

Improving the health status of aboriginal people in Canada: new directions, new responsibilities

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Abstract • Résumé

The study findings reported in this issue by Dr. Harriet L. MacMillan and associates (see pages 1569 to 1578) demonstrate that aboriginal people in Canada bear a disproportionate burden of illness compared with the general population. In this editorial the author examines some of the factors that have contributed to this situation, such as poverty, cultural barriers and jurisdictional problems. The way forward lies in supporting the aspirations of aboriginal people for self-determination. Aboriginal people in Canada need to recognize and use their own professional human resources and to adopt more responsibility for improving the health status of their communities. At the same time, there is a need for greater acceptance by aboriginal people of existing initiatives for health promotion and disease prevention.

Les résultats d'études dont le Dr Harriet L. MacMillan et ses collègues font état dans ce numéro (voir pages 1569 à 1578) démontrent que le fardeau de la maladie est excessif chez les peuples autochtones du Canada comparativement à ce qu'il est dans la population en général. Dans cet éditorial, l'auteur décrit certains des facteurs qui ont contribué à la situation, comme la pauvreté, les obstacles culturels et les conflits d'attributions. Le progrès repose sur l'appui des peuples autochtones qui aspirent à l'autonomie politique. Les peuples autochtones du Canada doivent reconnaître et utiliser leurs propres ressources humaines professionnelles et assumer davantage de responsabilité face à l'amélioration de l'état de santé de leur communauté. Par ailleurs, les peuples autochtones doivent accepter davantage les initiatives actuelles de promotion de la santé et de prévention des maladies.

Aboriginal people bear a disproportionate burden of illness in this country. The study findings reported by Dr. Harriet L. MacMillan and associates (see pages 1569 to 1578 of this issue) demonstrate that, compared with the general population, many aboriginal people are at increased risk for a range of health problems, including infectious diseases, diabetes, cervical cancer, suicide, injuries and substance abuse. What factors have contributed to this depressing situation? What is needed for change?

Demographics

In Canada, aboriginal people registered as "Indian" under the Indian Act are referred to as "status or treaty

Indians" and, more recently, as "people of the First Nations." Represented politically by the Assembly of First Nations, they number approximately 750 000 and live primarily on reserves, although over the past three decades as many as 40% have moved off the reserves, mostly into large urban communities.¹

Aboriginal people who are not registered as Indians under the Indian Act are referred to as "non-status Indians." This group consists of approximately 250 000 people and is represented politically by the Council of Aboriginal Peoples. The Métis are aboriginal people of mixed ancestry (originally French and aboriginal) and reside primarily in the western provinces. This group consists of an estimated 160 000 to 250 000 people and is represented by the Métis National Council. The ap-

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proximately 36 000 Inuit people in Canada reside in the Northwest Territories and northern Quebec and are represented by the Inuit Tapirisat of Canada.¹

Contrary to common perception, most aboriginal people do not live on a reserve or "out there" somewhere. They are dispersed throughout Canada — in urban centres and rural communities as well as on reserves. The implication of this fact is that most health care providers have some patients who are aboriginal. To provide sensitive, culturally appropriate health care services for these patients, physicians need to be more aware of the social and political issues that affect the health status of aboriginal people.

The context of health

Despite the fact that the Canadian health care system has been praised as one of the best and most progressive in the world, quality health care is out of reach for many aboriginal Canadians. Federal-provincial jurisdictional disputes, cultural barriers and geographic isolation have impeded the access of aboriginal people to the health care system.²

The federal government maintains that the provision of health care to status Indians is a matter of custom and policy rather than a treaty right. Universal hospital and medical insurance now provides a basis for the delivery of health services to aboriginal people through the provincial health care systems.³ Although the Medical Services Branch of Health Canada provides public health services and noninsured health benefits for First Nations communities, the fact remains that these supplemental services are not adequate to achieve equity in health care for aboriginal people.²

Despite recent reductions in infant mortality rates,² the overall health status of aboriginal people remains poorer than that of the general population of Canada. Health problems of concern include mental illness, alcoholism and fetal alcohol syndrome, suicide, family violence, injuries, diabetes, tuberculosis, HIV infection, obesity and hypertension.² Incidence rates for these health problems among aboriginal groups are often several times higher than those in the general population; for example, the suicide rate among aboriginal men aged 15 to 25 is seven times the national average.⁴

On the positive side, preliminary data suggest that some subgroups of the aboriginal population have lower incidence rates of heart disease and cancer. However, knowledge about the contributing factors to the health status of aboriginal people is limited; in general, the literature does not address the role of confounding factors such as poverty, which has had a devastating effect on health status. Poverty creates dependency, limits self-expression and contributes to the demoralizing acceptance of substandard community infrastructures.

Canada's health care system is in a state of flux. Fed-

eral and provincial cutbacks, changes to comprehensive coverage and the difficulties faced by health care professionals who practise in the North are having a detrimental effect on the provision of health care services in aboriginal communities. In addition, because of self-exclusion, insufficient information and a lack of recruitment, mainstream health promotion and disease prevention programs are not reaching aboriginal people.

Meeting the multifaceted health care needs of aboriginal communities requires trained personnel in accredited fields. The short-term training given to the lay community health workers and community health nurses who provide limited diagnostic and therapeutic services on reserves is not sufficient to maintain an equitable health service, nor is it sufficient to meet the demands of current and new responsibilities or to keep abreast of new technologies.

New directions, new responsibilities

Although politics and health are closely linked, it is time for aboriginal people to look beyond the politics and address health care issues directly. There is a need for aboriginal and nonaboriginal Canadians to be more aware of the health issues affecting aboriginal communities. It is difficult to establish true partnerships between different societies when one is subject to the discretionary power of the other and the golden rule has come to mean "Those who have the gold, rule." It is essential that such partnerships be established and that special efforts be made to ensure their success. There is also a need for aboriginal organizations that will focus specifically on health issues, and for health care data systems that will include information on all aboriginal groups, not just the First Nations.⁵

Aboriginal communities need to recognize and use their own professional human resources. More recognition for aboriginal professionals is also needed on the part of policy-makers, government agencies and non-aboriginal health care professionals. Most people working in federal health care programs are not aboriginal; regrettably, many aboriginal people feel that federal aboriginal health care represents a large employment agency limited to members of the dominant society. This is an unfortunate situation that runs counter to government employment initiatives and deprives many capable aboriginal people of the opportunity to assume increased levels of responsibility in the health care field on behalf of their own communities, to whom they have a commitment that goes beyond the usual work day.

At the same time, there is a need for greater acceptance and utilization by aboriginal people of the health care resources already available to them. Aboriginal communities need to participate actively in existing initiatives for health promotion and disease prevention and to address health care issues of particular relevance to

aboriginal women. Although it is important to adapt existing services so that they are culturally appropriate, and to address issues such as the role of traditional healers, aboriginal people should not be co-opted into pursuing alternative or traditional health care methods to the exclusion of Euro-Western medicine.

It should also be recognized that the aboriginal community includes all aboriginal people in Canada, regardless of their location or occupation. Members of professional organizations such as the Native Physicians Association in Canada (NPAC), Native Psychologists in Canada (NPC) and the Aboriginal Nurses Association of Canada (ANAC) are part of this community and should be regarded as primary providers, partners and advocates. The NPAC includes over 100 physicians of aboriginal ancestry; most members are women working in primary care, and roughly 50% are actively involved in aboriginal health.⁶ The newly incorporated NPC now numbers 30,⁶ and there are at least 250 aboriginal nurses in Canada (ANAC: unpublished data, 1995). As more health care professionals of aboriginal ancestry identify themselves, and as more aboriginal people graduate as health care professionals, all three organizations will continue to grow.

The aspirations of aboriginal people must be recognized as the basis for action. New strategies and new infrastructures for the delivery of health care need to be brought forward and tested. Initiatives that facilitate self-determination, such as the commitment of the Medical Services Branch to the transfer of responsibility for health care to the community level,⁷ should be given priority. Consideration should also be given to the establishment of a national institute of aboriginal

health. Such an institution could monitor health status, serve as a sounding-board on health care issues and, eventually, assume responsibility for the health care programs currently administered by the government agencies.⁸

Although some gains have been made, there is still a significant imbalance between the health status of aboriginal people in Canada and that of members of the dominant society. The factors that determine the health of a community are multifaceted and complex: aboriginal communities are no exception. Even though their path to better health may be different from that taken by mainstream society, aboriginal communities should settle for nothing less than equity in health services; only then can they attain the health status enjoyed by other Canadians.

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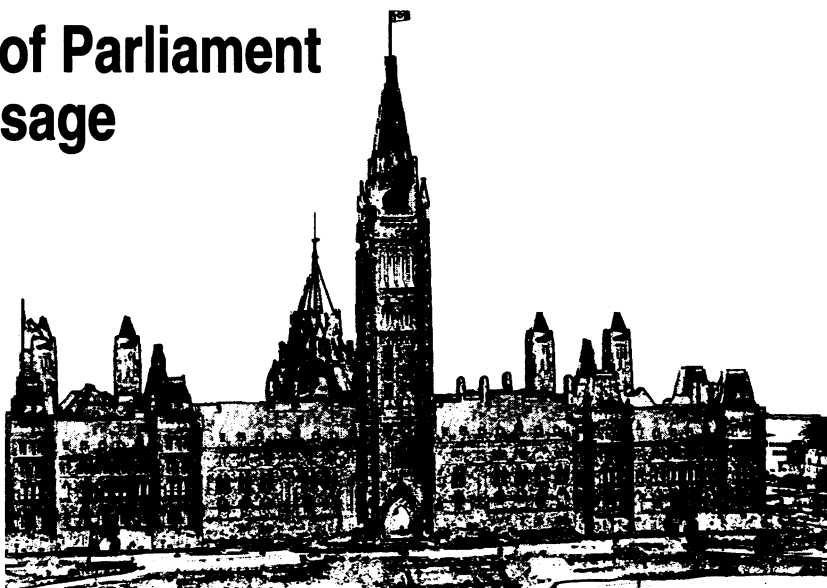
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