

HEALTH SECTORAL SESSION
BACKGROUND PAPER

Prepared by Health Canada
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INTRODUCTION

The purpose of this paper is to provide a common context for all participants in the Health Sectoral Session being held as part of the follow-up to the April 19, 2004 Canada-Aboriginal Peoples Roundtable.

BACKGROUND

Supporting the identified need for a renewed dialogue that would contribute to transformative change and improve the lives of Aboriginal people in Canada, the Right Honourable Paul Martin chaired the Canada-Aboriginal Peoples Roundtable on April 19, 2004. The Roundtable was to signal a strong desire to strengthen the relationship between the Government of Canada and Aboriginal leadership and a commitment to achieving tangible progress in improving the health and well-being of Aboriginal peoples and communities. There were four outcomes emanating from the Roundtable, including:

- producing a Roundtable Report, *Strengthening the Relationship*, which provides a written record of what was heard at the Roundtable (completed);
- developing an Aboriginal Report Card;
- holding sectoral follow-up sessions on quality of life issues discussed at the Roundtable; and
- holding a policy meeting between Aboriginal leadership and members of the Cabinet Committee on Aboriginal Affairs.

The April 19, 2004 Roundtable focussed on five areas: achieving results, economic development, education, health and housing. At the Roundtable conclusion, the Prime Minister committed to convening a series of sector-specific policy sessions in partnership with Aboriginal peoples. The sessions are to involve Aboriginal experts and organizations, provincial and territorial health practitioners, community health workers, National Aboriginal Organization representatives, Federal/Provincial/Territorial government officials, and private sector representatives, as well as other experts from across Canada. The six sector issues identified were: health, life long learning, housing, economic development, negotiations, and accountability.

On September 13, 2004 the Prime Minister chaired a Special Meeting with First Ministers and Aboriginal Leaders to discuss joint actions to improve Aboriginal health, and adopt measures to address the disparity in the health status of this population. First Ministers and Aboriginal leaders agreed to work together to develop a blueprint to improve the health status of Aboriginal peoples and health services in Canada through concrete initiatives for:

- improved delivery of and access to health services to meet the needs of all Aboriginal peoples through better integration and adaptation of all health systems;

- measures that will ensure that Aboriginal peoples benefit fully from improvements to Canadian health systems; and
- a forward looking agenda of prevention, health promotion and other upstream investments for Aboriginal peoples.

The blueprint will recognize that programs and activities to be undertaken must recognize and respect the unique, specific and different needs of all Aboriginal peoples regardless of age, gender or geography. The blueprint will be developed within the next year in collaboration with First Ministers and Aboriginal Leaders.

In support of the agreed upon directions, the federal government also announced a series of new federal commitments to improve health services and reduce the gap in health status between Aboriginal and non-Aboriginal Canadians. The funding announced includes:

- **\$200 M** for an **Aboriginal Health Transition Fund** to enable governments and communities to devise new ways to integrate and adapt existing health services to better meet the needs of Aboriginal people.
- **\$100 M** for an **Aboriginal Health Human Resources Initiative** to increase Aboriginal people choosing health care professions; adapt current health professional curricula to provide a more culturally sensitive focus; and improve the retention of health workers serving Aboriginal people.
- **\$400 M** for **health promotion and disease prevention programs** focusing on diabetes, suicide prevention, maternal and child health, and early childhood development.

The Health Sectoral Session is a process that will be complementary, but not a direct follow-up, to the September 13, 2004 Special Meeting between First Ministers and Aboriginal Leaders. It is intended to bring together experts to explore and provide advice on health in a way, complementary to the development of the blueprint, that will allow greater examination of Aboriginal health from the perspective of the distinct needs of First Nations, Inuit and Métis. This session will also draw in perspectives related to unique needs with respect to geography (urban, rural and remote) and gender.

CURRENT SITUATION - THE HEALTH SYSTEM

Aboriginal people face similar health challenges no matter where they live. Effective solutions require an inclusive approach that engages all Aboriginal people. At the same time, the diversity that exists among Aboriginal people and their different pasts, perspectives, cultures and needs need to be taken into account.

Federal/provincial/territorial governments and Aboriginal organizations are all involved in Aboriginal peoples' health. To improve Aboriginal health, we should explore ways to work together more effectively.

The primary federal role is to ensure access to health services to First Nations living on reserve and to Inuit living in Inuit communities. Through the First Nations and Inuit Health Branch (FNIHB) of Health Canada, the federal government delivers:

- some targeted health promotion programs for all Aboriginal people, regardless of residency;
- public health and community health programs to First Nations living on reserves;
- primary care in remote and isolated First Nations reserves; and
- insurance coverage of drug dental, vision and medical transportation for all status First Nations and Inuit through the Non-Insured Health Benefits program.

Approximately 80% of First Nation communities are involved in the devolution process. The federal government plays a significant national leadership role in areas such as research and evaluation, and policy development in respect of the special relationship between the federal government and Aboriginal peoples.

Provincial governments provide universal insured health services (e.g. physician and hospital services) to all citizens, including all Aboriginal groups. Provinces also provide community and public health programs, long-term care, nursing homes, and home and community care for all residents, including Aboriginal people, unless they live on reserve.

In the Territories, the federal government has devolved health services to the Territorial governments. However, the federal government continues to deliver some targeted programming to First Nations and Inuit in the territories - mostly in prevention and promotion activities.

The health system for Aboriginal people is challenged by the health status of Aboriginal people being significantly poorer than the average Canadian. There are unclear jurisdictional roles between provinces, territories, federal government and Aboriginal peoples. There are also gaps and discontinuity between federal programs and services and provincial services, a situation further complicated by the fact that many Aboriginal people live in rural and remote communities where access to health care services is limited.

CURRENT POLICY ENVIRONMENT

In the **2003 Health Accord**, First Ministers recognized that addressing the serious challenges that face the health of Aboriginal peoples would require a dedicated effort. To this end, the federal government committed \$1.3 billion in Budget 2003 to support health programs for First Nations and Inuit. First Ministers also committed to collaborate with Aboriginal people to meet the objectives in the Accord, to address the gap in health status through better integration of services, and to consult with Aboriginal peoples on the development of a comparable Aboriginal Health Reporting Framework.

Budget 2003 further confirmed the federal government's intention to take concrete actions to

improve health status of Aboriginal people. Numerous budget announcements targeting Aboriginal people, also included initiatives in, housing, education, culture, business development, water and sewer, policing. Taken together, these new investments make up a substantial package that contributes to the health of Aboriginal people.

The **February 2004 *Speech From the Throne*** called for Aboriginal people to share in Canada's good fortune and participate fully in national life. It also outlined the importance of a better start in life for Aboriginal children, education and skills development for Aboriginal individuals, and improved governance and economic opportunities for Aboriginal communities.

In support of the identified need for a renewed dialogue that would contribute to transformative change and improve the lives of Aboriginal people in Canada, the Right Honourable Paul Martin chaired the unprecedented ***Canada-Aboriginal Peoples Roundtable*** on April 19, 2004. The goals of the Roundtable included a renewal of the relationship between the Government of Canada and Aboriginal leadership and discussion of meaningful ways of making tangible progress on improving the health and well being of Aboriginal peoples and communities.

The Health discussion that was part of the Canada-Aboriginal Peoples Roundtable acknowledged that although progress in closing the gap has been made, there is still room for improvement. During this Health discussion, the following key issues were raised:

- mental health, including suicide prevention;
- health care system access;
- need for a holistic approach to health and wellness, including a balance between traditional medicine and healing and western medicine; and
- healthy children's development.

The September 2004 First Ministers' Meeting resulted in a ***Ten Year Plan to Strengthen Health Care***. The plan identifies a number of elements including Prevention, Promotion and Public Health. This Plan identifies the need to accelerate reform and ensure better access to key tests and treatments, as well as to increase the number of doctors, nurses and other health professionals. This Plan will improve access to home and community care services and to safe and affordable drugs. To support this element, the federal/provincial/territorial (F/P/T) governments committed to further collaboration and cooperation in developing a coordinated response to infectious disease outbreaks and other public health emergencies through the new Public Health Network. F/P/T governments also committed to accelerating work on a pan-Canadian public health strategy and working across sectors through initiatives such as healthy schools. There was also a commitment by the federal government to ongoing investments for needed vaccines through the National Immunization Strategy.

The **October 2004 *Speech From the Throne*** clearly stated that we must do more to ensure that Canada's prosperity is shared by Canada's Aboriginal people – First Nations, Inuit and Métis. The Speech continued to say that, although we have made progress, it is overshadowed by the rates of fetal alcohol syndrome and teen suicide in Aboriginal communities. These are the intolerable consequences of the yawning gaps that separate so many Aboriginal people from

other Canadians – unacceptable gaps in education attainment, in employment, in basics like housing and clean water, and in the incidence of chronic diseases such as diabetes. The Speech also identified that on September 15, all First Ministers agreed on the *Ten Year Plan to Strengthen Health Care*.

CURRENT SITUATION - THE ABORIGINAL POPULATION

According to the 2001 Census, about a million people, or 3.3% of Canada's population, identify themselves as Aboriginal:

- 62% as First Nations;
- 30% as Métis;
- 5% as Inuit; and
- 3% as people with more than one identity.

Despite improvements over the past 20 years, the health status of Aboriginal people remains substantially poorer than that of the general Canadian population. On practically every health status measure, the health of Aboriginal people is worse than the overall Canadian population.

There is no single or simple explanation for poor health status. As with any population, Aboriginal health status is determined by a range of factors, including socio-economic factors, such as education, income, housing, employment, etc. Changes within the health system may have a positive impact on health outcomes, particularly if addressed in tandem with action impacting other determinants of health.

Aboriginal people live in many types of communities:

- About 45% of First Nations live on reserves. Almost as many (43%) live in urban areas. Another 12% live in rural non-reserve communities.
- The majority (68%) of Métis live in urban areas, with nearly a third (29%) living in non-reserve rural areas.
- Inuit live predominantly in non-reserve rural areas (69%), mostly in the north, with just under one third (27%) living in urban areas.

Compared to the population as a whole, the Aboriginal population in Canada is young, mobile, rapidly growing in numbers, and increasingly concentrated in large urban and inner city areas. The proportion of Aboriginal children under five years of age is approximately double the proportion for the Canadian population as a whole (10.5% of Aboriginal population is from 0 to 4, the comparative statistic for the Canadian population is 5.8% (2001 Census).

The data in this section sometimes refers to Aboriginal people and sometimes refers only to First Nations or Inuit. This is due to the limitations on the data sources that do not provide comparable information on all Aboriginal peoples.

HEALTH ISSUES

The health status of Aboriginal people, relative to the rest of the Canadian population, is poorer on many measures. Although there are significant gaps in information related to the health of First Nations, and Inuit, and in particular Métis, there is sufficient data to show that despite progress there remains a significant health gap.

Life Expectancy

The life expectancy of First Nations men is 7.4 years less than other Canadian men and the life expectancy of First Nations women is 5.2 years less than other Canadian women. In 2000, the infant mortality rate for First Nations was 6.4 per thousand as opposed to 5.5 for the general population.

Chronic Diseases

There is a much higher incidence of chronic diseases among First Nations and Inuit populations, when compared to the general population:

- *Circulatory disease* is the number one leading cause of death among First Nations and Inuit;
- First Nations and Inuit report 16% higher rate of *heart problems* compared to the general population; 6.9% of Métis and 4.9% of Inuit report higher rates of heart problems compared to the general population;
- *Diabetes prevalence* was 15.5% among First Nations and Inuit peoples, while prevalence in the Canadian population during the same period was just over 4.7% (2002 First Nations Regional health Survey).

Children's Health

First Nations children are at higher risk across almost all indicators of health. In 2000, the infant mortality rate in First Nations was 6.4 deaths per 1,000 live births. The infant mortality rate has been falling steadily since 1979, when the rate was 27.6 deaths per 1,000 live births. The infant mortality rate for Inuit in Nunavik, at 24.9 deaths per 1,000 live births, surpasses, by far, that of the First Nations.

Compared to non-Aboriginal children, First Nations children also experience:

- a higher rate of Sudden Infant Death Syndrome (5 to 10 times higher according to one study of British Columbia and Alberta deaths);
- higher incidence of vaccine preventable infectious diseases;
- higher prevalence of obesity and Fetal Alcohol Spectrum Disorder (FASD) (1997 RHS);
- increased rates of lower respiratory tract infections (bronchitis, pneumonia and croup)
- increased rates of ear infections (otitis media) (1997 RHS); and
- 4 times the likelihood of being hospitalized for respiratory infections in the first year of life, compared to non-Aboriginal children (1997 RHS).

First Nation children on reserve also suffer from unhealthy birth weight. In 2000, of the 10,489 First Nations births where information was recorded, 21% were classified as high birth weight, almost double the Canadian rate of 13%.

Suicide

Suicide among First Nations youth has been occurring at an alarming rate in recent years. It is now among the leading causes of death for First Nations between the ages of 10 and 24, with the rate estimated to be five to six times higher than that of non-Aboriginal youth. In 1999, suicide accounted for 38% of all deaths in First Nations youth (aged 10-19) and 23% of all deaths in First Nations early adults (aged 20-44).

The First Nations suicide rate in 2000 was 24.1 per 100,000, over twice the Canadian rate of 11.8 deaths per 100,000 population. Comparisons with data from 1979-93 suggests that this rate has not decreased over time.

All First Nations age groups up to age 65 are at increased risk of suicide, compared with the Canadian population. The greatest disparity with the Canadian rates for suicide is for females aged 10 to 19, where the First Nation rate is approximately seven times the Canadian rate. In addition, suicide prevention has been identified as the number one health priority among Inuit. The overall Inuit suicide rate is 11 times the Canadian rate.

HIV/AIDS

- In Canada, 437 cases of Acquired Immune Deficiency Syndrome (AIDS) were reported among Aboriginal persons up to December 31, 2001.
- The proportion of AIDS cases among Aboriginal persons climbed from 1% of all cases in Canada before 1990 to 7.2% in 2001.
- The proportion of Aboriginal people with HIV who are under 30 years of age, female or injection drug users are all greater than the corresponding proportions among non-Aboriginal cases.

Tuberculosis

Tuberculosis rates in the First Nations population remained 8 to 11 times higher than that of the general Canadian population throughout the 1990s. This has been attributed to overcrowded housing and its association with an increased risk of tuberculosis. The 2000 First Nations tuberculosis rate of 34 cases per 100,000 population (approximately six times the Canadian rate) was due in part to large outbreaks in several regions - 41% of total tuberculosis cases occurred in five communities.

Environmental Health

A healthy environment is one of the determinants of health and quality of life in Canadian communities – this is a particular concern for Aboriginal communities.

While there has been recent investments in improving the quality of drinking water in First Nations communities on reserve, other significant environmental health gaps continue to exist.

Concerns about human exposure to elevated levels of contaminants in fish and wildlife species that are important to the traditional diets of northern Aboriginal people, led to the establishment of the Northern Contaminants Program (NCP). Traditional/country foods continue to be an integral component of good health for Aboriginal people. The social, cultural, spiritual, nutritional and economic benefits of traditional foods must be considered alongside the risks of exposure to environmental contaminants through consumption.

Connections between housing conditions and health status have often been made. In 2000-2001, only 55.8% of homes on First Nations reserves were considered adequate, although this number is up 11.2 percentage points from 11 years earlier. In addition to housing adequacy, overcrowding remains a problem: 19% of the dwellings on reserves have more than one person per room, compared with only 2% of dwellings for Canada as a whole. Overcrowding may greatly increase the risk of transmitting communicable diseases, as can be seen with tuberculosis; as the average number of persons per room increases, so does the rate of tuberculosis.

Mould in houses has also been identified as a problem in First Nations communities. Inadequate housing can lead to mould growth, which may lead to a number of health problems. For example, First Nations children suffer from high rates of bronchitis and asthma and the prevalence of asthma has increased in recent years.

Availability and Access to Services

There have been substantive changes over the last twenty years in the Aboriginal health systems that have contributed to improving the health services available to Aboriginal people. Such health system changes include:

- I. the greater role of Aboriginal people in the planning, management and delivery of health services;
- II. the integration of many federal hospitals and facilities into the provincial health system; and
- III. the general improvement in the quality and access to care for people living in rural and remote areas.

However, problems of access and availability remain. The National Aboriginal Health Organizations Public Opinion Poll on Health Care (July 2003) shows that First Nations living in isolated/remote communities report a higher degree of difficulty in accessing dentists, family doctors, pediatricians, and other medical specialists, but also report the highest ease of access to Community Health Representatives, social workers and mental health workers. In general, the NAHO poll shows that First Nations respondents living in small communities reported more difficulty in getting appointments with health care providers than their counterparts living in medium or large-sized communities. This was particularly true in respect of their accessibility to dentists, social workers, drug and alcohol treatment workers, family doctors, pediatricians, and obstetricians/gynecologists.

Access to, and quality of, health care varies. Two-thirds of FN peoples near or on-reserve (67%) and 73% of Métis provided a positive rating (excellent or good) of the quality of health care

received.

Some FN people near or on-reserve, however, have felt discriminated against because of their background. In fact, 15% reported having been treated unfairly or inappropriately by a health care provider in the last twelve months because they are Aboriginal; 75% of these respondents were receiving their health care off-reserve when experiencing this treatment.

Connectivity

F/P/T governments have made significant and concrete investments in telehealth (TH) and the electronic health record (EHR). While both are seen as improving the coordination of care, TH has been seen as essential to providing timely access to health professionals, and making speciality services available in under serviced areas. Both TH and EHR, through their ability to rapidly transmit essential clinical information, are key to reducing waiting times.

The federal government, through a number of different programs and initiatives, has helped to develop and support community and school connectivity, provincial and territorial EHR applications and TH networks, and targeted applications for schools, businesses, and government on-line services.

The Romanow Report, *Building on Values: The Future of Health Care in Canada*, suggested that long-term strategic investments in TH and EHR are key to improving access to health services for Canadians in rural, remote, and northern communities. Coordinated approaches with P/T governments, however, are essential to ensuring timely access to quality health services to First Nations and Inuit communities.

Indicators

There are several challenges to obtaining good quality data on Aboriginal populations. Two of the main issues - the inability to consistently track treatment and outcome data specific to Aboriginal clients once they are in the provincial or territorial system and the difficulty in distinguishing among Aboriginal groups - continue to confront us. Administrative health records are an important source of information, but most federal/provincial/territorial databases do not identify people by ethnicity. Since most tertiary health care is delivered by the provinces/territories, the ability to extract and analyse health data of Aboriginal clients are severely impaired. Surveys may provide a good method for monitoring behaviours associated with disease, use of health services, and self-reported disease. However, surveys generally rely on self-identification, which may or may not meet the federal government's definition of First Nations. Also, most national surveys do not cover on-reserve populations, or those in the far north, making comparisons to the general population difficult.

The 2003 First Ministers Accord on Health Care Renewal directed Health Ministers to consult with Aboriginal peoples on the development of a comparable Aboriginal Health Reporting Framework. They further agreed to engage Aboriginal peoples in this effort, to use comparable indicators, and to develop the necessary data infrastructure.

The FPT Advisory Committee on Governance and Accountability (reports to the Conference of Deputy Ministers of Health) established a Task Group to develop the Aboriginal Health Reporting Framework (AHRF). The Task Group is comprised of representatives from the federal government, provinces and territories, as well as the national Aboriginal organizations, including the Assembly of First Nations, the Congress of Aboriginal Peoples, the Inuit Tapiriit Kanatami, the Métis National Council, and the Native Women's Association of Canada. Although not a member of the Task Group, the Pauktuutit Inuit Women's Association is invited to provide their perspective. To start the Task Group has identified seven existing indicators measured by 10 items. These indicators include:

- Life expectancy;
- Infant mortality;
- Birth weight;
- Suicide;
- Diabetes prevalence;
- Smoking rates; and
- Early Childhood Development.

It is important to note that these indicators are not available for all Aboriginal people. The availability of Aboriginal specific health information, including First Nations on-reserve, varies between the Provinces and Territories. In addition, each jurisdiction may use different methods to identify their Aboriginal clients. This results in varying data quality in each jurisdiction, making comparisons difficult and perhaps even inappropriate.

Over the longer term there will be interest in the development of culturally appropriate indicators. These will be developed by the Task Group through a process of discussion with Aboriginal groups and communities across Canada. Once these discussions are completed, materials and feedback will be developed into a more complete indicators framework by technical experts and a final consensus conference will be held with Aboriginal groups to validate the indicators and framework. A number of important goals will be realized in the development of the reporting framework. They include:

- the identification of indicators that will help in understanding (in order to reduce) the health disparities between Aboriginal peoples and non-Aboriginal people;
- creating a framework that is both technically adequate and policy relevant to federal, provincial/territorial and Aboriginal governments, organizations and agencies;
- being inclusive and respectful of cultural needs and expectations;
- reflecting the 2003 First Ministers' Accord on Health Care Renewal; and
- being cognizant of information governance issues which are important to Aboriginal people.

CONCLUSION

Closing the gaps in health for Aboriginal people means addressing both health status, and access and quality of health services. This will require the concerted and collaborative efforts of

federal, provincial and territorial governments working closely with Aboriginal peoples, not only in the health sector but also in other sectors to have a real and measurable impact on the broad determinants of health.

The overarching theme of the Health Sectoral Table is the long-term vision of a sustainable, effective and integrated health system where:

- Aboriginal people have access to quality health services in a seamless way, through better integration and adaptation to Aboriginal needs;
- Aboriginal people have equitable access to health services similar to other Canadians living in comparable geographic locations;
- Aboriginal people have an increased role and capacity in the planning and delivery of health services; and
- Aboriginal people benefit from health promotion and disease prevention measures that will have the greatest impact in reducing the gap in health status.

It will also be important for the Health Sectoral Table to have strong linkages to other sectoral tables with respect to the social, economic and environmental factors which influence Aboriginal health.

The Health Sectoral Table will provide an opportunity to draw upon expertise to identify markers for progress in addressing health and the broad determinants of health in a way that is tailored to the unique needs of First Nations, Inuit and Métis.