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TRC CTA

HEALTHCARE SERVICES

INDIGENOUS HEALTHCARE EDUCATION AND PRACTICE:
A Community-Led and Community-Informed Collaborative Initiative

Please note:

This Companion Guide is a resource created to complement the online modules.

This online module was developed by the Office of Professional Development and Educational Scholarship (Queen's Health Sciences) and the Northern Ontario School of Medicine (NOSM) to address the Calls to Action set forth by the Truth and Reconciliation Commission. This project is made possible with funding by the Government of Ontario and through eCampusOntario's support of the Virtual Learning Strategy. To learn more about the Virtual Learning Strategy visit the eCampus Ontario website (*click to view*).

MODULE 05 COMPANION GUIDE

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MODULE 05 COMPANION GUIDE

MODULE INTRODUCTION

Welcome to the learning module titled "Healthcare Services." This module is part of the seven-module series titled "Indigenous Healthcare Education and Practice: A Community-Led and Community-Informed Collaborative Initiative." Throughout the modules in this series you will be connecting the 2015 Truth and Reconciliation Commission (TRC) of Canada Calls to Action (CTA) report, a report designed to advance the process of Canadian reconciliation and redress the legacy of residential schools, to healthcare and education practice.[1]

For your interest, explore the Truth and Reconciliation Commission of Canada Calls to Action report.

Truth and Reconciliation Commission of Canada: Calls to Action

Calls to Action (CTAs) addressed in this module include: CTA 10, CTA 18, CTA 19, CTA 20, CTA 21, CTA 22, CTA 23, CTA 24, and CTA 62.

The modules in this series can be used to increase your awareness and knowledge of Indigenous healthcare education and practice. You will learn about historical perspectives of Indigenous Peoples in Canada and their implications for health outcomes, biases, racism, and discrimination in healthcare, Indigenous ways of knowing, healthcare rights and services, culturally safe healthcare, and intersections between education and healthcare. This module will specifically educate you on some of the various healthcare services available for Indigenous Peoples in Canada as well as highlight the challenges they may face accessing these services.

Note that these modules should be viewed as an introduction to Indigenous healthcare education and practice. It is important to continue to reflect and engage with this material over time, as our understanding and perspectives of this material are influenced by broader social and contextual factors. Please also recognize that decisions in regard to policy and legislation are constantly changing so it is important to keep up to date on current events. Gaining and understanding Indigenous healthcare education and practice is a lifelong journey that involves a willingness to learn, practice, and self-reflect. As you work through the modules of this series, please also acknowledge that the term health encompasses physical, spiritual, emotional, and mental wellness.

Content Warning: The content covered by this module may be difficult to process due to the challenging nature of the material. This may particularly occur if you have lived-experiences in relation to this material or are learning about these realities for the first time. We ask all learners to access supports if necessary.

Page Link:

https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

End of Module Introduction

MODULE 05 COMPANION GUIDE

HEALTHCARE SERVICES

In this module, you will learn about the historical and modern-day barriers, disparities, and risks associated with access to health services that are experienced by Indigenous Peoples in Canada. You will start the module by learning about the effects of laws, acts, and policies in healthcare on Status First Nations, non-Status "Indians", Métis, and Inuit in Canada. You will also learn about the non-insured health services and benefits (N I H B) program for First Nations, Métis, and Inuit patients; its implementation in the Yukon and British Columbia; and the barriers to accessing N I H B. Finally, you will learn about practical strategies you can adopt to promote positive change for Indigenous healthcare.

After completing this module, you will be able to:

- Identify the differences in health needs and provision of healthcare.
- Describe the various health services that are delivered to Indigenous Peoples and how multi-jurisdictional healthcare (federal, provincial, regional) can increase the risk of critical incidents, adverse events, medication errors, administrative barriers, and/or interruptions in the continuity of care.
- Describe the differences in provincial healthcare, federal healthcare, and community organizations that deliver healthcare on and off reserves .
- Articulate the diversity of access to federal N I H B for First Nations (Status and non-Status), Métis, and Inuit.

Introduction: Access to Healthcare Services for Indigenous Peoples in Canada

The access to health services by a diverse group of individuals in Canada, including Indigenous Peoples, is a vastly important aspect of healthcare. The provision of healthcare to Indigenous Peoples living in Canada is complicated for several reasons, including:

1. Federal and provincial/territorial jurisdictions are ambiguous
2. Indigenous and treaty rights are not recognized
3. Diverse needs of Indigenous Peoples and communities are not being met

Throughout this module, you will explore each of these three points in more detail to gain a comprehensive understanding of the gaps in healthcare access and quality for Indigenous Peoples in Canada. Before describing these three points in detail, it is important to gather a general understanding of some of the healthcare disparities for Indigenous Peoples in Canada and how they have come to be.

Gaps in Healthcare Services in Canada

The Canada Health Act (C H A) provides for universal access to healthcare, but inequalities exist. In spite of some recent improvements in health indicators, it is widely recognized that there are major inequalities in health between Indigenous Peoples and non-Indigenous peoples.[2] Severe and persistent health implications result from the health disparity faced by Indigenous Peoples compared to the non-Indigenous population. Indigenous Peoples continue to suffer a heavier burden of illness, as well as the onset of chronic illness and disability at younger ages than their non-Indigenous counterparts.[3] These

implications also include higher rates of chronic disease, trauma, interpersonal and domestic violence, and suicide, as well as lower life expectancy and higher infant mortality rates.[4]

Canada's overall average infant mortality in 2013 was 5 per 1000 live births. In Nunavut, however, where 85% of the population is Inuit, the average infant mortality in 2013 was estimated to be 18 deaths per 1000 live births, more than three times the national rate.[4]

Five of the main factors contributing to the disparity in healthcare outcomes include the traumatic historic experiences with healthcare, power imbalance, differences in perspectives, structural barriers, and limited access.

History and Power Imbalance

The social, political, and colonial history that Indigenous Peoples have experienced combined with modern-day interactions with healthcare providers and power imbalances within healthcare services have led many Indigenous Peoples to develop a pronounced mistrust and apprehension of accessing health services.[5, 6, 7, 8] This has resulted in poorer health and general well-being outcomes for Indigenous individuals. For instance, Indigenous Peoples face a greater likelihood of being diagnosed at a later stage of disease than non-Indigenous people.[7] As such, the investment in community preventative Indigenous-led programs are a vital pillar to improving health.

Differing Perspectives and Structural Barriers to Care

Patient-centred care approaches are vital aspects of healthcare that can repair or build relationships. However, structural barriers have prevented patient-centred care approaches in the healthcare experience of Indigenous patients.[9] Furthermore, the dominance of biomedical perspectives in the Western healthcare system may have contributed to the gap in present day Indigenous health inequalities.[5]

Other structural barriers to care related to health policies include the medicine-based (not relationship-based) and assembly line approach to care, improperly financed on-reserve health services, and the inaccessible and inequitable distribution of physicians.

“We need more doctors, period [...] Maybe 5 or 6 doctors here 24 hours a day, not all at the same time, but to look after the people with diabetes [...] There’s nobody doing too much about it...There’s about 10 or 15 doctors [in town] for a population of how many thousand, 10 000 people? And we don’t get that [...] 7,000 Indian people here on the reserve, what’s the ratio of doctor for people [here]?”

- Key patient quote[9]

Challenges to accessing care derived from various structural barriers include:

- Geographic isolation
- Appointment allocation
- Physician shortages, physicians coming and going from community, and healthcare worker turnover/lack of continuity of care
- No time to develop patient/provider relationships

- Patients are required to tell their story over and over
- Primary care reduced to referrals and prescriptions
- Long wait times

Access

In Canada, access to healthcare services is universal to all its citizens under the C H A, and the system is well known as one of the best globally. Under the C H A, access is defined as the equitable distribution of services to those in need for the common good and health for all residents. Equitable access does not imply that everyone receives the same number of services, but rather the fair and just distribution of resources, where the service provided is based on need.[10]

Despite the C H A, not all Canadians have equal access to healthcare services. Persistent inequalities in health status and access to healthcare services for Indigenous Peoples represent serious concerns as they also face barriers to achieve equitable access.[5, 10, 11, 12]

Alt Text: Inequality in healthcare continues to persist in Canada.

Compared to other groups in Canada, Indigenous Peoples tend to experience more difficulties in accessing healthcare services.[13] Data from the First Nations Regional Longitudinal Health Survey (2002-2003) indicated that 35% of Indigenous respondents felt that their access to healthcare services was less than Canadians in general.[14]

Learn about some of the difficulties faced by Indigenous Peoples in accessing healthcare services.

Quality Care

While 67% rated positively the quality of healthcare received, 24% rates their care as worse than that of Canadians. Respondents cited a alack of quality care and inaccessibility as the main reasons fort heir poor ratings of the quality of care they received.

Type of Treatment

15% of respondents in the National Aboriginal Health Organization poll reported unfair or inappropriate treatment from a healthcare provider in the past year, the majority of these being in off-reserve settings.[16] Most indicated their Indigeneity as the main reason for inappropriate treatment.[14,16]

Access to Specialists

A study reporting healthcare services use by First Nations in Manitoba found that while the health status of First Nations people is poorer than Manitobans in general, their access to specialists was overall significantly lower than that of their non-Indigenous counterparts.[15]

Receiving Healthcare

Findings from the 2003 National Aboriginal Health Organization poll revealed that 18% of First Nations respondents indicated that they had not received needed healthcare in the past year compared with 12% in the Canadian population.[16]

Waiting Times

Long waiting times was cited as the primary reason Indigenous peoples did not have access to the needed care.[14]

Apply Your Knowledge: Healthcare Disparities

Shah et al. (2020) found marked healthcare disparities for First Nations people living with diabetes in First Nations communities, including that they were:

- Less likely to have a regular family physician (85.3% versus 97.7%) and had lower continuity of care with that physician than other people in Ontario (mean score of 74.6 versus 77.7 respectively);
- Less likely to see specialists; and
- More likely to be admitted to the hospital for ambulatory-care-sensitive conditions (2.4% versus 1.2%).[17]

Answer the question using the information from the study.

Question: What do you think this information tells you about access to healthcare services?

Feedback: Most simply put, this data suggests that First Nations people with diabetes in Ontario had poorer access to and use of primary care than other people with diabetes in the province.

For your interest, read the study by Shah et al. (2020).

Use of the health care system by Ontario First Nations people with diabetes: a population-based study

Recall that the provision of healthcare to Indigenous Peoples living in Canada is complicated for several reasons, including:

1. Federal and provincial/territorial jurisdictions are ambiguous
2. Indigenous and treaty rights are not recognized
3. Diverse needs of Indigenous Peoples and communities are not being met

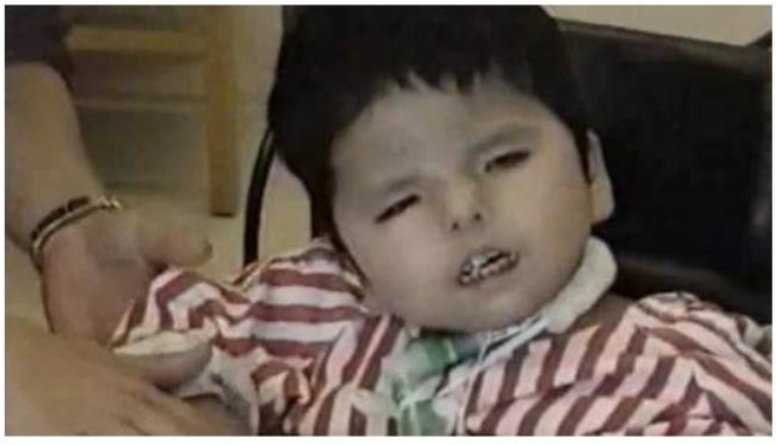
1. Multi-Jurisdictional Ambiguities

The division of powers within the Constitution Act resulted in the federal government being assigned responsibility for "Indians" while healthcare is a provincial and territorial responsibility. The provision of healthcare for Indigenous Peoples sometimes lands in a gray area with neither the federal government nor the provinces/territories wanting to take responsibility. Ambiguous and fragmented jurisdictional issues, including federal programs, provincially provided services, and highly bureaucratized add-ons, fail to meet the needs and constitutional rights of Indigenous Peoples.[4] This continues to result in "frustration, confusion, unmet health care needs and, most concerning, higher mortality and morbidity of Indigenous Peoples."[7] The situation of Jordan River Anderson was a classic case of this jurisdictional quagmire.

Example: Jordan's Principle

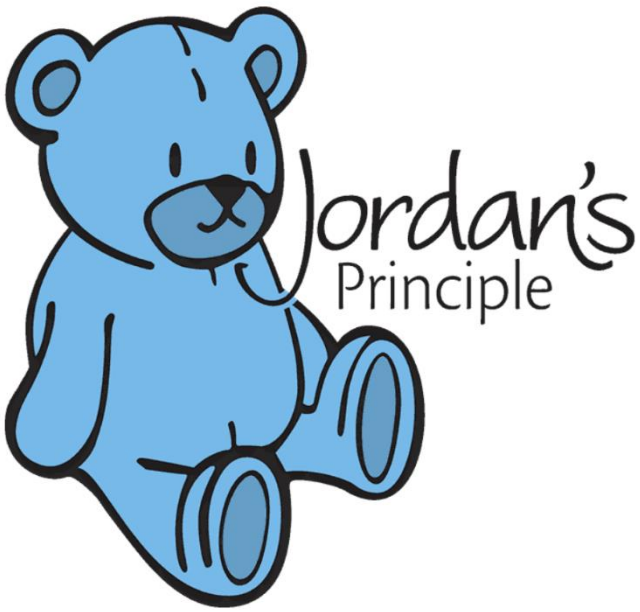
Jurisdictional disputes between the Government of Canada and provincial governments often result in service inequities and delays for Indigenous patients. A key example of this is the case of Jordan River Anderson.[18, 19]

Jordan River Anderson was a Cree child from northern Manitoba who was born with a rare neuromuscular disorder such that he spent his entire life in a hospital. When he was two years old, he would have been stable enough to go home with medical equipment and support. However, neither the province nor the federal government was willing to provide funding to support this transition. Jordan died at the age of five without ever being able to live at home with his parents and siblings.[18, 19]



Alt Text: Jordan River Anderson.[34]

In 2016, Canadian Human Rights Tribunal declared Canada's delivery of services for First Nations children "discriminatory":



Alt Text: Jordan's Principle logo. © First Nations Child and Family Caring Society.[35]

"Canada's conduct was willful and reckless resulting in what we have referred to as a worst-case scenario under our Act."[18]

- Canadian Human Rights Tribunal Orders Compensation 2019, CHRT 39 paragraph 234

After extensive lobbying by Indigenous groups, the federal government passed **Jordan's Principle**, a legislative agreement which states that Indigenous children should have access to the products, services, and supports they need, and determining who is responsible for paying can be decided afterwards. Jordan's Principle also states that "...any public service ordinarily available to all other children must be made available to First Nations children without delay or denial." This policy applies to "all First Nations children, regardless of whether they live on or off-reserve" and requires that the government department first approached to address the medical needs of the child will pay for the service.[18]

2. Indigenous and Treaty Rights

Another reason that the provision of healthcare for Indigenous Peoples is challenging is recognizing Indigenous and treaty rights. These rights were entrenched in Section 35 of the Constitution Act, 1982, and although these rights are not defined, they include the right to healthcare.[21] The right to healthcare is also recognized in international legislation, such as the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Of the 70 historic treaties in Canada with several modern treaties, land claims, and self-government agreements, only a few of these modern treaties have healthcare provisions.[21]

Similarly, the laws that support healthcare for Indigenous Peoples are scanty.

Learn about the law supporting healthcare for Indigenous Peoples in Canada.

Indian Act

The Indian Act (refers to section 73 g) states that the Governor in Council may make medical treatment and health service regulations for "Indians."[22] In addition, Section 81 allows Band Councils to make by-laws that "provide for the health of residents on the reserve and to prevent the spreading of contagious and infectious diseases."[22]

Indian Health Policy

Examples of federal health policy include the Indian Health Policy, 1979, which recognized that First Nations and Inuit communities could assume responsibility for health programs.

Canadian Health Act (C H A)

The C H A, passed in 1984, does not address healthcare for Indigenous Peoples at all. Canada maintains that the provision of healthcare to Indigenous Peoples is a matter of policy, not rights.

Health Transfer Policy

The Health Transfer Policy devolved the administration of health programs to many First Nations and Inuit communities.

Since the Health Transfer Policy, many individual First Nations and regional health organizations have signed health transfer agreements with the federal government to provide health services within communities. Community health programming has evolved over the past 30 years with the addition of services, such as diabetes prevention and home and community care. Community clinics might also offer provincially funded programs. Thus, First Nations people living on-reserve and Inuit living in their traditional territory have access to a range of health programs and services within their community. First Nations and Inuit people living away from their community can access the provincial or territorial healthcare system.

Métis

For many years, the provision of healthcare to Métis people was largely ignored by the federal government. The 2016 Supreme Court Daniels decision confirmed that the Métis were also a federal

responsibility. The Métis have been able to leverage funding for health supports and services, and in 2017 signed a historic Canada-Métis Nation Accord that prioritizes health. For Métis peoples' health services, funding is channeled through provincial organizations such as the Métis Nation of Ontario.

Alt Text: Métis flag.

3. Identifying the Diverse Health Needs of Indigenous Peoples

The federal government is finally taking a distinctions-based approach to health by recognizing that the three groups of Indigenous Peoples in Canada - First Nation, Inuit, and Métis – have different needs and priorities. These needs and priorities are often determined by where Indigenous Peoples live and their accessibility to healthcare programs and services.

Compare barriers to Indigenous Peoples in rural and urban communities.

Indigenous Peoples in Rural Communities

Many Indigenous patients, particularly those in remote and northern communities, experience difficulty accessing healthcare services. Some barriers specific to those in rural communities include:

- Difficulty recruiting healthcare providers to communities;
- Lack of specialist services; and
- Substantial travel costs and time for patients seeking care.[7]

As a result of these barriers, patients experience longer wait times to see healthcare providers and specialized medical professionals. This delays the diagnosis of illnesses, and can subsequently result in less continuity of care, and reduce the overall effectiveness of health services.

Indigenous Peoples in Urban Communities

Indigenous Peoples in urban communities also face significant barriers in accessing healthcare, some of the most prominent of which are the failure to provide proof of health insurance and inadequate care for mental health conditions and substance use disorders.[7]

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To learn more about the healthcare services available to Indigenous Peoples and the barriers that many Indigenous Peoples face when trying to access healthcare services, you will explore the eligibility, available benefits, and barriers to the Non-Insured Health Services and Benefits (N I H B) program.

Non-Insured Health Services and Benefits (N I H B)

The N I H B program provides eligible First Nations and Inuit patients with coverage for a range of health benefits that are not covered through other social programs, private insurance plans, or provincial or territorial health insurance.[23]

As articulated by the Government of Canada, the clients eligible for N I H B must be a resident of Canada and must also be:

- "A First Nations person who is registered under the Indian Act (commonly referred to as a [S]tatus Indian);"
- An Inuk recognized by an Inuit land claim organization; or
- A child less than 18 months old whose parent is a registered First Nations person or a recognized Inuk." [23]

As of March 2015, there were approximately 825,000 First Nations and Inuit individuals eligible for N I H B. The N I H B provides a range of benefits to its clients.

Learn about the benefits of the N I H B.

Medical Services and Supplies

The N I H B provides access to "medically necessary" services, medical supplies and equipment, pharmaceuticals, vision and dental care, and mental health counselling that are not covered under provincial/territorial health programs.

Medical Transportation

It covers medical transportation to access services not available in an individual's community.

Compensation

In situations where services are provided through another insurance plan, it is the responsibility of the N I H B program to coordinate payments with the appropriate provincial/territorial or First Nation, in order to ensure that patients receive the services they require.[24]

In recent years, there has been a push by the federal government for the transfer of responsibility for health programs and services to communities. In some cases, this has resulted in self-government.

Explore two examples to see how this transfer of responsibility impacts N I H B programming and health benefits.

Yukon

In the Yukon, in which all First Nations are self-governing and community members are beneficiaries of their First Nation regardless of Status, First Nations can take over the responsibility for health providing programs and services from the federal/territorial government. First Nations that have taken over the responsibility of providing health services receive a lump-sum transfer payment to do so.

N I H B still provides funding to Yukon First Nations based on the number of registered Status First Nation people they have as members. Oftentimes, Yukon First Nations will pool the resources and funding provided by N I H B and will redistribute them to both Status and non-Status beneficiaries.[33]

British Columbia

Similarly, in 2013, the First Nations Health Authority (FNHA) assumed responsibility from the First Nations and Inuit Health Branch (FN I H B) for the administration of healthcare programs and services for 203 First Nations communities across British Columbia.[7]

Barriers to Accessing N I H B

While N I H B exists and is extremely beneficial to Indigenous Peoples, there are many barriers to access. The 2017 program evaluation commissioned by Health Canada reported the major barrier to accessing N I H B benefits as a large degree of ambiguity surrounding eligible benefits, goods, and services covered under the program.[24] Other cited barriers included:

- Issues with the coordination of benefits between N I H B and provincial/territorial health insurance programs;
- Issues navigating coordination with other health benefit programs;
- High administrative costs and burden stemming from "a lack of administrative consolidation of different types of services, such as dental, pharmacy, medical equipment, and vision"; and
- High medical transportation costs.[24]

As a result of this program evaluation, recommendations were made to expand local access to care and explore alternative healthcare models, particularly in rural and isolated Indigenous communities, as a means of improving N I H B clients' health.[24] Further program evaluations were completed and reported upon within the First Nations Health Transformation Summit Report in 2018. This report shared barriers to accessing N I H B-related healthcare cited by First Nations adults including costs not covered by the N I H B, a lack of knowledge around N I H B coverage, and N I H B denial of coverage.[25]

A key takeaway from the First Nations Health Transformation Summit Report was that healthcare funding structures for Indigenous citizens need to be transformed and that "...closing the health gap could not occur without sustainable, long-term, and flexible funding..." [26] This report also states that current funding models, including N I H B, are insufficient in addressing health needs and current health gaps. Further, it reiterates the notion that the administrative burden needs to be considered in any systems-level change striving to improve the Indigenous Canadians' access to health services.[26]

The terms defined in various laws and Acts have historically granted a range of benefits to specific groups of people, while excluding others within Canada. Established in 1876 and amended in 1985, the

definitions within the Indian Act are often large barriers to N I H B access. Similarly, the legislature stated in the Constitution Act of 1982 can also act to create a gap in access.

Learn more about how the definitions of various Indigenous Peoples within these Acts can create differential access to healthcare programming like N I H B programs.

Status First Nations

The Indian Act defines "Status Indian" as First Nations individuals registered under the Indian Act on the Indian Register. Under the Indian Act, "Status Indians may be eligible for a range of benefits, rights, programs and services offered by the federal and provincial or territorial governments", including N I H B.[22]

This act only applies to Status First Nations and has not historically recognized Métis and Inuit, even though they are Indigenous to Canada. As a result, Métis and Inuit Peoples have historically not had "Indian [S]tatus" or the rights to services and funding associated with this status.[27, 28]

Non-Status Indians and Métis

"Non-Status Indians" are First Nations individuals who are not registered under the Indian Act. These individuals may not qualify for Status based on the Indian Act or they may have lost their Status prior to the passage of Bill C-31 in 1985 through the marriage of a non-Status individual.

Non-Status First Nations are not eligible for N I H B and other federal rights and benefits. Similarly, Métis are not eligible for the N I H B program. Despite the Supreme Court ruling in 2016 stating that "Indian," as defined by section 91(24) of the Constitution, now includes non-Status First Nations, as well as Métis citizens, this ineligibility persists as these changes applied only to the Constitution, not the Indian Act.[27]

Inuit

In Canada, Inuit are a distinct legally recognized Indigenous group as defined in the Constitution Act of 1982. Inuit are eligible for N I H B as long as they are recognized under the Nunavut Land Claims Agreement or the Inuvialuit Final Agreement.[28, 29]

Other Available Health Services in Canada

N I H B programming is not the only healthcare service available to Indigenous Peoples in Canada.

Explore three different healthcare services and programs available to Indigenous Peoples: the Indian Health Policy, the First Nations and Inuit Health Branch (FN I H B), and Aboriginal Health Access Centres.

Indian Health Policy

Adopted in 1979, the Indian Health Policy formalized the federal government's responsibility for providing healthcare coverage and services to eligible Indigenous Peoples, including:

- Status First Nations individuals "registered under the Indian Act (commonly referred to as [S]tatus Indians)";
- "Inuk individuals recognized by an Inuit land claim organization"; and/or
- Children "less than 18 months old whose parent is a registered First Nations person or a recognized Inuk" through the N I H B program.[4, 23]

First Nations and Inuit Health Branch (FN I H B)

The FN I H B provides support for on-reserve health services across Canada. The type and level of service varies by community. In select communities, FN I H B also funds programs for specific priority conditions and populations including diabetes management programs, perinatal and early childhood support programs, and substance use treatment and awareness programs.

Other considerations related to FN I H B services include:

- Physician services are not funded by N I H B (a program of the FN I H B) as these are considered a provincial responsibility. There may be agreements between provincial governments and physician groups to provide care in Indigenous communities.
- Like any other resident, Indigenous individuals are also eligible for provincial health insurance and drug benefit programs, as well as funded home, community, and long-term care services.

Aboriginal Health Access Centres (AHACs)

In Ontario, AHACs are community-led, provincially funded, and aim to provide culturally safe primary care and social services for off-reserve Indigenous individuals. They provide "a combination of traditional healing, primary care, cultural programs, health promotion programs, community development initiatives, and social support services." [30] AHACs are designed to serve as entry points into the provincial health system for Ontario communities experiencing barriers to accessing healthcare. In 2021, there were 10 operating AHACs in Ontario.

Logo for Ontario's Aboriginal Health Access Centres. The Government of Ontario provides more information on Aboriginal Health Access Centres *(click to view).*[31]

Practical Strategies for Reducing Barriers to Healthcare Services

Watch the video of Yolanda Wanakamik, the Director of Indigenous Affairs at the Northern Ontario School of Medicine, describe some practical strategies to implement the TRC Calls to Action (3:45).

TRC CTA: Understanding Policies and Health Outcomes

Start of Video Transcript:

[text] Please introduce yourself and your role in the health professions.

[Yolanda Wanakamik] Sure. My name is Yolanda Wanakamik and I am the Director of Indigenous Affairs at the Northern Ontario School of Medicine.

[text] What are some practical strategies for integrating Indigenous Ways of Knowing into healthcare practice and education?

[Yolanda Wanakamik] Yes. That's the key word, practical strategies, because there are lots of strategies that are out there. There's lots of information out there, you know. But some of the practical things that I always like to tell people to think about when they're starting this journey and this work is to acknowledge how racism and colonization are intertwined and deeply impact healthcare outcomes for Indigenous Peoples. There are many scholars doing this work to sort of make it practical and hands-on for people to access to really understand that those are some basic concepts, that you need to understand to be able to view what's going on in Indigenous health. Understanding the Indian Act is also something that's extremely important to understanding health outcomes because these policies undermine healthcare initiatives and programs and services in this country. Knowing what the residential school is is really important. And it isn't something that is universally taught in our K-12 sector. It needs to be taught in that sector and people have to understand that experience in this country and where those policies came to start and why they were there and how they still continue today. I think understanding the differences, there are significant differences between the federal and provincial healthcare systems in this country. So understanding that from an Indigenous perspective means that, you know, healthcare services are provided by the federal government. In the rest of Ontario, it's provided by the provincial government, so there's quite a differentiation between the two systems. So understanding and knowing that from a public policy sort of perspective is really important. And I think the other thing that's important is to think about implicit bias, trauma-informed care, and understanding how we all have biases. It doesn't matter, you know -- if I'm an Indigenous woman, I have biases as well so recognizing and acknowledging those biases are really, really important. And I think understanding that that learning begins with you and it can't be just something that we are looking to others to inform us about. Right? There is some level of understanding. If you're in a great undergraduate program or post-graduate program, you know, I would hope that your faculty is teaching some of this to you in different context no matter what your undergrad degree is in. I think it's important to understand the Indigenous context in Canada, even more so in Ontario and to your specific area and region. I think those are things that you can do to reach out for that learning and not just expect others to sort of hand that to you in a book or in a journal or -- you know so it's piecing all those things together. And then it's also understanding, I think, from a community perspective. So when you are in a community and understanding the differences between, you know, the federal system and the provincial system, go out and try to learn about that. Like what is the difference between one and the other? You know participating in Indigenous community gatherings. You know oftentimes people ask me, am I allowed to go to this? Of course you're allowed to go to this. It says everybody is welcome, so that means you as well so -- and I don't think that, you know, it should be compartmentalized. I think it's very open and Indigenous people invite others to come, and learn, and be a part of, and support the work that they're doing.

End of Video Transcript.

Multiple practical strategies exist to address the differences in health needs and to reduce the barriers to healthcare service access.

Learn more about these solutions.

Employ Culturally Appropriate Practices

Urgently enhance the delivery of culturally appropriate practices in emergency.[14]

Address Structural Injustices

Attention is required to address the structural injustices that act as barriers to access, such as addressing the stigma, stereotyping, and discrimination experienced by Indigenous Peoples in this study.[14]

Educate Yourself on Cultural Values

This entails the need to recognize cultural values, to question common assumptions, to foster a trusting relationship and a safe space between nurse and patient, to acknowledge cultural individuality, and to "treat people with dignity and compassion." [32]

Become an Advocate

Use your social capital as a healthcare professional to promote change and become an advocate for Indigenous healthcare that will lobby for changes in legislation (e.g., improved access, equitable resources, support needs and rights). Advocacy may also involve sharing information through your social networks (e.g., media, interpersonal interactions, etc.).

Page Links:

https://doi.org/10.9778/cmajo.20200043

https://www.ontario.ca/page/aboriginal-health-access-centres

https://player.vimeo.com/video/677201167?h=0312aaad66

End of Healthcare Services

MODULE CONCLUSION

In this module, you learned about the historical and modern-day barriers, disparities, and risks associated with the access to health services experienced by Indigenous Peoples in Canada. Next, you understood the effects of laws, acts, and policies in healthcare on Status First Nations, non-Status Indians, Métis, and Inuit in Canada. You also learned about the N I H B program, its implementation in Yukon and British Columbia, and barriers to accessing N I H B to some Indigenous Peoples. Finally, you recognized practical strategies you can adopt to promote positive and meaningful change for Indigenous healthcare.

You have completed one of the seven learning modules within the series "Indigenous Healthcare Education and Practice: A Community-Led and Community-Informed Collaborative Initiative." The modules within this series aim to increase your awareness and knowledge of Indigenous healthcare education and practice. These modules explore how Indigenous Peoples' health outcomes have been negatively impacted by colonial policies and practices, and how the health and well-being of Indigenous Peoples can be improved through the inclusion of traditional healing practices and by addressing biases, racism, and discrimination within the healthcare system.

Acknowledgements

This online module was developed by the Office of Professional Development and Educational Scholarship (Queen's Health Sciences) and the Northern Ontario School of Medicine (NOSM) to address the Calls to Action set forth by the Truth and Reconciliation Commission. This project is made possible with funding by the Government of Ontario and through eCampusOntario's support of the Virtual Learning Strategy. To learn more about the Virtual Learning Strategy visit the eCampus Ontario website (*click to view*).

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