Executive Summary

Introduction

This report is a comprehensive study of the health care needs of Aboriginal residents in the Waterloo Wellington LHIN (WW LHIN area). This study was commissioned by the LHIN in order to better understand the demographics, health status, service use patterns and community health perspectives of Aboriginal residents in the LHIN's service area. Multiple lines of enquiry informed this report. These included Statistics Canada profiles of the First Nations, Métis and Inuit ancestry residents of the WW LHIN areas (Aboriginal Peoples Survey and Census, 2006); two resident focus groups conducted in February 2011 and an online resident questionnaire.

Demographic profile

Statistics Canada data provided a representative statistical description of the LHIN service area in terms of demographics, income, education, housing, as well as health. It also provided comparative data for the Aboriginal and non-Aboriginal population in the area. While offering a comprehensive statistical profile, the Statistics Canada data could not provide the context. This was provided by fifty-two First Nation and Métis people who participated in focus groups, and surveys.

The demographic characteristics of the Aboriginal population in the WW LHIN services area were based on the 2006 Aboriginal Peoples Survey (APS) and Canadian Census. Aboriginal residents made up 1.5% of the WW LHIN's total population. Conservative extimates suggest that the population had grown by 34% since 2002. The population was young with a mean age of 29 years compared to 36.9 years for the total WW LHIN population. The majority of Aboriginal residents had migrated to the area for work and family reasons.

Some key determinants of health were also drawn from the statistical surveys. Although Aboriginal residents in WW LHIN had higher educational attainment and personal and household income as compared to the Ontario and Canadian Aboriginal populations, both education and income levels lagged behind the total LHIN population. Unemployment levels were also relatively high (9.6% vs. 5.2%) compared to the total LHIN population, although the Aboriginal population was over represented in the labour force (77.7% vs. 71.5%). This difference in labour force participation may be attributed to the Aboriginal population's relatively lower average age and fewer numbers of people over the age of 65.

Major findings: Key health concerns for Aboriginal population

In spite of the lower average age of the Aboriginal population, the incidence of chronic health conditions was higher among Aboriginal residents for all long-term health conditions for which comparative data wass available (arthritis/rheumatism (23% vs. 15.7%), asthma, high blood pressure (15% vs. 14.7%), diabetes and chronic bronchitis). The most commonly reported long-term health conditions were arthritis/rheumatism, asthma, high blood pressure, stomach problems/ulcers, and chronic bronchitis. Estimated

rates of asthma (17%vs. 7.9%), diabetes (7.5% vs. 3.9%) and chronic bronchitis (7% vs. 2%) are about twice as high for Aboriginal residents as compared to the total population in the service area.

Access to traditional Aboriginal care arose as a primary area of concern for Aboriginal residents. The 2006 APS data indicated that Aboriginal residents in the WW LHIN had less access to First Nation, Métis or Inuit traditional medicines as compared to Ontario and Canadian Aboriginal populations. Focus group and resident survey findings provided converging evidence that Aboriginal residents are interested in a balanced care system blending Western medical models, holistic traditional care and alternative health care models.

Additional concerns for the community, as determined by focus groups and the resident survey included rising chronic health rates, social determinants of health including education, poverty, and employment, diet/weight, and mental health. Problems with access and quality of care were a lack of trust of the medical system, feelings a lack of empowerment and the lack of emphasis on holistic care.

Major findings: Community recommendations for improving Aboriginal health

The following strategies were described by focus group participants in response to improving access and quality of care in the WW LHIN region.

1. Opening a local Aboriginal health care centre to increase local access to traditional Aboriginal health care models. Alternatively, services can be offered in an existing centre and engaging traditional healers to provide services within the community.
2. Advocating for support services to the Aboriginal community to assist them understand their health care rights, find appropriate health professionals and needed services, and lobby for greater inclusivity of Aboriginal perspectives in mainstream medical practice.
3. One suggestion from the focus groups called for mandatory cultural sensitivity training for all health providers. While some suggested that training should be Aboriginal-specific others indicated that this would be unrealistic and suggested that a more appropriate solution would be general (not Aboriginal-specific) cultural sensitivity training.
4. Empowerment training or services to help Aboriginal community was suggested as a strategy for improving access and quality of care issues
5. Some respondents asked for opportunities for the Aboriginal community to come together in sharing circles to discuss health concerns and provide support and information to other members in accessing care.
6. Health education and information distribution to the Aboriginal community on health issues that are of particular concern for Aboriginal people was suggested. Drafting a list of local health care providers who employ a holistic care approach was given as an example.

Conclusion

The Aboriginal Needs Assessment is a step in a process of engagement to dig a little deeper into the health needs of the communities. Needs were discovered and potential solutions proposed by residents. It is now appropriate for the LHIN to work with the various stakeholders who understand the needs and their contexts and whose understanding of the impact of the potential solutions would be invaluable.

The primary challenge of implementing the recommendations is that there are few local Aboriginal organizations and none of those that do exist have a focus on health. However, based on the participation in the focus groups, there is a strong but vocal contingency of community members who are interested in working to address Aboriginal health care needs in this service area.