

## Native Health in Canada

Canada boasts one of the best health care systems in the world in terms of accessibility and affordability, yet large segments of the Canadian population remain challenged in terms of health, education and literacy - all of which are inextricably interconnected in the Canadian fabric. Aboriginal Canadians are the group most affected by these challenges, partly due to geography, but mostly due to history and the introduction of “western” culture.

Settlers and explorers brought “western” diseases, food and eating habits to Canada, thus altering the traditional diet of the Aboriginal people. Prior to contact, Aboriginal communities often died from parasitic diseases and fishing or hunting accidents. The introduction of infectious diseases (particularly smallpox and tuberculosis) had a dramatic effect on the Aboriginal population. More recently, the causes have changed again—by 1986 the most prevalent health problems were heart disease, hypertension, diabetes, obesity, cancers, and a new epidemic of accidents, injuries and the associated adverse effects of these. Furthermore, infectious diseases remain at a persistently higher level among Natives than for the rest of the Canadian population (Waldram, et al., 1997; Weiss, 1996).

Why is the health status of the Canadian Aboriginal population different from the non-Aboriginal population despite the 1966 Canada Health Act that established guidelines for health care in Canada, commonly known as Medicare and entrenched the main principles on which Medicare is based are: universality, accessibility and portability?

One reason is due to the expanse of Canada. Many pockets of Canadians, especially Aboriginals, live in geographically isolated areas. In the great Canadian north life can be harsh and access to good health care, scarce. Care is generally provided by nurses and midwives, qualified doctors are few. The principles of Medicare then, are often not realized by many Aboriginals. Individuals with significant health problems and women experiencing problematic births must be evacuated by air to more central hospitals adding financial strain, not to mention discontinuity of cultural practices, and lack of familial support to the stress of patients receiving care.

Life expectancy and infant mortality rates indicate that geographically isolated communities are disadvantaged. In addition there has been a significant difference between the Aboriginal and non-Aboriginal population - a difference that begins at birth. The major contribution to the reduced life expectancy at birth among Canadian Aboriginals has been their higher rate of infant mortality (IMR) which in 1993 was approximately 12 (per 1000 live births)—about twice the non-Aboriginal rate (OECD, 1998). Life expectancy for Aboriginal and non-Aboriginal Canadian men in 1980 was approximately 65 and 72 years respectively, while Aboriginal and non-Aboriginal women lived approximately 72 and 80 years respectively (Waldram, et al., 1997:69).

Further differences occur between the female Aboriginal and non-Aboriginal population in terms of cervical cancer, with the Aboriginal rate being substantially higher. Differences in access and knowledge about the importance and purpose of cervical cytology tests (pap tests) is a contributor to this difference, as is the need for more care givers who are culturally sensitive and provide culturally appropriate education materials (Hislop, et al., 1996). Today there are relatively few Aboriginal

health professionals in Canada, although various education initiatives are helping to increase the numbers (Robb, 1996). It is hoped that the differences between Aboriginal and non-Aboriginal health status will lessen as the number of Aboriginal health professionals increases and Aboriginal people receive more culturally appropriate care.

Aboriginals have started innovative health programs such as Anishnawbe in Toronto. This program has its roots in the late 1970s as a Native diabetes program, but has now grown to a health centre staffed by Native or Aboriginal people who provide more culturally appropriate methods of care and encourage both health education and health care (Lowry, 1993).

#### Sources

Hislop, T.G., H. F. Clarke, M. Deschamps, 1996. "Cervical Cytology Screening: How can We Improve Rater Among First Nations Women in Urban British Columbia." Canadian Family Physician. (September; Vol.42: 1701-1708).

Lowry, Fran, 1993. "New Healing Centre in Toronto Opens Eyes of Non-Native MDs Who Work There." Canadian Medical Association Journal. 148(2):270-272.

OECD Health Data, 1998. Paris: OECD.

Robb, Nancy, 1996. "Micmac medical student becomes role model for his community." Canadian Medical Association Journal. Jan.1; 156(1):67-68.

Waldram, James B., D. Ann Herring, T. Kue Young, 1997. Aboriginal Health in Canada: Historical, Cultural and Epidemiological Perspectives. Toronto: University of Toronto Press.

Weitz, Rose, 1996. The Sociology of Health, Illness, and Health Care: A Critical Approach. Belmont, California: Wadsworth Publishing Company.

Weitz, Gregory, and Lynne Lonquist, 1994. The Sociology of Health, Healing, and Illness. New Jersey: Prentice-Hall, Inc.