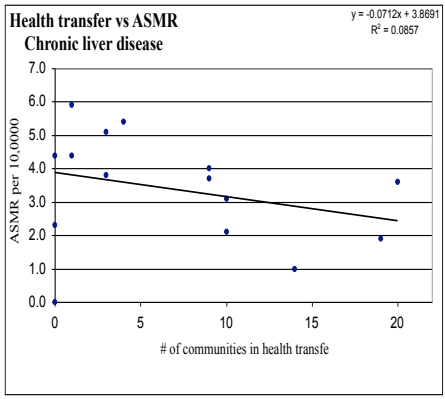
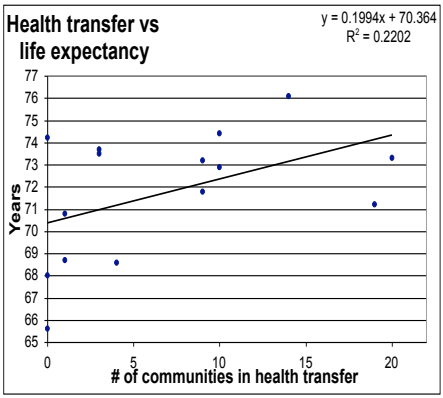


Figure 2. Health rank vs. rank of health region by the number of communities involved in BCTC and health transfer. One is the lowest ranking, lowest health status, and the least number of communities participating in health transfer and the BCTC process, while 20 is the highest health status ranking and the most number of communities participating in health transfer and the BCTC process within a health region. (Trend line and equation do not imply correlation, they are only a representation of the best linear fit.) Source: British Columbia Ministry of Health Service, Vital Statistics Agency. 1991-2001, Status Indian population. British Columbia Treaty Commission, 2004. First Nations participating in BCTC process — Bands participating identified by statement of intent filed by each First Nation.

When the health transfer and BCTC indicators are combined as a single index of linkage social capital by adding the number of communities in both health transfer and BCTC processes for each health region together, a positive correlation to health is observed (Figure 2).

Positive trends between health status and linkage social capital indicators are also observed for some individual age standardized mortality rates and life expectancy (Figure 3). These trends further substantiate a positive correlation in active engagement between First Nations and the Canadian governments and First Nation health status. They demonstrate that in health regions where First Nations have control and authority for social services in their own communities, those communities also have better health.





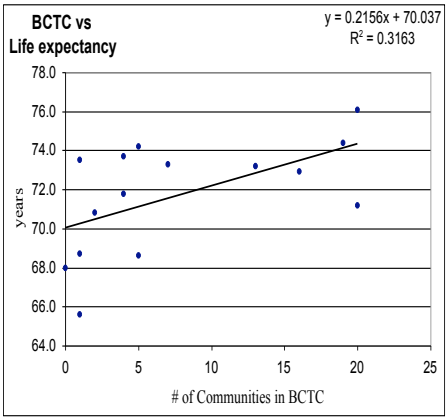


Figure 3. The relationship between linkage social capital and health status of First Nations in British Columbia health regions. Trend line and equation do not imply correlation; they are a representation of the best linear fit. Source: British Columbia Ministry of Health Service, Vital Statistics Agency. 1991-2001, Status Indian population. British Columbia Treaty Commission, 2004. First Nations participating in BCTC process — Bands participating identified by statement of intent filed by each First Nation.

Health regions with a high number of listings in the *Guide to Aboriginal Organizations and Services* did not have better health than those with few listings. For example The Vancouver health region has the most listings in the *Guide to Aboriginal Organizations and Services* and reports the poorest First Nation health status.

Conclusions

Maintaining balanced relationships necessitates identifying all parties involved in the social context, including the appropriate municipal, provincial, and federal government agencies. Communities exist regardless of external political institutions, but they are implicated in their resource acquisition and consumption. How communities balance their relationships with the Canadian governments, other First Nations, and their members is important too and affects population health status.

Communities that are not recognized and included in social service development may not meet the needs and goals of individuals who consume these services. The linkage social capital indicators demonstrate how, with increased recognition and inclusion, the constituents of the communities who participate in these relationships have better health than those who are not effectively included. The communities with relationships that promote recognition and inclusion may meet their constituent's needs and goals through leveraging resources and the development of common understandings and responsive policies.

Policy implications resulting from this research must address how First Nations off reserve are included and recognized in social service production. This population must be included in relationships producing commodities that they consume either by extending current policies in health transfer and the BCTC process, or by devising new policies that detail how they are to be included in social service production.

Increasing First Nation participation in First Nation social service development improves the responsiveness of policies, knowledge transfer, and identifies common needs and goals to improve First Nation health. Relationships that have more opportunity for direct First Nation control are more likely to improve First Nation health status than those relationships that limit their active participation in social service development.

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