

BRINGING RECONCILIATION TO HEALTHCARE IN CANADA

Wise Practices for Healthcare Leaders



Medicine wheels represent the alignment and continuous interaction of the physical, emotional, mental, and spiritual realities. April 2018

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EXECUTIVE SUMMARY WITH RECOMMENDATIONS FOR WISE PRACTICES

This HealthCareCAN Report discusses critical issues facing Indigenous Peoples in Canada, and the role that Canadian health leaders play in helping to close the health gap. It also presents wise practices for health leaders and organizations to address the health-related Calls to Action of the Truth and Reconciliation Commission of Canada (TRC) based on a literature review, interviews with key stakeholders, and case studies of several health care organizations. The term “wise practices” is widely used in Indigenous contexts to describe locally appropriate Indigenous actions that contribute to sustainable and equitable conditions.¹

Many stakeholders, including governments, health agencies, physician and nurse organizations, hospitals and health regions, and others have already taken steps to address the health-related TRC Calls to Action. While these activities represent important first steps, transformative system-level and organization-level changes are needed to improve the health of Indigenous peoples in Canada. For the purposes of this brief, three inter-related areas of action have been identified:

1. Re-align authorities, accountabilities and resources;
2. Eliminate racism and increase cultural safety; and
3. Ensure equitable access to health care.

Health leaders in Canada can work within their organizations to implement wise practices that address the TRC’s recommendations. The most important element in both the design and delivery of these changes, however, is that health leaders are guided by and work with local, provincial, and national Indigenous leaders and organizations. Otherwise, they risk reproducing existing colonial structures in the health care system.

Health leaders should consider the following wise practices to guide them in their work to advance reconciliation. The focus of these wise practices is to effect change at the level of the health care organization or institution. Furthermore, leaders of organizations can advocate alongside their Indigenous partners for system-level changes to policy, funding, and governance.

Policy and Systems Change

1. Support local First Nations, Inuit, and Métis leaders in conjunction with their national counterparts at the Assembly of First Nations, Inuit Tapiriit Kanatami, and Métis National Council as they negotiate, develop, implement, and evaluate health transformation agreements, and advocate for policy and systems change.

Community Engagement

2. Identify key stakeholders for community engagement and build relationships with them. Stakeholders include representatives from local and regional FN/I/M governments and local Indigenous health service organizations, Indigenous clients, and others. When reaching out to key stakeholders, follow engagement protocols articulated by their respective organizations. Create partnership agreements that include process evaluations and accountability measures for any shared initiatives related to Indigenous health and wellness.
3. Make reconciliation and Indigenous health equity part of the organization’s strategic plan.

Recruitment and Retention of Indigenous Staff and Health Care Providers

4. Promote the involvement of Indigenous peoples in the organization by recruiting them for governance and leadership positions, advisory circles, community liaisons, Elders’ councils, and other roles; formalize reporting and action-based accountability by the non-Indigenous leadership to prevent tokenistic or non-meaningful engagement.

5. Recruit, retain, and mentor Indigenous staff and health care providers at all levels of the organization, including procurement; create working and learning environments where they can thrive, and where Indigeneity and Indigenous knowledge are valued.

Anti-Racism and Cultural Safety Education

6. Provide anti-racism and cultural safety education to all members of the organization; develop and implement safe processes for both employees and clients to debrief racist or culturally unsafe experiences in the organization; develop and implement processes to document these instances and track progress.
7. Support Indigenous learners in the health professions by creating safe and respectful clinical learning environments that are free of racism and discrimination; participate in health science outreach programs for younger students.

Indigenous Client Care and Outcomes

8. Enhance the journey of Indigenous clients through the practice of trauma-informed care and programs such as Indigenous navigators, access to traditional foods and healing practices, support from Elders, and land-based healing; the specific initiatives should emerge from the recommendations made by local Indigenous communities, advisors, and clients.
9. In jurisdictions where data related to race and ethnicity is available, track health outcomes for Indigenous vs. non-Indigenous clients in the organization; appropriate Indigenous data stewardship agreements must be developed and followed.
10. Understand and support changes to address Indigenous social determinants of health.

For more detailed guidance and other suggestions, health leaders should review the section on Implementing the TRC's Calls to Action towards the end of this document.

ISSUE

At the 2016 National Health Leadership Conference (NHLC), co-hosted by HealthCareCAN and the Canadian College of Health Leaders, over 700 health leaders selected and debated a number of priority policy issues as part of the Great Canadian Healthcare Debate. After a rigorous process of determining the top policy issues, the resolution that won overwhelming support (73%) was to make implementation of the health-related Truth and Reconciliation Commission of Canada (TRC) recommendations the number one priority, not just for 2017, but until the recommendations are fully implemented.

The 2017 NHLC featured a special plenary session entitled *“Advancing the Truth and Reconciliation Commission’s Health-Related Calls to Action: How do we achieve better value, higher quality care, and better outcomes for Canada’s Indigenous populations?”* Participants heard from Indigenous health leaders and other key stakeholders regarding strategies and recommendations for Canadian health leaders and for health organizations to help close the health gap.

This HealthCareCAN Report, funded by a grant from The McConnell Foundation, discusses many of the critical issues facing Indigenous Peoples in Canada, and the role that Canadian health leaders may play in helping to close the health gap. It also explores some concrete actions that health organizations have already taken to address the health-related recommendations of the TRC, and highlights a number of wise practices to further advance cultural integration in health services.

This Report uses a strengths-based approach and the contents highlight the strategies, policies, and practices that identify, acknowledge, and leverage the strengths and resources of Indigenous peoples and Indigenous communities across Canada. Within the document, the term “Indigenous” peoples is used with respect, in place of Aboriginal, First Nations, Inuit, and Métis.

The term “reconciliation” is found many times within this Report and the term means different things to different people. Common themes include acknowledging the wrongs of the past, knowing our true history, recognizing the inherent rights of all Indigenous peoples, and restoring balance to relationships between Indigenous and non-Indigenous peoples. Reconciliation is also an ongoing process requiring a collective effort to find a new way forward.

METHOD

A HealthCareCAN Steering Committee was formed to guide identification of key issues and the research approach. An environmental scan and literature review were completed. The Steering Committee helped to select 18 key informants from 14 organizations who were interviewed by telephone using a standard interview guide in September–October 2017. These informants included representatives of hospitals, regional health authorities, Indigenous health programs, universities, health organizations such as the Canadian Patient Safety Institute, and physician and nursing groups. Some of the interviewees self-identified as Indigenous. A list of this report’s Key Informants is provided in Appendix A. The standard interview guide employed for this work can be found in Appendix B.

This Report is also informed by the Public Policy Form conference entitled *Partners in Reconciliation: Recognizing and Respecting Indigenous Health* held on September 27, 2017 in Ottawa. The well-attended and inspiring conference focused on truth and reconciliation, strategies for implementing the TRC’s health-related Calls to Action, building cultural competence and safety for Indigenous inclusion in Canada, and transforming health care services and institutions so that Indigenous peoples can participate fully. The conference summary, which includes the conference program and speakers, can be found [here](#).

BACKGROUND

The Truth and Reconciliation Commission of Canada was established in 2008 as a result of the Indian Residential Schools Settlement Agreement (IRSSA), the largest class action settlement in Canadian history. In May 2006, the IRSSA settled multiple class action suits against the Canadian government, Anglican Church, Presbyterian Church, United Church, and Roman Catholic Church by past full-time students of Canada's Residential School system which operated from 1884 to 1996.

At its peak, the residential school system operated 130 schools in every province and territory except for Newfoundland, Prince Edward Island and New Brunswick. It is estimated that 150,000 First Nations, Métis, and Inuit children were forcibly removed from their communities to attend the schools. The class action suits represented an estimated 80,000 surviving residential school survivors who were enrolled in the schools full-time. It is important to note that IRSSA did not include students who attended residential schools as "day scholars." In June 2015, The Federal Court of Canada approved a motion for two First Nations in British Columbia to proceed with a class action suit for these day students.

The National Centre for Truth and Reconciliation at the University of Manitoba was created to preserve the memory and legacy of Canada's Residential School system. It is the permanent home for all statements, documents, and other materials gathered by the TRC.

As a result of settlement negotiations within the IRSSA, Canada was required to provide sixty million dollars to establish and fund the Truth and Reconciliation Commission. The Commission was mandated to: "reveal to Canadians the complex truth about the history and the ongoing legacy of church-run residential schools..." and, "guide and inspire a process of truth and healing, leading toward reconciliation within Aboriginal families, and between Aboriginal peoples and non-Aboriginal communities, governments, and Canadians generally."ⁱⁱ The Commission reviewed thousands of documents and heard from hundreds of witnesses at national events across the country.

In December 2015, the Truth and Reconciliation Commission of Canada released its final report. The Commission's report highlights some of the troubling disparities in health outcomes between Indigenous and non-Indigenous people in Canada, including:

- An infant mortality rate for First Nations and Inuit children ranging from 1.7 to over 4 times the non-Indigenous average;
- Nearly twice the rate of diabetes among Indigenous people aged 45 and older compared to non-Indigenous people; and,
- An overall suicide rate among First Nation communities that is about twice that of the total Canadian population.

The report noted that Canada has a long history of colonialism in relation to Indigenous peoples. This history and its policies of cultural genocide and assimilation have left deep scars on the lives of many Indigenous people and communities, as well as on Canadian society, and have deeply damaged the relationship between Indigenous and non-Indigenous peoples. The Commission identified reconciliation as an avenue to repair these relationships.ⁱⁱⁱ

In June 2015, the TRC released 94 "Calls to Action" which cover the broad themes of child welfare, education, language and culture, health, and justice. The "Calls to Action" are aimed at redressing the legacy of residential schools and advancing the process of Canadian reconciliation. The complete text of the health-related recommendations can be found in Appendix C.

RESPONSES TO THE TRUTH AND RECONCILIATION COMMISSION REPORT

The “Calls to Action” envisioned a role for all Canadians in improving health outcomes for Indigenous Peoples in Canada. All levels of government and many other organizations are required to work in partnership to drive effective solutions. Canadian health leaders, and the organizations for which they work, also have a critical role to play in helping to address colonialism and close the Indigenous health gap. This is a leadership challenge that must be met.

The Federal government has clearly stated its intention to prioritize issues related to Indigenous Peoples in Canada. Their focus is on a “... a renewed, nation-to-nation relationship with Indigenous Peoples, based on recognition of rights, respect, co-operation, and partnership.”^{iv} The Federal government has recently taken numerous steps aimed at improving Indigenous health, and a number of these are outlined in Appendix D. Provincial and territorial governments have also taken steps to advance the health of Indigenous peoples, and these are discussed in the same appendix. Appendix D also highlights how physician and nurse organizations are actively advancing the TRC recommendations.

CRITICAL ISSUES FOR CLOSING THE INDIGENOUS HEALTH GAP

As the previous section demonstrates, many stakeholders have taken steps to address the health-related TRC Calls to Action. While these activities represent important first steps, there are still many challenges facing Indigenous peoples in Canada.

For the purposes of this brief, three inter-related potential areas of action for Canadian health leaders have been identified:

1. Re-align authorities, accountabilities and resources;
2. Eliminate racism and increase cultural safety;
3. Ensure equitable access to health care.

1. Re-align Authorities, Accountabilities and Resources

At the 2016 Great Canadian Healthcare Debate, Dr. Alika Lafontaine (the sponsor of the Indigenous health motion that garnered top support) argued for transformational change and the re-alignment of authorities, accountabilities, and resources. As the Truth and Reconciliation Commission demonstrated, the systemic barriers that have caused differences in health status between Indigenous and non-Indigenous Canadians must be confronted. As the Truth and Reconciliation Commission of Canada recommendation #18 makes clear, previous government policies have undermined Indigenous health status. For too long, decisions about health care and other services have been made without the full involvement of people to whom these services are provided. There is a need to transform the health system for Indigenous peoples to ensure that the right systems, policies, and legislation contribute to the right care, at the right time, in the right place. This means ensuring that Indigenous peoples can exercise their inherent rights to control their own health services.

Dr. Lafontaine and others noted that change will be achieved through a return of accountability, resource allocation, and responsibility to the individual communities to which Indigenous people belong.^v Currently, if Indigenous communities do get direct funding for health services, it is often allocated to specific health services which may not reflect the needs of the communities. These parameters are strictly enforced and do not permit flexibility in the event of a crisis.^{vi} More Indigenous ownership regarding the design and control of health services will help to address Indigenous communities’ health needs and challenges. Appendix E outlines the health-related roles and responsibilities of the federal, provincial, and territorial governments.

There are examples of this kind of ownership of services in both Canada and the United States. In the U.S. Indian Health Service, more than half of federally recognized tribes operate health facilities or programs. Fully 40% of funding appropriated to the Indian Health Service by Congress is administered by these tribes.^{vii} One of these systems is the Southcentral Foundation based in Anchorage, Alaska. This system was created, managed, and owned by Alaska Native people.^{viii} Moving from a system centrally managed by the bureaucrats at the Indian Health Services to one controlled by the population has resulted in some significant improvements. In 1996, only 35% of the population had a designated primary care provider. That number has now increased to 95%.^{ix} Before the changes, the average wait time for a routine appointment was four weeks, and now same-day access is the norm. Childhood immunization has increased by 25% and Southcentral scores in the 75th percentile or better on key health status indicators.^x Finally, Southcentral has been featured as an exemplar of quality improvement by many organizations including the Institute for Healthcare Improvement.

In Canada, a notable attempt to change the status quo of Indigenous health services delivery is the First Nations Health Authority (FNHA) in British Columbia. While stopping short of transferring control of services to communities, the FNHA is responsible for planning, management, service delivery and funding of health programs, in partnership with First Nations communities in BC.^{xi} The FNHA also collaborates with the provincial ministry and health authorities to attain better outcomes for First Nations who access provincial health services.^{xii} Other major changes, such as the charter agreement between the federal and Ontario ministries of health and the Nishnawbe Aski Nation (NAN) for a community planned and delivered health system, are also evolving. In every case, appropriate capacity building and mentorship in the communities is necessary to achieve success. This should include having Indigenous leaders on the governing board, Indigenous community members as part of advisory committees, and clear mandates and responsibilities among all parties.

HealthCareCAN's key informant interviewees agreed that the current structure of authorities, accountabilities, and resourcing for Indigenous health contributes to the health disparities between Indigenous and non-Indigenous people. Interviewees noted that this negatively affects access to care, promotes inequities, and may even further entrench racism within the system. The historical division between the department of Indigenous and Northern Affairs Canada (INAC) and Health Canada's First Nations and Inuit Health Branch (FNIHB) has created many issues of accountability. FNIHB's contractual environment with Indigenous peoples is seen as stringent and limited. It was noted that the funding envelope system for targeted programs does not always involve communities in decision-making about resource spending, and informants indicated that funding is often project-based and not designed for long-term sustainability. Respondents also said that community-based funding is stretched, and does not reflect increases in population. They also described an insufficient focus on disease prevention and health promotion.

On a related note, while respondents commented positively on the BC FNHA, it was understood that similar models are not automatically transferrable to other jurisdictions. Regional contexts, community needs and strengths, and local treaties all play a role in determining the best model for planning, management, service delivery, and funding of Indigenous health programs in different provinces, territories, and regions. Models enacted at the local level can be adapted to the specific health needs and culture of the area. Health leaders and care providers must understand that Indigenous cultures are diverse and they should be familiar with the history, culture, language, and traditions of the specific communities they serve.

Top challenges in serving Indigenous patient/communities

When asked about their top challenges in serving Indigenous patients/communities and in achieving cultural integration in health services, representatives of health care organizations and authorities mentioned a wide variety of issues such as vast geography, understanding cultural needs and preferences, discrimination by health care providers, and even Indigenous patients' reticence about accessing health services. It was noted

that health care providers need to learn more about colonialism, as well as Indigenous cultures and Indigenous health, and they will have difficulty serving Indigenous patients without this knowledge.

The Whitehorse General Hospital's First Nation Health Programs offer daily visits with a liaison person to offer emotional support or information about care; provide assistance with Non-Insured Health Benefits (NIHB) for financial assistance and travel; provide access to traditional food and medicine; keep family members informed and supported, with patient guidance; and work with outside agencies to arrange for services and supplies.^{xiii}

The Government of Canada states that, "Jordan's Principle provides that where a government service is available to all other children, but a jurisdictional dispute regarding services to a First Nations child arises between Canada, a province, a territory, or between government departments, the government department of first contact pays for the service and can seek reimbursement from the other government or department after the child has received the service. It is a child-first principle meant to prevent First Nations children from being denied essential public services or experiencing delays in receiving them."^{xiv}

Key informants also said limited time and resources can make it challenging to develop and sustain strong relationships with Indigenous communities. For example, Most Inuit communities are served by nursing stations. Doctors are available in larger regional centres and specialized services are often offered in southern centres, requiring patients to travel great distances, geographically and culturally, to access these services.^{xv} That said, health leaders expressed a strong desire to learn from Indigenous communities, help build their capacity, and honour and respect traditional approaches to health and healing. Respondents shared a number of encouraging and progressive approaches to serving Indigenous patients and communities. For example, the use of telemedicine to facilitate general and specialty healthcare continues to grow as broadband infrastructure is developed in rural and remote areas. Research on feasibility and implementation along these lines is being carried out. Personal videoconferencing services using a personal computer is spreading, and will serve more rural and remote Indigenous communities. Remote access research is also expanding, which is necessary for the more widespread use of sensors, apps, and mobile technologies to support self-management. Strong partnerships with Indigenous communities are necessary to optimize the use of these innovations.

Jurisdictional Ambiguity

Key informants also noted that "jurisdictional ambiguity" -- or uncertainty regarding which level of government is responsible for delivering and funding services for specific groups of Indigenous people -- also contributes to health disparities. This ambiguity exists at all levels of the health care system, and may impede the optimal allocation of resources to reduce disparities between Indigenous and non-Indigenous health outcomes. Jurisdictional ambiguity also applies to Indigenous people who may not know how to access health services. Health leaders indicated that there are too many authorities and competing jurisdictions, e.g. federal, provincial, on reserve, off reserve, etc. There was agreement that additional law and policy changes, such as Jordan's principle, are required. It was noted that Indigenous health policy with entrenched principles is lacking, and that this is a shared responsibility among all key stakeholders. A stronger legislative framework to provide structure is required, and much of the current thinking is based on colonialism. A "distinctions based" approach to policy should also be considered, where appropriate, given the distinctions and differences among Indigenous peoples. Legislation and laws that limit Indigenous practice of traditions -- many of which are lands-based -- also need attention. Care must be taken to ensure that policy changes involve Indigenous people from the outset, and do not negatively impact existing programs or services that are working well.

The First Nations principles of OCAP (ownership, control, access, and possession) are a set of standards that establish how First Nations data should be collected, protected, used, or shared. OCAP is an expression of First Nations jurisdiction over information about their communities and community members.^{xvi}

Based on the Daniels judgment, which means that Métis and non-status Indians are “Indians” under section 91(24) of the *Constitution Act 1867*,^{xvii} the Federal government will also have to assess the exclusions from Federal programs and benefits, including non-insured health benefits. Currently, the Indigenous and Northern Affairs Canada website states, “The ruling does not impact on Métis and non-Status Indian eligibility for programs and services currently targeted to Status Indians.”^{xviii}

Engaging Indigenous patients and communities

Leaders of hospitals, health authorities, and other health organizations discussed a variety of approaches to engage Indigenous patients and communities. These have included direct engagement with Indigenous

leaders and Indigenous communities to identify common priorities (e.g. less emergency care and more home care) and bring the community voice to regions. Many Indigenous organizations and communities have policies, guidelines, and protocols related to consultation. Health care organizations and leaders must ask about and respect relevant guidelines and protocols in order to build and maintain meaningful relationships with Indigenous organizations.

Engagement is also made possible by leveraging the relationships that academic or other partners have already established with Indigenous communities. Some health organizations and associations include Indigenous representatives on their governing body or have established Indigenous health (sub) committees. Others design and undertake research and community health studies with the direct involvement of the Indigenous community, thereby building community-by-community relationships to better understand strengths, challenges, needs, and opportunities.

The Eagle Moon Health Office of the Regina Qu’Appelle Health Region (SK)^{xix} works with departments in the health region to assist with improving service delivery to better meet the needs of Indigenous people. EMHO brings Indigenous community members together with health care providers to collaborate and work toward meeting the holistic health needs of the population. The office supports and encourages cultural and traditional ways for Indigenous people as they journey on their path to wellness.

Health leaders also discussed the value of learning from and working with traditional knowledge keepers, empowering Indigenous experts, and supporting traditional medicine and healing. Involving Indigenous patient representatives at the organizational or community level, such as in wellness councils, was also recommended. Key informants indicated that leaders and health care organizations must commit to building trusting relationships. Some suggested researching and learning from other models and examples of good collaboration.

Some organizations expressed unease with respect to engaging Indigenous groups in their activities. Sources of unease included not knowing which groups to approach or how to engage, and sometimes not understanding the mandate or mission of Indigenous organizations. Many health care leaders recognized that Indigenous communities have their own distinct stories and cultures, and the importance of understanding community priorities, expectations, and preferences. Health care leaders know that respectful relationships with Indigenous people and groups are critical, however some are unsure of how to demonstrate this respect and empathy. This tension may be eased by learning about Indigenous cultures and organizations, engaging in cultural safety training, and meeting with

local Indigenous communities. Asking Indigenous clients what they need (e.g. what a new client waiting area should look like), and “meeting them where they are at” is also important. Indigenous mentors may also help to facilitate engagement. Some key informants suggested a nation to nation approach, community by community. All key informants agreed that engagement is an ongoing process.

2. Eliminate Racism and Increase Cultural Safety

In early 2017, HealthCareCAN and the Canadian College of Health Leaders commissioned Ipsos Public Affairs to survey members about major issues in health care. More than 225 members responded and of these, 51% noted that race-based discrimination against Indigenous people is present in their organization. A similar survey of more than 1,000 members of the public found that half of Canadians believe discrimination against Indigenous people exists in Canadian health care, with 1 in 5 saying it is a “big problem.”^{xx} Additionally, there is a need to make greater efforts to ensure that reports of discrimination are taken more seriously. Often patients who express concerns are dismissed as being overly sensitive and their complaints are ignored.^{xxi} The HealthCareCAN-CCHL Ipsos-Reid member survey found just 52% of responding members said their organization has a formal process for reporting race-based discrimination.^{xxii} This result can be strengthened, and organizations must see this as a performance management issue where complaints are addressed appropriately and in a timely manner.

Empirical research suggests that racism adversely affects the health of non-dominant racial populations in multiple ways.^{xxiii} There is no shortage of examples that demonstrate the impact racism has on the safety of Indigenous patients. Cases such as that of Brian Sinclair, a 45-year old Indigenous man who died due to a health system that neglected him and his totally treatable bladder infection after having been ignored in the ER for 34 hours,^{xxiv} or Aklavik elder Hugh Papik who died after suffering a stroke and denied treatment because he was accused of being drunk rather than actually sick^{xxv} are well known. Similarly, experiences of racism have been reported in multiple Indigenous survey studies, across a variety of geographic settings.^{xxvi} One Canadian study, for example, found that Indigenous patients strategized about how to manage racism before presenting in a hospital emergency department, and also worried that their health concerns would be dismissed because of assumptions made about them by health providers.^{xxvii}

All key informants contacted for this Report agreed that racism exists in health care. They cited examples pertaining to long wait times, patients turned away from health organizations, and racial slurs. The majority of interviewees indicated that reporting incidents or racism is done through their regular complaints process. Other approaches such as bringing complaints to a hospital’s Indigenous Advisory Council or directly involving the appropriate manager or director were mentioned. Online processes to report racism must be user friendly and accessible to community members. Posters and other visual reminders about zero tolerance for racism and for reporting racism were also suggested. It was agreed that racism needs to be addressed at all levels of the health care system, not just within service delivery. Informants noted that racist behaviour must never be condoned and appropriate disciplinary action must be taken in cases of racism.

For more on cultural safety and related concepts, watch this [5-minute video](#) from Northern Health, BC.^{xxviii}

Cultural Safety

The racism experienced by Indigenous people seeking health care must be eradicated. Health care organizations need to take steps to correct the organizational processes and beliefs that allow this to happen. Many individuals and health care organizations are gaining a greater

understanding of the terms and concepts related to cultural safety, and anti-racism education and policy is a foundation for cultural safety. Cultural safety may be defined as, “[a]n outcome that is based on respectful engagement which recognizes and strives to address power imbalances inherent in the health and social services system. It results in an environment free of racism and discrimination where people feel safe receiving health care.”^{xxix} Health leaders should note that Indigenous peoples determine what is safe.

The Government of the Northwest Territories (GNT) provides a good example of commitment to ensure cultural safety and respect throughout the health and social services system. GNT works to ensure the health and social services system is more responsive to Indigenous peoples’ perspectives and experiences through ongoing

Cultural safety and humility are being integrated into Health Standards Organization standards, and health service organizations will be given the opportunity to be recognized by Accreditation Canada if meeting the associated criteria.^{xxx}

engagement with Indigenous peoples, agencies, governments, and regional wellness councils. It strives to ensure that cultural safety is authentic and integrated into all aspects of the health system. GNT acknowledges that cultural safety has to be planned and coordinated across every part of the health system, integrating policy and program design, front line service delivery, staff development and competence, research and knowledge capacity, and traditional methods.^{xxxi}

Cultural safety training programs, similar to the one recommended after Mr. Papik's death, have begun to be implemented across the country. Since 2006, the Provincial Health Services Authority in British Columbia

has delivered a large-scale cultural safety and anti-racism initiative. The online program "Core Indigenous Cultural Competency Health Training," focuses on building capacity among non-Indigenous health care providers to provide culturally safe care.^{xxxii} Similar programs have been developed in other provinces and territories, and in nursing and medical education across Canada.^{xxxiii} While these are steps in the right direction, TRC recommendation #23 calls for cultural safety training for all health care providers, and recommendation #24 calls for cultural safety courses in all faculties of nursing and medicine. These programs need to become universal, and key informants noted that cultural safety is always required for good practice. One participant suggested that cultural safety needs to be viewed as important as clinical practice safety. It was also suggested that organizations should consider tracking breaches of cultural safety, as long as the incidents and stories could be captured safely. This could ultimately help to limit and ideally, eradicate, future incidents.

The Canadian Patient Safety Institute (CPSI) has worked with Health Canada's First Nations and Inuit Health Branch (FNIHB) to support the development of policies and procedures for the introduction of new incident reporting structures and a dashboard for monitoring patient safety incidents.^{xxxiv} CPSI has also worked with FNIHB to develop patient safety competencies for nursing staff working with Indigenous patients and communities. (Chris Power, CPSI, personal interview, September 14, 2017) Despite these initiatives, there are gaps in both research and clinical practice about how to define, implement, and monitor Indigenous patient and community safety. In the future, there should a focus on research related to this area, and on how to apply the resulting evidence in clinical settings.

Of the key informants who were asked, all agreed that health care education is ready to add cultural safety skills assessment as a graduation/residency requirement. As part of this initiative, some of the health care training approaches may need to change, and Indigenous knowledge holders should play a stronger role in knowledge transfer. Health education institutions and programs should explore increasing their linkages with Indigenous groups and organizations, and work to ensure that Indigenous students are progressing through and completing their programs in a culturally safe manner.

Wise practices for cultural safety generally involve leadership commitment, system-wide involvement, cultural safety defined by patients, a more diverse workforce, culturally appropriate facilities, and staff development.^{xxxv} Key informants discussed online or classroom-based Indigenous cultural safety training courses with community teachers, and some said they are mandatory for staff. Workshops and YouTube videos on this topic were also mentioned. Other initiatives included creating safe physical environments (e.g. colours, textures, deinstitutionalizing space); connecting staff and programs with Indigenous community members; and providing specific education for locum physicians who may be less familiar with the needs and preferences of local Indigenous communities. Some respondents cautioned that education must have wide reach within an organization so that it is not only experienced by the "converted". Respondents also emphasized the importance of including self-reflection in program design. And, while cultural safety education is important, it does not necessarily address existing power issues and must include an examination of cultural values.

BC's Indigenous Cultural Safety (ICS) Training Program^{xxxvi} has been used as a model in other Canadian jurisdictions. It was developed by the Provincial Health Services Authority (PHSA) Aboriginal Health Program. The online program was designed to increase knowledge, enhance self-awareness, and strengthen the skills of those who work directly and indirectly with Indigenous peoples. The goal of the ICS training is to further develop individual competencies and promote positive partnerships.

It was noted that an important concept that links to cultural safety is **trauma-informed care**, or care that is sensitive to how a person's lived experiences can impact their health behaviours and health status. This is necessary so that a patient is not retraumatized within the health care setting. When health care providers adopt a trauma-informed approach, they consider a person's reactions (such as treatment refusal or mistrust) as a possible result of previous experience or injury, rather than just as sickness or bad behaviour.^{xxxvii} A trauma-informed service provider, organization, and system realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, patients, residents, and others involved in the system; and responds by integrating knowledge about trauma into policies, procedures, practices, and settings.^{xxxviii} Indigenous patients need to know that trauma can impact the way they see themselves and the way they feel about the world. This is part of building capacity. Health care providers and leaders, meanwhile, have to make the link between trauma and the

challenges their clients, patients, and even co-workers face.^{xxxix} Leaders and providers should examine their policies and procedures and have open conversations regarding how these can be made more culturally sensitive and safe for patients. The ongoing trauma that Indigenous patients and families experience in the health system must end.

Cultural safety exists when patients say it exists. It is a journey that starts with being patient- and family-centred. (Quote from a key informant, September 2017)

Recruitment and Retention of Indigenous Staff and Providers

The majority of interviewees did not have specialized programs to recruit and retain Indigenous staff in their organizations. It was noted by more than one key informant that this should be a strategic initiative, not one that is led solely by an Indigenous program or office. Token or symbolic Indigenous representation on staff is not acceptable. While all interviewees agreed that more Indigenous staff and providers are necessary, it was noted that capacity is sometimes lacking and that time, investment, and mentorship is needed. Indigenous children and youth would also benefit from Indigenous role models who are health care providers, researchers, administrators, or leaders of health organizations.

The First Nations Health Managers Association expands health management capacity for First Nations Organizations. It develops and promotes quality standards, practices, research, certification, and professional development to expand capacity for members and First Nations organizations.^{xl}

One key informant indicated their organization carries out "listening days" where senior leaders and representatives from the Human Resources department meet to discuss strategies to enhance the recruitment and retention of Indigenous staff, as part of their "reconcile-actions." The group is considering the self-identification of staff so as to determine whether the staff represents the diversity found in the community, and as a step to create an inclusive workforce.

While a key goal is to ensure that Indigenous and non-Indigenous staff and service providers work together respectfully, successful retention of Indigenous staff is often a concern. One key informant mentioned the

apparent segregation and racism felt by Indigenous staff and the importance of fully including Indigenous staff as part of the team. Indigenous staff should be consulted as to what works well and what needs to change within the organization. Adding cultural competency to job descriptions and performance evaluations will set clear expectations. Health care leaders should also ensure that their organizations are forging positive relationships with and offering relevant education and training opportunities to Indigenous staff.

Indigenous Patient Journey

Key informants from health care organizations and regions identified numerous ways to enhance the Indigenous patient journey, with a focus on mental, emotional, spiritual, and physical health. These include advocating for Indigenous patients and customizing health care processes as much as possible. Specialized programs and clinics (e.g. diabetes, mental health, chronic disease management, primary care, and nutrition) can also be designed with the specific needs of Indigenous patients in mind. Cultural helpers for spiritual and cultural support were also mentioned, and these individuals can also help health care providers and leaders to better understand Indigenous patients. Patient navigation, health coordination services, and assistance with discharge planning/community resourcing can also facilitate the patient journey. Involving patients and families in care team meetings and providing services in the relevant Indigenous languages (or offering translation services) are other opportunities. Indigenous staff and Indigenous physicians are valuable resources on the patient journey. Ceremony rooms and outdoor tents can also provide important sacred spaces.

Indigenous Patient Navigators and Liaisons at the Thunder Bay Regional Health Sciences Centre provide a variety of services for Indigenous patients, including interpretive services; support before, during, and after clinical appointments; linking patients and families to community resources; information and education in a culturally-sensitive manner; liaison and advocacy services with the patient, family, and care team; and assistance with discharge planning.^{xii}

At Sioux Lookout's Meno Ya Win Health Centre, traditional food (Miichim) is an important part of the daily lives of many clients. Traditional foods are offered on a weekly basis, and premade frozen Miichim meals are available for patients who want their traditional diets on a daily basis. All traditional "uninspected" food is donated by local hunters, gatherer, and outfitters.

Another way to look at the Indigenous patient journey is through process mapping or **patient journey mapping**, which involves collaboratively producing a visual representation of the steps and processes a patient moves through during their episode of care. This allows participants to understand the current reality of the patient journey, as well as identify what is working well and what can be improved.^{xiii} Patient journey mapping is a way for communities to bring their voice to the health care system and identify opportunities for change. It is also a means to identify local solutions and concrete actions that can be taken at the local level.^{xiii} Patient journey mapping can also uncover the jurisdictional complexities facing Indigenous patients once they leave an acute care setting and transition back to their community, for example. Better understanding the patient journey can also help to find ways of including more Indigenous knowledge as part of the patient journey, and not just as an afterthought.

Indigenous determinants of health

Opportunities exist for governments and health leaders at all levels to begin addressing Indigenous health problems that originate outside of the health care system itself. Housing, education, employment, poverty, food security, water safety, social supports, early child development, and the environment are just some of the determinants of Indigenous health. Racism toward Indigenous people is also a determinant of health,^{xiv} as is sociocultural and political sovereignty.^{xiv} These matters deserve attention and require long-term solutions, which can be difficult when governments change. It is critical for health leaders and care providers to understand the impact these factors have on the individuals and groups they work with. At a broader level, leaders can show support for progressive policies that address social determinants of Indigenous health. Planning and resources are needed in this regard.

Social procurement

The federal government and a number of provincial/territorial governments have established procurement strategies for Indigenous businesses. These initiatives create partnerships, help Indigenous businesses sell products and services, and support capacity development among Indigenous

peoples and communities. Hospitals and other health organizations may also be able to support Indigenous communities through social procurement. This may be one important step toward reconciliation.

Notwithstanding complex contracting mechanisms and purchasing models, hospitals and health organizations can support social procurement through their policies and bidding process, by engaging with local Indigenous communities about opportunities to supply goods or services, and by leveraging the long-term value of purchasing decisions^{xvii} (including community impact, environmental impact, and the social well-being of purchasing decisions). Leaders could seek out, for example, strategic and innovative food supply chain practices that can contribute to building respectful relationships between public agencies and Indigenous harvesters, entrepreneurs, and businesses. Doing so can result in a significant opportunity to promote local inclusion and can influence other health care organizations to do the same. Health leaders should reflect on how their organizations' purchasing power can help to build social capital and create positive social outcomes among Indigenous peoples.

Equality means treating people the same, regardless of their needs. Equity means getting people the resources they need. As Health Quality Ontario states, "Health equity allows people to reach their full health potential and receive high-quality care that is fair and appropriate to them and their needs, no matter where they live, what they have or who they are."^{xviii}

3. Ensure Equitable Access to Health Care

Equitable access can be defined as the opportunity for patients to obtain appropriate health care services based on their perceived need for care. This necessitates consideration of not only availability of services but quality of care as well.^{xviii} For Indigenous peoples in Canada, there are challenges in both areas.

3a. Availability of services

Difficulties in accessing health services are particularly acute for many of Indigenous Peoples in Canada. Many live in communities where extensive travel is required to access appropriate care.^{xix} One in five Indigenous patients is required to travel more than 250 km for treatment.¹ These distances can lead to delays in screening and complications in treatment.ⁱⁱ Even in those communities with health centres, the staff and/or equipment are not always sufficient to provide necessary care. And, as many remote communities only have physicians on a visiting basis, the nursing stations are critical to meeting health needs.

Other significant challenges relate to the Non-Insured Health Benefits Program, which is designed to provide coverage to registered First Nations and recognized Inuit for a specified range of medically necessary items and services that are not covered by other plans and programs. This program covers travel for patients to visit providers who bill provincial governments directly, such as physicians. This is not always the case when Indigenous patients seek access to other providers such as physiotherapists and speech language pathologists. In these latter cases, Indigenous people may be blocked from receiving necessary health services.ⁱⁱⁱ

For Indigenous people living on reserve, there are often numerous steps to getting the necessary government approvals and accessing care. Even those living off reserve can face multiple steps prior to receiving access. The lack of accessible health care services has a significant impact on the health status of Indigenous peoples in Canada. Delays in access can lead to increased medical complications,ⁱⁱⁱ and can also mean that opportunities for early detection and treatment are missed.^{iv} A 2015 Statistics Canada report found that First Nations adults are more than twice as likely than non-Indigenous Canadians to die under the age of 75 from avoidable causes.^{iv} These include injury, tuberculosis, pneumonia and breast cancer. Finally, as the increase in suicides among Indigenous communities has demonstrated, this lack of access has tragic consequences for Indigenous children and youth.^{vi}

Most key informants said their organizations had not conducted a formal **health equity assessment** to examine social inequities in health or specific policies in their organization. Access to relevant data, particularly at regional or provincial levels, was seen to be a challenge. Other challenges related to geography (large regions), the number of distinct Indigenous communities in a given region, the diversity of culture and languages, and the strong community relationships needed to execute a valid needs assessment. Research has shown that making equity a priority critical to the organization's mission, and building it into all high-level decision-making, is an important concrete action to improve health equity.^{lvii} One key informant said their strategy would be to examine new policies, procedures, and programs with a health equity lens.

Key informants shared some specific **mental health programs and initiatives** aimed at Indigenous peoples in their communities. Respondents noted that planning often occurs with staff, community members, health care professionals, and other agencies working as partners. Local, non-professional counsellors may be trained to provide basic mental health services in their communities, frequently in remote regions. Some service delivery organizations have mental health advocates or liaison workers who assist with referrals to community supports. The current structure of authorities, accountabilities, and resourcing that contribute to health disparities can also create challenges when responding to mental health needs and crises. Key informants indicated that transitional programs can also be difficult to find or access. In addition, mental health services may not be funded to the same level on reserve, and are often provided by paraprofessionals or generalists when the services would be provided by specialists for non-Indigenous Canadians.^{lviii} And, while Jordan's principle is designed to reduce these inter-jurisdictional issues for children and youth, no such guarantee is in place for Indigenous adults.

Many key informants noted that there is a general lack of understanding among health care providers and leaders about the challenges many Indigenous communities face in accessing care, whether because of funding arrangements, transportation issues, or not knowing how or where to seek care. In addition to understanding the challenges associated with accessing care on reserves, leaders should also be aware of the access issues faced by Indigenous peoples residing in urban areas. Poverty, challenges associated with making and keeping appointments, the location of health services, experiences of marginalization and racism within health care settings, or navigating unfamiliar surroundings can all play a role. These issues are real and the system must respond effectively. This requires new and innovative approaches, and the involvement of Indigenous communities to develop them.

On a related note, as capacity building becomes vital for communities seeking to plan and deliver their own health services, **health services evaluation** is growing in importance and relevance to Indigenous health and healthcare. Health leaders can support health care managers and providers at the community level to build capacity to evaluate their health services and outcomes using Indigenous evaluation frameworks that are relevant and meaningful.

3b. Quality of Care

Even where there is access to services, there can be marked inequities in outcomes due to the quality of services being offered. Services that are neither acceptable nor appropriate are likely to be underutilized, or may risk more harm rather than benefit to certain populations. According to research undertaken by the former Health Council of Canada, health care environments can feel alienating when they do not respect traditional Indigenous approaches to healing and place a premium on Western credentials. This can increase the distance between patient and provider and oftentimes works alongside the racism discussed above.^{lix} This alienation is compounded when Indigenous patients travel long distances and are separated from their families and communities.

This lack of cultural appropriateness leads to differentials in therapy and service. For example, evidence from the Canadian Institute for Health Information indicates that Indigenous patients are under-represented in kidney transplantation, despite having a higher burden of disease.^{lx} Health equity audits of the dialysis program in the Saskatoon Health Region found that the vast majority of patients were First Nations people, yet the education program designed to help people manage their diabetes and therefore avoid dialysis had low participation rates from First Nations. This indicates that some aspect of this program that was not meeting the needs of the Indigenous population.^{lxi}

Supported by an Elders' Council consisting of representatives from across the NWT, the Aboriginal Wellness Program at the Stanton Regional Health Authority includes language services, patient supports, healing practices, northern foods, and traditional medicine.^{lxii}

Canadian health leaders can tackle the appropriateness of Indigenous health care services in partnership with Indigenous communities. For instance, there should be an increased effort to integrate traditional healing practices within health care delivery; a requirement of meeting TRC recommendation #22. It is possible to have the traditional and Western healing approaches work alongside one another. This requires recognizing the existing knowledge and traditional medicine within the local community, and building ties with practitioners so that interested patients can be connected with them. The concept of integration can also mean creating space within our existing system to acknowledge and support these services, including access to traditional medicine, ceremony, and

foods. Examples of such integration already exist across the country. Whitehorse General Hospital in the Yukon has been working to integrate traditional and western medicine for more than 20 years. Seven programs including traditional medicine and nutrition, as well as a physical space for a healing room have been provided. Similar healing rooms exist in other hospitals including the Royal Jubilee Hospital in Victoria.^{lxiii}

From an Indigenous patient's perspective, quality of care may also be associated with more Indigenous peoples working in the health system. As discussed earlier, attempts to increase the Indigenous representation in hospital leadership positions, including on hospital Boards, as well as to increase the number of Indigenous physicians, nurses, and other health care providers, are being undertaken across the country. Efforts must continue to ensure that health care environments are supportive of these providers so that they stay and thrive in these positions. More work is needed in this area to address the objectives of the TRC recommendation #23.

IMPLEMENTING THE TRC CALLS TO ACTION

There are numerous opportunities for health care organizations and health associations to contribute to implementing the health-related TRC Calls to Action. To begin, health leaders can connect with Indigenous communities to learn about and understand their strengths and needs; involve them from the outset in planning, service delivery, and evaluation activities; and respect robust engagement and consultation processes. Indigenous health goals should be reflected at the highest level within the organization and there should be Indigenous representation on the governing body. Health leaders must call for and embrace Indigenous advisors or advisory councils or similar groups at provincial, regional, and organizational levels, and there must be comprehensive recruitment strategies and safe spaces to build the necessary relationships. There is a need for an Indigenous health system that is safe, meets quality standards, and is patient-, family-, and community-centered. Canadian health leaders must support Indigenous partners as they advocate for these changes. Additionally, members can work on addressing the challenges within their health institutions and communities that exacerbate disparities in health status between Indigenous and non-Indigenous people in Canada. Leaders can support policies that will positively impact the health of Indigenous peoples, including health transfer initiatives. Coalitions or partnerships with other health organizations or even private sector organizations committed to addressing the Calls for Action present opportunities to advance this critical issue in a timely manner.

While health organizations are at different places on this journey, many have taken important steps to advance reconciliation and address the TRC's Calls to Action. Concrete examples include discussing the Calls to Action with staff, and getting their input on ways to move forward. One organization began with including a land acknowledgement at every staff orientation. Other institutions have shared and discussed HealthCareCAN's 2016 Issue Brief on the TRC's Calls to Action, and have used this as a basis for their action plan. Inviting Indigenous leaders and Elders into the organization to share their experiences and take part in improvement initiatives was also mentioned. One organization discussed its steps to draft a commitment statement to its Indigenous communities, including services, engagement and partnerships with the local Indigenous communities, planned policy reviews, and action plans. Many organizations have begun increasing cultural competence and cultural safety of their staff and institutions through education, as well as deepening their understanding about Indigenous health equity. Training in this area should be offered to all staff and service providers, as well as to leaders and Board members. It was noted that health leaders must be clear that there is zero tolerance for racism. The provision of trauma-informed care is also vital. Organizations can continue their efforts to recruit Indigenous staff and physicians, and to support traditional medicine and Indigenous healing practices within their facilities, on reserve, and in urban communities.

Health leaders must advocate for substantive investments in Indigenous health programs, and resources to (re)build capacity in Indigenous health organizations. Indigenous leadership needs to be involved at all levels of the health care system. Health leaders should encourage Indigenous-led evaluation at local, regional, and provincial levels, and work within their scope to address the health outcomes of Indigenous patients and communities. Health leaders can also promote the more widespread use of new technologies that can enhance self-management and help Indigenous patients take an active role in their health.

Many respondents suggested that it was important to just "get going" and to tackle the Calls to Action with the involvement Indigenous communities. One key informant suggested that the best way to go about implementing these TRC recommendations is to create the expectation that they are mandatory. Organizations need to act to implement change based on the TRC and report back to their Boards and communities on their progress. CEOs need to be accountable for actions and progress. It was also suggested that organizations leverage their existing internal structures to address the Calls to Action. At Alberta Health Services for example, this includes working with their 15 Strategic Clinical Networks and the Indigenous Health Program to determine how to achieve the recommendations.^{lxiv}

Health leaders must recognize that cultural competence is a lifelong process and that biases must be examined on a regular basis. Leaders must remind others of this fact, and organizations must listen and provide space for learning.

CONCLUSION

The Truth and Reconciliation Commission of Canada highlighted the systemic policies and structures that have contributed to health disparities among Indigenous peoples. The health-related Calls to Action provide a framework for moving forward within the health sector. This brief has attempted to outline some of the opportunities and challenges for advancing these recommendations. Recognizing the broader need for health care transformation, it highlights wise practices that Canadian health leaders can undertake within their own institutions and at a systems level. There is much work to do and Indigenous peoples' rights to self-determination (including for health and wellness programming) must be recognized.

Like all Canadians, health care leaders should begin by acknowledging the past and accepting the truth, followed by working collaboratively with their Indigenous partners to create meaningful change. Cultural competence is a lifelong journey and leaders need moral courage to influence positive, lasting health system transformation. Leaders should actively engage in the reconciliation process by reaching out and building relationships with local Indigenous communities that can guide their direction and their progress. The answers lie in respectful relationships with Indigenous peoples and communities.

APPENDIX A: LIST OF KEY INFORMANTS

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Tracie Smith

Senior Director, Communications and Engagement
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APPENDIX B: KEY INFORMANT INTERVIEW QUESTIONS

Questions for experts: (a subset was used)

1. To what extent is the current structure of authorities, accountabilities, and resourcing for Indigenous health a contributing factor to health disparities between Indigenous and non-Indigenous people? Please elaborate.
2. To what extent does “jurisdictional ambiguity” regarding the care of Indigenous patients contribute to health disparities? What law or policy changes are needed to address this?
3. How well do you think non-Indigenous health systems respond to access issues and the health needs of Indigenous communities?
4. What are the issues or discrepancies between the standard of care for Indigenous patients and non-Indigenous patients? How can these issues/discrepancies be addressed?
5. How can the health system address the Indigenous determinants of health?
6. How can health care organizations involve the Indigenous grassroots, patients, elders, etc. in true partnership?
7. Do you believe that racism against Indigenous people exists in the health care system? What can be done to eradicate this?
8. What is the best way for health care organizations and health associations to contribute to implementing the health-related TRC recommendations?
9. How do you define cultural safety and how can this be strengthened in the health system?
10. Do you have other comments or suggestions you’d like to share on any of these matters?

Questions for health care organizations/health authorities: (a subset was used)

1. What are your top challenges in serving Indigenous patients/communities and in achieving cultural integration in health services?
2. What is the process to engage Indigenous patients/communities in your activities?
3. What has your organization done to advance reconciliation and the health-related recommendations of the TRC?
4. Do you have any programs to recruit and/or retain Indigenous staff/health care providers?
5. Does your organization have a process for reporting incidents of racism? Is this working?
6. What does your organization do to enhance the Indigenous patient journey (e.g. patient journey mapping)?
7. What cultural safety best practices has your hospital/health organization embraced?
8. Does your organization have any specific mental health programs or initiatives aimed at Indigenous people in your community?
9. Have you ever conducted a health equity assessment to examine social inequities in health and/or specific policies and programs in your organization? What were the results?
10. Do you think health care education is ready to add cultural safety skills assessment as a graduation/residency requirement?
11. Do you have other comments or suggestions you’d like to share on any of these matters?

APPENDIX C: HEALTH-RELATED CALLS TO ACTION OF THE TRUTH AND RECONCILIATION COMMISSION OF CANADA¹

18. We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. 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.

23. We call upon all levels of government to:

- i. Increase the number of Aboriginal professionals working in the health-care field.
- ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
- iii. Provide cultural competency training for all healthcare professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

55. We call upon all levels of government to provide annual reports or any current data requested by the National Council for Reconciliation so that it can report on the progress towards reconciliation. The reports or data would include, but not be limited to:

¹ These recommendations are also contained within the recommendations of the Report of the Royal Commission on Aboriginal Peoples (1996).

- i. The number of Aboriginal children—including Métis and Inuit children—in care, compared with non-Aboriginal children, the reasons for apprehension, and the total spending on preventive and care services by child-welfare agencies.
- ii. Comparative funding for the education of First Nations children on and off reserves.
- iii. The educational and income attainments of Aboriginal peoples in Canada compared with non-Aboriginal people.
- iv. Progress on closing the gaps between Aboriginal and non-Aboriginal communities in a number of health indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.
- v. Progress on eliminating the overrepresentation of Aboriginal children in youth custody over the next decade.
- vi. Progress on reducing the rate of criminal victimization of Aboriginal people, including data related to homicide and family violence victimization and other crimes.
- vii. Progress on reducing the overrepresentation of Aboriginal people in the justice and correctional systems.

APPENDIX D: GOVERNMENTAL AND HEALTH ASSOCIATION/PHYSICIAN AND NURSE GROUP ACTIONS

The **Federal government** has clearly stated its intention to prioritize issues related to Indigenous Peoples in Canada. Their focus is on a "... a renewed, nation-to-nation relationship with Indigenous Peoples, based on recognition of rights, respect, co-operation, and partnership."^{lxv} The Federal government has recently taken numerous steps aimed at improving Indigenous health through the Canadian Institutes for Health Research (a priority area focused on health and wellness for Aboriginal people), a Ministerial Special Representative responsible for negotiating a settlement with members of the class action representing residential school day scholars,^{lxvi} and a Ministerial Working Group charged with reviewing all laws and policies related to indigenous peoples. In late 2016, the Federal government also launched an independent national inquiry into missing and murdered Indigenous women and girls.

The Federal budget released in March 2017 included \$828 Million of net new money over the next five years for Indigenous health purposes.^{lxvii} The government also announced it would pay for a companion to travel with Indigenous women when they leave their communities to give birth. This was a change in policy based on significant feedback from Indigenous health experts.^{lxviii} In April 2017, the Federal government dropped its objection to the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).^{lxix} Also in April 2017, the Federal government and the Métis National Council signed the Canada-Métis Nation Accord to set priorities and develop policy in areas of shared interest.^{lxx} In June 2017, the government and the Assembly of First Nations signed an MOU on shared priorities under a new permanent bilateral mechanism process, and the government announced that the funding model for First Nations infrastructure would allow funds to be carried over from year to year.^{lxxi} In July 2017, Canada's Department of Justice released a set of principles respecting the Government of Canada's relationship with Indigenous Peoples, and these principles address reconciliation, engagement, Indigenous rights, and the inherent right to Indigenous self-government.^{lxxii} In August 2017, the federal government announced that Indigenous and Northern Affairs Canada (INAC) would be disbanded and replaced by a Department of Crown-Indigenous Relations and Northern Affairs, and a Department of Indigenous Services. And, in October 2017, Health Canada issued tender for a partner to help develop courses for employees on Indigenous culture and health.

Provincial and territorial governments have also taken steps to advance the health of Indigenous peoples. At their July 2015 First Minister's meeting, Canada's premiers met with Indigenous leaders and pledged their support for the TRC recommendations.^{lxxv} Since then, many provinces and territories have made progress on the health-related recommendations. For example, the government of the **Yukon** has produced an action plan to address the TRC recommendations. Successes include healing rooms in all new continuing care facility designs, traditional food preparation areas in some facilities, programs enabling Indigenous students to job shadow nurses and other health providers, and mandatory cultural competency training for all front-line staff of the Health and Social Services department.^{lxxvi} Progress has also been made in the **Northwest Territories**, including work to establish an Aboriginal Health and Community Wellness Division at the Health and Social Services Authority, setting up an Indigenous Advisory body to advise the government on matters related to the planning of an Aboriginal wellness centre; and creating a fund to provide mental health and wellness services to address the harms caused by residential schools.^{lxxvii}

The government of **British Columbia** has reaffirmed its commitment to advance the process of reconciliation with Aboriginal peoples. Moreover, the BC First Nations Health Authority (FNHA) is the first in the country to involve a formal collaboration for health services between the federal government, the province, and First Nations communities. In 2013, this authority assumed the programs, services, and responsibilities formerly handled by Health Canada's First Nations Inuit Health Branch - Pacific Region. FNHA is designed to deliver programs and services, as well as fostering a health and wellness approach that reflects the culture of First Nations.^{lxxviii}

In July 2017, the province of **Ontario**, Canada's health minister, and the Nishnawbe Aski Nation (NAN) signed a "landmark" health transformation agreement they say will begin the process of decolonizing the provision of care in the province's north. The three parties agreed to a series of principles that any First Nation-led health care system must adhere to, while vowing to pool money to better address poor health outcomes in Ontario's northern and remote reserves. Prior to this, the government of Ontario released a plan regarding Ontario's commitments to reconciliation with Indigenous peoples. Health-related commitments in the plan included: the establishment of up to six new or expanded Indigenous Mental Health & Addictions Treatment and Healing Centres; investing in mental health and wellness programs; supporting culturally-based suicide prevention strategies for children and youth; and developing an action plan for responding to social emergencies in Northern First Nation communities.^{lxxxix}

In December 2016, the government of **Quebec** announced an inquiry into the treatment of Indigenous people by various public services in the province including the police, correctional services, youth protection and health systems.^{lxxx}

Health care organizations and associations have also been active with respect to the TRC recommendations. For example, the **Royal College of Physicians and Surgeons of Canada** created an Indigenous Health Advisory Committee to oversee its work to advance Indigenous health. This group is comprised primarily of Indigenous peoples. They have developed fact sheets and a discussion paper and are now collaborating with the Indigenous Health Working Group at the **College of Family Physicians of Canada** (CFPC), as well as other health care organizations, to increase cultural safety and anti-racism education in health care. As another example, the College of Family Physicians of Canada and the **Indigenous Physicians Association of Canada** have partnered to create the Indigenous Health Working Group (IHWG). It works with Indigenous communities and organizations to enhance Indigenous health, well-being, and access to health care. This is done through education, practice resources, and advocacy.

The **Canadian Medical Association** (CMA) has stated "the importance of recognizing and not forgetting the terrible impact that the residential school system has had and, as a consequence of ongoing intergenerational trauma, continues to have, on the health of many First Nations, Inuit and Métis people of Canada."^{lxxxix} In August 2016, it held a special pre-General Council session on Indigenous health. The Canadian Nurses Association (CNA) works to advance Indigenous health through its partnership accord with the Canadian Indigenous Nurses Association through its Canadian Network of Nursing Specialties. CNA is a supporter of Jordan's Principle and Shannen's Dream, campaigns that address inequities in health, social, and education services provided to Indigenous children.

The **Canadian Paediatric Society** (CPS) is one of more than 11 national organizations involved in a long-term initiative to reduce the health inequities facing Indigenous children and youth in Canada. The goal of *Many Hands, One Dream* is to build a new vision of health that has children, youth, and families at its core.^{lxxxii} The CPS also has other resources to help health professionals working with First Nations, Inuit, and Métis children and youth.

The **Association of Faculties of Medicine of Canada** (AFMC) is exploring the social accountability of medical schools in addressing Indigenous health. It has developed a position statement, issued a press release on its commitment to addressing the TRC's recommendations, and held a panel discussion in 2017 regarding educating future physicians about Indigenous health and issues of safety and accessibility.^{lxxxiii} In follow up to the panel discussion, the AFMC created a network in Indigenous health with representatives from each faculty of medicine in Canada to address Indigenous health education.

The Indigenous Women's Health Committee of the **Society of Obstetricians and Gynaecologists of Canada** (SOGC) is actively engaged in promoting health equity for Indigenous women and offers their expertise to advance community-led projects and programs.^{lxxxiv}

APPENDIX E: FEDERAL, PROVINCIAL AND TERRITORIAL RESPONSIBILITIES FOR HEALTH SERVICES

The organization of Canada's health care system is largely determined by the Canadian Constitution, in which roles and responsibilities are divided between the federal, provincial, and territorial governments. The provincial and territorial governments have most of the responsibility for delivering health and other social services. The federal government is also responsible for some delivery of services for certain groups of people including First Nations people living on reserves; Inuit; serving members of the Canadian Forces; eligible veterans; inmates in federal penitentiaries; and some groups of refugees.

Through the Health Services Integration Fund, Health Canada is working with other provincial, territorial, and First Nations and Inuit organizations to:

- Improve the integration of federally-funded health services in First Nations and Inuit communities with those funded by the provinces and territories;
- Build multi-party partnerships to advance health service integration;
- Improve First Nations and Inuit access to health services; and
- Increase the participation of First Nations and Inuit in the design, delivery, and evaluation of health programs and services.

Direct federal delivery of services to First Nations people and Inuit includes primary care and emergency services on remote and isolated reserves where no provincial or territorial services are readily available; community-based health programs both on reserves and in Inuit communities; and a non-insured health benefits (NIHB) program (drug, dental and ancillary health services) for First Nations people and Inuit no matter where they live in Canada. In general, these services are provided at health centres, nursing stations, in-patient treatment centres, and through community health promotion programs. Increasingly, both orders of government and Indigenous organizations are working together to integrate the delivery of these services with the provincial and territorial systems.^{lxxxv}

The Prime Minister's October 2017 mandate letter to Minister of Health Ms. Petipas Taylor stated she is to "Work closely with the Minister of Crown-Indigenous Relations and Northern Affairs and the Minister of Indigenous Services, to help make systemic change in the government's provision of health care services to Indigenous Peoples and to reduce the health inequities between Indigenous Peoples and non-Indigenous Canadians." The mandate letter also indicated there would be a transfer of responsibility for the First Nations and Inuit Health Branch (FNIHB) from Health Canada to the new Ministry of Indigenous Services.^{lxxxvi}

The provinces and territories administer and deliver most of Canada's health care services. Each provincial and territorial health insurance plan covers medically necessary hospital and doctors' services that are provided on a pre-paid basis, without direct charges at the point of service. The provincial and territorial governments fund these services with assistance from federal cash and tax transfers.

The provincial and territorial health insurance plans determine which services are medically necessary for health insurance purposes. To be in compliance with the *Canada Health Act*, the full cost of a medically necessary service must be covered by the public health insurance plan. The roles of the provincial and territorial governments in health care include:

- Administration of their health insurance plans;
- Planning and funding of care in hospitals and other health facilities;
- Services provided by doctors and other health professionals;
- Planning and implementation of health promotion and public health initiatives; and
- Negotiation of fee schedules with health professionals.

Most provincial and territorial governments offer and fund supplementary benefits for certain groups (e.g., low-income residents and seniors), such as drugs prescribed outside hospitals, and hearing, vision and dental care, that are not covered under the *Canada Health Act*.

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