


First Nations, Inuit and Métis health: Considerations for Canadian health leaders in the wake of the Truth and Reconciliation Commission of Canada report

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Abstract

First Nations, Inuit and Métis peoples living in Canada face profound health disparities relative to non-Indigenous Canadians on almost every measure of health and well-being. Advancing health opportunities for Indigenous peoples require responses at all levels of healthcare delivery and policy. Therefore, it is critical for health leaders and providers within Canada's healthcare institutions, systems, and settings to understand and address the determinants of health unique to Indigenous peoples, including the legacy of colonialism and both long-standing and present-day racism. The Truth and Reconciliation Commission of Canada provides a starting point from which positive responses to injustices can be advanced.

Introduction

The purpose of this article is to highlight some of the ways in which the health of Indigenous peoples (Note 1) within Canada is unique and reasons why it warrants consideration separate from the health of the settler Canadian (Note 2) population and from other racialized and minority groups in Canada. In so doing, this article is meant to challenge health leaders and health organizations to examine whether and how their policies and practices are able to respond to the profound health inequities facing Indigenous peoples in Canada today. We emphasize the contribution that the historical legacy of colonialism has made to long-standing and present-day racism (both interpersonal and systemic) and to the profound and persistent social and health disparities experienced by Indigenous peoples. The findings and recommendations of the Truth and Reconciliation Commission (TRC) of Canada¹ provide a starting point from which positive responses to these injustices can be advanced.

Historical legacy—Colonialism is a determinant of health

Indigenous peoples are the original inhabitants of the area now considered Canada. They are not a single cultural group but rather distinct and diverse constitutionally recognized peoples with specific Aboriginal and treaty rights.² Their history since contact with settlers includes colonization, forced assimilation, and near cultural annihilation, which can be directly attributed to racist beliefs about Indigenous peoples and their values, culture, and ways of life which underwrote the actions of early European colonialists and persist to present day.^{1,3} The government-funded and church-led Indian Residential School System (IRSS) represents the most striking contemporary Canadian example of a systematic assault on Indigenous peoples and Indigenous ways of life. Children were separated from

their families and communities and were indoctrinated into Western Euro-Christian culture through placement in residential schools. Although the last of these schools closed in 1996, their more than century-long influence operated to dismantle political and social institutions of Indigenous communities and displace Indigenous peoples from the land.¹ The resultant cultural genocide persists through collective and intergenerational trauma and loss of culture, language, and tradition, which continues to impact more than 4 million Indigenous people within Canada today.

Contemporary realities—Health disparities and the burden of racism

Indigenous peoples in Canada face extreme disparities when compared to their non-Indigenous counterparts on virtually every measure of health and well-being. Loss of language and culture and disconnection from the land resulting from historical tragedies such as IRSS are known to heighten socio-economic inequalities and health disparities.³⁻⁵ Indigenous peoples are also overrepresented in the child welfare and correctional systems and experience considerable disparities in income, education, housing security, food security, rates of violence, and health indicators when compared with non-Indigenous Canadians⁶ (see Table 1⁷⁻¹⁵). In the 25 years, since the United Nations introduced its Human Development Index (HDI) as an overall measure of

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Table 1. Canada's Indigenous peoples and communities

Population size	An estimated 1.4 million people who self-identify as Indigenous currently live in Canada, representing 4.3% of the population. ⁷
Population trends	Indigenous peoples represent the fastest-growing segment of the population. ⁸ Children and youth represent a larger proportion of the Indigenous population than their non-Indigenous counterpart. ⁸
Indigenous languages	Approximately 60 Indigenous languages are spoken. ⁷
Cultural groups	There are over 600 distinct First Nations cultural groups or nations. ⁹
Food security	Rates of food insecurity on reserves have ranged from 20% to 80%. ¹⁰ Rates of food insecurity for Indigenous people living off reserve were three times higher than for settler Canadians. ¹¹
Access to clean water	Approximately 20% of Canada's Indigenous communities have unsafe water (ie, 116 communities were under long-term boil water advisories in 2011). ¹²
Rates of violence	Indigenous women are three and a half times more likely to experience violence than non-Indigenous women. ¹³ Seventy-five percent of Indigenous women experience family violence at least once in their lifetime. ¹⁴
Incarceration	Rate of incarceration of Indigenous adults in Canada is 10 times higher than non-Indigenous adults. ⁷
Education	Twenty-two percent fewer Indigenous peoples in Canada obtained high-school diplomas when compared to non-Indigenous Canadians. ¹⁵
Income	Median income for Indigenous adults is substantially lower than for non-Indigenous Canadians (ie, 25% lower in 2006). ¹⁵

Table 2. Health indicators for Indigenous peoples in Canada

Indicator	Indigenous experience as compared with non-Indigenous Canadians (except as noted)
Life expectancy	Five to seven years shorter for First Nations ¹⁷
Rates of avoidable mortality	Twice (men) ¹⁸ Two and a half times (women) ¹⁸
Primary causes of avoidable mortality	Diabetes, drug and alcohol disorders, and injuries ¹⁸ (note: injuries alone are the leading cause of death among Indigenous peoples under the age of 45) ¹⁹
Infant illness and mortality	Approximately 10% higher ²⁰
Rates of disability	Twenty-nine percent for Indigenous adults living on reserve (compared with 26% for non-Indigenous Canadian population) ²¹
Alcohol use	Consumption (First Nations) less frequent ²¹ Ten percent more likely to drink heavily ²¹
Illicit drug use	More than double ²¹
Pain-related conditions	Overall higher rates of pain-related conditions (eg, ear and dental infections, arthritis) ²²⁻²⁴ Less likely to receive treatment ²²⁻²⁴
Rates of myocardial infarction	Twenty percent higher ²⁵
Rates of type 2 diabetes	Four times higher ²¹
Rates of obesity	Double (on reserve) ²⁶
Poor oral health	Primary source of health disparity between Indigenous and non-Indigenous children ²¹
Rates of TB	Twenty-six times higher than non-Indigenous (Canadian-born) Canadians ²⁷
Rates of HIV	Five to eight percent of people with HIV are Indigenous, while representing only three percent of the Canadian population. ²⁸
Rates of suicide	Approximately one-third of Indigenous youth deaths attributable to suicide ²⁹ (note: suicide rates range from over 800 times the national average to no reported history) ³⁰

population development and general well-being, Canada has consistently scored in the top 10 of HDI world rankings. Yet, the development status of Canada's Indigenous peoples is alarmingly poor with rankings compared more closely to those of countries in the global south.¹⁶ This pattern holds true across all age groups as well as for outcomes of both morbidity and mortality (see Table 2¹⁷⁻³⁰ for detailed examples).

Mitigating high rates of morbidity and premature mortality among Indigenous peoples in Canada is complex and must consider the broad array of interrelated health determinants unique to these peoples, including those arising from the legacy

of colonialism. Early colonialists depicted Indigenous peoples as intellectually inferior, savage, and untrustworthy, and these attitudes persist to present day.³ Furthermore, the damaging contribution of colonialism to stigmatized conditions such as high rates of substance dependence, obesity, and unemployment in present day often serve to reinforce and legitimize racist perceptions and unfair treatment of Indigenous peoples.³ Negative and damaging stereotypes of Indigenous peoples both constitute and perpetuate racism at all levels of Canadian society.

In healthcare systems/settings, Indigenous people experience a disproportionate burden of racism that is both

interpersonal and systemic in nature.^{3,31} Examples of interpersonal racism include acts of discrimination ranging from neglect to acts of physical violence.³ Numerous population surveys indicate Indigenous peoples perceive or experience high rates of interpersonal racism (up to 78%) within healthcare settings.³¹ This form of racism can be intentional or can persist even among individuals morally opposed to racism through unintentional differential treatment or damaging assumptions.³¹

Systemic racism refers to “requirements, conditions, practices, policies, or processes that maintain and reproduce avoidable and unfair inequalities across ethnic/racial groups.”³² This form of racism can be subtle but widespread; it creates imbalances in power and resources among different groups and limits certain groups’ participation in political, social, and economic arenas.³¹ Viewed in this way, racism is a determinant of health. Like other broad determinants, appropriate interventions at multiple levels of healthcare delivery and policy are required to mitigate its negative influence on health equity.³

Jordan’s Principle provides a well-publicized example of Indigenous people’s response to systemic racism in the contemporary Canadian healthcare context. Jordan’s Principle was created following the 2005 death of 5-year-old Norway Cree House Nation child Jordan River Anderson after he spent 2 years in hospital awaiting the resolution of jurisdictional disputes about funding for his home care. Unanimously approved by Canadian Parliament in 2007, Jordan’s Principle states that no status First Nations or Inuit child should be denied services (ie, services that would ordinarily be available to other Canadian children) on the basis of a jurisdictional funding dispute.³³ In cases involving a dispute, the first government or government department approached is to pay for the child’s care with issues of funding to be resolved afterwards.³³ However, there is growing recognition that the government’s narrow interpretation of Jordan’s Principle is in itself an example of systemic racism. By narrowing the definition of cases where Jordan’s Principle applies so that virtually no cases qualify, the federal government fails to adequately address the issue of healthcare inaccessibility faced by Indigenous children in Canada.³³ Policy-driven systemic racism also operates through the Indian Act, child-welfare legislation, non-insured benefit programs, state-imposed Indigenous identity requirements, and standards of care, to name a few (Note 3).^{3,31}

Post-TRC—A time for awareness and response

The TRC reports that “For over a century, the central goals of Canada’s Aboriginal policy were to eliminate Aboriginal governments; ignore Aboriginal rights; terminate the treaties; and through a process of assimilation, cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada.”¹ Many Canadians are poorly informed about the history of Canada’s treatment of Indigenous peoples and are unaware that all Canadians benefit from treaties.¹ Moving towards reconciliation and improving health equity for Indigenous peoples in Canada requires us to first

acknowledge and actively learn about the history of colonization and its present-day repercussions.

With the completion and publication of the TRC report in 2015, 94 calls to action frame priorities to both redress the grievous legacy of the IRSS and support reconciliation to establish and maintain mutually respectful relationships between Canada’s Indigenous and non-Indigenous peoples.¹ In the context of health, the TRC concluded that advancing the health opportunities for Indigenous peoples requires us to identify and remove barriers to health equity that Indigenous peoples in Canada face in their day-to-day lives, including their experiences of healthcare delivery at the provider, institutional, and system levels.¹

Calls to action listed directly within the “health category” (#18-24) lay out responsibilities for governments and institutions to recognize healthcare rights of Indigenous people of Canada, to identify and close gaps in health equity by identifying and addressing these groups’ unique health needs, to recognize the value of Indigenous perceptions of health and knowledge of traditional healing and practice, to increase the number of Indigenous healthcare professionals, and to incorporate education and training in the health professions that ensure cultural competency (including knowledge of Indigenous health issues, history, formal Aboriginal rights, and Indigenous teachings and practices).³⁴ Many additional calls to action (ie, those identified under categories of language and culture, justice, professional development of public servants, educators, and reconciliation) have relevance across multiple jurisdictions, including for health leaders and administrators.

We draw specific attention to the need for leaders within the healthcare system to take seriously these calls to action and, together with Indigenous peoples (including community members and elders) and Indigenous healthcare personnel, to become advocates for just policies and practices. National health professional organizations have already begun to address needs identified in the TRC calls to action by developing strategies and guidelines that can serve as useful models for other clinician groups, service providers, educators, and administrators alike.^{2,31,35,36}

Common among these initiatives is the recognition of the need to foster cultural competence and safety, including finding ways in which Indigenous holistic notions of health and healing practices can coexist with Western biomedicine. Formal Western biomedicine follows an individualistic and atomistic medical paradigm. Definitions of health that are narrowly focused on physical health and absence of disease fail to adequately capture broader notions of health held by many Indigenous cultures.^{5,37} Specifically, balance between physical, mental, emotional, and spiritual well-being is an integral element of health and living a good way of life for many Indigenous peoples, as are alternative and traditional healing practices. The medicine wheel is a symbol common to many Indigenous cultures and represents varying perceptions of the balance that exists among elements of health, stages of life, seasons, and directions, among others.³⁸

Traditions, norms, and symbols of shared meaning (such as the medicine wheel) are unique for the many Indigenous cultures that exist in Canada. Therefore, it is important to recognize and respect diversity, particularly as it influences the health and determinants of health of both individuals and communities. In recognition of cultural differences among Indigenous communities and between Indigenous and non-Indigenous peoples, the TRC refers to the need to “provide cultural competency training” as one of its calls to action.³⁴ However, a number of initiatives caution that a focus on the technical skills, knowledge, and attitudes that typically constitute goals of “competence” do not go far enough.^{2,35} Rather, the concept of *cultural safety* is advanced in discussions of educational interventions to improve care for Indigenous peoples both in Canada and worldwide.

Originating in the context of Māori health in Aotearoa, or New Zealand, cultural safety goes beyond simple awareness of or respect for cultural difference or the development of knowledge and skills. Cultural safety requires healthcare professionals to reflect upon the ways in which their own culture and social location shape both their actions and others’ responses to them.^{2,3} By healthcare professionals critically interrogating their own biases, prejudices, and stereotypical assumptions, the ways in which power differentials and racism operate in interactions with diverse service users is brought to light.^{2,3} The concept of cultural safety requires attention and action to address power differentials between service providers and users. In order to offer more effective and equitable care to patients of diverse backgrounds, providers recognize and destabilize power imbalances that characterize encounters in clinical settings and enable the patient to define what safe service looks like (Note 4).²

Among the most challenging post-TRC actions within healthcare institutions and systems will be to examine, identify, and modify policy and standards of practice that either obviously or inadvertently foster inequitable healthcare and health outcomes for Indigenous people. It is somewhat curious that although there is a great deal of scholarship on the subject of research ethics involving Indigenous peoples and groups, clinical and organizational healthcare ethics are much less developed where Indigenous peoples are concerned. The *Tri-Council Policy Statement 2 (TCPS-2): Ethical Conduct for Research Involving Humans*³⁹ serves as a guide for ethical research involving humans in Canada. Chapter 9, which applies directly to Indigenous peoples appeared only in the revised second iteration of the TCPS in recognition of the need to ensure that the value of respect for human dignity and principles of respect for persons, concern for welfare, and justice are interpreted and applied through a lens that is attentive to the historic, cultural, linguistic, and economic uniqueness of First Nations, Inuit and Métis peoples of Canada as well as to earlier injustices pervasive in research involving Indigenous people.³⁹ The relevance of chapter 9 to this discussion is the ethical framework and consultative process that was used to incorporate Indigenous world views to explore, create, and shape policy.⁴⁰ It may be that organizational ethics processes within

healthcare systems could provide a similar type of ethical space for respectful community-level reflection and consultation regarding policy and practice with the potential for institutional- and system-level change in healthcare. The TRC report offers a framework for such an endeavor, as does the United Nations Declaration on the Rights of Indigenous Peoples (Note 5).

Conclusion

The interplay of social, political, historical, cultural, environmental, geographic, and economic factors that directly and indirectly shape Indigenous health needs to be understood as a “culmination of cultural wounds inflicted upon whole communities and whole ways of life.”⁴² Achieving health equity for Indigenous peoples in Canada requires responses and reconciliation at all levels of healthcare delivery and policy, as well as social change to address broader determinants that negatively impact health.

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Notes

1. The term “Indigenous” is meant to capture all those who identify as First Nations, Inuit, Métis, and/or Aboriginal within Canada, recognizing that some individuals/peoples (including the TRC) prefer to use the term “Aboriginal.”
2. The term “settler” refers to non-Indigenous persons who historically migrated to Canada to establish permanent residence and to colonize the land in accordance with imperialist European nations.
3. These examples are outside the scope of this article; for more information and a fuller discussion, see the 2015 report by Allan and Smylie, *First Class Peoples, Second Class Treatment*.³
4. The Indigenous Physicians Association of Canada in collaboration with The Association of Faculties of Medicine of Canada has developed a set of recommended core competencies for Canada’s 17 medical schools, intended to provide medical educators with the knowledge and skills to engage in patient-centered and culturally safe care when working with Indigenous patients/service users.
5. It is worth noting that Canada recently removed its objector status to the United Nations Declaration on the Rights of Indigenous Peoples as of May 2016—nearly 10 years after, it was adopted by 144 states in 2007.⁴¹

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