

socio-economic status, geography, lack of infrastructure and staff, jurisdictional ambiguities, and language or cultural barriers. While some barriers can be common to First Nations, Inuit and Métis alike, others vary significantly by both location of residence and by status.

Geographic, Socio-Economic, and Cultural Barriers to Equity in Health Services Access

Socio-economic barriers include lower levels of education and income. These barriers may reduce the quality of health care that individuals receive by delaying the early diagnosis and treatment of an illness or impede an individual's ability to pay for prescription medication or access additional health care services currently extra billed by physicians. This challenge to access is highlighted in Canada's increasingly urban Aboriginal homeless population. The latest Statistics Canada Census data reveals that of the substantial off-reserve First Nation population,ⁱⁱ three out of four live in urban areas.⁶ On-reserve housing conditions, lack of services and employment opportunities⁷ no doubt have contributed to this migration into the cities. However, sometimes the search for a better life in the city can lead to homelessness. While estimates vary, a study by Hwang (2001) reveals that Aboriginal people are over-represented in Canada's overall homeless population by a factor of ten; that is, in Canada's major urban centres they constitute a proportion of the homeless population that is ten times greater than their representation within the general population of that city. For example, while individuals of Aboriginal origin represent 3.8% of Edmonton's, 1.9% of Calgary's, 1.7% of Vancouver's, and 0.4% of Toronto's general population, they constitute 35%, 18%, 11% and 5% of the homeless population within these cities respectively.⁸ Homeless people encounter additional barriers to accessing health services which can include an inability

to provide proof of insurance coverage, mental illness or substance abuse problems, and a health care system that does not provide adequate treatment.⁹ Together, these barriers can result in neglect of personal health issues.

For the approximately 50% of Canada's Aboriginal population that lives in rural and remote locations, low population density, lack of transportation infrastructure, ability to speak only Aboriginal languages, long wait times, inadequate human resources, and northern climate conditions also act as significant barriers to health care access.¹⁰ Large distances and low population density mean higher service delivery costs per capita, resulting in reduced access to health services and health professionals.¹¹

It is this same geographic remoteness which, in particular, acts as a barrier in Canada's North, an area characterized by rural and remote communities. Tait (2008) notes, for example, that of the 52 communities across Inuit Nunaat that are home to most of Canada's Inuit population, none have year-round road access and only a few have hospitals. In these types of communities, provision of health services tends to be through health centres primarily staffed by a nurse rather than a doctor. Patients are less likely to access more specialized health care professionals such as dentists, family physicians, and other medical specialists, largely because these professionals tend to be non-residents and only fly into communities for short durations to see patients.¹² The remoteness and isolation of communities also translates into low retention of health professionals.¹³ Rural and Aboriginal communities face critical shortages of medical personnel. The nursing profession is considered to be in crisis and, proportionately, the number of physicians serving this population is

“under half of that serving the cities.”¹⁴ A lack of permanent health professionals coupled with low retention rates result in less continuity of care, which reduces the effectiveness of health services.¹⁵ For example, patients must undergo a lengthy paperwork process which can take days or even months to complete in order to obtain a drug exemption for a drug not currently listed on the Non-Insured Health Benefit (NIHB) Program's Drug Benefit List.ⁱⁱⁱ This process is complicated when patients must rely on visiting specialists who are only available for appointments once a month.¹⁶

The implications of a lack of access to health services in the North have meant that patients must leave their communities to access more specialized care. They are typically sent to urban locales in the south for medical emergencies, hospitalization, appointments with medical specialists, diagnosis and treatments.¹⁷ This means leaving behind their communities and their support networks. For 2005, 5% of Inuit adults in Inuit Nunaat indicated they had to temporarily be away from home one or more months due to illness.¹⁸ A lack of translation services can add additional stress to patients who speak only their Aboriginal language as they are unable to understand neither the nature of their illness nor the treatment prescriptions.

Not only must individuals have physical access to health services in order to have positive health outcomes, but the nature, quality and appropriateness of such services must also be considered. Halseth and Ryser (2006, 2007) point out that urban service delivery models (for example, rigid delineated job responsibilities between physicians and nurses) do not work well in rural and remote locales.¹⁹ One of the factors that affects the nature and quality of services is whether the service is timely. One of the obvious

ⁱⁱ According to the 2006 Statistics Canada Census data, only 40% of First Nations people are estimated to be living on reserve, while the remaining 60% live off reserve.

ⁱⁱⁱ The NIHB Drug List is a listing of drugs provided as a benefit by the Non-Insured Health Benefits Program. The drugs included on this list are those considered to be most cost effective.



effects of systemic barriers to access like long waiting lists and lack of health professionals is that early diagnosis of illness and disease is inhibited. Naturally, if individuals do not feel they are able to access medical help regularly, or even trust their health care professionals, they will be less likely to seek help when they experience symptoms. This means that diseases that are treatable when detected early are often not found until treatment or total recovery is no longer possible. Research has indicated that Aboriginal people are more likely to be diagnosed at a later stage of a disease than non-Aboriginal people, thus contributing to higher mortality rates.²⁰ These rates have been attributed to limited access to screening and treatment services as well as lack of awareness for early detection and prevention.

As well, because health is shaped by particular cultural, social and economic contexts, health care services must be responsive to diverse population segments,

and its failure to do so in the past has resulted in calls for cultural competency training for health professionals.²¹ Rohan points to lack of communication with health providers, lack of respectful or compassionate treatment, racism and discrimination as reasons for why health service provision must be more culturally appropriate. In addition, many Aboriginal people have a more holistic concept of health and healing that embodies a balance between mind, body, spirit and emotion, suggesting a need to include traditional practice-based service options as well as Euro-western American ones, and greater Aboriginal control of design and administration of health services for their communities.²² Transferring health services through First Nations and Inuit Health Branch (FNIHB) Transfer Agreements to First Nations communities seems to be a step in the right direction as there appears to be greater satisfaction and more accountability back to the community with these services.²³

Jurisdictional Barriers to Equity in Health Services Access

Jurisdictional issues also hamper access to health care services. Currently, Aboriginal peoples' access to health services and programs is fragmented given the complex nature of the health care system for Aboriginal peoples.²⁴ The federal government is responsible for providing limited primary health services for Inuit living within traditional territories and registered/status Indians^{iv} living on reserve. This responsibility is primarily vested in the FNIHB, which works with First Nations and Inuit organizations to carry out health promotion and protection activities, and provides funding for the delivery of community-based health programs to on-reserve and in Inuit communities, as well as drug, dental and other health services available through the Non-Insured Health Benefits Program (NIHB).^v One of FNIHB's key roles is the provision of primary care services on-reserve in remote and isolated areas where provincial services

^{iv} Registered, status or treaty Indian refers to those who reported they were registered under the Indian Act of Canada. Treaty Indians are persons who are registered under the Indian Act of Canada and can prove descent from a Band that signed a treaty. The term "treaty Indian" is more widely used in the Prairie provinces (Statistics Canada, Definitions, <http://www12.statcan.ca/english/census01/products/analytic/companion/abor/definitions.cfm>).

^v The NIHB program covers people for crisis intervention and mental health counseling, certain medical supplies and equipment, drugs, dental care, vision care, and medical transportation (see First Nations and Inuit Health: Benefits, Ottawa, ON: FNIHB, http://www.hc-sc.gc.ca/fnih-spni/nihb-ssna/index_e.html).

are not readily available.²⁵ In 2007, Health Canada reported that FNIHB provided primary health care to about 200 remote communities, as well as home and community care in 600 communities. They also operated 223 health centres and 74 nursing stations in semi-isolated communities. The Branch employed 22 physicians and 675 nurses, and was responsible for direct program delivery in two hospitals.²⁶ In addition, FNIHB also provided 41 alcohol and drug treatment centres and nine solvent abuse centres. Inuit living outside their traditional territories and registered/Status Indians off-reserve receive their medical care from provincial and territorial governments who deliver universal health services to all Canadians.

The complexity of the health care system for Aboriginal peoples has resulted in unequal access to health services. First, the NIHB program applies only to status Indians and Inuit, not to the Métis and other Aboriginal peoples who do not qualify for registration under the Indian Act. Second, devolution or transfer of responsibility to communities (in accordance with the Health Transfer Policy) or to health boards and other authorities has resulted in unequal provision of health services between provinces/territories, uneven distribution between communities, and very limited opportunity for increased funding.²⁷ As of 2001, 82% of eligible First Nations and Inuit communities had or were in the process of transferring responsibility.²⁸

It has also led to disputes between various levels of government over responsibility to pay for particular health services. The death of Jordan River Anderson, a young Cree boy who died while waiting for federal and provincial governments to resolve jurisdictional issues, underscores the inequity of health service provision for Aboriginal peoples.²⁹ Blackstock et al. (2005) identified 393 First Nations children (from 12 of the 105 First Nations

child welfare agencies) who were affected by similar jurisdictional disputes.³⁰ Extending these findings to all First Nations child welfare agencies suggests that thousands of First Nations children are potentially being denied access to government services each year.³¹

Similarly, the jurisdictional limitations that fail to recognize Métis identity and rights have resulted in health disparities among the Métis.³² While Métis have access to mainstream services, little or no attention is paid to their specific cultural or geographical needs.³³ While the federal government has recently included Métis in Aboriginal initiatives, funding has not been equitable to that of First Nations and Inuit or to the broader Canadian society.³⁴

Strategies for Improving Access to Health Services

Strategies to improve Aboriginal peoples' access to health services must be multi-pronged, targeting not just efforts to improve access by increasing an individual's ability to be seen by health professionals in a timely manner, but also the many socio-economic disparities that act as barriers to accessing health services. Approaches that take into account the social, economic, political, and cultural impacts on health, such as social determinants-based frameworks, must be applied. Until these disparities diminish, access to health services will continue to be a concern for Aboriginal peoples.³⁵

A new approach to health care provision has been called for in order to improve health outcomes for Aboriginal peoples. Rohan identifies four characteristics that are integral to such a new approach, including:

- provision of culturally-sensitive and appropriate health care services
- a shift towards preventive health and health promotions services

- the need to build on Aboriginal capacities and strengths
- emphasis on local control and authority over health care services³⁶

Key elements of such an approach include strategies that focus on the development of education and labour policies that will support the recruitment and retention of health human resources³⁷ and incorporation of holistic Aboriginal concepts into education and training of individuals, as well as integration of traditional Aboriginal and mainstream medicines to address the 'whole person.'

To ensure that health care services are culturally sensitive and appropriate, cultural awareness training that includes an understanding of the historical, cultural and socio-demographic realities of Aboriginal people and their communities must be provided for non-Aboriginal health practitioners,³⁸ and more Aboriginal health professionals must be trained and recruited to redress the current imbalance of Aboriginal representation in the health professions. As noted by the Aboriginal Nurses Association of Canada (2001), Aboriginal health professionals have "direct personal experience within the cultural context of their Nations and communities," a deep understanding of the problems affecting the health status of their communities, and the spectrum of values, worldviews and lifestyle characteristics of their communities.³⁹ This need has been recognized by the FNIHB through the Aboriginal Health Human Resources Initiative, a \$100 million contribution spanning five years targeted at increasing "the number of Aboriginal people working in health careers," retaining "health care workers in Aboriginal communities," and changing "educational curricula to yield health care providers that are culturally competent in providing health care services to Aboriginal people."⁴⁰ Development of cultural brokers and support for access to traditional healers and Elders would also assist with more culturally relevant service provision.



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