INDIAN PARTICIPATION IN HEALTH POLICY DEVELOPMENT: IMPLICATIONS FOR ADULT EDUCATION

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ABSTRACT/RESUME

In 1979, responding to the appalling statistics on Indian health, the Federal Government announced a review of the issue. The Minister specified that Indian representatives would be consulted, and appointed two commissions to investigate. This paper outlines the process of policy development in general in relation to this specific on-going concern.

Comme suite aux statistiques désespérantes publiées en ce qui concerne la santé des indigènes, le gouvernement fédéral a annoncé en 1979 que la situation ferait l'objet d'une étude spéciale. Le ministre a précisé que des représentants de la communauté indigène seraient consultés, et il a nommé deux commissions pour procéder à l'enquête. Cette étude décrit d'une façon générale l'évolution d'une politique en rapport avec ce problème spécifique d'intérêt constant.
INTRODUCTION

In September, 1979, the Honourable David Crombie, then former Minister of Health and Welfare, issued a statement representing "current Federal Government practice and policy in the field of Indian health." Crombie declared that the "Federal Government is committed to joining with Indian representatives in a fundamental review of issues involved in Indian health when Indian representatives have developed their position, and the policy emerging from that review could supercede this policy". The policy statement was preceded by intense lobbying by Indian bands and organizations to repeal restrictive service guidelines introduced in September 1978, to correct abuses in health delivery, and to deal with the environmental health hazards of mercury and fluoride pollution affecting particular communities. As an indication of good faith the objectionable guidelines were withdrawn, to be replaced by professional medical or dental judgement, or by other fair and comparable Canadian standards. Two commissions were subsequently established: one, under Justice Thomas Berger, to inquire into methods of consultation which would ensure the involvement of Indian people in decisions affecting the provision of health care to them, and a second, under Dr. Gary Goldthorpe, to inquire into alleged abuses in medical care delivery at Alert Bay, British Columbia.

The commitment to consultation between Health and Welfare Canada and their Indian clientele parallels a commitment espoused since the early 1970's by the Department of Indian and Northern Affairs to involve Indians in planning and administration of their affairs (Weaver:200).

On the recommendation of Justice Berger an annual sum of $950,000 was allocated for distribution by the National Indian Brotherhood to develop health consultation structures within the national Indian community. The possibility exists, therefore, for Indian people to make their own assessment of their health needs, to propose their own priorities for health policy and to create the structure within which ongoing health policy review and consultation can take place.

My interest in these developments has been stimulated by an invitation to assist the Union of Ontario Indians in training community personnel to participate in the policy consultation process. The Union recognized, as do other Indian organizations, that effective participation requires knowledge of the health field and of the process of policy development, which few of their constituents now possess.

The purpose of this paper is to analyze the policy process as it operates in the context of Indian health provisions and to identify the interventions most likely to achieve the substantive Indian participation sought by both Indians and government. Such an analysis should provide guidance for the adult education effort being undertaken with community personnel. The historical and organizational context within which current consultations are being undertaken are set out briefly at the outset.

HISTORICAL NOTES ON INDIAN POLICY CONSULTATION

The affairs of Indians in Canada have historically been managed along the
lines of colonial administration which formally excluded them from participation in decision-making. The Hawthorn Report of 1966 noted that:

The basic reason for the absence of Indian pressure on governments for most of the post-confederation period is simply that they were formally outside the federal and provincial political systems. They lacked the federal franchise until 1960 and, with the exception of Nova Scotia, the provincial franchise until the post World War II period. As a consequence they lacked even that minimum ability to influence the political authorities which comes from being on the voters' roll.

Their impotence was furthered by a basic (Indian Affairs) Branch policy which lasted from the early thirties to the early postwar years. A Branch directive in 1933 stated that Indian complaints had to be routed through the (local Indian) agent, on the grounds that the practice of Indians attempting to deal directly with Headquarters involved an unnecessary waste of time, and interfered with efficiency in the conduct of official business (Hawthorn: 364).

The alternative route of independent political organization to influence decision-making was impeded by geographical dispersion and isolation of bands, parochial concerns reinforced by tribal and language differences, and, in the 1930's, a government proscription on independent fund raising to support Indian political activity.

In the post World War II period the dismantling of colonial empires and the emergence of civil rights issues in the United States promoted a reassessment by the Canadian government of its management of Indian Affairs. In the late 1960's the government launched a formal consultation process on Indian policy, soliciting response to a set of questions on revision of the Indian Act. The consultation meetings of 1968-69 were abruptly concluded in June 1969 with the presentation of A Government Statement on Indian Policy, popularly known as The White Paper. The proposals contained in the White Paper, that Indians and Indian lands should become Canadian with no distinctions of status, bore no resemblance to anything Indian spokesmen had presented in the consultation meetings and were promptly and universally rejected by Indians across Canada. Faced with unified opposition to the policy, the government officially shelved it and began allocating funds to Indian organizations to facilitate the development of an Indian position on reform of the Indian Act.

The legacy of this history, which still pervades policy discussions, is lack of faith on the part of Indians in the intentions of government and skepticism in many quarters of government that Indians have the capability of contributing significantly to complex decision making.

The political consciousness which resulted from the threat to Indian survival posed by the White Paper has given rise to the formation of vigorous Indian
organizations across Canada in the past ten years. While much of the organizations' activity has focussed on land claims, health issues have also surfaced from time to time, for example with the threat to Indians' life and health created by mercury pollution in northwestern Ontario.

When Health and Welfare Canada announced cutbacks in Indian health care in September 1978 the organizations were an important vehicle for channelling protest. It was logical then that Justice Berger should recommend that the projected consultation on health policy should be developed by the Indian Provincial and Territorial Organizations (P.T.O's).

GOVERNMENT AND COMMUNITY STRUCTURES

The health policy consultations involve those persons of native ancestry who are entitled to be registered under the terms of the Indian Act (1951). Inuit, Metis and Non-Status Indians are excluded from this definition. Federal Government involvement in Indian health stems from the general provision in the British North America Act that "Indians and lands reserved for Indians" fall within the federal rather than the provincial sphere of responsibility. For other Canadians, except those living in the Yukon or Northwest Territories, health care falls under Provincial responsibility.

Within the Federal Government, Indian Health Services are administered under Medical Services Branch of Health and Welfare Canada while related areas such as water and sewage facilities, housing, and local government are administered by the Department of Indian Affairs.

Inter-governmental and inter-departmental divisions of responsibility generate debate and delay in dealing with issues, as for example, when mercury pollution, a provincial environmental concern, affected the health of Indians, an area where D.I.N.A. and Health and Welfare are jointly responsible.

Medical Services Branch is structured as a decentralized bureaucracy, (Figure 1) with policy directives emanating from Ottawa and implemented by regional administrators and on site health professionals. Bureaucratic lines of authority inhibit responsiveness to local concerns and tend to maintain a flow of communication encapsulated within the system. Professional autonomy in medical issues, which is accommodated within the bureaucracy, tends also to inhibit involvement of persons, i.e. Indians, who are outside the system.

The Indian political system, responding to the need to establish communications with government and bureaucracy at various levels, has developed a parallel structure (Figure 2). In Indian organizations the flow of authority is upward from band members to chief and council on each reserve, to regional councils of chiefs, to provincial organizations and finally to the National Indian Brotherhood which brings together issues of common interest from its constituent members across the nation. It is important to note that N.I.B. is regarded by the P.T.O's as a federation which has no authority to direct political decision-making but is required to reflect the interests of its members. Similarly the provincial and regional councils are expected to provide a voice for local concerns and to rigorously respect the prerogatives of band chiefs and councils.
FIGURE 1

HEALTH AND WELFARE CANADA
STRUCTURE OF MEDICAL SERVICES BRANCH

Range of Responsibility

Cabinet
Treasury Board

Minister

Deputy Minister
Welfare

Deputy Minister
Health

National
Assistant
Deputy Minister

Director General Policy
Planning & Evaluation

Director General Operations

Director, Indian/
Inuit Policy

Director
Planning

Director
Evaluation

Provincial
Regional
Director

Regional
Zone
Zone
Zone

Nurse
Doctor
Environmental
Health Officer

Local
NIB
PTO's
Consultation

Indian
Patients
The difficulties of developing forceful and unified positions in such a structure are evident. Similar to the interest groups which Lindblom describes in *The Policy-Making Process*, much of the P.T.O. activity "is actually given over to clarifying the implications of policies for (their) own membership and is therefore not even designed to achieve direct influence on policy makers" (1968:68).

**INFLUENCING THE POLICY PROCESS**

Policy analysts emphasize that policy formulation, especially in the public domain, is an ongoing process which is typically conservative. Lindblom observes that "Usually what is feasible politically is policy only marginally different from existing policies." Rather than decrying such constraints, Lindblom suggests that the small, incremental changes raise the level of competence of policy by concentrating on familiar, better-known experience, reducing the number of alternatives to be explored and the complexity of factors to be analyzed (Lindblom: 26-27). Richard Rose in *The Dynamics of Public Policy* states that:

> "The past commitments of government - whether measured by legislation, by public expenditure or by personnel - are so vast that no political party could hope to overturn or greatly alter the bulk of commitments within a four or five-year grant of office by election. Among the actions that the government of the day does take, the most frequent are those that add on to existing commitments (1976:21)."

Granting the validity of these assessments, it is unlikely that the review of Indian health policy will introduce a significantly new vision to the field. Indians must therefore look to means of establishing a role for themselves in which they can exert continuing influence on the evolution of health policy.

Analysts also point out that although politicians may set the direction of policy it is substantially shaped within the bureaucracy by the multitude of interpretations necessary for implementation. Thus commitments to change gained in the political sphere can be eroded if the administration is wedded to past practice. Especially in periods of economic slow-down, concern about public expenditures brings budget review to the fore as a primary instrument for appraising policy choices. Regular program evaluation, including cost-benefit analysis, is regarded now as a normal and necessary part of the planning process. If Indians are to achieve substantive participation in the policy process they need to seek ways of breaking through the exclusiveness which has characterized the Medical Services bureaucracy where administrative interpretation, budget planning and program evaluation take place.

James Anderson proposes that the policy process can be conceptualized as a sequential pattern in which five functional categories of activity can be distinguished. The categories are:

1. problem definition and agenda setting, getting on the government agenda for action;
FIGURE 2

INDIAN POLITICAL STRUCTURE

Range of Responsibility

National
Indian Brotherhood

Provincial and Territorial Organizations
PTO
Provincial

Regional Chiefs
Regional Chiefs
Regional

Band Council
Band Council
Local

Band Members
2. policy formulation, developing alternative ways of dealing with identified problems;
3. policy adoption, by legislation or other legitimizing procedures;
4. policy implementation; and
5. policy evaluation, examining impact and effectiveness.

(1976:5)

Anderson's categories are useful for examining more closely the critical issues which need to be considered by Indians and their organizations if they wish to capitalize on the Minister's invitation to develop a position on health issues and Justice Berger's recommendation that structures to support ongoing consultation should be established.

**Problem Definition and Agenda Setting**: At any given time there are numerous items being proposed for public action by interested segments of the population. The problems selected for action must generally be regarded by the political community as having significant public support and falling within the jurisdiction of governmental authority. Despite their minority status in the Canadian population, representing approximately 1.5% of the whole, Indians have been relatively successful in the past ten years in claiming attention for their concerns. Probably their most important lever derives from the social and political value of equity, which implies that in a democratic society just treatment of members requires special measures to compensate for inequalities. The social and economic disadvantage of Indians in contemporary society is seen by many as a consequence of unjust treatment in the past and therefore their presentations have a moral force which helps to gain a place on the public agenda. Also in the past ten years Indians have acquired skills in using the courts to establish the legal merit of certain claims, and in recruiting the support of interest groups such as environmentalists, churches and human rights advocates.

However, getting on the agenda for public consideration of their problems is not synonymous with influencing policy. For example, criticisms of the White Paper were sufficient to stop its implementation, but a dozen years later there has been no change in the Indian Act which institutionalizes an obsolete form of Indian-government relations. Lindblom points out that interest groups are more effective in drawing attention to problems than in developing solutions. When articulation of problems creates a climate for change, lengthy delays in developing alternatives can mean that other issues gain primacy and new efforts have to be made to get on the public agenda for decision making.

Since Indian priorities in health planning are likely to vary from one regional group to another, it will be important to establish with the Minister that a new policy should acknowledge the legitimacy of such variation. New initiatives should not be limited to the minimal areas in which national consensus can be achieved, nor delayed until a comprehensive "Indian position" is articulated. Influencing revision of health policy will require that Indians mount an ongoing effort to define problems and press for change, utilizing current definitions of "public interest" to bolster their arguments, and recruiting allies
Policy formulation: Policy alternatives are usually presented in terms of rational analysis of the problem, and projected benefits of the solution proposed. Policy makers also look at the costs associated with the alternatives, both monetary and political costs of bypassing competing priorities. Political decision makers rely on the best information available, which may be researched by commissions of inquiry, consultant analysts, civil servants with program responsibility, or partisan interest groups. The complexity of any social issue is such that analysis is always insufficient to account for the potential impact of all variables and rational analysis is always supplemented with value judgements and speculation.

The role of interest groups in generating policy alternatives is discussed at some length by Lindblom in *The Policy Making Process*. He suggests that partisan analysis, to be effective, need not include all the facts and present a balanced point of view, since interest group positions will probably be examined in the context of information from other sources. If interest groups can rationalize their positions as sharing common values with the policy makers, their views are more likely to gain acceptance.

Indians and their organizations are handicapped in developing comparative analyses of medical strategies and program costs by the lack of medical and financial professionals in their membership. On the other hand, they have superior access to information about problems in matching needs and services at the delivery level. They also are in a position to investigate the personal and community conditions which contribute to suicide, alcohol abuse, accidents and violence, which constitute the greatest threats to the life and health of youth and young adults. Health professionals acknowledge their impotence to improve Indian health in the face of problems which derive from social and environmental conditions, spiritual malaise, and self imposed risks.

The president of the National Indian Brotherhood has stated that:

"To be forced to live a life that is totally out of one's own control is a source of constant stress, and leads to weakness and demoralization of individuals and entire communities. We as Indian people have been forced into coerced dependence upon paternalistic and ever-shifting federal policies and this situation has contributed to a great extent to the manifestations of social ill health now seen among us, including alcohol and drug abuse, family breakdown, suicides, accidents, and violent deaths. There is increasing evidence that the stress of dependence and uncertainty leads to physical sickness and disease as well."

(Starblanket : 1979)

Indian organizations have already begun to map out strategies for revising the health care system and their role in it. (Berger: 1980:15-15). The directions proposed rest on a political analysis - that the fit between needs and services, the appropriate distribution of services, and the countering of health destroying
dependency can best be achieved by introducing community control of health programs and promoting community responsibility for sustaining health.

The proposition that community responsibility for health programs will reduce morbidity and mortality rates cannot be argued by citing demonstrable cause-effect relationships. It is a hypothesis which draws some support from the experience of developing countries. The strategy of placing responsibility for solving Indian problems in the hands of Indians is one which accords with the ideology espoused by government in the past decade. What remains to be demonstrated is that local, regional and provincial organizations have the capability to set up responsible and effective health programs under community control.

To counter the persistent tendency to centralize government control of decision making and exclude laymen from directing the practice of professionals, it will be necessary for Indians to mobilize evidence that their alternative structures are effective in improving the health status of the people and that they are cost-efficient.

The invitation from the minister to present a position from which new policy can be formed is seductive. If Indian people respond by attempting to propose solutions to old and resistant problems they might well find that they are predicting more benefits than could realistically be achieved in the short term. Their credibility as joint policy makers might then be jeopardized.

The most promising course of policy change would appear to be establishing demonstration areas where alternative health structures are introduced. The experience gained in demonstration projects, if disseminated to other groups, could provide the basis for rational planning and adaptation of programs to regional variations. Health policy formulation would be perceived as an evolutionary process producing appropriate, effective and varied structures. The thrust of national policy would be to foster the process of adaptive program development. Within this context the benefits of community control could be tested and its form of implementation refined over time.

Policy Adoption and Implementation: The limitations of policy statements in effecting change and the role of administrators in shaping the operational policy are illustrated by the course which has been followed in applying the policy announced by Mr. Crombie in September 1979.

The 1979 policy acknowledged the "intolerably low level of health of many Indian people" and made a commitment to seek improvement by building on the three pillars of community development, a collaborative relationship between Indians and the Federal Government, and the resources of the existing Canadian health system. The one concrete decision included was the withdrawal of the guidelines for health service cutbacks introduced in September 1978.

Three months after the policy was announced the Conservative government was defeated. The Liberal Government, on taking office, decided to honour the commitment made by their predecessors and to recognize the work of the two commissions, Berger's and Goldthorpe's, which had been established.

In February 1981 a senior civil servant described the impact of the policy
on the bureaucracy. The application of professional judgement in provision of eyeglasses, dental care and prescription drugs had resulted in mushrooming costs in the first two categories, and the approved budgets were grossly inadequate, creating pressures on other categories of budget expense. There were no interpretations of which "comparable Canadian standards" would be selected to establish service levels. The commitment to improve health through community development touched on an area outside the jurisdiction of Health and Welfare. The traditional relationship between Indians and the Federal government is undergoing constant redefinition and is defined differently by various actors in the relationship.

In short, the new policy, with the obligations it implied, and the expectations it created, was a bureaucratic headache. In the absence of interpretations of terms and guidelines for practice, it could not be implemented except in sporadic and inconsistent fashion. The policy directorate of Health and Welfare in 1981 was gathering advice from the operations bureaucracy as to how the policy might be interpreted in practice. In the meantime, in another direction, policy discussions were going on with the National Indian Brotherhood and the Provincial and Territorial organizations. Indian people, bureaucrats and field personnel all were ill-informed about their respective rights and obligations and the confusion was causing stress and dissatisfaction in all quarters.

In their presentation to Dr. Goldthorpe's inquiry into incompetence and discrimination in local health service, the Nimpkish Band of Alert Bay, B.C. proposed a new structure for the delivery of health care. They recommended the creation of a Nimpkish Health Board which would exercise jurisdiction over all matters related to the health of Nimpkish people. A proposed Nimpkish Health Centre would be the focal point for a comprehensive network of health services, with professionals employed by the Board. A central principle in the plan was establishing accountability of health staff to the Indian people. The arguments presented by the Nimpkish have so far met resistance from the district hospital, the provincial medical association, the local non-Indian community and Medical Services Branch.

The judgement of the Nimpkish was that unless they gained a foothold in the implementation of policy, the adoption of reformed principles would have little impact at the community level.

Clearly, the capacity to plan and manage units for the administration of health programs will require a significant upgrading of administrative skills in the communities and regions which press for this alternative. Without such structural change, the gains made in political negotiations are likely to be changed beyond recognition as they are transmitted through successive layers of the bureaucracy.

Policy Evaluation: Along with lobbying efforts of Indian people, a major stimulus to the current policy review has been the evidence drawn from health statistics that the health of Indians is intolerably poor. Mortality rates of various age groups, life expectancy, hospital usage, incidence of particular diseases, etc., provide a means of comparing Indian health indicators with national norms. For
example, the rates of perinatal mortality among infants in the Northwest Territories are: 10 per thousand for the white population, 28 per thousand for Indians, and 40 per thousand for Inuit, compared with 17.6 perinatal deaths per thousand for the whole of Canada. (Berger, 1980b:22).

Effectiveness of programs to improve health can be monitored through these statistical indicators. However, statistics cannot explain the story behind particular incidents which add up to change or resistance to change. Social scientists and professionals have devised means of measuring social impact of measures taken. These social impact studies are often used in conjunction with program evaluations measuring achievement of program goals on various scales including the criterion of efficiency, that is, achieving maximum benefits at minimum cost.

Although a crisis can precipitate new policy directions, incremental changes arising from recurring policy review are important components of policy development.

Indian organizations have participated in one aspect of program evaluation, the channelling of user response to the policy makers to pinpoint areas of dysfunction. Complaints about communication problems between health personnel and patients, for example, have prompted effort to provide interpreter services in some situations, while the attitudinal problems which constitute an even greater problem in communication have not been the object of problem-solving efforts.

Integrating Indian participation in the evaluation process would mean giving them access to statistical information, the means to investigate impact issues, and some input into setting priorities in a situation of finite resources. It is relatively comfortable for program staff to deal with criticism coming from outside the system, because outsiders' judgements can always be faulted as not having all the facts. Including Indian representatives in a research and development cycle would involve sharing power which now resides predominantly in the bureaucracy. It would require that Indians become proficient in weighing research data and negotiating priorities.

The character of much Indian-government interaction at present is confrontative rather than collaborative. The government has declared that the relationship between Indian people and the Federal Government:

"must be strengthened by opening up communications with the Indian people and by encouraging their greater involvement in the planning, budgeting and delivery of health programs " (Canada: 1979).

Indian people have moved from a stance of submission to one of challenge. The memory of past betrayals makes it difficult to distinguish between collaboration and capitulation. If evaluation, including Indian input is to be a stimulus to policy development rather than precipitating defensive conservatism, the participants in evaluation need to be clear that they share overarching and mutually confirming values.
Examining the structure within which ongoing policy consultation would take place, it is possible to identify the information which needs to be accessed, the skills which need to be developed, and the communication networks which need to be established and maintained to support the process. This analysis provides direction for focussing adult education efforts to respond to these needs.

Indians now have, through the National Indian Brotherhood and the Provincial and Territorial Organizations, considerable knowledge about policy making process and strategies for getting issues on the government agenda for decision making. Bringing this knowledge to bear in effecting policy reform is impeded by the restricted mandate held by the organizations, and the geographical dispersion and diversity of their constituencies. Ponting and Gibbins observe that organizations like the National Indian Brotherhood often find themselves "working on a plane that is not well understood at the grass roots level" (1980: 241). In the face of government reluctance to accord to Indian organizations anything more than a marginal and advisory role in planning (Weaver, 1981: 201) a well informed and supportive constituency is essential to effectiveness.

Indians at the community level have an acute awareness of health problems and program impacts. In some localities, like the Nimpkish band, they have formulated community-based strategies for acting on that awareness. However, information about how to inject community initiatives into the bureaucratic system and how local perceptions can be accommodated in policy formulations remains a mystery to most community people.

An adult education effort to bridge the gap which now exists between Indian communities and their policy strategists would focus on demystifying the process by which empirical evidence, or first-hand experience, becomes the data base for policy formulation. The capacity of unsophisticated populations to reflect on their experience and conceptualize alternative paths in a larger context has been confirmed in field projects employing participatory research methods. (Tandon and Fernandes: 1981; Tobias: 1981). The key to successful community participation in a cycle of research and development lies in engaging the people whose experience is being analyzed in the process of analysis so that the connections between observable reality and abstract formulations are evident to all the participants. Thus, the sense of alienation which community people experience when information collected from them is employed in mysterious ways by technocrats, and the frustration of organization personnel at the lack of comprehension and support of their initiatives, will be reduced. The actors who have tended to operate on different planes expand their competence by gaining effective access to information held by each other.

Involvement in a participatory process of research and development will require that Indians acquire a number of specific skills. Information on particular features of community experience must be selected and organized to support new initiatives. Proposals must be written with pragmatic attention to the values, procedures and constraints which operate in the realm of bureaucracy and the
public domain. The hopes and needs of the community must be interpreted in terms of specific goals, cost forecasts and projected outcomes. Evaluation must be applied as a tool for development, not evaded as a threat to program survival.

While a small corps of program directors and policy planners in the national and regional Indian organizations have gone far in developing the technical skills to engage with these facets of planning, many Indians at the community level perceive these technical functions as the preserve of bureaucrats and consultants. The mushrooming body of experience in adult education attests to the fact that when adults, whatever their level of formal education, have an opportunity to learn new skills which relate to their perceived needs and personal goals, they are both highly motivated and proficient learners (Knowles, 1970; Barndt, 1980). Unquestionably, the diffusion of technical planning skills beyond the national and regional organizations and into the communities is essential for effective Indian participation in policy development. Local health committees and district health boards have already emerged in a number of regions as focal points for Indian involvement in health planning. A concerted adult education effort is now needed to facilitate and extend the penetration of Indian people into the health management territory occupied predominantly by professionals and bureaucrats.

Justice Thomas Berger's Report of Advisory Commission on Indian and Inuit Health Consultation (1980a), revealed that innovative projects in Indian health management were born and often died unknown and unheralded. He recommended that a national Indian health conference be convened to promote the exchange of information and experience among dispersed Indian communities. While a high profile information forum will undoubtedly serve to raise Indian consciousness of options available in health planning, creating and maintaining communication networks to share knowledge and mobilize action must be established as a complementary priority. Existing lines of communication among interested parties in Indian health tend to be inefficient, blocked, or distorted. Some problems of communication within the Indian political system and the medical services bureaucracy, and between Indians and government, have been mentioned already. Although communications within and between these systems might be rendered more effective through adult education interventions, perhaps the most productive initiative would be to focus on facilitating community-to-community communication.

The differential pace of development in dispersed Indian communities has been a persistent problem in formulating global policy. Berger proposes that exchange of information on health planning strategies, successful and problematic experiments, would be an effective stimulus to local health development. Since the primary and preferred mode of communication at the community level is oral, the opportunity for person-to-person exchange will need to be supported by purposely created networks, which have ongoing financial support. The techniques of popular education employed in China and other developing countries could be utilized to maximize the efficiency and effectiveness of a community directed education effort. (Chu: 1978)

This discussion of the role of adult education in health policy development
has focussed on action in the Indian community. Clearly such actions will not be productive unless there is corresponding movement in the existing health care system.

Priority will have to be given to "promoting the capacity of Indian communities to play an active, more positive role in the health system and in decisions affecting their health" in practice as well as principle (Canada: 1979). The shift from a paternalistic, treatment oriented approach will require re-education of government and professional personnel as well as Indians.

CONCLUSION

Health policy consultation is emerging as an arena of working out a kind of collaborative relationship between Indians and the Federal Government which has not been attained in other areas of planning and negotiation. In the consultation Indians are handicapped by local and regional fragmentation, lack of substantive knowledge in the health field, and lack of experience with the policy process typical of government practice. The Indian community is strengthened by a cross-national determination to gain a larger degree of self-governance.

The Federal Government is motivated to pursue consultation by the democratic ideal of equity and by the embarrassment of having a visible minority in abominable health. The government role in designing new health structures is limited by the innate conservatism of government and the complexities of inter-departmental collaboration.

Both Indian and Government statements have expressed the perception that increased Indian participation in policy planning is necessary and acceptable as a means of effecting change. While the health minister's statement discusses only developing a position in preparation for policy reform, Justice Berger's commission report refers to the need for establishing structures for ongoing consultation. Indian organizations are promoting community control of health planning and programs as part of an overall thrust toward self-governance.

How Indians will participate in health policy development remains to be determined. The foregoing analysis supports the view that the substantive Indian participation in policy development sought by Indians and government will require that Indians acquire the expertise to contribute at every stage of the policy process: in problem definition, formulating action alternatives, negotiating adoption, influencing interpretation and implementation, and reviewing and revising ongoing programs. Substantive Indian participation in all these phases will require a radical revision of the structural relationships which have prevailed in a colonial environment. Both Indians and Government personnel will need to engage in a re-education process to facilitate the absorption of new knowledge about the other's ways, attitudinal change, and development of organizational structures to translate the promise of consultation into the reality of social change.
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