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The Accessibility of Healthcare for Indigenous Seniors in Canada

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ABSTRACT

Healthcare is an essential human right that is imperative to one's survival. However, in Canada accessibility of healthcare is greatly impaired for Indigenous people, and in particular Indigenous seniors. As such, this paper reviews the status quo of healthcare accessibility for Indigenous seniors in Canada, specifically examining what barriers have led to the lack of accessible healthcare, and what mitigating strategies can be put in place to alleviate the situation. Historically, the rights and culture of Indigenous Canadians have been systematically suppressed, both within and outside of the field of healthcare, leading to severe mistrust in the state and thus the healthcare system. Currently, Indigenous seniors face both tangible barriers including geography, poverty, and poor policy, and more abstract, cultural barriers, such as racism and mistrust, which contribute to lacking healthcare accessibility. To address these barriers, the overarching themes of all solutions include increasing cultural safety practices, investment in rural healthcare resources, and building trust.

Introduction

Indigenous communities across Canada commonly face difficulties accessing quality healthcare resources, with seniors bearing a significant brunt of the deficiencies in the healthcare system. As more research is done on Indigenous healthcare accessibility, a comprehensive review of the current literature is crucial to understanding the depth and breadth of the issue. This review sets out to address the following questions: What barriers have contributed to the lack of accessibility to health resources and infrastructure for Indigenous seniors in Canada? What mitigating policies can be put in place to remedy the situation? In order to answer these questions, this paper breaks down the historical context that has led to the status quo of Indigenous healthcare, the health disparities Indigenous peoples face, current barriers to access, and current initiatives, as well as makes recommendations for future policy and research.

Definition of Terms

Before addressing the current literature on healthcare accessibility for Indigenous communities in Canada, it is important to define several key terms. According to the Canadian Government, "Indigenous peoples" is a collective name for the people native to North America and their descendants. The Canadian Constitution recognizes three groups of Indigenous peoples including the First Nations (formerly "Indians"), Inuit, and Métis, which are distinct groups with their own unique cultures, histories, and traditions. According to the 2021 Canadian Census, more than 1.8 million people in Canada identify as Indigenous, representing 5% of the total Canadian population (Government of Canada, 2024). In Ontario, as of 2016, Indigenous people represent 2.8% of the total population, and the province currently holds the largest Indigenous population. Moreover, demographically, Indigenous peoples are the fastest-growing and youngest group in Canada (Ministry of Indigenous Relations, 2018).

In this paper, “healthcare” refers to all services that fall under the health services umbrella. This includes hospitals, clinics, vaccinations, primary care, health screenings, STI testing, mental health services, et cetera.

In Canada, “reserves” refers to land set aside by the government for First Nations people. The other two Indigenous groups, Métis and Inuit peoples, do not hold reserve land. Reserves range from small to large, and urban to rural. These reserves are primarily governed by the First Nations groups that occupy them; however, the ultimate authority still lies with the Canadian government (Government of Canada, 2023).

As this paper features extensive discussions on the differences between “rural” and “urban” communities, it is also imperative to set a standard for these terms. Rural communities can be defined in accordance with Ontario's Ministry of Health and Long-term Care in 2011, which states rural communities are those “with a population of less than 30,000 that are greater than 30 min away in travel time from a community with a population of more than 30,000.” The definition of “urban communities” is more nuanced, especially in Northern Ontario, where the typical notion of high population density does not apply. As a result, “urban communities” are better defined in relation to the resources available, including healthcare, education, and goods and services that would be unavailable elsewhere in the region (Burnett et al., 2020).

According to Statistics Canada, the senior age group can be defined as those aged 65 and over (Statistics Canada, 2001). An important distinction to make when discussing seniors in Indigenous communities is that between seniors and elders. “Elder" is a much more specific term and has implications regarding the leadership role that they play in Indigenous society (Queen’s University, n.d).

Methods

This review was conducted by searching databases including Google Scholar and PubMED using key words including “Indigenous,” “Canada,” “healthcare,” “seniors,” and “accessibility.” Articles dating from 2000 to 2009 were included if they related very closely to the topic; otherwise only articles after 2010 were included. Finally, all academic articles that were part of the review were a part of peer-reviewed journals.

Historical Context

Prior to colonization, important aspects of Indigenous culture, religion and economics centered around their relationship to the land. As a result, during Canada’s colonization, stark differences in European and Indigenous cultural practices resulted in disputes over land and significant violence against Indigenous people, whose resistance to colonization was overarchingly referred to by white settlers as the “Indian Problem.” In order to “fix” it, the federal government enacted the Indian Act in 1876, which gave the responsibility for all matters relating to Indigenous peoples and lands to the government (Richmond & Cook, 2016). The fundamental goal of the Indian Act when it was enacted was “civilizing the Indians,” under the assumption that the Indigenous people were inherently inferior and uncivilized. As a result, its many provisions extended across all aspects of Indigenous life. The Indian Act tried to overwrite Indigenous traditions, education systems, and ownership of land. The Indian Act also established the institution of residential schools, which served as the government of Canada’s method for forcibly assimilating Indigenous children into the general population and erasing Indigenous culture. The repercussions of these actions eroded whatever small amount of trust existed between the Indigenous communities and the Canadian government (Richmond & Cook, 2016).

The establishment of racially segregated “Indian hospitals" in the late 1800s and early 1900s furthered this damage. These hospitals originated with federally-funded Christian missionary efforts to provide care on some Indigenous reserves. They did not offer Indigenous medicines or medical practices, but rather served as another assimilation tactic to replace traditional healthcare methods with Western medicine. With the rising rates of tuberculosis in the 1930s, the number of Indian hospitals drastically increased as the federal government took over (Schultz et al., 2021). However, instead of receiving consistent and standard medical care, Indigenous patients were subject to medical experimentations, often without their consent. Further, many patients had no choice but to endure the treatment they received at Indian hospitals, as a 1953 amendment to the Indian Act made it illegal for Indigenous people to refuse medical care and leave the hospital before discharge (Lux, 2010). While Indian hospitals were short lived, closing by the 1960s, they caused irreparable damage to Indigenous peoples and their trust in the Canadian Government. With the advent of Medicare in the 1960s, the federal government signed agreements with provincial governments to allow Indigenous peoples to access provincial health services off reserve, while the federal government maintained control over health care on reserve. With very few changes up to the present day, this system still maintains many ingrained problems, making accessibility of healthcare extremely difficult (Burnett, 2023).

Health Disparities

Indigenous people in Canada experience significantly higher levels of morbidity and mortality than the non-Indigenous population. Although rates of infectious diseases and their resulting deaths have been declining, a number of chronic conditions are on the rise. Canadian studies have found that 7% of Indigenous participants between the ages of 55 to 64 reported more than three chronic conditions, compared to the 2% in the non-Indigenous group of the same age group. Further, only 10.5% of First Nations seniors report having no health conditions, a figure that is significantly below that of the general population (Hillier & Al-Shammaa, 2020). More specifically, chronic disease including arthritis, hypertension, cardiovascular diseases, and cancer are far more prevalent among Indigenous peoples than the general Canadian population. Moreover, diabetes rates are also increasing, with 19.7% of Indigenous adults having a diabetes diagnosis, and one in three Indigenous seniors aged 55 and older being diagnosed with diabetes (Hillier & Al-Shammaa, 2020).

These issues are exacerbated by the lower quality of life due to limited essential resources like clean water and nutritious food. Currently, 29 boil water advisories are in effect in 27 communities (Government of Canada, 2024). This decreased water quality has major repercussions on health, as it increases the risk of transmission for waterborne diseases dramatically (Bradford et al., 2016). Further, the poverty experienced by Indigenous populations also increases health disparities. For example, poor nutrition and lack of food security can lead to both malnutrition and an increase in diet-related health problems (Wahi et al., 2020).

Current Barriers to Access

In the status quo, a number of barriers now prevent healthcare accessibility among Canadian Indigenous communities, especially for seniors. These barriers include both tangible issues, such as geography, poverty, and poor policy, and more abstract, cultural problems, such as racism and mistrust.

Geography

Geography poses a major challenge: 32 of the 49 First Nations reserves in Northwestern Ontario are only accessible by ice roads or plane, making urban resources difficult to access and limiting the delivery of consistent healthcare services (Burnett et al., 2020). Even in areas with permanent health centres, services are mainly run by nurses or community health workers, not MDs. Consequently, these clinics are only equipped to handle a portion of the medical needs for the community, forcing many to travel long distances in order to access specialists and advanced medical treatment (Nguyen et al., 2020). This is especially relevant for seniors, as they are at greater risk for more complex medical issues that are not able to be treated by local health care facilities.

For example, older Indigenous populations report higher rates of diabetes, arthritis, stroke, heart disease, and other chronic health conditions. Further, Indigenous seniors living in rural areas also face issues with finding access to homecare workers, as most remote communities tend to be majority older people and minors, with a relatively smaller amount of working-age people. As a result, this growing shortage has led to many seniors faced with deciding whether to leave their communities for urban centres (Habjan et al., 2012).

These issues are further exacerbated by the lack of transportation infrastructure, and the inadequate capacity of the more urban hospitals. The bus lines that many Indigenous communities rely on for transport have decreased over the past several years (Burnett et al., 2020). Further, even when Indigenous people living in rural communities find their way to hospitals, they are still unable to get a place to stay while getting treatment. This is especially prominent in Sioux Lookout, Ontario, which serves 1,222 patients a month, but can not accommodate the same population, forcing patients into hotels in further-away towns. This is especially a problem for the elderly population due to their restricted mobility and greater healthcare needs (Law, 2023).

Poverty

Poverty also plays a significant role as a barrier to accessing healthcare for Indigenous Canadians. In 2015, the unemployment rate of Indigenous populations was 12.4%, as opposed to 6.8% for the general Canadian population. Further, there is also a pronounced wage gap, with Indigenous Canadians earning a median total income of $21,875 compared to $34,604 for non-Indigenous individuals (Nguyen et al., 2020). This poses a major issue for accessing additional health care services not covered by the Indigenous specific health insurance program, the Non-Insured Health Benefits (NIHB) or provincial governments. This is particularly a problem for patients with common diseases like diabetes, which requires supplies that are only partially covered by insurance to treat. Low income can also impact the ability to travel off reserve for treatment. While some supplementary insurance coverage is provided to specific low income residents and seniors, many services still are not covered. For example, many Indigenous seniors are not able to afford long-term care housing despite high needs (Kim, 2019).

Poor Policy

A deeply rooted systemic issue that continues to plague Indigenous communities across Canada is the poor coordination of healthcare responsibilities between the federal and provincial governments. Because of the Indian Act, the responsibility for Indigenous health care provisions falls under the jurisdiction of the federal government instead of provincial governments, which govern healthcare for the general population (Richmond & Cook, 2016). As a result, the federal government established the Non-Insured Health Benefits (NIHB) program for Indigenous people (Government of Canada, 2024).

However, this program has many issues that pose barriers to Indigenous people accessing healthcare. For example, because many service providers require Indigenous patients to pay up front and later request reimbursement from NIHB, Indigenous patients often struggle with affording these large out-of-pocket costs (Indigenous Primary Health Care Council, 2022). Further, while the NIHB program does compensate for some travel costs for Indigenous patients living in rural areas, reimbursement standards are largely not reflective of the recent inflation in gas prices. Moreover, out-of-pocket costs, such as travel and accommodation, are not reimbursed when more than one approved escort is required. Finally, the range of services covered by the NIHB is also limited and is often more difficult to access for Indigenous people living off reserve (Indigenous Primary Health Care Council, 2022).

Racism

Due to Canada's history of colonialism and the demonization of Indigenous populations, anti-Indigenous racism is a major barrier to accessing healthcare for Indigenous peoples. This is a problem on both a systemic and personal level. For instance, on a systemic level, most reserves have had their healthcare budgets capped for decades, in comparison to Canada's non-Indigenous healthcare investment, which has been steadily increasing at 1 to 3% every year (Canadian Institute for Health Information, 2023). On the personal level, anti-Indigenous racism is prevalent in many healthcare workers' interactions with their patients. A report from Saskatoon found that sixteen women were coerced into having tubal ligation immediately after delivery or during labor. Nurses, social workers, and doctors pressured these women at their most vulnerable state into an irreversible form of birth control (Boyer, 2017). Another report from Manitoba describes the death of Brian Sinclair from a treatable bladder infection after being ignored for 34 hours in the Emergency department. While Sinclair was visible to the emergency department staff, they ignored him under the assumption that he was homeless or intoxicated, and thus not requiring treatment. These are just two examples of the anti-Indigenous racism that is extremely prevalent throughout the healthcare field. These instances of racism are further exacerbated by the lack of cultural safety training for many healthcare providers (Boyer, 2017).

Mistrust

Due to both modern and historical factors, Indigenous distrust of the healthcare system is high. This is a large problem in both urban settings and remote areas. In more urban settings, the majority of Indigenous people do not have access to a long-term health provider and often use walk-in clinics or emergency rooms. As a result, they are not able to build long-term relationships with healthcare providers and are instead subject to potential discrimination and inadequate care (Burnett et al., 2020). In remote or fly-in communities, distrust of healthcare providers is also highly prevalent due to the inability for these providers to develop trusting relationships with the communities they are serving. Often there is little community consultation, and healthcare workers are not permanently available to provide care to a specific community (Nguyen et al., 2020).

On a broader level, due to the erosion of trust created by the residential schools and other historical factors, Indigenous communities often have a complex relationship with vaccinations. Even up to the 20th century, vaccinations were only made available to children after treaty payments. Moreover, as many of the parents of the current generation of Indigenous youth grew up going to residential school, there is a lack of trust in the government, which then leads to lower vaccination rates (Burnett et al., 2020).

Current Initiatives

In the past several years, a number of initiatives to remedy the epidemic of healthcare inaccessibility have been implemented, to varying degrees of success.

Successful Initiatives

One of the most effective initiatives to address the lack of healthcare accessibility and trust has been increasing the presence of consistent, long-term healthcare providers for Indigenous communities. One study found that in a particular semi-rural region with a long-term healthcare provider, vaccine knowledge was better, trust was well established, and overall accessibility to healthcare was better. In this case, a nurse had served the community for over 20 years and was able to commute to work daily. This allowed for a trusting relationship between the provider and the community to be built. For example, people without personal identification were to receive healthcare services due to having a personal relationship with the provider (Burnett et al., 2020).

Another successful initiative in British Columbia was the First Nations Health Authority (FNHA), established in 2011, which is the first province-wide health authority of its kind in Canada. The FNHA is run by a combination of Indigenous and non-Indigenous Canadians, and in collaboration with BC First Nations, the Province of BC, and the Government of Canada, FNHA has worked to put Indigenous healthcare back into the hands of Indigenous people. They have done this by assuming healthcare responsibilities that were previously handled by the federal government. For example, they provide services including immunization, mental health services, and injury prevention. Most significantly, they have worked to increase the involvement of the grass-roots community to set new standards for BC's First Nations health governance. This resulted in "The 7 Directions," which provides new fundamental standards and instructions for the new health and governance relationship (Richmond & Cook, 2016).

Unsuccessful Initiatives

Unfortunately, there have also been many unsuccessful attempts to create legislation to address Indigenous healthcare issues, largely due to the lack of political incentives. For example, in 2005, the Kelowna Accord was proposed to improve education, living conditions, and employment for Indigenous peoples through a $5 billion investment. As part of the accord, several healthcare targets were also set regarding the reduction of infant mortality, youth suicide, diabetes, and childhood obesity over the next five to ten years, as well as dramatically increasing the number of Indigenous health professionals in the same time frame (Richmond & Cook, 2016). However, while it was endorsed by Prime Minister Paul Martin, it was not endorsed by his successor, Prime Minister Stephen Harper. As a result, the Harper administration did not proceed with the accord. Although some funding was allocated under Harper to achieve the goals set out by the Kelowna Accord, it was dramatically cut from its original target. The Kelowna Accord was meant to have dedicated $600 million to improving Indigenous standards of living in 2006 alone, but in reality, only $150 million in 2006 and $300 million in 2007 was allocated to similar projects (de Bruin, 2021). Ultimately, although some progress was made, there was still a lack of significant change to address the problems the Kelowna Accord set out to rectify.

Recommendations for Policy and Research

The government must take strong measures to remedy these issues. In order to address the issues of geographic divide, action must be taken to establish permanent healthcare clinics in rural areas. Despite the expense, it is crucial to set up these healthcare centres in even the most remote communities, as through them, trust can be built between the healthcare workers and Indigenous residents, leading to overall better healthcare quality and accessibility. Increasing representation of Indigenous people in healthcare is also crucial to earning back the trust of Indigenous communities. This means investment in the education and upbringing of Indigenous children, as well as providing a pathway for them to succeed in the medical field.

However, in the short term, implementing policies requiring better sensitivity and cultural training for healthcare professionals would help dismantle harmful racial stereotypes and unconscious bias. The implementation of this system would require a number of different factors, including collaboration and partnerships with the community and the inclusion of Indigenous peoples' healthcare knowledge, as well as community collaboration that is built on mutual and reciprocal trust (Brooks-Cleator et al., 2018). Further, it is important to acknowledge the power dynamics between the provider and the patient, and shift the dynamic so that the power is in the hands of the patient. This can look like allowing patients to share in decision-making and provide feedback on the cultural sensitivity of the interaction. Especially with regards to Indigenous patients, it is vital the healthcare providers are fully aware of the broader context of the patient's life. This includes respecting their cultural values and practices, as well as acknowledging the effects of colonialism as a social determinant of health. Finally, it is imperative that individuals and organizations undergo self-reflection on their historical treatment towards Indigenous patients, such as potential cultural insensitivity and racism. This will help to uncover unconscious biases and systemic racism, which will allow for more effective treatment of Indigenous patients (Brooks-Cleator et al., 2018).

Currently, there are increasing numbers of organizations that offer indigenous cultural safety training across Ontario, including the Indigenous Primary Health Care Council, Cancer Care Ontario, Native Canadian Center of Toronto, the University of Toronto, and more (Webb et al., 2023). These training programs include modules which address the history of colonialism and its impact on health, as well as encourage self-awareness and self-reflection amongst participants. Many of these programs offer both in-person and online training, making it accessible to many healthcare workers across Ontario and Canada. While many of these programs were only recently implemented, studies have found that this training has raised healthcare workers' awareness of systemic racism and unconscious bias in healthcare to a level that engenders self-reflection. Further, many student healthcare professionals, government employees, and registered nurses have reported interest in continuing their learning about Indigenous cultural safety beyond these programs, and many are expected to implement what they learned in their practical work (Webb et al., 2023).

In terms of future research, it is important to look into the perspective of Indigenous seniors on reserves in Canada about the problems they face in accessing health care and potential solutions that they believe will be effective. Although studies like this have been done in the past, there needs to be a more present perspective on the issue. Specifically, there is a gap in research on the accessibility of healthcare in the intersection between Indigenous people and seniors that needs to be addressed. Furthermore, additional research should be done on cultural competency and sensitivity training, specifically evaluating the results that these strategies bring and which methods produce the most effective outcomes. Studies like this will be able to aid in policy decision-making in the future, and help to prioritize implementing the most effective strategies.

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