



## Disparities in health outcomes and inequities in the quality of health care services for Aboriginal Peoples

Aboriginal Health Advisory Committee — May 25, 2012

### Purpose

This is a review of evidence on the disparities in health outcomes and the inequities in the quality of health care services provided to Aboriginal Peoples when compared to general populations.<sup>1</sup> It serves to inform, sensitize and provide direction for the Royal College to conduct meaningful discussions on Aboriginal health.

### Introduction

There is a difference between “disparity” and “inequity.” Naomi Adelson, PhD, in the Canadian Journal of Public Health says it best: “Health disparities are those indicators that show a disproportionate burden of disease on a particular population. Health inequities point to the underlying causes of the disparities.”<sup>2</sup> This discussion paper will look into both strata.

It is well documented that disparities on the basis of race exist in Canada.<sup>3</sup> A leading scholar at the Harvard School of Public Health, Dr. Nancy Krieger, argues in a work published in 2011 that it is very important to understand the history of disease progression from ancient societies and their implications for improving population health and promoting health equity.<sup>4</sup> She presents strong evidence that cultural history is linked to current health disparities and inequities.

Although Aboriginal Peoples in Canada comprise only 3.4 per cent of the general population, they carry an inordinate balance of health issues in early childhood development, maternal health, community health, mental health, and chronic disease.<sup>5</sup>

To improve these, it is essential to understand the historical, social, political and ethical contexts of disparities. By its own admission, Canada recognizes the extent of the disparities. In 2004, a Federal/Provincial/Territorial health disparities task group stated that one of the most important factors contributing to health disparities is Aboriginal identity.<sup>6</sup>

Pathways to addressing health disparities and inequities are complex. In 2009, the National Collaborating Centre for Aboriginal Health categorized the determinants of health into four categories: social determinants (e.g., political, holistic, adequacy of public health data), proximal determinants (e.g., health behaviours, education, food insecurity), intermediate determinants (e.g., systems, infrastructure, cultural support) and distal determinants (e.g., colonialism, racism, self-determination).<sup>7</sup> As such, principles to foster Aboriginal health must be interconnected and holistic, recognizing the stages of an Aboriginal person’s development from infancy to old age.

### Programs that promote positive change are working

In fairness to the discussion there are positive programs in place that are making a difference. There are many examples of native-led and collaborative measures to address Aboriginal health. The National Aboriginal Health Organization (NAHO) highlights a list of community based projects that reconcile health care disparities and inequities.<sup>8</sup>

Core curricula for residents and physicians to promote culturally safe care for First Nations, Inuit and Métis patients were developed by IPAC and the Royal College in 2009. They also published a curriculum framework for continuing medical education<sup>9</sup> and IPAC with the Association of Faculties of Medicine (AFMC) produced a curriculum framework for undergraduate medical education.<sup>10</sup> These efforts could be further entrenched by expanding

the Objective Structured Clinical Examination (OSCE) to include clinical evaluations of physicians treating Aboriginal patients.

In October 2010, the Royal College provided critical care training to nurses at the Qikiqtani General Hospital (QGH) in Iqaluit, as part of a *Research to Action* pilot project in Nunavut. Following a focused needs assessment, an educational intervention customized to meet the particular needs of the nurses in QGH was developed and deployed. To address the issue of ongoing high attrition rate, a train-the-trainer component to the course was developed so that champions could be trained who would then provide ongoing training.<sup>11</sup>

The University of British Columbia (UBC) offers a certificate in Aboriginal health and community administration. Designed by The Institute for Aboriginal Health and Centre for Intercultural Communication and UBC Continuing Studies, the program is for benefit health and community administration staff currently and potentially employed in the Aboriginal health care field across British Columbia.<sup>12</sup>

Health Canada's First Nations and Inuit Health Branch (FNIHB) has sponsored a number of innovative public health projects with positive results.<sup>13</sup> Many subscribe to principles that set out guidelines for success. The Kenora Chiefs Advisory Public Health Pilot Project is an amalgamation of seven First Nation communities. Its guiding principles include

- respect for self-governance,
- support for individual community flexibility and
- recognition of the need for efficiency and accountability.

Another example shows the importance of fundamental principles. The File Hills Qu'Appelle Tribal Council Territory (FHQTCT) health project encompasses 11 First Nations in Saskatchewan. Its principles endorse

- First Nations control;
- holistic health; and
- collaboration with communities, providers and health care jurisdictions.

In all cases community involvement was a key operating principle in a First Nations health care system. Health delivery worked well when community governance structures were respected. Maternal and child health, home and community care, diabetes education, midwifery, environmental health and youth strategies were given special attention. Block funding agreements ensured continuity of programs and a degree of Aboriginal control.

If anything can be gleaned from community based projects two lessons stands out:

- Aboriginal people want more health not more health care.<sup>14</sup>
- First Nations self-determination cannot be supported when funders hold the power. This is why values and principles must also look at structural and systemic controls of resources contributing to health and health care.

### **Health disparities and negative outcomes – unpacking health inequities**

There are four stark facts that distinguish Aboriginal Peoples from the rest of Canadian society:

- they are the fastest growing demographic group in Canada;
- almost 60 per cent of the population is under 25 years of age — which points to tremendous opportunities in education and productivity;<sup>15</sup>
- more than half of all Aboriginal people live off-reserve — meaning that exposure to Aboriginal patients can occur anywhere, particularly in urban centres; and

- like native peoples in Australia, New Zealand, and the United States (CANU countries), Canada's Aboriginal peoples continue to suffer low quality of health compared to the general population.

One of the root causes for the low quality of health is the detrimental effects of colonization.<sup>16</sup> An Australian study has unequivocally demonstrated that the forced removal of children from their families to assimilate indigenous peoples has affected health for generations.<sup>17</sup>

Another important underlying cause of Aboriginal Peoples health inequity is residential schools. Although residential schools in Canada — designed to integrate children into mainstream society by destroying their cultural bonds — no longer exist, the legacy of damaged persons coming out of the system harms the health and wellbeing of their descendants. As described in a Canadian Medical Association commentary, "culturally safe health care becomes a core principle for the reorientation of health services to better meet the needs of vulnerable groups irrespective of their ethnic background."<sup>18</sup> Learning from history is to understand the Aboriginal patient and is a valuable exercise.

The legal framework that exists in Canada in regards to its Aboriginal Peoples is, in of itself, exacerbating health inequities. The concept of "Indian status" is offensive enough but when coupled with legal categories of registered, non-registered and treaty aboriginals,<sup>19</sup> non-status First Nations and Métis peoples face a bewildering array of access barriers to health care. To add further to the confusion, Canada's Indian Act — enacted in 1876 and rooted in colonial ordinances and royal proclamations — forms the basis for federal jurisdiction on reserves superseding provincial or territorial health laws. For example provincial smoking bans don't apply on reserve lands unless bands make a bylaw enforcing them.<sup>20</sup>

### **Facts around health disparities and negative outcomes**

Studies of indigenous peoples pour in and provide a continuous source for the health research stream. In 2001 the World Health Organization (WHO) published a comprehensive *Global Compendium of Indigenous Health Research Institutions* around the world. Its index covered no fewer than 200 institutions.<sup>21</sup> This is not an exhaustive list. The WHO also publishes a series of publications related to mental and physical health and racism.<sup>22</sup>

Australia's Aboriginal Peoples suffer tremendous health disparities brought on by social problems akin to people living in developing countries — and indigenous people living in Canada. With only 2.5 per cent of the population, Australia's native people endure high rates of poverty, unemployment, imprisonment, infant mortality, drug abuse, alcoholism, diabetes and heart disease.<sup>23</sup> The government's response is to take control and force improvement measures on these people. Outcomes are poor; the lack of consultation and cooperation in the intervention undermines indigenous communities' trust in the health system. Aggressive policies fuel fear and mistrust, hardly a good starting point for high-quality care. Canada's Aboriginal people fare no better.

According to Statistics Canada, First Nations, Métis and Inuit people suffer a greater burden of morbidity and mortality than non-Aboriginal Canadians; this is in part due to the higher rates of socio-economic disadvantages in Aboriginal populations.<sup>24</sup> In 2009 the United Nations Children's Fund (UNICEF) broadcast the results of a report on the health of Aboriginal people in Canada. The work was done in conjunction with the National Collaborating Centre for Aboriginal Health. The report concludes that "health disparities between First Nations Métis and Inuit children relative to national averages is one of the most significant children's rights challenges facing our nation."<sup>25</sup> Study after study continuously confirms the prevalence of chronic disease associated with poor living conditions.

St. Michael's Hospital in cooperation with the Canadian Institutes of Aboriginal Health Research conducted a systematic review of literature in the CANU countries on understanding the current quality of diabetes care for Aboriginal Peoples. Articles numbered 1,658; this is an astonishing number considering it represents only the tip of the iceberg for a serious health problem in western countries. Not surprisingly, risk factors were found to be high and there were large variations in quality within and between jurisdictions. However, there were positive signs of interventions that improved the quality of care in Aboriginal settings — namely emphasis on feedback (measurement) systems, clinical education and decision support and practice guidelines sensitive to the Aboriginal condition.<sup>26</sup>

### **Defining the baseline of high-quality health care**

The Royal College has adopted the following eight dimensions of quality: safety, accessibility, acceptability, appropriateness, provider competence, efficiency, effectiveness and outcomes. These dimensions touch the breadth of health care to enhance both patient and provider experience. The dimensions represent factors that overlap; they are not mutually exclusive. Their weight and influence are also dependent on care settings (e.g., team-based care, information systems) and other factors affecting program initiatives (e.g., social determinants of health, investment, policies).<sup>27</sup>

Leading quality improvement practices involve all stakeholders — including patients — consult across professions and measure results. Collaboration, communications and transparency are keys to success in achieving quality outcomes.

### **Traditional medicine has its place**

Traditional medicine is an acknowledgement of the value of “Indigenous knowledge” in its application in contemporary settings. It is identified by the WHO as a protected and cherished right in Aboriginal health and wellbeing. It promotes a holistic and collaborative approach to medicine and as such should be a foundation for the values and principles in Aboriginal health.<sup>28</sup>

The Aboriginal medicine wheel strongly relates to the determinants of health. The medicine wheel is a First Nations framework for Aboriginal health and wellbeing. It has universal concepts that are applicable to all Aboriginal Peoples. Its principles are based on four broad aspects of the human condition: the physical, the emotional, the intellectual and the spiritual — all interrelated.<sup>29</sup>

A qualitative study by a University of Saskatchewan faculty, the lead author a Plains Cree, found four consistent themes aptly lend themselves in describing Aboriginal health:

- medicine wheel aspects,
- value of health,
- environmental factors and
- economic factors.<sup>30</sup>

These are holistic perspectives entrenched in the determinants of health and they present an excellent basis for common ground between western medicine and “Traditional Indigenous” healing practices. This study shows that Aboriginal people are open to both worlds in their maintenance and pursuit of health and wellbeing.

### **Culturally safe care battles stereotypes and misinformation**

Promoting culturally safe care for First Nations, Inuit and Métis patients is rooted in the education of its health care providers. The Indigenous Physicians Association of Canada (IPAC) and the Royal College developed such a core curriculum for residents and physicians in 2009.<sup>31</sup> Here are some historical, political and cultural facts — from the curriculum — that

provide a starting point for understanding the health of indigenous peoples in Canada and around the world:<sup>32</sup>

- There are 300 to 350 million indigenous people worldwide in 72 countries; the definition of “indigenous” in some cases is contentious. The United Nations (UN) defines indigenous people as “the inheritors and practitioners of unique cultures and ways of relating to other people and to the environment. Indigenous peoples have retained social, cultural, economic and political characteristics that are distinct from those of the dominant societies in which they live.”
- There are 50 Aboriginal languages spoken in Canada; Cree, Inuktitut and Ojibway are the most common.
- In 2007 Canada, the United States, Australia and New Zealand voted against the UN’s *Declaration on the Rights of Indigenous Peoples*. The declaration outlaws discrimination and promotes indigenous peoples’ rights for self-determination. Canada argued that most of these rights were enshrined in other treaties. The Assembly of First Nations in Canada continues to lobby the government to ratify the declaration.
- A 1920 federal policy made residential school compulsory for all First Nations children; the policy’s purpose was to assimilate children and distance them from family and community. This policy meets one of the five criteria for genocide: forcibly transferring children from one group to another.
- The percentage of First Nations people who consume alcohol is less than the comparable percentage for the general population. A common stereotype perpetuates the opposite view.

### **Ethical research fuels health and health care equity**

Using Aboriginal knowledge to address disparities in health status must be the paramount reason for research; research for other than altruistic reasons present ethical issues. The Canadian Institutes for Health Research (CIHR) has developed ethical guidelines involving Aboriginal people. This framework espouses respect, reciprocity, relevance and responsibility which embrace collaboration, trust, transparency and full-participation in translating research into actions.<sup>33</sup>

One study in *Medical Education* of medical students participating in international health electives (IHEs) mirrors somewhat the interactions of non-Aboriginal physicians with Aboriginal patients. Five themes were portrayed: uncertainty about how best to help, perceptions of “Western” medicine as different, moving beyond one’s scope of practice, navigating different cultures of medicine and unilateral capacity building.<sup>34</sup>

### **Conclusion**

Canada’s Aboriginal Peoples suffer the worst health of any group. The legacy of colonization has deeply affected this outcome. Many forces continue to exacerbate disparities in health status and their underlying causes. First Nations, Métis and Inuit people are also the youngest groups in Canada. Perhaps this points to more emphasis needed in pediatrics, maternal and family health, early childhood development and youth engagement.

Principles for medical educators that embrace indigenous knowledge in traditional Aboriginal medicine and imprint its values in the education of medical students, residents and practising physicians will no doubt yield positive results. There are many native led and collaborative programs that show demonstrable improvements in health and care.

In 1998, the International Decade of the World’s Indigenous Peoples began.<sup>35</sup> Since then, awareness of these people’s plight has grown, their important contributions to the world

have gained more recognition and research on their human condition has flourished. In real terms, not much has changed. The challenge lies in making an impact beyond the rhetoric.

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