

communications, cultural safety, and traditional medicines will be addressed, as they each influence how Indigenous peoples view and experience health care in Canada. The fact sheet will conclude by providing strategies and innovations for improving Indigenous peoples' access to health services.

The current health disparities and inequitable access to health care experienced by Indigenous peoples in Canada must be conceptualized within the context of past and present manifestations

of colonialism (Allan & Smylie, 2015). Indigenous peoples' historic experiences, including relocation of Inuit to southern hospitals and sanatoria for the treatment of tuberculosis and treatment received in the often inferior, racially-segregated, Indian hospitals have left enduring impacts on how they perceive medical professionals and the mainstream healthcare system (Lux, 2016). The continued coercion of Indigenous women into tubal ligation underscores the ongoing institutional injustices faced by

Indigenous peoples (Boyer & Bartlett, 2017). These historic examples, together with negative contemporary interactions with health care providers, have resulted in many Indigenous individuals having a pronounced mistrust of and apprehension in accessing health services, which ultimately impacts their health and well-being (Browne et al., 2011; Horrill et al., 2018; Lavoie, 2018; Logan McCallum & Perry, 2018).

The current health disparities and inequitable access to health care experienced by Indigenous peoples in Canada must be conceptualized within the context of past and present manifestations of colonialism

(Allan & Smylie, 2015).



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Accessibility of health services

Accessibility can be understood as “the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them” (Evans, Hsu, & Boerma, 2103, p. 546). Indigenous peoples do not have equitable access to health services compared to the general Canadian population due to geography, health system deficiencies, and inadequate health human resources.

One’s location of residence determines one’s access to timely and localized health services. Indigenous peoples live in urban centres, as well as in rural, remote and northern communities across Canada. According to Statistics Canada (2017), approximately 80% of Métis live in urban centres; close to half (44.2%) of registered First Nations people live on reserve, with the remainder living off-reserve; while the majority (72.8%) of Inuit continue to live in Nunangat.² Indigenous peoples experience specific challenges related to the

accessibility of health services across all geographic regions; however, the challenges are more acute in rural, remote and northern communities. The rural and remote location and small population size of communities in these regions can make it challenging to recruit and retain health professionals, leaving many communities with critical shortages of medical personnel (Huot et al., 2019; Mew et al. 2017; Oosterveer & Young, 2015). These communities typically rely on non-resident health professionals who fly into communities for short durations to see patients (Nelson & Wilson, 2018; Oosterveer & Young, 2015; Wallace, 2014). For First Nations living on reserve, long wait lists and lack of available doctors or nurses pose significant barriers to receiving health care (First Nations Information Governance Centre, [FNIGC], 2018). Other barriers to accessing health care cited by First Nations adults relate to Non-Insured Health Benefits (NIHB), including “costs not covered by the NIHB, lack of knowledge around NIHB coverage, and NIHB denial of coverage” (FNIGC, 2018, p. 20). Prohibitive transportation costs also pose a significant barrier to accessing health care (FNIGC, 2018). These types of barriers can lead to unmet health needs.

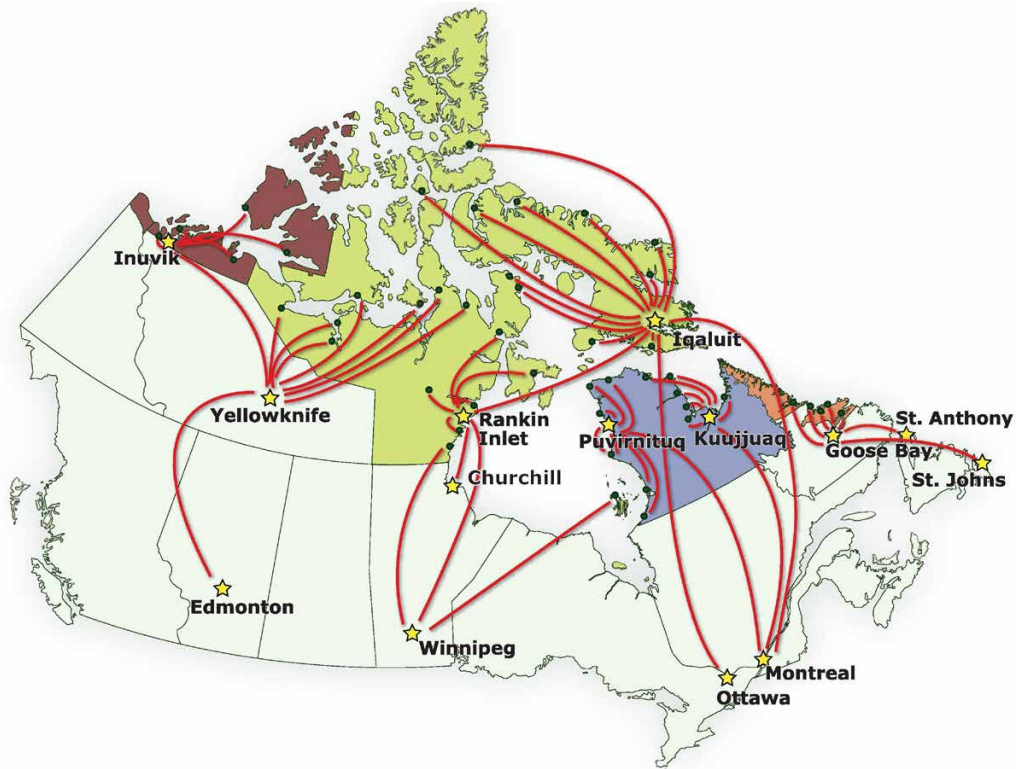
Data from the 2012 Aboriginal Peoples Survey (APS) showed that Inuit face similar challenges. Even though 70% of Inuit in Nunangat had been seen by a medical professional (primarily a physician or nurse), only 23% had a regular medical doctor and 14% indicated they had experienced unmet health care needs (Wallace, 2014). Amongst the most common reasons given for unmet health care needs was that the health service was not available in the area (25%) or at the time required (15%).

Indigenous peoples experience specific challenges related to the accessibility of health services across all geographic regions; however, the challenges are more acute in rural, remote and northern communities.



² Inuit Nunangat is comprised of the Inuvialuit Settlement Region (Northwest Territories), Nunavut, Nunavik (Northern Quebec), and Nunatsiavut (Northern Labrador).

FIGURE 1: INUIT MEDICAL TRAVEL MAP



Source : Inuit Tapiriit Kanatami (ITK), (2014, p. 32). Reproduced with permission courtesy of ITK, 2019.

Longer wait times to see health care providers and specialized medical professionals can delay the diagnosis of illnesses, result in less continuity of care, and reduce the effectiveness of health services overall (Horrill et al. 2018; Huot et al., 2019). Given the lack and shortage of health professionals within Indigenous communities, many individuals are transported to urban and southern-based hospitals for medical emergencies, hospitalization, appointments with medical specialists, diagnosis and treatments, often leaving behind families and support networks for extended periods of time (Huot et al., 2019; Mew et al., 2017; Oosterveer & Young,

2015; Patterson, Finn, & Barker, 2018; Wallace, 2014). Lavoie and colleagues (2015) stress that while medical relocations can be a one-time event taking place over a period of hours or days, the reality is that for many Indigenous peoples, “medical ‘relocation’ is a misnomer,” as the back and forth “circuit” between the home and urban settings for health care can become “a permanent feature of peoples’ lives” (p. 296).

Given the lack of accessibility to health services, the patient journey for Inuit can include lengthy travel between their northern home communities to southern hubs such as

Edmonton, Winnipeg, Ottawa or Montreal (Figure 1). According to King et al. (2019), this extensive and expansive travel “render[s] the healthcare costs in these communities some of the most expensive in world” (p. 3). Indigenous peoples can experience financial hardships, loneliness, emotional stress, and elevated anxiety and fear associated with medical relocations, which may delay recovery (Cameron et al., 2014; Huot et al., 2019). Due to these issues, some Indigenous peoples may be reluctant to seek help when they experience symptoms, resulting in a delayed diagnosis and treatment. In fact, research has shown that Indigenous people

are more likely to be diagnosed at a later stage of a disease than non-Indigenous people, thus contributing to poorer health outcomes and higher mortality rates (Lavoie, Kaufert, Browne, & O’Neil, 2016).

Living in an urban centre can provide better access to a range of healthcare services. However, studies suggest that Indigenous peoples may experience multiple and intersecting challenges in accessing urban health care services, including racism and discrimination, long wait lists, and culturally unsafe care (Cameron et al, 2014; Goodman et al., 2017; Logan McCallum & Perry, 2018; Smylie, Firestone, Spiller, & Tungasuvvingat Inuit, 2018). These experiences can result in perceptions that the health system is “uncaring and disrespectful to Indigenous clients, in effect denying them care” (Nelson & Wilson, 2018, pp. 23-24). These barriers to care

can have tragic health outcomes, as evidenced by the experience of Brian Sinclair, an Anishinaabe man who was sent to Winnipeg’s Health Sciences Centre for a treatable bladder infection. In this case, Mr. Sinclair actively sought out healthcare services, yet after waiting thirty-four hours in the emergency waiting room without being seen by a physician, he was discovered dead. The denial of care for Mr. Sinclair can be attributed to anti-Indigenous racism and stereotyping, whereby he was seen as homeless and drunk rather than as a patient in need of and deserving of care (Allan & Smylie, 2015; Brian Sinclair Working Group, 2017; Logan McCallum & Perry, 2018).

With elevated admissions to hospitals at rates that are approximately five times greater than the general population, homeless Indigenous peoples in urban centres face unique challenges in accessing health

services (Hwang, 2001). These include the inability to provide proof of insurance coverage, the inability to afford prescription medication, mental illness or substance abuse issues, and a health care system that does not provide adequate treatment. Collectively, these barriers can result in the neglect of personal health issues. This is particularly worrisome given the overrepresentation of Indigenous peoples amongst the homeless population in Canada. They are “10 times more likely to access homeless emergency shelters than non Indigenous people, representing approximately 30 percent of all shelter users,” yet they represent approximately five percent of the Canadian population (Employment and Social Development Canada, 2018, p.3). However, these numbers can fluctuate widely among cities (Brandon et al., 2018).



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Since the 1960s, the federal government has adopted the position that health services are provided to First Nations in Canada “as a matter of policy only for humanitarian reasons and not due to any Aboriginal or Treaty rights”

(Lavoie et al., 2016b, p.8).

Availability of health care services

The availability of health services occurs when there is a “sufficient supply and appropriate stock of health workers, with the competencies and skill-mix to match the health needs of the population” (Global Health Workforce Alliance, 2019). As discussed in the previous section, there is a dearth of health care workers and services in some regions of Canada, which disproportionately impacts the health outcomes of Indigenous peoples. In addition, there are differences and discrepancies in funding and programs for First Nations, Inuit and Métis, compounded by jurisdictional complexities and ambiguities.

Since the 1960s, the federal government has adopted the position that health services are provided to First Nations in Canada “as a matter of policy only for humanitarian reasons and not due to any Aboriginal or Treaty rights” (Lavoie et al., 2016b, p.8). The First Nations and Inuit Health Branch (FNIHB) of Indigenous Services Canada funds and delivers community-based health promotion and disease prevention programs, home and community care, and programs to control communicable diseases and address environmental health issues, as well as hires over 800 nurses and home care workers to work directly in First Nations and Inuit communities (Indigenous Services Canada [ISC], 2018). Registered/Status

Indians living off reserve, Inuit living outside their traditional territories, and Métis receive medical care from provincial and territorial governments which deliver universal health services to all Canadians. Since 1989, the federal government has promoted the devolution or transfer of responsibility for health programs and services to communities through several mechanisms, including funding agreements established in accordance with the Health Transfer Policy,³ self-government agreements, as well as Indigenous Regional Health Authorities. As of 2008, 89% of eligible First Nation and Inuit communities had or were in the process of transferring responsibility (Lavoie, 2018). Twenty-two self-government agreements have been

³ See Indigenous Services Canada. (2005).

negotiated, giving 43 Indigenous communities law-making authority to determine their priorities in key areas, including health (Crown-Indigenous Relations and Northern Affairs Canada, 2018). Some Indigenous regional health authorities have also emerged with higher level⁴ responsibilities. In 2001, the Northern Inter-Tribal Health Authority (NITHA) was established, providing culturally-based third level services for 33 First Nations in Saskatchewan (NITHA, 2019a). In 2013, the precedent-setting First Nations Health Authority (FNHA) assumed responsibility from FNIHB for the administration of health care programs and services for 203 First Nations communities across British Columbia (FNHA, n.d.-a).

Decades of complex, ambiguous and fragmented jurisdictional issues, however, continue to result in frustration, confusion, unmet health care needs and, most concerning, higher mortality and morbidity of Indigenous peoples (Greenwood et al., 2018; Lavoie et al., 2015). As stated by Martin and colleagues (2018) “[a] dizzying array of services in the health-care system, including

federal programmes, provincially provided services, and highly bureaucratized add-ons together continue to fail to meet the needs and constitutional rights of Indigenous people” (p. 1729).

Jurisdictional barriers have led to lengthy disputes between various levels of government over who has financial responsibility for particular health services for Indigenous peoples. The case of Jordan River Anderson underscores the inequity of health service provision for Indigenous peoples and children living on reserve. A Cree child from the Norway Cree House Nation in northern Manitoba, Jordan was born in 1999 with complex health issues. He died in 2005 in a Winnipeg hospital at the age of five after waiting two years for federal and provincial governments to resolve the issue of who should pay for the necessary specialized care in his home community (Chambers & Burnett, 2017; Jordan’s Principle Working Group, 2015). On February 26, 2016, a landmark ruling of the Canadian Human Rights Tribunal (HRT) called on the Government of Canada to end racially discriminating against 165,000 First Nations children

and to provide equitable funding and access to health, education and social services, with a fifth non-compliance order issued in February 2018 (First Nations Child & Family Caring Society of Canada, 2018). The Canadian government has been working to address these inequities, committing \$382.5 million towards a Jordan’s Principle Child-First Initiative, with 171,000 requests for First Nations children already approved as part of this initiative (Government of Canada, 2018). Ultimately, ongoing jurisdictional disputes, funding inequities and structural discrimination raise “questions about where responsibilities [lie] for the ‘implicit social contract’ guiding Canada’s vision of equitable health care,” and how this affects the health and well-being of Indigenous peoples (Greenwood et al. 2018, p. 1647).

Likewise, the jurisdictional limitations that fail to recognize Métis identity and rights have resulted in ongoing health disparities among the Métis (Chartrand, 2011; Martens et al., 2010). While Métis have access to mainstream services, little or no attention has been paid to their specific cultural or

⁴ There are three levels of health services. First level services are those provided in the community directly to community members. Second level services are provided primarily by higher level Indigenous authorities such as multi-community bands and Tribal Councils, and typically include program design, implementation and administration, supervision of first and second level staff, clinical support, consultation, and advice and training. Third level services are provided directly to second level partners and include disease surveillance, communicable disease control, health status monitoring, epidemiology, specialized program support, research, planning, education, training and technical support (NITHA, 2019b). Few Indigenous communities have responsibility for third level health services.

geographical needs. On April 14, 2016, the Supreme Court of Canada (SCC) ruled its judgment in *Daniels v. Canada*, that “Métis and non-status Indians are “Indians” under s. 91(24) of the Constitution Act (1867).” However, it remains unclear as to whether or how this judgement may impact the extension of federally-funded healthcare to Métis and non-status Indians currently provided to First Nations and Inuit (Lavoie, 2018).

Acceptability of health care services

The acceptability of health services can be understood as a “people’s willingness to seek services” because of perceptions they are effective and health care providers are responsive to them and free of social and cultural biases (Evans et al., 2103, p. 546). For Indigenous peoples, the

acceptability of health services is based on the fundamental shift in the power imbalances between patients and their care providers, and the way in which health care is delivered to improve their health outcomes. Several dimensions of health services are foundational for Indigenous peoples’ health and well-being. Culturally safe, appropriate and patient-centred care are interrelated concepts that have gained credence as fundamental for Indigenous peoples’ health care. These concepts incorporate several key elements:

1. health services are perceived as being free from bias, discrimination and racism;
2. the unique and holistic health care needs of Indigenous peoples are respected and met;
3. and Indigenous peoples are collaborators with health providers as active agents

in the provision of their health care (FNHA, n.d.-b; Hobgood, Sawning, Bowen, & Savage, 2006; Lavoie et al., 2013).

Indigenous concepts of health and well-being include a balance between mind, body, spirit and emotion; as well as living a good life in harmony, reciprocity and relationship with other human beings and the natural world. As such, there is a need to include cultural and traditional practices and options in addition to, or complementary to, biomedical models of health (Browne et al., 2016; Tagalik, 2018; Truth and Reconciliation Commission of Canada [TRC], 2015). Patient-centred care reframes the dynamics of top-down health care decision-making to focus on a patient’s agency and ability to communicate and manage decisions around self-care. This includes considerations

Indigenous concepts of health and well-being include a balance between mind, body, spirit and emotion; as well as living a good life in harmony, reciprocity and relationship with other human beings and the natural world.



for traditional healing and approaches. Finally, the concept of trauma- and violence informed care is increasingly informing care for marginalized individuals who have experienced varying forms of violence with traumatic impacts on an ongoing basis (Browne et al., 2016). This concept involves care that is respectful and affirming, with health providers who recognize the intersecting health effects of violence and other forms of inequity, understand the social context of health, and work to ensure that patients are not re-traumatized by their encounters with the health system.

Good communication between health care providers and patients is central to the acceptability of health services. Good communication helps reduce the stress that Indigenous patients may feel when they do not speak either English or French as their primary language; it allows them to communicate specific health questions, needs or concerns; and it allows them to fully understand the nature of their illness or diagnosis, their treatment directives, and how to follow them, including the use of medications and prescriptions (Cameron et al., 2014; Office of the Languages Commissioner of Nunavut, 2015; Oosterveer & Young, 2015). Good communication can be facilitated through use of Indigenous translators, patient navigators, Indigenous health workers,

plain language and culturally appropriate health education resources, culturally sensitive and empathetic personal contact, as well as by acknowledging and respecting Indigenous family structures, taking time to establish relationships with patients, reflecting on one's behaviours and beliefs in interactions with patients, and actively involving patients in decision-making about their care (Jennings, Bond, & Hill, 2018; Shahid, Finn, & Thompson, 2009). These facilitators are foundational to applying cultural safety in health care settings, and improving Indigenous peoples' access to healthcare services.

Given that Indigenous peoples' interactions with health providers have been shaped by experiences of unsafe care, lack of respectful or compassionate treatment, racism, and discrimination (Cameron et al., 2014; Horrill et al., 2018; Ringer, 2017), the Truth and Reconciliation Commission of Canada (2015) called on all levels of government to "provide cultural competency training for all health-care providers" as integral to closing the health gaps between Indigenous and non-Indigenous peoples (p. 323). Cultural competency and safety training has since been taken up by a number of health institutions and organizations. Serving 16,000 Cree living in Northern Quebec, the Cree Board of Health and Social Services of James Bay (CBHSSJB), "began

a major restructuring to make patient engagement and cultural safety a priority and core component of the organization" in order to improve their access to healthcare (Ringer, 2017, p. 214). Acknowledging their prominent role as "gatekeepers to the healthcare system," nurses have also adopted a strategy of practicing within a cultural safety approach to improve Indigenous peoples' access to healthcare (Horrill et al., 2018, p. 6).

Indigenous control over the design and administration of health services is recognized as central to ensuring cultural safety in health care provision in their communities (Cameron et al., 2014; Horrill et al., 2018; Ringer, 2017). The movement towards cultural safety and humility in health services delivery to Indigenous peoples is also gaining traction on a broader scale. For example, the FNHA has developed separate declarations of commitment on cultural safety and humility in health services delivery to First Nations peoples in British Columbia, which has been signed by health regulators, Emergency Management Services, Providence Health Care, the BC Deputy Minister of Health, and the CEOs from each of BC's six health authorities (FNHA, 2017a, b, c, d).



Strategies and Innovations for Improving Indigenous Peoples' Access to Health Services

The Truth and Reconciliation Commission identified the need to address health inequities as critical to the reconciliation process. Specifically, Call to Action #19 urged that measurable goals be established to “identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities... [including] the

availability of appropriate health services” (TRC, 2015, p 322).

There have been repeated calls to close the health gap between Indigenous and non-Indigenous peoples in Canada. To do so, the intersecting determinants of health that impede Indigenous health outcomes must be addressed, including access to housing, clean water, food security, education and employment, among others (Browne et al., 2016). Current health structures, policies, and systems must be transformed so that Indigenous peoples receive equitable access to

healthcare. Jurisdictional issues must also be resolved, including government compliance with the 2016 Canadian Human Rights Tribunal ruling to end racial discrimination against First Nations children, and true and ongoing investment in their health and well-being. Until these disparities diminish, access to health services will continue to be a concern for Indigenous peoples.

Key approaches to ensuring that Indigenous peoples' access to health care is optimized, comparable and equitable to non-Indigenous Canadians include:

Indigenous control over the design and administration of health services is recognized as central to ensuring cultural safety in health care provision in their communities

(Cameron et al., 2014; Horrill et al., 2018; Ringer, 2017).



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- committing to end jurisdictional issues, primarily through equitable funding and ending inter-governmental disputes that lead to poorer health outcomes for Indigenous peoples (Greenwood et al., 2018; Lavoie, 2018);
- training professionals across all public health disciplines and specializations in the delivery of culturally safe care, including actively dismantling racism, discrimination, and negative stereotyping of Indigenous peoples (Browne et al. 2016; Horrill et al. 2018; Nader, Kolhdooz, & Sharma, 2017; Smylie et al., 2018);
- engaging with Indigenous peoples to understand and develop health care practices that are meaningful to them, including traditional health practices and medicines (Browne et al. 2016);
- emphasizing community ownership and authority over health care services (Davy, Harfield, McArthur, Munn, & Brown, 2016, Browne et al., 2016);
- encouraging students in health care fields to seek out placements in rural, remote, northern and on-reserve Indigenous communities (Coke, Kuper, Richardson, & Cameron, 2016); and
- developing strategies for the recruitment and retention of Indigenous and non-Indigenous health human resources for on-reserve, rural, remote and northern communities (Vogel, 2019; Nader et al. 2017; Oosterveer & Young, 2015).



Innovations

A number of innovations are underway across Canada that seek to improve the health status of Indigenous peoples. Examples of a few include:

Aboriginal Health Access Centres (AHACs)

A network of ten Indigenous community-led, primary health care organizations across Ontario, serving Indigenous peoples in urban, rural, northern and on-and-off-reserve communities.

allianceon.org/aboriginal-health-access-centres

Akausivik Inuit Family Health Team - Medical Centre

A health centre that provides culturally appropriate primary care for Inuit living in Ottawa.

aifht.ca

Alberta Health's 'virtual' public health TB clinic

Established in 1999 as part of a restructuring of Alberta's TB program, the 'virtual' clinic serves all non-major metropolitan and on-reserve First Nations tuberculosis cases and their contacts. The clinic allows Indigenous people living in rural Alberta to be managed for their TB on site rather than having to travel long distances for treatment.

All Nations, Healing Hospital (ANHH)

Located in Fort Qu'Appelle, the ANHH is owned and operated by the 15 First Nations of the File Hills Qu'Appelle Tribal Council and Touchwood Agency Tribal Council. Affiliated with the Regina Qu'Appelle Health Region, the health care centre delivers a range of acute, palliative care, emergency services, women's health and midwife services, and laboratory and radiology services that are holistic, culturally-safe, patient-centred, and available in the five different languages of the region.

fortquappelle.com/health-emergency/all-nations-healing-hospital

My Child, My Heart

A community-based program provided in the community of Pinaymootang, Manitoba that allows First Nations children living with complex medical needs to receive the care they need in their own community.

nog.ca/wp-content/uploads/2018/10/Module-1-Appendix-B-Ninijjaanis-Nide-Parent-Tool-Kit.pdf



San'yas Indigenous Cultural Safety Training

A training program provided by the Provincial Health Services Authority in BC to enhance cultural safety knowledge and skills for professionals and organizations working with Indigenous peoples and communities. The program also hosts a national Indigenous Cultural Safety Learning Series through webinars.

sanyas.ca/health-authorities/provincial-health-services

Conclusion

This fact sheet provided an overview of ongoing challenges in the accessibility, availability and acceptability of health service provision to Indigenous peoples in Canada, with a view to identifying opportunities for addressing these challenges, and thus improving their health and well-being. Indeed, advancing this important social determinant of health requires challenging manifestations of ongoing colonialism, improving health systems and health human resources, addressing jurisdictional ambiguities, providing equitable funding for health programs and services, and supporting community-driven, culturally appropriate and culturally safe care for First Nations, Inuit and Métis peoples across Canada.

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