Steven Caron

Major Research Paper

Addressing the disparities in health care and health outcomes between Indigenous and non-Indigenous peoples in Canada

Graduate School of Public and International Affairs
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Abstract

Evidence suggests that Indigenous peoples in Canada experience poorer health outcomes than non-Indigenous Canadians. These health burdens likely stem from a number of factors, including discrimination, limited access to health care services, and suboptimal social and economic conditions arising from colonization. This paper explores the nature of and potential factors that have influenced health disparities faced by Indigenous peoples in Canada. In particular, I discuss the evolution of Indigenous health care policy since the establishment of the Canadian constitution in 1867 as well as the current health care landscape. I further provide a number of recommendations for policymakers to consider in pursuit of parity and improvements in health care and health outcomes for Indigenous peoples.

Who are the Indigenous peoples of Canada?

As per section 35(2) of the 1982 Constitution Act, ‘Aboriginal peoples’ is the term used to collectively refer to First Nations, Inuit and Métis individuals, who represent the first and original inhabitants of Canada ("Constitution Act," 1982). In this research paper, I use the term ‘Indigenous peoples’ rather than ‘Aboriginal peoples’ when referring to this collective group. Although the terms are synonymous, and ‘Aboriginal peoples’ remains the collective legal term in legislation and policy documents, the latter term has become less popular in recent times; Indigenous peoples is currently the preferred term. Where possible and appropriate, however, I use the names of distinct groups or nations.

Indigenous peoples are comprised of heterogeneous groups. Three primary groups can be distinguished: First Nations, Inuit, and Métis. These further break down into more than 50 First Nation nations and 630 First Nation communities (Government of Canada, 2020a), 53 Inuit communities throughout Inuit Nunangat – which means "the place where Inuit live" (Government of Canada, 2020b) – and numerous Métis settlements, communities and identities (Barkwell, 2016). Each group is unique with its own history, culture, and languages, among other things. In the most recent census, approximately 1.67 million people in Canada – around 4.9% of the Canadian population – identified themselves as an Indigenous person (Statistics Canada, 2016).

First Nations represent the largest of the three Indigenous groups, including just under one million self-identified citizens in the most recent census (Statistics Canada, 2016). This group includes both status/registered and non-status/unregistered “Indians” (as per the Indian Act of Canada). Inuit, the original inhabitants of the Arctic region of Canada, comprise the smallest of the three groups with around 65,000 self-identified members (Statistics Canada, 2016). Métis stand at roughly 587,000 (Statistics Canada, 2016). However, there remains some debate about who is considered Métis. For the purposes of this paper, I use the definition of the Métis National Council, which states that "Métis" means a person who self-identifies as Métis, is distinct from other Aboriginal peoples, is of historic Métis Nation Ancestry and who is accepted by the Métis Nation. Métis are currently recognized as being from Manitoba, Saskatchewan, Alberta, as well as certain parts of Ontario, British Columbia, and the Northwest Territories (Métis National Council, 2002).

Despite the heterogeneity of Indigenous peoples in Canada and the distinct groups they comprise, the Canadian government has historically regarded Indigenous peoples as a largely homogeneous group. As a result, only a small portion of Indigenous peoples have typically been considered when developing and implementing legislation and policies.

Introduction

Canada is widely regarded as having one of the highest qualities of life in the world (OECD, 2020). Although a myriad of factors contribute to this acclaim, an advanced healthcare system is a major component of the equation (OECD, 2020). However, the Canadian health system is complex. This is largely due to the separate jurisdictional entities – i.e., provinces and territories – that independently control healthcare in their respective areas. Therefore, health service and delivery is not always equal across jurisdictions (National Collaborating Centre for Aboriginal Health, 2013). Matters become even more complex when Indigenous health care and jurisdiction are factored in. Although regarded highly around the world, the Canadian health care system nevertheless contains major gaps and inadequacies, including failure to provide Indigenous peoples with their inherent right of health.

In particular, notable disparities exist between Indigenous and non-Indigenous health care and health outcomes. These disparities affect both children and adults. For example, a recent report by Statistics Canada (Kumar & Tjepkema, 2019) indicated that between 2011 to 2016, First Nations people experienced a suicide rate three times higher than that of the non-Indigenous population. For Inuit, that rate was even more startling, reported to be 6-11 times higher. Perhaps most striking, however, is that more than a third of all Indigenous youth deaths were a result of suicide (The Aboriginal Healing Foundation, 2007). Moreover, infant mortality rates for First Nations and Inuit children range from 1.7 to over 4 times the non-Indigenous rate (The Truth and Reconciliation Commission of Canada, 2015). First Nations people are six times more likely than the general population to suffer alcohol-related deaths, and more than three times more likely to suffer drug-induced deaths (The Truth and Reconciliation Commission of Canada, 2015).

In addition, lower life expectancy and the prevalence of chronic conditions — such as hypertension, obesity, diabetes, and arthritis — disproportionately burden Indigenous peoples. Specifically, First Nation adults aged forty-five years and older have diabetes at close to twice the rate of non-Indigenous peoples (Kumar & Tjepkema, 2019). For instance, non-insulin dependent diabetes mellitus (NIDDM), once nonexistent within the Indigenous population, now represents a major health concern for Indigenous peoples both in Canada and abroad (Adelson, 2005).

Similarly, tuberculosis – a disease that is both curable and preventable – is reported to be more than 40 times higher among Indigenous people living on-reserve than among non-Indigenous peoples. Among Inuit in Canada, the rate of tuberculosis is now more than 290 times higher than non-Indigenous peoples (Patteron, Finn, & Barber, 2018). This is hardly a recent development afflicting Indigenous peoples. For example, on June 6, 1829, tuberculosis wiped out an entire Indigenous group known as the Beothuk, inhabitants of Newfoundland before and at the time of European contact. Shawnadithit, believed to be the last Beothuk, died of tuberculosis on that day in Newfoundland after the disease had previously killed off her relatives (Marsh, 2013). However, the Government of Canada only recently made the elimination of tuberculosis across Inuit Nunangat a priority in 2018 (Indigenous Services Canada, 2018a).

This reality results in preventable deaths from diseases and suicides which have considerable social impact (Suicide Prevention Australia, 2016). The impact of such deaths is even stronger in small tight-knit Indigenous communities, where many people are related (Kumar & Tjepkema, 2019). These preventable deaths not only result in bereavement to the immediate family and friends of the deceased, but also to the community and society as a whole.

This grief is further amplified when the person being mourned is young, taken before his/her time. The negative impacts from these health disparities and their effects create a perpetuating traumatic cycle that can be hard to break out of, without increased and focused attention, causing more health issues and preventable deaths (Adelson, 2005).

These gaps in health outcomes have prompted urgent calls to action from the recent Truth and Reconciliation Commission of Canada (TRC), including full health care rights for Indigenous Peoples, the elimination of health disparities, antiracist decolonization of the health sector, and self-determination in use of and access to traditional knowledge, therapies and healing practices (The Truth and Reconciliation Commission of Canada, 2015).

All this said, in recent years, Indigenous health care and health outcomes have been improving (Indigenous Services Canada, 2018b). For instance, life expectancy statistics show an increase of one to two years on average from the recorded life expectancy of Indigenous peoples in 2001 (Statistics Canada, 2015).

But despite advances in health care services and health outcomes in Indigenous peoples, there remain a number of challenges that must be overcome to achieve parity with non-Indigenous peoples. In pursuit of this parity, some have attempted to lay the blame on Indigenous peoples themselves, suggesting that the disparity in health is directly attributable to specific Indigenous traits and genes (Adelson, 2005). However, evidence hardly supports this view. Historically, Indigenous people did not face many of their current health challenges and burdens until Europeans arrived, bringing new infectious diseases and imposing a health-care structure that deemed traditional Indigenous medicine as less important and effective than their `modern` system (Robinson, 1988). Moreover, studies have found that health disparities are rooted in economic, political and social inequities, along with lack of autonomy imposed by colonialism which has rendered Indigenous peoples unable to make decisions regarding their own health (Adelson, 2005).

In addition, the poorest and most disempowered within Indigenous communities are often the sickest and least likely to be able to change or remove themselves from their immediate circumstances. Referred to as an “endless circle of disadvantage”, many Indigenous peoples in Canada are caught in a seemingly never-ending cycle of poverty, alcoholism, violence, educational struggles and ill health (Kendall, 2001). Systemic factors such as unjust laws and discriminatory policies and practices greatly influence and shape the health care disadvantages faced by Indigenous peoples in Canada (Adelson, 2005). Until such injustice, socioeconomic and political factors are addressed, health care disparities will remain.

In this research paper, I explore the disparities in health care and health outcomes between Indigenous and non-Indigenous peoples. To do so, I start with a history of the evolution of Indigenous policy and health policy. I then take a look at the current Indigenous health landscape, some of the opportunities and challenges and, finally, consider steps that the Canadian government can take, in partnership with Indigenous peoples, to close the gaps in health care and health outcomes between Indigenous and non-Indigenous peoples. I conclude by offering recommendations that could be beneficial for all Indigenous groups.

Chapter 1 – Evolution of Indigenous policy and health policy in Canada

Since its creation, Canada’s Indigenous policy has been rooted in colonialism, systemic racism, and discriminatory practices (Leslie, 2002). This has had a significant effect on the health care and health outcomes of Indigenous peoples in Canada. Indigenous peoples in other settler-colonies such as Australia and New Zealand have experienced similar detrimental forces (Paradies, 2016). Recent developments in Indigenous health legislation and policy have improved Indigenous health care and health outcomes (Indigenous Services Canada, 2018b), but improvements have yet to result in equality. This chapter examines the different legislation, policies and practices that have played the biggest role in the health care and health outcomes experienced by Indigenous peoples.

Constitution Act (1867)

The 1867 Constitution Act (formerly known as the British North America Act 1867) created the decentralized dominion that currently represents Canada. The Act also defined the structure and operations of the Government of Canada (GoC), along with the justice and taxation systems ("Constitution Act," 1867). In addition, the foundation upon which the GoC relates to Indigenous peoples was laid with this act. In particular, this piece of legislation set the framework for future Indigenous legislation and policy in the Canadian context with just seven words (National Collaborating Centre for Aboriginal Health, 2011). In essence, as per Section 91(24), "Indians[1], and Lands reserved for the Indians" became a federal responsibility ("Constitution Act," 1867). It specified, therefore, that matters concerning Indigenous peoples – including Indigenous health – and their territories, were exclusively an area of federal jurisdiction.

In parallel, the Act stated that health care and health care services for the general population represented an area of provincial jurisdiction (Josée G Lavoie, Kornelsen, Boyer, & Wylie, 2016), thus creating ambiguity regarding responsibility for health care services for

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[1] The term Indian was used at the time and is still the legal terminology in the Constitution and the Indian Act

Indigenous peoples. This ambiguity is still persistent today. Therefore, while no specific health care provisions were outlined, the Act plays a major role in shaping the current disparities in health care and health outcomes between Indigenous and non-Indigenous peoples.

One of the most controversial aspects of the 1867 Constitution Act was its definition of Indigenous peoples. Originally, the Act legally recognized only First Nations peoples as "Indians". Subsequent court cases helped expand the definition to include other Indigenous groups. Specifically, in 1939, the Supreme Court of Canada ruled that Inuit were also considered "Indians", and that they were included within the fiduciary responsibility of the federal government (Bonesteel, 2006; Supreme Court of Canada, 1939). Almost 80 years later, in 2016, the Supreme Court of Canada finally recognized Métis and non-status First Nation peoples as per the Constitution Act (Supreme Court of Canada, 2016). However, this ruling hardly equalized resource allocation across all Indigenous groups. For example, Métis and non-status First Nations peoples continue to fight for the same rights and benefits that First Nations and Inuit receive as per the Indian Act. I explore this topic further in the following section.

Indian Act (1876)

> *"The great aim of our legislation has been to do away with the tribal system and assimilate the Indian people in all respects with the other inhabitants of the Dominion as speedily as they are fit to change (McDonald, 1887)."*

Nine years following the implementation of the 1867 Constitution Act, the 1876 Indian Act was adopted in an attempt to centralize all previous Indigenous policies. This all-encompassing piece of legislation still governs practically every aspect of a Status Indian's[2] life,

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[2] Status Indian refers to registered First Nations people under the Indian Act

including health. By today’s standards, the Indian Act is colonial, discriminatory, and racist; the intention behind it was actually to civilize and assimilate Indigenous peoples. In essence, it was developed and implemented under the assumption that Indigenous peoples were inferior, unequal, and uncivilized (Richmond & Cook, 2016) therefore it is not surprising that Indigenous peoples face poorer health care and health outcomes.

Many colonial and discriminatory policies were developed and implemented in the spirit of the Indian Act. These policies negatively affect many socioeconomic indicators, including health. Some examples include the forced relocation of Indigenous peoples onto reserves[3], the pass system[4], children being forced to attend Residential schools, the prohibition of ceremonial practices such as the Pot Lache, the removal by social services of children from their families and communities, and the list goes on (Adelson, 2005). While many of these policies have long since been removed or are no longer enforced, many others still exist such as the registration of First Nation peoples by an Indian registrar and the removal by social services of children from their families and communities. These policies cause untold harm and trauma to Indigenous peoples. Many have even been deemed cultural and colonial genocide (The Truth and Reconciliation Commission of Canada, 2015; Woolford & Benvenuto, 2015). This trauma has resulted in the separation of families and the absence of individuals, and especially children, from their communities; loss of language, culture and traditions; intergenerational transmission of trauma; and marginalization. All these effects have taken a toll on the physical and mental health of Indigenous peoples. Thus, past and current policies have created the disparities between health outcomes between Indigenous and non-Indigenous peoples (Aguiar & Halseth, 2015).

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[3] Deliberate initiatives by the Government of Canada to move Indigenous communities to reserve lands for administrative and/or development purposes

[4] Regulations requiring First Nation peoples obtain a permit to leave their reserve

As can be gleaned from this section’s introductory quote, the Indian Act intended to impose assimilation on Indigenous peoples. In consequence, every aspect of the Act, including the health provisions, must be evaluated and viewed critically through this lens.

Moving to the health side of things, section 73 of the Indian Act defined the legislative authority for the federal government’s obligation for Indigenous health. In this section, the Act identified the Governor in Council as having the authority to make regulations to: a) prevent, mitigate and control the spread of diseases on reserves, whether or not the diseases are infectious or communicable; b) provide medical treatment and health services for Indians; c) provide compulsory hospitalization and treatment for infectious diseases among Indians; and d) provide for sanitary conditions in private premises on reserves as well as in public places on reserve (Canada, 1985a).

Thus, the Act laid out the federal government’s obligation for Indigenous health. However, the federal government’s obligation as outlined covers only First Nation peoples living on reserve and Inuit living in their traditional territory. This specification created even further ambiguity with respect to health services for First Nations living off-reserve, Métis, and Inuit living outside of their traditional territories. Certain benefits, such as Non-insured health benefits (NIHB), discussed in a following chapter, are available to all registered First Nations and Inuit regardless of location. However, Métis and non-registered First Nations are unable to access any health benefits. Moreover, the majority of health services available on reserve remain harder to access for First Nations living off-reserve, non-status First Nations, Inuit living outside of their traditional territory, and Métis, because they need to get them through a provincial health care system. Indigenous peoples are more likely to face language barriers and racism in a provincial system that keep them from getting the necessary health services (Allen, Hatala, Ijaz, Courchene,

& Bushie, 2020). These exclusions create a gap in coverage among Indigenous groups that remains to this day.

Moreover, the Act has helped shape the public perception that Indigenous peoples are "sick and defenseless," and a burden to the country, requiring federal handouts through programs. These programs, in fact, are chronically underfunded when compared to similar programs for non-Indigenous peoples and they are just asking to receive equal services and programs as their non-Indigenous neighbours (Richmond & Cook, 2016).

Until now, the 1876 Indian Act remains the only national-level legislation for Indigenous peoples (Richmond & Cook, 2016). As mentioned, it was developed and implemented with the intention of assimilating them into the Canadian population. The fact that it remains the foundation upon which Indigenous policy and Indigenous health policy are based reflects the historic relationship between Indigenous peoples and Canada.

Residential schools

> *"Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic" (The Truth and Reconciliation Commission of Canada, 2015).*

In 1920, Deputy Minister of Indian Affairs Duncan Campbell Scott bluntly stated the above in reference to a main goal of the Indian Residential School policy. In the spirit of the Indian Act, many policies have had large negative impacts on the health of Indigenous peoples. For instance, Residential schools negatively impacted the health of the children who attended, both immediately and over the long-term (Wilk, Maltby, & Cooke, 2017). At the height of the Residential school era (1877-1996) in Canada, there were 139 schools. Every province and territory had at least one except Prince Edward Island, Newfoundland and New Brunswick, and an estimated 150,000 Indigenous children attended a Residential school throughout the period (Blackstock, 2007). Although the last one closed in 1996, many of those same children continue to live and deal with the negative physical, emotional and psychological health consequences of the Residential schools (Blackstock, 2007). For instance, Ruby Firth, a former student at a Residential school in the Northwest Territories, explained to the Commission the lasting effect of the conditions experienced.

> "I've got chronic bronchitis today. Every winter I get pneumonia like two or three times and I'm on two puffers 'cause when I was in Stringer Hall residential school they used to put us in these little skinny red coats that weren't even warm enough for winter. And we used to have to walk across the street to go to school… Both my lungs are 50% scarred from having pneumonia seven times in [residential school]. That's always going to be there, it's never going to go away (The Truth and Reconciliation Commission of Canada, 2015, p. 206)."

This serves as only one of many examples of past policies perpetuating negative health consequences for Indigenous peoples even after its active lifespan has expired. In fact, not only were the children who attended residential schools negatively impacted during and following their attendance at the schools, but many unwittingly transferred on their trauma to their children, and even grandchildren in some cases (The Truth and Reconciliation Commission of Canada, 2015).

Health Transfer

> *"The Federal Government realizes that only Indian communities themselves can change these root causes and that to do so will require the wholehearted support of the larger Canadian community. Hence, the goal of Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves (Indian Health Policy, Department of National Health and Welfare Canada, 1979)."*

Over the last forty years, there has been a change in the GoC's approach to Indigenous health policy. The approach centers largely on a vision of transferring provision and delivery of health services to Indigenous peoples (Department of National Health and Welfare Canada, 1979).

This trend began with the Indian Health Policy of Canada in 1979 which was the first national Indigenous health policy (National Collaborating Centre for Aboriginal Health, 2013). As seen in the introductory quote of this section, the stated goal of the policy was increasing the level of health in Indigenous communities while also passing on the management and control to communities and Indigenous peoples themselves. The policy was a three page document that recognized that First Nation and Inuit communities could take over any or all aspect(s) of the administration of their own community health programs, at their discretion and with the support of the Department of National Health and Welfare. The policy, which is still in force today, recognizes three pillars: 1) Community development which recognized the existence of 'conditions of poverty and apathy' that were holding communities back from better health care and health outcome; 2) the traditional relationship of the Indian people to the Federal Government which recognizes that the Federal Government 'serves as advocate of the interests of' Indigenous communities and that it must establish better commination with communities and encourage greater involvement in the planning and delivery of health services; and 3) the Canadian health system which reaffirmed federal, provincial and Indigenous community roles in health care (Department of National Health and Welfare Canada, 1979)(Health Canada 2000a).

After ten years of work and consultation, the most substantive thing to result from the 1979 policy was the Indian Health Transfer Policy which was developed and released in 1989 (Josée G Lavoie, 2013). It provided a framework for the taking over of control of health services by Indigenous peoples and established an approach for transfers to occur based on the idea of self-determination in health (Jacklin & Warry, 2004). Through this process, the decision to enter into transfer discussions with Indigenous Services (formerly Health Canada) via the First Nations Inuit Health Branch (FNIHB)[5] rested with each community. Once involved in transfer, communities and Tribal Councils were able to take over the planning and delivery of health care services at a pace determined by their individual circumstances and health management capabilities. Under the policy, individual communities have negotiated to transfer varying levels of health care delivery to the community level.

However, the policy itself intended to integrate Indigenous health care into the national system. The Health Transfer Policy does "achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves" and does acknowledge a "special relationship" between First Nations and the federal government (Department of National Health and Welfare Canada, 1979). However, an issue with the policy is that while it transfers a range of services, including medical insurance, public health, and uninsured services, to Indigenous communities, it doesn't eliminate the pre-existing dependent relationship. Thus, for example, proposals for community health plans must still be approved by

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[5] Discussed in further detail below.

the federal government. The policy also fails to recognize traditional Indigenous health practices in the transfer agreements. In addition, funds are frozen once the transfer is complete. Many First Nation communities took the view that "in the absence of recognition of title and treaty rights, control over economic resources, political autonomy, improved standards of living and changes in the attitudes of non-Indigenous Canadians towards First Nations, health care services alone are unlikely to result in significant improvements in the health status within First Nations (Adelson, 2005)."

Child Welfare System

Although the last Residential school closed in 1996, it has been suggested that the schools actually just morphed into today's child welfare system (Blackstock, 2007). This colonial system has allowed provincial child welfare laws to replace the systems that Indigenous peoples historically used. The provincial laws remove Indigenous children from their families and communities on the grounds that the parents are not fit to have children. Removal is based on factors that the state's colonial policies perpetuated such as poverty and alcoholism (Blackstock, 2007). In fact, there are now more First Nations children in child welfare care than at the height of Residential schools (Blackstock, 2016a). Much like Residential schools, the removal of children from their homes results in the separation of families and the absence of minors from their communities. This separation and absence often leads to the loss of their Indigenous language, culture and traditions. These effects have taken a toll on the physical and mental health of Indigenous peoples. This is just another example of the policies that have created the disparities between health outcomes between Indigenous and non-Indigenous peoples (Aguiar & Halseth, 2015). It is important to note however that unlike Residential schools, this policy still exists today and perpetuates the "endless circle of disadvantage" referred to earlier.

Combined these colonial structures set the stage for a debilitating, systemic public policy that continues, still today, to powerfully shape patterns of Indigenous health care and health outcomes. The systems of care for Indigenous peoples, including health, were developed based on a foundation of racial discrimination, colonialism and a lack of recognition of the self-determination of Indigenous peoples and governance in communities. While more progressive policies are now being enacted, there is still more work to be done to close the gap in indigenous health care and health outcomes.

Chapter 2 – 21st century developments in Indigenous health policy

Ever since European contact, Indigenous peoples in Canada and abroad have fought for equality. Indigenous health policy continues to demonstrate widespread neglect and to highlight the absence of political will to improve access to health care services and health outcomes (Leeuw, Greenwood, & Cameron, 2009). However, the 21st century has provided some positive developments in Indigenous health care and health outcomes in Canada and globally. In turn, this has put additional pressure on the Government of Canada to focus on issues of inequality, discrimination and colonialism. This chapter examines those developments.

United Nations Declaration on the Rights of Indigenous Peoples

In the 21st century, Indigenous peoples, as a collective global group, have received more attention and support from the international community. The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) was adopted by the General Assembly on Thursday, 13 September 2007 (United Nations General Assembly, 2007). Incidentally, Canada was one of the four countries that voted against. There were, however, 144 votes in favour, ensuring that the declaration passed. Canada has since changed its position in regards to the vote and supported the Declaration (Moreton-Robinson, 2011).

Health care is specifically mentioned in is Article 24. This article recognizes that “Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services” and “Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right (United Nations General Assembly, 2007).” In taking measures to achieve these goals, countries are obligated to pay particular attention to the rights and special needs of Elders, women, youth, children, and persons with disabilities. Indigenous peoples have the right to be actively involved in developing, determining, and administering health programs that affect them. (United Nations General Assembly, 2007).

Canada has committed to fully implementing the declaration. This includes closing the disparities in health care and health outcomes between Indigenous and non-Indigenous peoples. Therefore, UNDRIP is a tool that Indigenous peoples can use and refer to in order to remind the federal government of its responsibility in respect to Indigenous peoples. Even though the implementation of UNDRIP cannot be guaranteed in a legal sense, it does foster a “starting point for a relationship” (Beatty, 2014).

Jordan’s Principle

With so many health care systems responsible for serving Indigenous peoples, disputes between the federal and provincial/territorial governments involving jurisdictional responsibility over health care to Indigenous peoples are common (MacDonald & Attaran, 2007). Even Indigenous children experience barriers to health care such as service delays, disruptions and denials due to jurisdictional payment disputes.

Jordan's Principle is an example of a child-first principle ensuring that a child doesn't pay the price for jurisdictional disputes between federal and provincial/territorial governments regarding payment for First Nation child services. The principle was created in response to a dispute that cost a child his life. Jordan River Anderson was a young boy from Norway House Cree Nation in Manitoba who became the victim of a jurisdictional dispute between the Governments of Canada and Manitoba in 1999. The two levels of government disagreed about who bore the responsibility for the cost of his treatment. Consequently, his treatment was delayed for over two years to allow the two to resolve who was responsible. During the two year dispute, Jordan River Anderson, a vulnerable child, passed away (Blackstock, 2016b). With Jordan's Principle, the government of first contact pays for the service and seeks reimbursement at a later stage, if appropriate (Blackstock, 2012).

Jordan's Principle itself came into effect in 2007 following the passage in the House of Commons of a Private Member's motion M-296 (First Nations Child and Family Caring Society of Canada, 2014).There have however been issues with implementation. For instance, in 2016, the Canadian Human Rights Tribunal (CHRT) determined the Government of Canada's approach to services for First Nations children was discriminatory (Blackstock, 2016a) . One way the federal government is addressing this is through a renewed approach and funding to Jordan's Principle (Government of Canada, 2020c)

Current political environment in relation to Indigenous health

The recent political environment seems favourable for Indigenous peoples. In fact, the Prime Minister has stated that “no relationship is more important to our government and to Canada than the one with Indigenous peoples. It is time for a renewed, nation-to-nation relationship with Indigenous Peoples, based on recognition of rights, respect, co-operation, and partnership (Prime Minister of Canada, 2015).” In support of this claim, significant funding has recently been dedicated to close disparities between Indigenous and non-Indigenous health care and health outcomes. For instance, in Budget 2019, the federal government planned to spend $4.5 billion over the following five years to try to narrow the socio-economic gap between Indigenous and non-Indigenous peoples (Finance, 2019).

Moreover, the most recent mandate letter (as of December 2019) for the Minister of Indigenous Services specifically states that the Minister should “co-develop distinctions-based Indigenous health legislation, backed with the investments needed to deliver high-quality health care for all Indigenous Peoples (Prime Minister of Canada, 2019b).” This suggests understanding and acknowledgement, at the highest political level, that there is a need for stronger health support for Indigenous communities. And, since the Prime Minister has explicitly requested that the Minister of Indigenous Services follow through with co-developing health legislation, it is reasonable to expect legislation to be tabled within the current Government’s mandate, which is four years as of October 20th, 2019.[6]

Similarly, the Prime Minister chose to highlight Indigenous health in a separate Minister’s mandate letter. The Prime Minister asked the Minister of Canadian Heritage to

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[6] Assuming an election isn’t called or triggered early. As the current Government is a minority, the chances of this occurring are increased.

“develop additional programming to increase Canadians’ participation in sport, with a particular focus on Indigenous Peoples. This should increase awareness of the physical and mental health benefits of participation in sport (Prime Minister of Canada, 2019a).” This again demonstrates interest and commitment, at the highest political level, to address Indigenous health issues and to use multiple strategies from a whole of government of approach to succeed as opposed to leaving the whole responsibility to only one Minister and Department.

Thus, in recent years, there have been promising signals that Canada intends to focus more on improving the health care and health outcomes of Indigenous peoples. These include UNDRIP, Jordan’s Principle and Canada’s current political environment in regards to Indigenous peoples. Despite these signals, numerous disparities remain between the health care and health outcomes of Indigenous and non-Indigenous peoples such as suicide rates, mortality rates and life expectancy. Critics have also criticized the pace at which the Canadian government has advanced on overcoming these challenges.

Chapter 3 – Current health care landscape

Fourteen health care systems currently exist in Canada. The first thirteen systems are the individual systems serving each province and territory (Josée G Lavoie et al., 2016); the last – and often forgotten – health care system is run by Indigenous Services Canada (ISC)[7] through the First Nations and Inuit Health Branch (FNIHB). All fourteen of these systems play a role in

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[7] Formerly through Health Canada (HC) before the creation of ISC and the subsequent transfer of FNIHB to ISC.

providing health care and services to Indigenous people, both on and off-reserve (Adelson, 2005).

FNIHB

The 1984 Canada Health Act requires that provinces and territories provide coverage for insured services, such as medically necessary hospital and physician services, to all eligible residents, including First Nations, Inuit and Métis. Consequently, all Indigenous peoples – on- and off-reserve First Nations, non-status First Nations, Inuit living in and outside of their traditional territories and Métis – are eligible to and can theoretically receive health services ("Canada Health Act," 1984). In practice, access to these services is not equal. Indigenous peoples often mistrust Western health care systems, prejudices against Indigenous peoples exist in non-Indigenous health care systems sometimes resulting in inferior treatment and culturally tailored health services are generally unavailable (AFN, 2017).

Complementing the provincial and territorial health care systems is FNIHB, with regional offices in almost every province. This health care system strives to provide effective, sustainable, and culturally appropriate health programs and services that contribute to the reduction of gaps in health status between First Nations and Inuit compared to other Canadians. In pursuit of this aim, FNIHB funds or directly provides a range of health programs and services to First Nations and Inuit.

To improve health systems to better meet the needs of First Nations and Inuit, FNIHB works with its partners to develop sustainable, long-term, integrated solutions, through dedicated and collaborative efforts, including developing partnerships between provincial governments and First Nations to integrate federal and provincial health systems. FNIHB also supports the improved capacity of First Nations and Inuit communities to address their own unique health needs by increasing their control over health program design and delivery (Indigenous Services Canada, 2020b).

FNIHB however primarily serves on-reserve First Nations and Inuit that live in their traditional territory by supporting the delivery of health services. Although it provides Non-Insured Health Benefits (NIHB) to all First Nations and Inuit, individuals who reside outside the reserve or of their traditional territory have a much harder time accessing health services compared to people who live within their respective communities, because there health care systems off-reserve are geared for non-Indigenous Canadians, and do not offer culturally relevant options to Indigenous peoples. In addition, there is sometimes a language barrier that either keeps an Indigenous people from ever presenting themselves at a hospital or prevents them from getting the accurate treatment (Kydd, 1998). In addition, FNIHB does not serve in any way non-status First Nation people and Métis.

NIHB is a national program run by FNIHB that provides registered First Nations and recognized Inuit in Canada with coverage for a range of medically necessary health-related goods and services not provided through other private or provincial/territorial programs. Benefits include pharmacy benefits (prescription drugs and some over-the-counter medication), medical supplies and equipment, dental care, vision care, mental health counselling, and medical transportation benefits to access medically required health services not available on reserve or in the community of residence. This means that whether you live on or off-reserve, in or outside your traditional territory, as long as you are registered First Nations or recognize Inuit, you are eligible for coverage through NIHB (Indigenous Services Canada, 2019a).

However, the NIHB program is a major grievance of Indigenous peoples due to inadequate coverage, lack of timely access, and burdensome administrative processes. Improved services and access to NIHB are essential to addressing systemic inequities between Indigenous peoples and Canadians in health status and access to quality care, at individual, community and national levels (AFN, 2017).

The number of intersecting health care systems in Canada results in varying levels of access to health services and coverage for Indigenous peoples across the country. These differences result in disparities in health care and health outcomes between Indigenous and non-Indigenous peoples. Future policy reforms would need to consider improved access to health care services through all health care systems for all Indigenous peoples.

Increase in Indigenous-led health care partnerships

Despite discriminatory policies and systematic oppression, Indigenous knowledge and healing practices are still practiced today. This knowledge is the foundation of Indigenous-led health care partnerships which find themselves filling gaps in the existing health care system landscape in Canada. In contrast to models of health care based on the Western system that incorporate Indigenous knowledge, Indigenous-led health care partnerships go even further. They are born out of traditional Indigenous knowledge rather than Western medicine and structures. Local Elders, healers and Knowledge Keepers maintain and share their knowledge as opposed to physicians. These partnerships are often supported by Western knowledge and expertise, but the extent at which it is integrated is up to those maintaining the partnership: the local Elders, healers and Knowledge Keepers (Allen et al., 2020).

Critics argue that Indigenous medicine can’t be appropriately integrated into biomedical practices because of the cultural frameworks and the short-sightedness of biomedicine including assumptions and biases about mind–body dualism and rigid power hierarchies. Several Elders, healers and Knowledge Keepers assert that biomedicine can however be integrated more appropriately into Indigenous healing practices and knowledge systems, which are by nature more inclusive of the physical, emotional, mental and spiritual aspects of health and health care (Hill, 2009).

The largest local Indigenous-led health care partnership in Canada is the First Nation Health Authority (FNHA) in BC. In 2007, a three-year time frame was established for BC, Canada and BC First Nations to create a First Nations governing body to take over the delivery of health services from the Government of Canada. This time frame was erected in accordance with the Tripartite First Nations Health Plan. In 2013, after more than 10 years of negotiation and planning, the First Nations Health Authority (FNHA) became a reality. On its website, the FNHA proudly states that it is the first province-wide health authority of its kind in Canada (First Nations Health Authority, 2020). As of the writing of this research paper, it remains the only province-wide health authority.

However, First Nation communities from other provinces have expressed interest in moving towards such a model. For instance, Quebec First Nations signed a tripartite Memorandum of Understanding on health and social services governance. The release states that it “confirms the commitment made by all parties to address the challenges resulting from the multiple levels of jurisdiction” (Indigenous Services Canada, 2019b).

Furthermore, in Southern Alaska, a 2013 review of the Indigenous-led Nuka System of Care partnerships over a 10-year period, demonstrated improvements in different health indicators. The Nuka

System was respectfully designed in response to the desires of Indigenous Peoples who use and own it. It incorporates traditional Indigenous knowledge and cultural services. Results include reduced emergency department use by 42%, reduced hospital days by 36%, reduced staff turnover by 75%, increased childhood vaccinations by 25%, and increased patient and client reports of satisfaction in cultural safety at 94% (Gottlieb, 2013).

Evidence shows Indigenous peoples taking over their health programs is a positive step in closing the gap between Indigenous and non-Indigenous health care and health outcomes. In fact, Indigenous-led health partnerships seem to be an underutilized tool to improve access to care, adherence to care plans and many health outcomes (Allen et al., 2020).

Indigenous demographic trends

An increasing proportion of Indigenous peoples are moving off-reserve, often to urban areas (Walker, 2008). This creates a challenge to close the gaps in Indigenous health care and health outcomes in the framework of the current system. As previously mentioned, Indigenous health policy is geared to on-reserve First Nations and Inuit living in their traditional territories. It is therefore often not possible to access the same variety of culturally geared health services in urban areas that are available on-reserve or in Inuit Nunangat.

In urban areas, racism becomes more prevalent and creates barriers to accessing culturally relevant health care services. Indigenous status also doesn’t provide Indigenous peoples with the same benefits once off-reserve (Adelson, 2005). With increasing numbers of Indigenous peoples moving off-reserve or outside of their traditional territory, a review of Indigenous health policy and a modernization of how it relates to recent demographic trends are needed (Statistics Canada, 2016).

Data collection challenges

Governments need quality data to develop and implement effective policies and programs, and to demonstrate accountability. Such data is the basis upon which evidence-based decisions are made and monitored. However, data in regards to Indigenous Canadians has always been lacking. Data on Indigenous health care and health outcome indicators is equally sparse thus often making it difficult to measure progress (The Truth and Reconciliation Commission of Canada, 2015). The need for targeted data is further compounded by the vast diversity of Indigenous peoples (Steffler, 2016).

The replacement of the long form census in 2010, implemented for cost saving reasons, was destined to even further increase the difficulty in getting reliable and relevant data. In 2015 however, the long form census was brought back. Nevertheless, this census is only conducted every five years, which isn't frequent enough to adequately follow the progress of a priority issue.

Adding to the lack of data is the issue of data governance. In the past, Indigenous peoples weren't always consulted in regards to the data being collected on them or how it was being used. This has led to mistrust. The report of the Royal Commission on Aboriginal Peoples in 1997 explained the situation: "The gathering of information and its subsequent use are inherently political. In the past, Aboriginal people have not been consulted about what information should be collected, who should gather that information, who should maintain it, and who should have access to it. The information gathered may or may not have been relevant to the questions, priorities and concerns of Aboriginal peoples. Because data gathering has frequently been impacted by outside authorities, it has met with resistance in many quarters. (RCAP 1997, 4)"

Overall, the current landscape, political will and recent developments provide opportunities for Indigenous peoples and the Government of Canada to make progress in closing the gap in health care and health outcomes between Indigenous and non-Indigenous peoples.

Chapter 4 – Social Determinants of Health

> "Most ministries of health, health systems and health programmes are still primarily concerned with delivering the downstream interventions responding to the incidental needs and demands of individuals that constitute the traditional intramural health care services. These are important and need to be provided in any decent society. However, they are not effective responses to the old and new public health problems that continue to be produced and reproduced." (Blas & Kurup, 2010)

Indigenous health policy evidently needs to be a component of any plan to improve Indigenous health care and health outcomes. There is however research suggesting that health policy changes and reforms will only have a limited impact. The reason lies in the complex and colonial history between Canada and Indigenous peoples that has resulted in disparities in many socioeconomic categories (Adelson, 2005).

A 1974 report (Lalonde, 1974) was fundamental in refuting the view that better health was singularly impacted by the quality and level of health care given. It introduced the idea that there are social determinants (distinct from the health care system) that affect the health of individuals. Moreover, the report clearly stated that health policy recognizes that health requires investment and coordination on a whole range of economic, social, environmental and political forces in addition to health ones. There was also recognition that in creating the conditions for equitable access to health services among vulnerable populations, such as that of Indigenous peoples, particular attention must be paid to their unique cultural contexts and histories (World Health Organization, 1988).

According to the World Health Organization (WHO), social determinants of health (SDH) are the conditions, in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems (World Health Organization, 2020a). Bearing this in mind, Indigenous health policy is but one component of closing the gap in health care and health outcomes between Indigenous and non-Indigenous peoples. In fact, public health programs and policies frequently forget the impact and role that addressing social determinants of health can make in reaching health goals. This is a mistake and sacrifices many components of a full strategy to tackle the problem (Blas & Kurup, 2010) .

Moreover, often, the most severe health problems affecting Indigenous people are outside the realm of expertise and impact of health professionals since the foundations of the health issues are rooted in the colonial relationship between Canada and Indigenous peoples (Olsen, 1993). As such, conditions and policies that favour positive and improving employment conditions and housing conditions, are an integral part of any action plan (World Health Organization, 2020b). The reality is that many of the poorest and the ones with the bleakest future are the ones with the most problems, health and other, and are in the worst position to change and chart a new direction for themselves from their immediate circumstances. Referred to as an “endless circle of disadvantage” in the Report of the Royal Commission on Aboriginal

People (1996), too many Aboriginal people in Canada are caught in a seemingly never-ending cycle of poverty, violence, educational failure and ill health (Kendall, 2001). It follows therefore that helping these individuals exit the circle of disadvantage will improve all facets of their life, including health.

Canada has however continuously demonstrated inadequate approaches and resources for addressing the social determinants of Indigenous health (Reading & Wien, 2009). This has contributed to the disparities in health care and health outcomes between Indigenous and non-Indigenous Canadians. Consequently, a new approach that takes into consideration the funding needs to improve the social determinants of health is needed to see the desired progress.

Chapter 5 – Recommendations

The lack of progress in eliminating disparities in health care and health outcomes between Indigenous and non-Indigenous Canadians demands new policy approaches. Policies must integrate the perspectives and participation of Indigenous peoples in the planning, budgeting, and delivery of health services. This chapter will lay out a non-exhaustive list of policy recommendations aligning with the goal of inclusivity, embracing the Indigenous perspective and, most importantly, achieving results that significantly reduce and eventually eliminate the disparities in Indigenous health care and health outcomes.

Increased funding

Canada has historically underfunded Indigenous services. While there has been an increase in funding for Indigenous peoples and services in the last few years, many programs, including health, remain underfunded when compared to similar programs for non-Indigenous peoples (Josée G. Lavoie, Forget, & O'Neil, 2007).

There are critics who wish to maintain the status quo by using the argument that Canada's vast geography makes health care delivery for complex chronic illness difficult and costly. Geography though is no excuse for an inequitable distribution of advanced care where it only exists in the south and First Nations children, parents and communities endure stress to access it. (MacDonald & Attaran, 2007)

Need for Data and Evidence-Based Goals

Two major limitations of current policies surround the lack of health data on Indigenous peoples and the setting and monitoring of clear targets and goals. This needs immediate rectification, which can be achieved by collecting updated and accurate data on Indigenous health care and health outcomes such as mortality and disease rates and using this information to set ambitious targets and goals. For example, the effectiveness of primary health care interventions can be demonstrated through indicators such as immunization rates and post-natal outcomes in the short term, hospitalization data in the medium term, and shifts in morbidity patterns such as later diagnoses of tuberculosis or cancer over the long term (Health Canada, 2006). In parallel, appropriate benchmarks and indicators must be developed for Indigenous peoples. Because provinces have jurisdiction over health services, access to provincial data is also essential (Health Canada, 2006).

Obtaining precise information on Indigenous peoples as a collective group is difficult enough. It becomes even more difficult to get data split further down to be First Nations, Inuit and Métis specific; and then further by province and/or community; and then, when needed, even further sometimes e.g., by registered and unregistered First Nations peoples.

Lack of data not only renders measurement of progress more difficult, but also means that publicly reporting, whether by the media or the government, is also a challenge. Less reporting leads to less publicity in the mainstream media and population. This leads to the issue receiving less focus and intention, especially from decision makers thus creating a vicious circle, possibly leading to ignorance of the problem. Goals measured with data that decision makers, departments and health authorities need to report on publicly are therefore crucial to closing the gap.

In Australia, for instance, since 2007, the prime minister reports every year on the progress being made to eliminate the disparities in targets such as life expectancy and mortality rates for Indigenous children. The government has also established deadlines for eliminating health disparities in health care and health outcomes between Indigenous and non-Indigenous peoples. Since beginning to track this data, there has been progress on almost every measure (Australia, 2020). On the measures that are not on track to meet the target, it is at least known which ones are lagging behind. This allows for additional resources and corrective measures to be put in place to address the most pressing needs.

A recent example in Canada of an attempt to set a goal is that of eliminating tuberculosis from Inuit Nunangat by 2030, with an interim reduction in the reported rate of active tuberculosis of at least 50% by 2025. This goal was set by Natan Obed, President of ITK, and then Minister of Indigenous Services, Jane Philpott on December 10, 2018. Former Minister Philpott said in an interview that “we’re developing a very clear plan to ensure the housing issues are addressed, that the X-ray facilities and laboratory facilities are there, that the human resources are there." When a goal is clearly stated, it becomes easier for people to rally around what needs to be done and to develop a plan to get there.

While there is not much public information on the progress of tuberculosis elimination, there are concerns that progress has stalled (Oudshoorn, 2020). However, a plan to eliminate tuberculosis in Inuit Nunangat required resources and political will. Goals and data allow the media and/or government to report on the progress. A lack of data is equally newsworthy as oftentimes it suggests a certain degree of failure.

For instance, an issue such as high rates of tuberculosis in Canada could attract the public attention which ensures that decision makers stay focused on the issue. This highlights the importance of setting ambitious goals that can be measured and reported, so any policy reforms should have built-in reporting requirements to ensure proper data that can be used when evaluating programs and determining whether adjustments are necessary.   accurate and specific data on Indigenous peoples and should set ambitious goals which should be reported on by the prime minister or minister on a yearly basis to ensure accountability.

Social Determinants of Health

Societal factors also play an important role in health outcomes. In the aforementioned tuberculosis example in Inuit Nunangat, factors beyond the implementation of testing clinics and proper treatment are crucial to the elimination framework. Health care services alone are insufficient to address the problem (Lalonde, 1974). For example, 52% of Inuit in Inuit Nunangat live in overcrowded housing compared to 9% of Canadians (Inuit Tapirrit Kanatami, 2019), and 70% of Inuit in Inuit Nunangat are food insecure compared to 8% of Canadians (Leblanc-

Laurendeau, 2019). These two social determinants of health are key factors in permitting tuberculosis to thrive as it is easily spread in overcrowded housing and malnourished individuals are more susceptible to infection. If these conditions are not improved, health care service improvements alone will be unlikely to lead to the desired result (i.e., eradication of tuberculosis among Inuit communities).

Reductions in tuberculosis incidence, mortality, morbidity and other health outcomes have been observed historically as populations experienced improvements in social and economic conditions (Raviglione & Sulis, 2016). The poorest and most socially excluded populations carry the largest burden of disease. For this reason, it is important to consider all social determinants of health through poverty reduction measures and targeted interventions on high-risk populations.

Another example of a social determinant of health is access to clean drinking water. Potable water is critical for good health and a basic human right. However, as of the writing of this paper, there remain over 50 communities without access to clean drinking water (Indigenous Services Canada, 2020a). This situation complicates progress in health outcomes. Increased funding and improved policies to tackle all social determinants of health are thus crucial to closing the gap in health care and health outcomes between Indigenous and non-Indigenous peoples.

Indigenous-led health care partnerships

A new analysis published in the Canadian Medical Association Journal says evidence is emerging to suggest that Indigenous-led health care partnerships are improving health outcomes in Indigenous peoples (Allen et al., 2020). Indigenous-led health care partnerships provide innovative models of interprofessional collaboration, be it in community-based healing lodges, remote clinics or urban hospitals. Indeed, Call to Action 22 of the Truth and Reconciliation Report states, “We call upon those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients (The Truth and Reconciliation Commission of Canada, 2015).” In fact, voices have been increasing for a return to Indigenous healing knowledge and roots. Older generations often claim that the ancestral knowledge is either not known or misunderstood by the younger generations, and that what is known is often undermined by the current health system that the federal government has established for Indigenous people (Sweetgrass, 2010).

Moreover, Canadian Indigenous health literature is full of examples of “culture as cure.” Evidence shows that when health interventions in Indigenous communities are based on cultural knowledge, Indigenous health care and health outcomes improve including decreased rates of suicide and hospitalization, improved access to health care, improved coordination and increased investment (Manitowabi, 2009).

In a 2009 report, the Indigenous Physicians Association of Canada recommended placing increased importance and demonstrating increased openness on Indigenous medicines equal to that placed on biomedicine to further advance future health systems partnerships in Canada. This includes being open to patients’ disclosures of use of traditional medicines, building relationships with Indigenous healing practitioners, Knowledge Keepers and Elders, supporting the work Elders and healers do in the community, recognizing Indigenous holistic health definitions and indicators, learning local languages when working in Indigenous communities, and taking opportunities to experience and support local ceremonies, such as sweat lodges or sundances to create awareness and understanding (Allen et al., 2020).

As explained, evidence suggests that Indigenous-led health service partnerships improve health outcomes for Indigenous Peoples, as well as access to care, therefore this model should be increasingly supported and counted on to achieve results.

Health care professionals

Many health care professionals, but especially medical residents, spend a few weeks in remote Indigenous communities during their residencies. They are faced with the disparities in Indigenous health care and health outcomes as well as the negative consequences of Canada's colonial history on other socioeconomic indicators (Yeung et al., 2018). However, they are rarely given the proper preparation or tools to internalize their experience productively. In fact, the information and experience they take from their time in Indigenous communities is often internalized to produce even more prejudice and unconscious bias than they might have had. Proper orientation before and debriefing afterwards are important to ensure that doctors and health care professionals are aware of cultural differences and are not left with any biases (Yeung et al., 2018).

A 2013 study of 7,000 Indigenous people reported that almost one third (32.4%) of Indigenous patients said they were discriminated against in a medical setting most or all of the time (The New South Wales Nurses and Midwives' Association, 2017). One instance of such discrimination occurred in June 2020 while I was writing this paper. An Indigenous woman in Alberta was dismissed from a hospital on seven occasions without further tests or treatments, because she was Indigenous. It was eventually discovered that she had experienced numerous a stroke over the period she visited the hospital. In a statement, Alberta Health Services (AHS) "acknowledge[d] that institutional racism and stereotyping has kept people from getting the care they need" and " that the relationships between AHS and First Nations, Métis and Inuit Albertans must continue to improve, and we have more work to do (Fournier, 2020)." It is clear that better training and reviews are needed to ensure "all actors within the health system" are free of anti-Indigenous bias and racism. Another recent example occurred in BC where doctors played a game in which they guess the blood alcohol level of Indigenous patients. Mary Ellen Turpel-Lafond, a lawyer known known for her work on public-interest issues, particularly on the topic of child welfare, had this to say: "As an Indigenous person, I'm not completely shocked. The stories that I've heard are very difficult stories," she said. "In some instances, they're stories where a person's life has been lost. I certainly feel that pain that I'm hearing (McKeen, 2020)."

These recommendations are by no means an exhaustive list, however they provide considerations for co-development of new health legislation.

Chapter 6 – Conclusion

The systems of care developed and implemented by the Government of Canada for Indigenous peoples, including health care, provide services based on a foundation of racial discrimination, colonialism, and a lack of recognition of the self-determination of Indigenous peoples. These systems have caused political, economic and socioeconomic disparities between Indigenous and non-Indigenous peoples in Canada. Based on the evidence presented in this research paper, it is clear that changes are needed to close the gap in health care services and health outcomes between the two populations.

The current political climate provides an opportune time for Indigenous and non-Indigenous Canadians to begin the work necessary to close the gap in health care and health outcomes. The current approach to Indigenous health care is built on a Western medical system that does not integrate Indigenous knowledge and often excludes traditional beliefs and practices. Yet, evidence suggests that culture is an important factor in preventing health risks and that increased Indigenous control improves health care and health outcomes. These exclusions of traditional Indigenous practices therefore create challenges that are now inherently built into the current health care system.

Research has demonstrated the need for a national Indigenous health policy that recognizes and prioritizes the rights of Indigenous peoples in Canada in order to achieve equal health care and health outcomes (Adelson, 2005; Richmond & Cook, 2016). This calls for the creation and implementation of a new health policy that would replace the Indian Act in respect to health. If done properly, this would greatly help close the jurisdictional gaps that cause Indigenous peoples to be penalized. However, because health policy is only one component affecting the current gap in health services and outcomes, any impactful health policy would have to be developed in concert with other programs to effectively address all social determinants of health.

The Government of Canada and Indigenous partners should co-develop national Indigenous health legislation to update the colonial and outdated Indian Act, which was implemented and imposed on Indigenous peoples over 150 years ago. Concurrently, Indigenous organizations such as the AFN, ITK and Métis National Council should continue pushing the Government of Canada and provincial governments to take a whole of government approach and to tackle social determinants to health that takes into account the distinctions and needs of each Indigenous group. If history has taught us anything, without reforms in legislation and government action, the disparities in health care and health outcomes between Indigenous and non-Indigenous peoples will persist.

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