

Solutions to Issues of Equity in Primary Healthcare for Aboriginal People Living in Canada

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Aboriginal people living in Canada have a poor overall quality of health when compared to non-Aboriginal Canadian citizens. This paper reviews the disparities in physical, psychological, and social health between First Nations communities and non-Aboriginal Canadians. More specifically, we relate these issues and concerns to a lack of family physicians in First Nations communities and the negative impact this has on their quality of life.

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Introduction

FAMILY PHYSICIANS PLAY A PIVOTAL ROLE in our society as essential gatekeepers to our healthcare system. These physicians offer more than simple diagnoses of coughs and colds and work hard to provide primary care such as health protection, encouraging healthy and active living, management of diseases and disorders, and advocating on behalf of their patients. Family physicians also participate in secondary and tertiary care (especially in rural areas) by providing counseling on family planning and effective parenting, and participating in community organizations (1, 2). Numerous studies have shown that general practitioners who can effectively communicate with their patients experience better outcomes in terms of understanding medical information, adherence to treatment, and overall satisfaction with the medical process (3).

Despite having one of the most advanced healthcare systems in the world, an increasing shortage of family physicians in Canada has drastically hindered its ability to cope with a growing and aging population. Recent statistics show that approximately one million Ontarians are without a family physician or lack access to their services (4). In rural areas, the effects of this shortage are much more pronounced. While patients experience longer wait times, many general practitioners face a higher patient burden and more responsibilities than their non-rural counterparts. Due to this heavier workload, many rural family physicians are forced to reduce their contact time with patients and, thereby, the quality of care. Aboriginal communities, which are traditionally smaller and situated in remote settings, have been all but abandoned by the current primary healthcare system (5, 6). First Nations com-

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munities in Canada typically have a poorer overall quality of health than the non-Indigenous population as assessed by nearly every outcome measure (3). Most notably, the negative impact of this lack of primary healthcare can be seen in their physical, psychological, and social development.

Impact on Physical Health

Over the past few decades, researchers have witnessed alarming trends in Canadian Aboriginal communities that have significant implications for their overall health and wellbeing. These developments include a decrease in physical activity, an increase in the consumption of unhealthy processed foods, and an increase in unsafe sexual practices (7). With a lack of family physicians to advise them on healthy, active, and responsible living, numerous ailments such as obesity, diabetes, and HIV are becoming more prevalent amongst Aboriginal Canadians.

Obesity is a major health problem among Canada's First Nations. A study conducted by Lavallée and Bourgault found that Cree women living in northern Québec are over four times more likely to suffer from this disorder than non-Aboriginal women living in southern Québec (8). Other co-morbidities associated with obesity have also become endemic within First Nations communities, particularly type 2 diabetes (9). Although the number of individuals affected by diabetes has increased worldwide, the Aboriginal populations of many countries have witnessed a remarkably disproportionate increase in disease incidence (10). In Canada, type 2 diabetes is three times more common in First Nations communities than it is in the non-Aboriginal population. However, fifty years ago, diabetes and its associated health concerns were nearly nonexistent amongst these populations (11). The consequence of having a

high rate of diabetes has been devastating with many First Nations communities experiencing a surge in cardiovascular disease, retinopathy, nephropathy, and peripheral neuropathy (9, 12, 13). Aboriginal people living with diabetes and its associated complications often report constraints when performing physical activities, difficulties managing their diet, chronic pain, fatigue, and an overall lower quality of life (10).

In addition to diabetes, government agencies and organizations such as Health

Aboriginal populations of many countries have witnessed a remarkably disproportionate increase in disease incidence

Canada, Aboriginal Nurses Association of Canada, and Feather of Hope Aboriginal AIDS Prevention Society have voiced their concerns about the rising rate of HIV infection in the Aboriginal population (14). In the past decade alone, the rate of HIV infection among Canadian First Nations communities has increased more rapidly than in any other single ethnic group in the country. Although Aboriginal people only account for approximately 3.3% of the entire Canadian population, as of 2005, it was estimated that 3,600-5,100 Indigenous people were living with HIV. This finding is especially shocking considering that the Aboriginal population now represents 7.5% of all HIV infections and 22% of new cases reported in Canada. As the HIV epidemic among Canadian Aboriginal people is predominantly associated with injection drug use and unsafe sexual practices, a lack of family physicians to advocate against these harmful activities is allowing this problem to reach epic proportions (15).

Overall, it has been well established that family physicians play an active role in the management of chronic conditions through lifestyle and pharmacologic measures. However, due to a lack of general practitioners in First Nations communities to diagnose and treat these health concerns, many preventable diseases and disorders are becoming long-term illnesses.

Impact on Psychological Health

Individuals suffering from physical illnesses often develop psychological problems due to stress (10). In an urban centre, these problems can easily be treated with the appropriate preventative measures prescribed by one's family physician. However, since most Aboriginal communities lack general practitioners, these ailments become unmanageable and lead to a higher incidence of mental health problems (16).

Suicide is one of the most extreme indicators of stress and many Canadian First Nations communities experience higher rates than the general population (6). Aboriginal men between the ages of 15 and 25 are reported to have a suicide rate seven times greater than Canada's national average (16). Similarly, Aboriginal women are also suffering from a break-

Mental disorders often go unchecked in Aboriginal communities due to their decaying primary healthcare system

down in mental health. For example, Inuit women living in northern Québec are said to have an attempted suicide rate more than three times the average for non-Aboriginal women living in southern Québec (8). Government agencies are also voicing their concerns over this growing crisis. In

a study conducted by Statistics Canada, it was found that the Indigenous people living in Nunavut and the Northwest Territories have a two to five-fold higher rate of suicide when compared to the general Canadian population (17). Other psychological and emotional illnesses that disproportionately plague Canada's First Nations include depression, feelings of helplessness, and a lack of motivation (11).

Similar to non-Aboriginal individuals, many Aboriginal people experience psychological disorders such as denial and helplessness when faced with health uncertainty. However, in contrast to non-Aboriginal populations, these mental disorders often go unchecked in Aboriginal communities due to their decaying primary healthcare system (10, 11). For example, a short attention span, limited comprehension, and a lack of motivation to complete homework are becoming common problems experienced by Aboriginal students. In the Sandy Lake school-based diabetes prevention program, researchers found that Ojibway-Cree students in grades 3 to 5 who completed the year long healthy diet plan displayed higher curriculum knowledge, greater self-efficacy, and healthier behaviours than those individuals who did not receive a similar diet (18). Perhaps if there were more family physicians to promote the benefits of healthy eating, more students of Aboriginal descent could excel in their studies and pursue a higher education.

In general, family physicians provide psychological counseling and advice on coping with acute and chronic illness, dietary regimens, referrals to support groups, and suicide risk assessments. By increasing the number of general practitioners serving First Nations communities, one would expect to see a positive outcome in both the treatment and prevention of physical health concerns and, consequently, a

marked increase in the psychological well-being and mental health of many community members.

Impact on Social Development

Consistent with the notion that an individual's physical health affects their mental state is the idea that social development also influences one's physical and mental wellbeing (10). The shortage of family physicians serving Canada's Aboriginal population, who would normally address or report social issues relating to the family, has resulted in an increased incidence of a number of physical and mental ailments.

First Nations communities have one of the highest cigarette smoking rates of all Canadian ethnic groups. Not surprisingly, overindulgence in this narcotic has been linked to their higher rates of diabetes and suicide (11, 13). Amidst their struggles with diabetes, North American Aboriginal people

There are four-fold more adolescent mothers amongst Aboriginal women than there are amongst non-Aboriginal women

are witnessing an increase in the number of deaths due to cardiovascular disease. In Ontario alone, hospital admissions due to ischemic heart disease doubled in First Nations communities between 1987 and 1997, while declining in the general population over the same period. Although this trend has been correlated with many changes in Aboriginal lifestyles, one of the primary causes seems to be cigarette smoking from an early age. For instance, in Sandy Lake, a typical North American Aboriginal community, the rate of smoking exceeds

80% and 70% among Ojibway-Cree men and women, respectively, with the greatest increase in youths between the ages of 12 and 15 years. With more family physicians to screen and provide counseling for cigarette smokers, both cardiovascular disease and cancer (two diseases associated with cigarette smoking and the leading causes of death in North American Aboriginal populations) can be greatly reduced (19).

In addition to smoking, alcohol abuse also has serious ramifications on the health and social development of Aboriginal communities. One particular consequence of this addiction has been an increase in the number of infants born with fetal alcohol syndrome (FAS). For instance, the incidence rate of FAS from Sweden, Australia, the United States, and Canada has been estimated at 0.33 cases for every 1,000 births. However, upon closer inspection of Aboriginal populations, this value changes dramatically. In Williams and Odaibo's study, it was found that the incidence of FAS in the Aboriginal communities located in Northeastern Manitoba was 7.2 cases per 1,000 births. This finding is not only distressing because of the sheer number of Aboriginal infants born with FAS, but also because of the adverse lifelong complications associated with this disorder. Growth deficiencies, intellectual delay, behavioural disorders, and physical defects are just some of the problems experienced by children with FAS (20). Thus, one may speculate that if there were more general practitioners in these communities to advise pregnant women about the dangers of alcohol to their developing embryo, many of these social (and subsequent physical and mental) problems could be avoided.

Another social concern stemming from a lack of family physicians serving Aboriginal populations involves family planning. With very little medical guidance about the dan-

gers of unprotected sex and adolescent pregnancy, many Aboriginal females are becoming pregnant at a young age. In Québec there are four-fold more adolescent mothers amongst Aboriginal women than amongst non-Aboriginal women. According to Luo et al., this pattern can be explained by a discrepancy in maternal education. More specifically, they found that Aboriginal mothers with less than a grade 11 education were four times more likely than non-Aboriginal mothers to have a child during their adolescence (21). Another study conducted by Devries et al. also suggests that substance use and sexual abuse are other key predictors of adolescent pregnancy in First Nations populations (22).

Overall, it is clear that Aboriginal Canadians are experiencing similar social problems to those of their non-Aboriginal compatriots. However, unlike the situation in many non-Aboriginal communities, the lack of general practitioners to promote family planning, healthy living, and drug abuse prevention amongst First Nations populations has resulted in a breakdown of the social, physical, and psychological foundations holding these societies together.

Conclusion

Aboriginal Canadians continue to carry a disproportionate burden of physical disease, mental illness, and social problems when compared to non-Aboriginal Canadians. Although these concerns can be attributed to many factors, a lack of family physicians seems to be one of the fundamental causes. These healthcare professionals are unique in their capacity to have a positive impact on their patients and communities by providing a variety of services such as health service delivery, promotion of mental health, and social development. Although there have been some improvements in the status of Aboriginal primary

healthcare over the years (such as more culturally sensitive care), there is still a significant imbalance between the medical attention that Aboriginal and non-Aboriginal Canadians receive. It is our hope that with further research, new initiatives fostering more effective healthcare management and programs promoting rural primary healthcare, Aboriginal Canadians will receive medical treatment equivalent to that enjoyed by non-Aboriginal Canadians. H

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