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Recommendations:

Health Care Priorities in Northern Ontario Aboriginal Communities

By Julie Duff Cloutier, Nichola Hoffman, Kristin Morin, and John Dabous

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Purpose

Dr. Murray Trusler, a family physician working in remote aboriginal communities, began a letter writing campaign to Ontario provincial authorities, outlining some of the key health and social issues faced by these communities from his perspective (as cited in Kay, 2013). Dr. Trusler's letter was written nine years ago, yet, many of the issues raised remain pertinent at the current time. The identified issues were broad in scope and encompassed social determinants of health such as poverty, education, and the lack of adequate housing and infrastructure in Aboriginal communities. Healthcare issues, including access to provincial public health services, family health teams and electronic medical records, were raised as significant concerns, and remain relevant to the current time.

The Truth and Reconciliation Commission of Canada (TRC) recently released its Calls to Action (2015), which included many healthcare-related recommendations intended to improve the health status of Aboriginal persons in Canada that resonate with some of Dr. Trusler's identified issues. One of the suggestions put forth by the Commission to bridge the gap between mainstream and Aboriginal health outcomes pertained to requirements for intercultural competency education for healthcare providers and policy makers (TRC, 2015; First Nations Information Governance Centre [FNIGC], 2009).

> Intercultural competency can be defined as a set of congruent behaviours and attitudes that permit individuals to work effectively in cross-cultural settings
> (Cross et al., 1989; Betancourt, Green, Carrillo, & Ananeh-Firempong 2nd, 2003).

The purpose of this paper is to outline health care policy recommendations with a specific focus on the achievement of improved access and integration of culturally safe health care services to Aboriginal persons in Northern Ontario communities.

Background

Access to quality health care in rural, remote and northern communities is a long standing issue in Ontario (Jacklin & Warry, 2012). It is well documented that the burden of disease for Aboriginal communities is disproportionately higher than non-Aboriginal populations (Adelson, 2005; Jacklin & Warry, 2012). Aboriginal populations in Ontario have higher rates of diabetes, Chronic Obstructive Pulmonary Disease (COPD), infectious diseases, addiction and suicide (Warry, 2012; Health Canada, 2010). Jurisdictional issues regarding specific funding structures and the fragmentation of healthcare responsibilities and service provision between the federal and provincial governments further complicate healthcare for Aboriginal persons (Glazier, 2012; North East Local Health Integration Network [NELHIN], 2013a; Jacklin & Warry, 2012). Historically, the federal government provides targeted health care funding to Aboriginal communities on reserve, while the provinces are responsible for funding healthcare services off-reserve (Health Canada, n.d., Kelly, 2011). This funding currently resides under the First Nation Inuit Health Branch (FNIHB) at Health Canada. The Indian Health Transfer Policy (1986) was announced in 1986; the policy provided the option of transferring health funding and administrative responsibilities to Aboriginal communities to provide greater flexibility to communities over the provision of services (Health Canada, 2005; Jacklin & Warry, 2012). This allows Aboriginal communities to respond to their own community health needs within the accountability guidelines of the First Nation Inuit Health Branch (FNIHB) (FNIHB, 2008). The policy has since been modified to allow for flexible uptake for communities who wish to pursue variable degrees of authority over federal health service funding (Jacklin & Warry, 2012). The complexity of Aboriginal health status and health policy is poorly understood, however, enhanced self-governance has improved the quality and effectiveness of services in some communities from a client perspective (Lavoie & Gervais, 2012; Jacklin & Warry, 2012).

Ontario made efforts to address Aboriginal health challenges through the Aboriginal Healing and Wellness Strategy (AHWS), which led to the creation of ten Aboriginal Health Access Centres (AHACs) (Lavoie, 2013). The AHWS was originally funded by five provincial ministries including the Ministry of Aboriginal Affairs and the MOHLTC. The goal of this strategy was to create community-based primary care programs and resources for both on-reserve and off-reserve Aboriginal persons. Currently, AHACs are funded by the MOHLTC and the Local Health Integration Networks (LHINs) (Association of Ontario Health Centres, 2015). The LHINs have a mandate to plan the delivery of health services for the population they serve, including Aboriginal communities (MOHLTC, 2006; LHIN, 2015). This is especially important for the Northeast (NE) and Northwest (NW) LHINs as large proportions of Aboriginal persons in Ontario live within these geographic boundaries (NELHIN, 2013a; NWLHIN, 2013a). While we recognize attempts to streamline the funding process, conflict in jurisdictional interests continues to set the stage for suboptimal delivery of healthcare services for Aboriginal communities.

Recent Ontario government documents, which include the Patients First: Action Plan for Health Care, Ontario's Action Plan for Health Care, and the Rural and Northern Health Care Framework/Plan were produced to guide health care and policy for all Ontarians, as well as some of the key health and healthcare issues identified for Aboriginal people (MOHLTC, 2015a; MOHLTC, 2015). Key issues identified include equity, access, and culturally safe care. The focus on a 'person-centered' health care system recommends providing increased access to care in the right setting, from the right providers, and at the right time, through a lens of culture safety (MOHLTC, 2014). Seamless coordination of service and evidence-based care are also prioritized (MOHLTC, 2010; MOHLTC, 2015; LHIN, 2015). Person-centred care as emphasized in the above documents should be developed with cultural safety as its foundation.

Analysis

Dr. Trusler identified ten areas of concern in his letters, based on his experiences as a physician providing healthcare services to isolated Aboriginal communities in Northern Ontario. However, several of his suggestions, for example, those related to housing, education, policing, and infrastructure, fall outside of the primary aegis of the MOHLTC. This commentary focuses on those issues identified by Dr. Trusler that pertain to Ontario health policy and are relevant to the MOHLTC: access to provincial public health services; access to family health teams; and the use of electronic medical records. Further, while access to appropriate health care services remains an undeniable challenge for Aboriginal persons, Dr. Trusler's recommendations and priorities appear to have been developed in isolation and without consultation with members of the Aboriginal communities. Such a non-collaborative type of action is now considered inappropriate and may be perceived as yet another act of paternalistic colonialism imposing non-Aboriginal solutions to Aboriginal problems (Lavoie & Gervais, 2012; Jacklin & Warry, 2012). Thus, for the purposes of this critique, we offer recommendations that are congruent with the spirit of the findings of the Truth and Reconciliation Commission of Canada, (TRC, 2015).

Recommendations

To address some of the issues outlined by Dr. Trusler, our overarching recommendation is to expedite the implementation of the recently-mandated province-wide Indigenous Cultural Safety training (National Aboriginal Health Organization[NAHO], 2009) training for all public service employees in Ontario, with an initial focus on MOHLTC-funded health programs and services. Recent headlines have announced the Ontario government's plan to introduce such training, but to date, no specific formal plan has been implemented. In line with the Patient's First Action Plan (MOHLTC, 2015), Ontario has the opportunity to create a unique and targeted training curriculum aimed at educating and informing both health care providers and policy makers in the area of Aboriginal health care. Although there may be challenges in making such training relevant and impactful to practice (Puck, 2008), this does not negate the necessity of such training as a starting point to effective change.

Under the umbrella of cultural safety, this commentary provides further recommendations to build upon Ontario's existing culturally safe primary care models and expand into remote locations as well as enhance communication and coordination between aboriginal and non-aboriginal agencies. The term cultural safety is used to express an approach to healthcare that recognizes the contemporary constraints of Aboriginal people (Brascoupé, 2009). The concept of cultural safety represents the development and delivery of services tailored to Aboriginal people and other cultural groups, in all areas of public policy (Brascoupé, 2009). Enhanced communication and coordination can be facilitated by improving access to and the integration of, electronic medical records (EMR). Remote locations stand to benefit substantially from improved communication with mainstream health service providers across the province.

Interdisciplinary health care providers in Northern Ontario may benefit from streamlined access to integrated EMRs. EMRs and appropriate integrative systems have demonstrated a positive impact on patient care and interprofessional collaboration through safer, more accurate, and complete information sharing among health care providers, improved efficiency and communication, and reduced wait times for appointments, procedures, and laboratory test results (Davis et al., 2015; eHealth Ontario, n.d., ; Harper, Edge, Schuster-Wallace, Ar-Rushdi, & McEwen, 2011; Rosser, Colwill, Kasperski, & Wilson, 2010).

One potential complication for the increased use of EMRs is stewardship of the electronic data; Aboriginal communities typically have ownership and control of data collected in their communities according to OCAP (Ownership, Control, Access, and Possession) principles (FNIGC, n.d.). In addition, Bill 119 of the Personal Health Information Protection Act (PHIPA) specifically protects patients' personal health records across the health system (MOHLTC, 2016). A careful balance in regard to individual and community health data and the availability of access required to facilitate streamlined service may have to be considered (Kewayosh et al., 2015; Assembly of First Nations [AFN], 2013; Wilson, 2004). Of note, the Chiefs of Ontario (COO) and Institute of Clinical Evaluative Sciences (ICES) have recently entered into a Data Governance Agreement (COO, 2015) that could serve as a potential template to assist in the protection of Aboriginal people's health data within a provincial database. There is some precedence in applying this governance agreement to health information, specifically in regard to immunization records (COO, 2015). Mutually established solutions between Aboriginal organizations, the MOHTLC and the federal government are required to develop an EMR system that seamlessly coordinates with mainstream EMRs while respecting community and personal privacy concerns (Kewayosh et al., 2015; AFN, 2013).

In addition to EMRs, integrative collaboration is required to improve access to primary care in Aboriginal communities. Improving patient outcomes within a culturally safe and cost efficient manner may be achieved for Aboriginal communities through the expansion of interprofessional FHTs and AHACs (MOHLTC, 2012; Gocan & Woodend, 2004). Unlike AHACs, FHTs are not necessarily structured to offer traditional healing and/or spiritual services. For this reason, FHTs may require considerable flexibility within each community in order to accommodate identified community needs. Services should be planned and developed within the Aboriginal communities, incorporating culturally-appropriate values, beliefs, and identified needs, similar to existing off-and-on-reserve AHACs (Sioux Nations First Lookout Health Authority [SNFLHA], 2006; Association of Ontario Health Centres [AOHC], 2015).

Jurisdictional accountability and responsibility between the federal and provincial governments will also have to be considered in this planning. Aboriginal interdisciplinary FHTs may require a range of both

traditional Aboriginal and non-Aboriginal services for which the governmental financial responsibility may vary (SNFLHA, 2006; Ontario Regional HSIF Advisory Committee [ORHAC], 2011; NWLHIN, 2015). Presently, federal financial responsibility is weighted to on-reserve health clinic expenditures whereas provincial responsibility is weighted towards off-reserve publicly funded health services (SNFLHA, 2006; ORHAC, 2011). Service expansion may require collaboration between Aboriginal organizations and the federal and provincial governments (Adelson, 2005; Bisset, Cargo, Delormier, Macaulay, & Potvin, 2004; Tobe, Maar, Roy, & Warburton, 2015). Although there is the potential for interjurisdictional conflict, such collaboration has previously occurred in Ontario (SNFHLA, 2006; Davis, Reeve, & Humphreys, 2015).

The Trilateral Aboriginal Health Seniors Officials Committee in Ontario is an example of how different levels of government (federal, provincial and Aboriginal) are working to develop a framework for future health policy (COO, 2013).

The costs associated with EMRs and improved integration of services may be offset through the reduction of service duplication and increased efficiency of patient care across health sectors (eHealth Ontario, n.d.). However, there are other barriers associated with infrastructure, connectivity and technical limitations presenting interjurisdictional challenges outside the mandate of the MOHLTC (Ajami & Arab-Chadegani, 2013; Kewayosh et al., 2015).

As such, we recommend the planning and establishment of funding models to support not only the necessary cultural competence training, restructured FHTs, and access to EMRs, but also the necessary infrastructure to support these endeavours. This funding may potentially be addressed through the initiation of collaborative protocols to facilitate the coordination of healthcare services and infrastructure requirements between the federal and provincial governments, and Aboriginal peoples (Kewayosh et al., 2015; NELHIN, 2013; AFN, 2013).

A similar model has been applied in British Columbia and preliminary evaluations have shown investments in the improvement of primary care; health connectivity; e-health and health information transfer; and child and maternal health services, among others (Lavoie, Varcoe, Wong, & Fridkin, 2015; COO, 2013; First Nations Leadership Council, Canada, & British Columbia, 2007). In Ontario, the number of different treaties makes relationships between Aboriginal communities and the federal and provincial governments more complex (AOHC, 2015; Jacklin & Warry, 2012). Not only does the content of the treaties vary significantly, but there is variability in the way treaties are interpreted and valued by Aboriginal communities. Planning for this type of recommendation will have to occur at many different levels and the political climate and policy legacy surrounding health care will be very important to consider (Jacklin & Warry, 2012).

Conclusion

Fostering an environment of culturally safe practice throughout the province is a crucial step towards addressing the health disparities for Aboriginal people in Ontario. The MOHLTC has the opportunity to shift the focus from providing health care directed at Aboriginal populations, to working alongside Aboriginal communities in this regard. The needs and development plans should be created in collaboration with the members of the Aboriginal communities (ORHAC, 2011; NWLHIN, 2013a). Health care reforms should include additional and/or restructured FHTs, as well as improved integration of health services, facilitated through the enhanced use of EMRs. Significant resources and funding will be necessary to achieve such large-scale reforms. These recommendations are essential first steps towards improved cultural safety, equity in health care, and larger, impactful policy changes for Aboriginal health in Ontario.

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