Research Article

Assessing the Representation of People of African Descent on Nova Scotia's Community Health Boards

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Abstract

According to the Health Authorities Act (Section 62), Community Health Boards (CHBs) in Nova Scotia are intended to "contribute to health-system accountability by facilitating an exchange of information and feedback between the community and the provincial health authority." The present situation, however, is one in which health boards may not represent the demographic diversity of the community. This challenge may be particularly prevalent within African Nova Scotian communities. This paper will quantify whether people of African descent who serve on CHBs match the demographics of the community and discuss whether any discrepancies may affect policy initiatives within Nova Scotia Health. To answer these questions, we conducted a demographic analysis of 31 CHBs. The representation of African Nova Scotian participants on CHBs (5%) exceeds their representation within the total provincial population (2.4%); however, by removing the Southeastern Board, the representation of African Nova Scotians mirrors their representation in Nova Scotia as a whole. African Nova Scotians are overrepresented, to some extent, on CHBs. This overrepresentation is a factor of small sample size and skewed distribution. Even in historically African Nova Scotian communities like the Southeastern Board (with 85% of residents identifying as African Nova Scotians), the board demographics do not match the demographics of the communities they serve. Given the unique challenges African Nova Scotians face within Nova Scotia's health system, representation on all boards may be necessary. The challenges of robust engagement of marginalized communities could be addressed by dedicated recruitment efforts by Nova Scotia Health. Further, the lack of demographic information collected by either CHBs or by Nova Scotia Health presents an inability to address critical concerns within the African Nova Scotian community.

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According to Nova Scotia's Health Authorities Act, Community Health Boards (CHBs) are advisory organizations designed to provide input on "local perspectives, trends, issues and priorities, and to contribute to health-system accountability by facilitating an exchange of information and feedback between the community and the provincial health authority" (*Bill No. 1*, 2014, Section 62). They play a role in health promotion and allocate funding to local community groups via the NSH Wellness Fund (Nova Scotia Community Health Boards, n.d.). CHBs must have a minimum of nine members and a maximum of 15, unless otherwise prescribed by regulators (*Bill No. 1*, 2014, Section 64). To become a member, individuals must apply online through a Government of Nova Scotia portal. Once the application is submitted, the appointment process is conducted by the Chair of the Board through an open and transparent selection process prescribed by the regulations (*Bill No. 1*, 2014, Section 65).

Through appointments prescribed by Minister of Health and Wellness, CHBs are designed to be a mechanism to increase accountability, transparency, and system responsiveness to local perspectives (Nova Scotia Community Health Boards, n.d.). Boards are not responsible for adjudicating individual patient care concerns, nor do they govern or manage the delivery of health care services (*Bill No. 1*, 2014, Section 63). In theory, CHBs operate as a linkage between grassroots concerns and departmental policy priorities. In practice, however, this mechanism is not clear-cut. Patient-oriented practices, which will be referred to as public engagement throughout the rest of this paper, must reflect the needs of the government, provincial economic conditions, and the community it represents at the same time—all of which are fluid. The selection of non-professional representation in health policy is neither objective nor apolitical. Instead, existing power structures within the domain of health care services can privilege specific points of view, and silence others.

Scholars conceptualize public engagement as a planning apparatus for consultation to better improve specific systems (like health care), not deliberative practices as a whole (Coglianese, 2002). This perspective argues that "consultation" is a government technique used to collect public opinion on pressing political and policy issues (Fitzgerald et al., 2016; Reddel & Woolcock, 2004). It is impossible to improve the system without learning from those who utilize it. Learning from citizens, however, does not necessarily mean improving democratic practices (Adams, 2004). Public engagement is a method of collecting opinions on the administration of public services rather than including those participants in the internal workings of governance. Engagement becomes the only formal means for communities to influence policy deliberation and a foundational component of decision-making (Vigoda, 2002), but not of democracy. Ideally, policy outcomes through consultation reflect the needs, values, and demands of multiple stakeholders on particular issues (Lewis & Kouri, 2004).

While some authors acknowledge the importance of public opinion when evaluating citizen engagement practices, they also consider governmental accountability to be of equal importance when considering its success as a planning apparatus (Abelson & Eyles, 2004; Armstrong, 2009). Rowe and Frewer (2004) argue that public engagement techniques are not democratic because the government is not obliged to utilize public experiences in participation to improve the planning apparatus. In this understanding, citizen engagement is merely about listening to participants explain their experiences rather than making them equal partners in decision-making. In the absence of accountability, citizen engagement techniques do not function for the public but rather for the government (Rowe & Frewer, 2004).

When considering citizen engagement as an instrumental function for better health policy outcomes, one must evaluate how

effective it is in the design or redesign of policies and processes. Systems of measurement, or the effectiveness of practices, play a fundamental role in public attitudes toward citizen engagement (Abelson & Eyles, 2004). From the democratic point of view, some authors argue that policy outcomes alone do not reflect the success of citizen engagement as a co-operative planning apparatus (Rowe & Frewer, 2004). Rather, the success of citizen engagement is measured through the public's attitudes toward the process (Adams, 2004). In this sense, the legitimacy of the "output" has nothing to do with policy, but rather the impressions of the participants and the broader community (Schmidt, 2013). Halvorsen (2003), for example, views citizen engagement's success and the success of the state agency itself, as being dependent on the positive experiences of citizens within the process. The author concludes that governmental bodies can reduce citizen discontent toward specific policies by using high-quality participation that satisfies the consumers and improves experiential systems (Halvorsen, 2003). In specific cases, positive experiences in citizen engagement can transform negative opinions toward public deliberation and consultation. By improving citizen experiences with engagement techniques, the state becomes the benefactor of public attitudes both in improving flaws in administration of services and legitimizing governance choices (Hurley et al., 1994). Notably, however, this shift in public attitudes does not necessarily lead to effective governance.

History

A scan of the history of CHBs indicates the disjuncture between this ideal type of citizen engagement and the realities of co-operative governance models. During the 1980s and 1990s, most provincial governments in Canada began implementing regionalized plans for health care administration (Hurley et al., 1994). Many authors, such as Armstrong (2009), have come to understand the process as a means of integrating health care services for cost

containment while also responding to the needs of local communities (p. 97).

In 1994, the Government of Nova Scotia, headed by the Liberals, began significant efforts to regionalize health care administration. An internal review of health care entitled *The Blueprint for Health System Reform* dealt with a wide range of issues in health reform and concluded that a new format for health care governance was necessary, as the system in place was neither fiscally responsible nor accountable to the communities it served (Minister's Action Committee on Health System Reform, 1994). The report recommended that CHBs have the authority to determine policy, budgetary, and management decisions (Black & Fierlbeck, 2006), outside the existing traditional top-down model of administration into citizen engagement capacities. Though the report stated that CHBs should have autonomy in budgetary decisions, when they were legislated in 1996, the government restricted the authority and scope of the boards (Clancy, 1997). Instead, the responsibility of CHBs shifted from planning and managing health care administration to consulting duties (Department of Health, 1996). In practice, the government enhanced the role of administrators and reduced the mandate of CHBs.

Public Engagement and People of African Descent

Having diverse representation in leadership positions, especially within the health system, is cited as a social good that could assist in improving the quality of health services (Etowa & Debs-Ivall, 2017, p. 277). Research from the not-for-profit sector shows that diverse boards are more creative in their decision-making, have superior financial performance, and show increased responsiveness to their clients (Bradshaw & Fredette, 2013, p. 1112). Research in electoral behaviour indicates that racialized candidates are more likely to run for office if approached by a racialized local party president (Tolley, 2019). The example demonstrates the importance of descriptive

representation in facilitating further leadership and engagement among racialized communities.

Health institutions, however, are perceived by those working within them to do little to address deficits in descriptive representation among their leadership (Etowa & Debs-Ivall, 2017, p. 284). They opt instead to focus on fostering cultural competence among frontline staff, which does little to address the development of diverse institutional leaders (Etowa & Debs-Ivall, 2017, p. 288). Moreover, as Chung et al. (2012) show, members of marginalized communities are less likely to participate in community representational processes in health decision-making due to a lack of trust in the process of selection, and a lack of feeling heard (p. 1653).

Despite being the largest racialized community in the province, African Nova Scotians continue to be under-represented in civic life. The Commission on Effective Electoral Representation of Acadians and African Nova Scotians (2018) notes that the dispersed nature of communities of African descent in the province means that they are typically excluded from representation in the legislature without electoral mechanisms designed to account for this challenge (p. 6). African Nova Scotians are also suffering from a lower age-adjusted employment rate relative to the overall population, which, as One Nova Scotia highlights, reflects systematic challenges to labour market attachment and employment (One Nova Scotia, n.d.). This employment rate, despite One Nova Scotia's best efforts, is not improving (One Nova Scotia, n.d.).

A lack of representation of marginalized communities in socio-political systems is an indicator of social exclusion. It contributes to "the dispossession and devaluation of social and cultural capital" among communities (Gingrich & Lightman, 2015, p. 101). For marginalized community members from racialized minorities, this form of social exclusion is symptomatic of the existence of structural racism throughout our society (Galabuzi, 2012). People of African descent across Canada, and indeed in Nova Scotia, are often bestowed a racialized outsider status that removes them from Canadian society,

which includes political representation. These communities suffer from high levels of poverty and unemployment, housing discrimination, and a higher likelihood of proximity to waste and landfill facilities, toxic dumps, and pollution (Waldron, 2016; Maynard, 2017; Wane, 2005).

With these challenges in mind, a useful indicator of the strength of our health system and its capacity to account for the experiences of people of African descent in Nova Scotia, may be their representation on CHBs. Bradshaw and Fredette (2013) found that, among non-profit boards in Canada, ethnic diversity remains low despite the representation of women being comparatively high relative to the overall population (p. 1126). The determinants of this diversity were, in their view, macro-contextual, being impacted by the composition of the overall community (Bradshaw & Fredette, 2013, p. 1127). Chung et al. (2012) found that, among those interviewed in their study of desired characteristics of community representation, the core characteristics deemed to be significant were responsiveness and empowered inclusion (p. 1658). CHBs, if working effectively, ought to provide an opportunity for those marginalized within Nova Scotia's health system to demonstrate these characteristics.

Objectives

This paper seeks to quantify the descriptive representation of people of African descent on CHBs in Nova Scotia. This quantification may indicate the inclusion or lack thereof of people of African descent in public engagement processes across the province.

Hypothesis

H1: African Nova Scotian representation on CHBs will be less than or equal to the community's proportion of the population of Nova Scotia.

Null hypothesis: African Nova Scotians will be overrepresented on CHBs relative to their proportion of the population of Nova Scotia.

Methods

Located across Nova Scotia, CHBs are intended to represent the localized needs of each community in the province. Broken into four zones – Eastern (Cape Breton); Northern (St. Lawrence area); Western (South Shore); and Central (Halifax area) – each zone consists of between seven and eleven boards. We contacted the Nova Scotia Department of Health and Wellness in early September 2019, and asked them for the demographic makeup of CHBs. The Department of Health and Wellness forwarded our request to the Public Engagement and CHB Support division of Nova Scotia Health, which told us to contact the CHBs directly, as Nova Scotia Health did not collect demographic information from CHB members.

We visited each of the 37 CHB social media pages to see if they had their membership listed, and 29 of the 37 did have a membership listing. We then visited their publicly accessible social media pages to find their relevant demographic information (gender, African Nova Scotian or not). We contacted the eight CHBs that did not have a public listing of their membership. Two CHBs responded with their membership listing,

and six did not respond to comment. Of these six, the Halifax Community Health Board did not respond with their membership listing. This is a significant limitation to the research due to the historic African Nova Scotian population located within the Halifax region.

Results

Of the 37 CHBs, data was collected on the membership of 31 boards. As noted in Figure 1, boards marked with a "+" sign indicates that membership for multiple boards was reported in a lump sum, affecting nine boards in total. "Truro +" indicates CHBs from East Hants, North Shore, South Colchester, Truro Area, and Along the Shore; "Pictou +" includes Pictou West and Central/East Pictou; and "Digby +" includes Conseil de Santé de Clare and Digby Area (Nova Scotia Community Health Boards, n.d.).

Results reported spanned from 2017 to 2019, with room of variance depending on the frequency of membership updates. Of the 31 CHBs analyzed, there were a total of 287 members: 218 participants identified as female (76%) and 14 participants were African Nova Scotian (5%). As a comparison, in the total

Figure 1
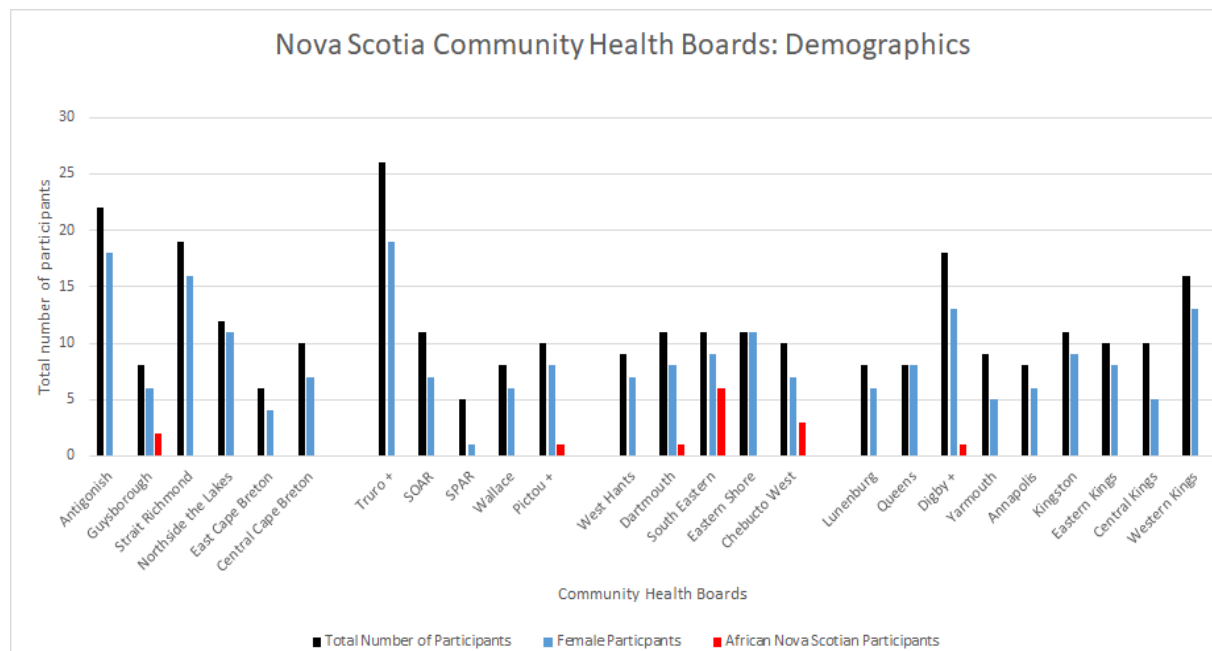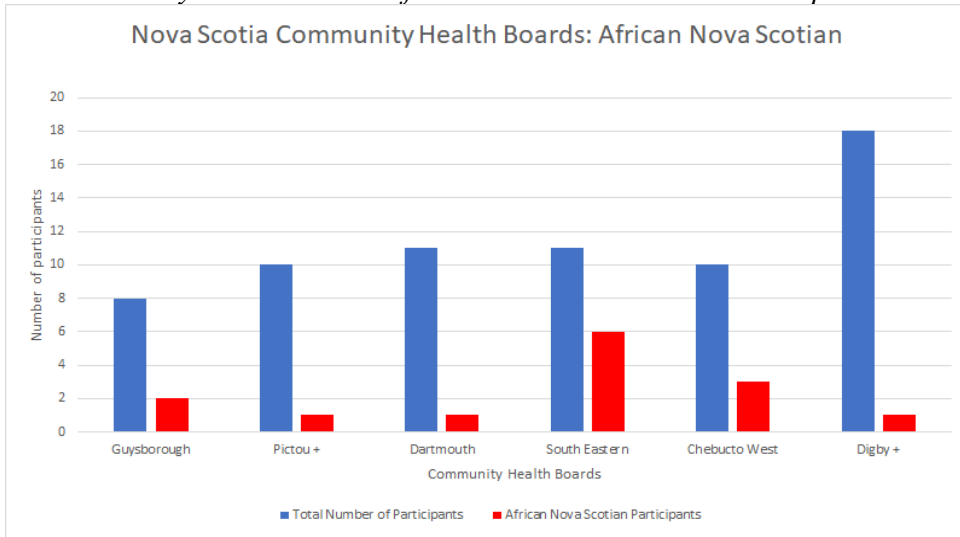*Nova Scotia Community Health Board Demographics (2017-2019)*

Figure 2

Nova Scotia Community Health Board African Nova Scotian Membership

Figure caption/chart title: Nova Scotia Community Health Boards: African Nova Scotian — Number of participants (y-axis) by Community Health Boards (x-axis: Guysborough, Pictou +, Dartmouth, South Eastern, Chebucto West, Digby +). Legend: Total Number of Participants, African Nova Scotian Participants.
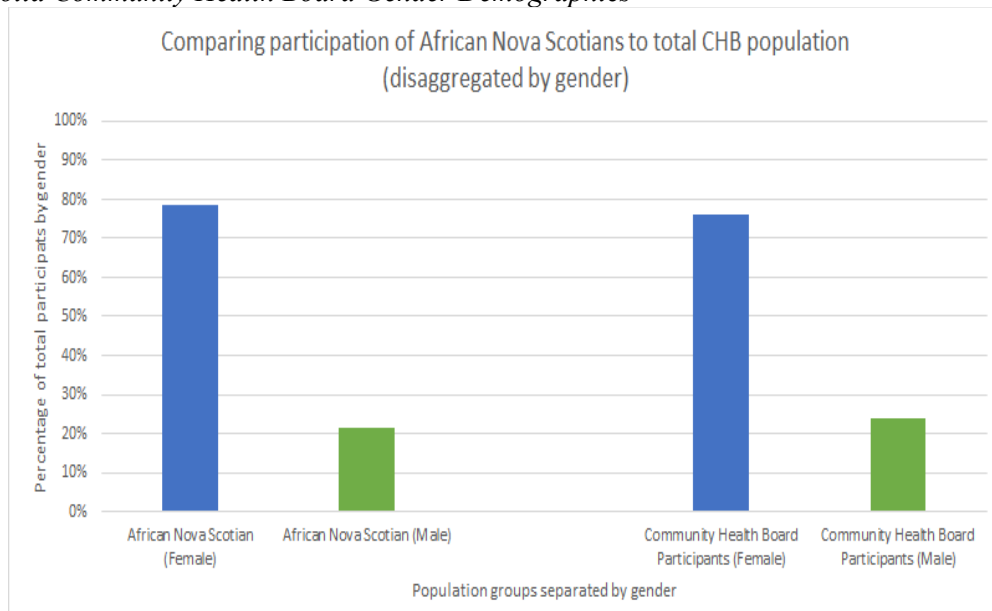
population of Nova Scotia, 51% of residents are female identifying and 2.3% are African Nova Scotian (Statistics Canada, 2016).

In relation to African Nova Scotian participants, although the rate of engagement is above the overall population, these numbers are dependent on the geographic location of the CHB. Only six CHBs reported having African Nova Scotian participants, and all have historic ties to African Nova Scotian populations. For example, the Southeastern CHB has higher levels of African Nova Scotian participants (55%) than any other region. The Southeastern CHB includes populations from North Preston, East Preston, and Cherry Brook, whose residents are roughly 85% African Nova Scotian, making these communities the oldest and largest African

Figure 3

Nova Scotia Community Health Board Gender Demographics

Chart title: Comparing participation of African Nova Scotians to total CHB population (disaggregated by gender) — Percentage of total participants by gender (y-axis) by Population groups separated by gender (x-axis: African Nova Scotian (Female), African Nova Scotian (Male), Community Health Board Participants (Female), Community Health Board Participants (Male)).

Canadian communities in the country (Kisely et al., 2008, 653).

Finally, we compared rates of African Nova Scotians disaggregated by gender to those of the total CHB participant population disaggregated by gender. We see similar rates of participation among African Nova Scotian women as we do within the total population of female CHB participants (78% to 75%).

Figure 4

Map of Central Zone Community Health Boards (Nova Scotia Community Health Boards, n.d.)
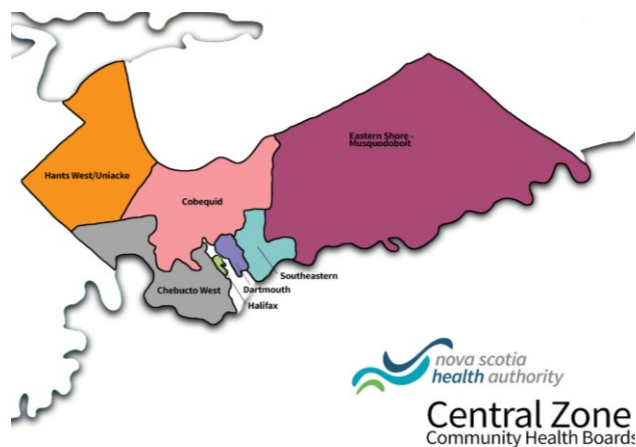
Discussion

Our results indicate that we should fail to reject the null hypothesis, with some small caveats. With 5% total representation on CHBs, there is an overrepresentation of African Nova Scotians on these public engagement bodies. Importantly, however, the bulk of that representation occurs in one CHB: Southeastern. The area that the Southeastern CHB encapsulates includes the following: North Preston, East Preston, Mineville, Cow Bay, Eastern Passage, Lake Loon, Cole Harbour, Lawrencetown and Cherry Brook. If we exclude the Southeastern CHB, the rate of African Nova Scotians relative to the general population is eight members out of 276, or 2.9%–a similar number to the representation of people of African descent in Nova Scotia. Maintaining consistent rates of African Nova Scotian representation relative to the overall population

presents a challenge for participation. As noted by the Commission on Effective Electoral Representation of Acadians and African Nova Scotians (2018), the relatively small population of African Nova Scotians compared to the total population of the province means that these communities have little capacity for political influence.

A similar dynamic could be at play within CHBs, where African Nova Scotian representation, excluding the Southeastern CHB, does not constitute a majority on any board, and only occurs on five of the 31 CHBs that responded. A scan of the citizen engagement literature indicates that, wherever possible, particular attention ought to be paid to marginalized communities, whose interests are unlikely to be represented in other ways (Howe, 2011, p. 24). In the CHB context, this attention may be overrepresentation of African Nova Scotians to better reflect community concerns, specific recruitment efforts aimed at attracting African Nova Scotian volunteers to CHBs, or a scan of barriers that interested community members experience in trying to participate in community processes.

Focusing on the Southeastern CHB in particular also provides potential insights into the efficacy of CHBs in predominantly African Nova Scotian communities. As noted above, the communities of North Preston, East Preston and Cherry Brook have the highest proportion of African Nova Scotians of any area in the province, with approximately 85% of the total population of the area identifying as African Nova Scotian. The Southeastern CHB, meanwhile, has six of 11 board members who are African Nova Scotian—a rate of 55%, which is 30% lower than representation within these communities. As Kisely et al. mention, these communities are disproportionately impacted by diseases such as diabetes, hypertension and psychiatric disorders, and seek out specialist mental health services less than the general population (2008, p. 656). The discrepancy between these numbers could reflect broader representation from communities such as Cole Harbour. It could also indicate, however, a lack of mobilization within that community to engage

in this particular health board's activity. The efficacy of CHBs in enhancing social and health-related well-being can only be adequately assessed through persistent dialogue among diverse populations. This potential lack of mobilization in the Southeastern CHB, given the health challenges that these communities currently deal with, could be a barrier to more responsive health policy for the area.

Within the data collection process, six CHBs did not respond to requests for demographic information. These were Central Inverness, North Inverness, Victoria, Shelburne—and, most importantly, Halifax and Cobequid. The Halifax and Cobequid CHBs represent a large, diverse population, and their results could change the overall results of this study. Future analyses must ensure the inclusion of all CHBs into the data-sets; however, this can only occur by making changes within Nova Scotia Health. There exists a devolved responsibility onto CHBs to report demographic information to the general public, yet the discretion to respond to inquiries is uneven throughout CHBs. Data collection and distribution must stem from Nova Scotia Health to ensure transparency and accuracy when reporting such information. Further, many CHBs only reported a small number of participants—often well under the criteria threshold of nine, as set out by the Health Authorities Act (*Bill No. 1*, 2014, Section 64). These results indicate two potential causes: A) many CHBs are not meeting the minimum threshold of participants, or B) some of the members on CHBs sit as a "ghost membership", or are registered members who do not actively participate. The phenomenon requires an in-depth analysis.

Conclusion

African Nova Scotians are overrepresented, to some extent, on CHBs. This overrepresentation, however, is a factor of small sample size and skewed distribution. By removing one board, the representation of African Nova Scotians mirrors their representation in Nova Scotia as a whole. This reflection of societal diversity within CHB diversity presents challenges for the

democratic engagement of these marginalized communities and could be addressed by dedicated recruitment efforts by Nova Scotia Health. Another critical challenge that emerged from our study was the lack of demographic information collected by either CHBs or by Nova Scotia Health. Demographic information on CHBs must be regulated by the provincial government to ensure that data-sets are reflective of current CHB compositions and accurately portray the diversity within the membership. A study of the efficacy of CHBs to address critical concerns within the African Nova Scotian community is needed to determine best whether these democratic mechanisms are useful, or are simply legitimation mechanisms for state policy initiatives.

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