

In Plain Sight

Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care

Data Report



*'20

Addressing Racism Review
December 2020



Acknowledgements



Emotional Trigger Warning

This report discusses topics that, for Indigenous peoples, may trigger memories of culturally unsafe personal experiences or such experiences of their friends, family, and community. The report is intended to explore the prejudice and discrimination experienced by Indigenous people in the health care system and to make Recommendations that will help eliminate Indigenous-specific racism and create substantive equity in health care experiences, services and outcomes. However, the content may trigger unpleasant feelings or thoughts of past abuse. First Nations, Métis and Inuit peoples who require emotional support can contact the First Nations and Inuit Hope for Wellness Help Line and On-line Counselling Service toll-free at 1-855-242-3310 or through hopeforwellness.ca. The Métis Crisis Line is available 24 hours a day at 1-833-MétisBC (1-833-638-4722). And the KUU-US Crisis line is available 24/7 at 1-800-588-8717 to provide support to Indigenous people in B.C. For more information, visit: kuu-uscrisisline.ca

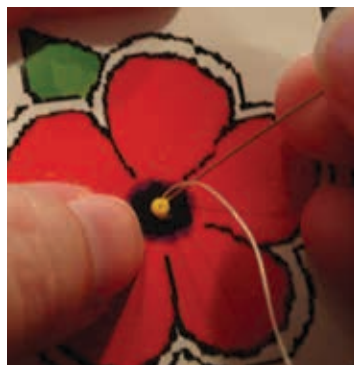
On June 19, 2020, I was appointed by British Columbia's Minister of Health, the Hon. Adrian Dix, to conduct a review of Indigenous-specific racism in the provincial health care system.

I acknowledge that the resulting Addressing Racism Review has taken place on the territories of First Nations peoples in B.C., and I also recognize the courage and determination shown by thousands of Indigenous people across the province who shared their experiences within the health care system to inform this report.

In addition, I want to acknowledge the work of the skilled, Indigenous-led team who supported the complex and urgent Review that provided the basis for this report. And I would like to thank the First Nations Health Authority, First Nations Health Council and Métis Nation BC for their strong support during the process. I also express my gratitude to the team at the Indian Residential School History and Dialogue Centre at University of British Columbia who provided collegial support and research to assist in the preparation of the report.

Finally, I acknowledge that British Columbians and the B.C. health care system are dealing with two pressing public health emergencies – the opioid overdose crisis, and the COVID-19 pandemic. Despite the immense challenges and pressures created by these health emergencies, thousands of health care workers – along with their leaders and organizations – found the time to participate in this Review. I thank them for that, and for their dedication to confronting the matters raised in this report and committing to implement the Recommendations.

Hon. Dr. M.E. Turpel-Lafond (Aki-Kwe)
Independent Reviewer



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Abbreviations and Acronyms

a/s	age standardized
AAC	average annualized change
ACSC	ambulatory care sensitive conditions
ALC	alternate level of care
AMI	acute myocardial infarction
B.C.	British Columbia
BCCDC	BC Centre for Disease Control
BCPSLS	BC Patient Safety Learning System
CABG	coronary artery bypass graft
CI	confidence interval
CIHI	Canadian Institute for Health Information
CKD	chronic kidney disease
COPD	chronic obstructive pulmonary disorder
CT	computerized tomography
CTAS	Canadian Triage & Acuity Scale
DAD	Discharge Abstract Database
DP	day procedure
DRIPA	<i>Declaration on the Rights of Indigenous Peoples Act</i>
ED	Emergency Department
FIT	fecal immunochemical test
FN	First Nations
FNCF	First Nations Client File
FNHA	First Nations Health Authority
GS&S	general signs and symptoms
HCC	high complexity chronic condition
HSM	Heath System Matrix
HWS	Health Workers' Survey
IPS	Indigenous Peoples' Survey
IP	inpatient
ISD	insufficient data
LAMA	leaving against medical advice
LCC	low complexity chronic condition

LTC	long-term care
M&A	mood and anxiety
MCC	medium complexity chronic condition
MCFD	Ministry of Children and Family Development
MCR	Métis Citizenship Registry
MDMA	3,4-methylenedioxy-methamphetamine
MH	mental health
MHSU	mental health and substance use
MNBC	Métis Nation British Columbia
MRI	magnetic resonance imaging
NACRS	National Ambulatory Care Reporting System
NINR	non-Indigenous & non-racialized
NP	nurse practitioner
OCAP®	ownership, control, access and possession
OCAS	ownership, control, access and stewardship
OPHO	Office of the Provincial Health Officer
OR	Other Residents
PCQO	Patient Care Quality Office
PG	Population Grouper
PHN	personal health number
PHSA	Provincial Health Services Authority
PREMS	Patient Reported Experience Measures Survey
PSBC	Perinatal Services BC
PTCA	percutaneous transluminal coronary angioplasty
PYLL	potential years of life lost
RHS	<i>Regional Health Survey</i>
SU	substance use
TDQSA	<i>Tripartite Data Quality and Sharing Agreement</i>
WHO	World Health Organization

Glossary of Terms

Anti-racism is the practice of actively identifying, challenging, preventing, eliminating and changing the values, structures, policies, programs, practices and behaviours that perpetuate racism. It is more than just being “not racist” but involves taking action to create conditions of greater inclusion, equality and justice.

Bias: A way of thinking or operating based explicitly or implicitly on a stereotype or fixed image of a group of people.

Colonialism: Colonizers are groups of people or countries that come to a new place or country and steal the land and resources from Indigenous peoples, and develop a set of laws and public processes that are designed to violate the human rights of the Indigenous peoples, violently suppress the governance, legal, social, and cultural structures of Indigenous peoples, and force Indigenous peoples to conform with the structures of the colonial state.

Cultural humility is a life-long process of self-reflection and self-critique. It is foundational to achieving a culturally safe environment. While western models of medicine typically begin with an examination of the patient, cultural humility begins with an in-depth examination of the provider’s assumptions, beliefs and privilege embedded in their own understanding and practice, as well as the goals of the patient-provider relationship. Undertaking cultural humility allows for Indigenous voices to be front and centre and promotes patient/provider relationships based on respect, open and effective dialogue and mutual decision-making. This practice ensures Indigenous peoples are partners in the choices that impact them, and ensures they are party and present in their course of care.

Cultural safety: A culturally safe environment is physically, socially, emotionally and spiritually safe. There is recognition of, and respect for, the cultural identities of others, without challenge or denial of an individual’s identity, who they are, or what they need. Culturally unsafe environments diminish, demean or disempower the cultural identity and well-being of an individual.

Culture: Refers to a group's shared set of beliefs, norms and values. It is the totality of what people develop to enable them to adapt to their world, which includes language, gestures, tools, customs and traditions that define their values and organize social interactions. Human beings are not born with culture – they learn and transmit it through language and observation.

Discrimination: Through action or inaction, denying members of a particular social group access to goods, resources and services. Discrimination can occur at the individual, organizational or societal level. In B.C., discrimination is prohibited on the basis of “race, colour, ancestry, place of origin, religion, family status, marital status, physical disability, mental disability, sex, age, sexual orientation, political belief or conviction of a criminal or summary conviction offence unrelated to their employment.”

Epistemic racism: Refers to the positioning of the knowledge of one racialized group as superior to another, including a judgment of not only which knowledge is considered valuable, but is considered to be knowledge.

Ethnicity: Refers to groups of people who share cultural traits that they characterize as different from those of other groups. An ethnic group is often understood as sharing a common origin, language, ancestry, spirituality, history, values, traditions and culture. People of the same race can be of different ethnicities.

Health equity: Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. “Health equity” or “equity in health” implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

Health care inequity: The practice of intentionally or unintentionally treating people differently and unfairly because of their race, sex, national origin or disability.

Health inequity: The presence of systematic disparities in health (or in the major social determinants of health) among groups with different social advantage/disadvantage.

Indigenous peoples: The first inhabitants of a geographic area. In Canada, Indigenous peoples include those who may identify as First Nations (status and non-status), Métis and/or Inuit.

Indigenous-specific racism: The unique nature of stereotyping, bias and prejudice about Indigenous peoples in Canada that is rooted in the history of settler colonialism. It is the ongoing race-based discrimination, negative stereotyping, and injustice experienced by Indigenous peoples in Canada that perpetuates power imbalances, systemic discrimination and inequitable outcomes stemming from the colonial policies and practices.

Intergenerational trauma: Historic and contemporary trauma that has compounded over time and been passed from one generation to the next. The negative cumulative effects can impact individuals, families, communities and entire populations, resulting in a legacy of physical, psychological, and economic disparities that persist across generations. For Indigenous peoples, the historical trauma includes trauma created as a result of the imposition of assimilative policies and laws aimed at attempted cultural genocide and continues to be built upon by contemporary forms of colonialism and discrimination.

Interpersonal racism: Also known as relationship racism, refers to specific acts of racism that occur between people, and may include discriminatory treatment, acts of violence and micro-aggressions.

Oppression: Refers to discrimination that occurs and is supported through the power of public systems or services, such as health care systems, educational systems, legal systems and/or other public systems or services; discrimination backed up by systemic power. Denying people access to culturally safe care is a form of oppression.

Prejudice: Refers to a negative way of thinking and attitude toward a socially defined group and toward any person perceived to be a member of the group. Like bias, prejudice is a belief and based on a stereotype.

Privilege: operates on personal, interpersonal, cultural, and institutional levels and gives advantages, favours, and benefits to members of dominant groups. Privilege is unearned, and mostly unacknowledged, social advantage that non-racialized people have over other racial groups.

Profiling is creating or promoting a preset idea of the values, beliefs and actions of a group in society and treating individuals who are members of that cohort as if they fit a preset notion, often causing them to receive different and discriminatory treatment.

Race: Refers to a group of people who share the same physical characteristics such as skin tone, hair texture and facial features. Race is a socially constructed way to categorize people and is used as the basis for discrimination by situating human beings within a hierarchy of social value.

Racism is the belief that a group of people are inferior based on the colour of their skin or due to the inferiority of their culture or spirituality. It leads to discriminatory behaviours and policies that oppress, ignore or treat racialized groups as 'less than' non-racialized groups.

Stereotype: A fixed image. Refers to an exaggerated belief, image or distorted truth about a person or group; a generalization that allows for little or no individual differences or social variation.

Substantive equality refers to the requirement to achieve equality in opportunities and outcomes, and is advanced through equal access, equal opportunity and the provision of services and benefits in a manner and according to standards that meet any unique needs and circumstances, such as cultural, social, economic and historical disadvantage.

Systemic racism is enacted through routine and societal systems, structures and institutions such as requirements, policies, legislation and practices that perpetuate and maintain avoidable and unfair inequalities across racial groups, including the use of profiling and stereotyping.

1. Introduction

In June 2020, B.C.'s Minister of Health commissioned an Independent Review of Indigenous-specific racism in the provincial health care system. The Review was met with extraordinary cooperation by the health system, including delegation under the *Ministry of Health Act* to access and examine data relevant to the scope of the Review.

Over a six-month period, a small team led by Dr. Mary Ellen Turpel-Lafond, carried out the Review, which involved extensive engagement, document review and qualitative and quantitative analysis of data regarding health system performance for Indigenous peoples, and their health outcomes. Almost 9,000 individuals directly shared their perspectives with the Review, and approximately 185,000 Indigenous individuals were reflected in the analysis of health sector data. The findings of this Review are described in three reports: a summary report; a long report; and this supplemental data report.

The Review sought to understand the prevalence of Indigenous-specific racism, the forms it takes, how it is experienced, and its impacts on health system performance and Indigenous peoples' health and well-being. As such, this was a first-of-its-kind examination of this issue in its depth and comprehensiveness, and the Review received more data than could be fully presented in either of the summary or long reports. This data is nevertheless important in its own right, and therefore this data report was prepared both to supplement the other reports issued by the Review, as well as serve as a stand-alone report on health system performance for Indigenous peoples in B.C.

This report provides analyses of qualitative and quantitative data which were created or obtained in the Review. Starting with the qualitative data, this Report includes analyses of the two surveys convened by the Review – the Indigenous Peoples' Survey (IPS) and Health Workers' Survey (HWS); submissions received by the Review through its toll-free phone line and email address; Indigenous patient complaints from external organizations; and a discussion board on discrimination in health care administered through the San'yas Indigenous Cultural Safety training of the Provincial Health Services Authority (PHSA). It should be noted that these surveys, and the individual submissions received, were not representative

In Plain Sight Summary of Key Findings

The first volume of reports released by the Review described the self-perpetuating cycle that holds Indigenous-specific racism in place in B.C.'s health care system – a cycle that is depicted in the following visual.

Through the process of settler colonialism in Canada, racist beliefs were perpetuated about Indigenous peoples. Those beliefs have evolved through time, but continue to persist in the form of negative stereotyping of Indigenous peoples as, for example, bad parents, less capable, and alcoholics. These stereotypes – consciously or unconsciously – result in discriminatory treatment of Indigenous peoples in health care. Abusive interactions take place, there is poorer quality of service, and inappropriate pain management for Indigenous patients. The result of discriminatory treatment, paired with intergenerational trauma and systemic racism, is less access to and avoidance of necessary health care. Cumulatively, this results in poorer health outcomes for Indigenous patients – and particularly Indigenous women.

The Review's recommendations seek to break this cycle and create cultural safety by shifting beliefs, behaviours and systems. Recommendations are grounded in Indigenous human rights as described in the *United Nations Declaration on the Rights of Indigenous Peoples*, and require strong anti-racism tools and the practice of cultural humility.

of randomized population-based responses, but represent the experiences of respondents.

This report then describes numerous quantitative data sources on health service utilization, including a focus on primary care and hospital services, and health outcomes including chronic conditions, mortality, and the association of racism with other self-reported health and wellness indicators. Data examining priority issues such as the two current public health emergencies, and mental health and wellness are included. A final discussion section offers some observations and conclusions relating to the disparities in Indigenous health outcomes and access to services as a result of insufficient and inadequate health system performance, and the disproportionate burden shouldered by Indigenous women in B.C.

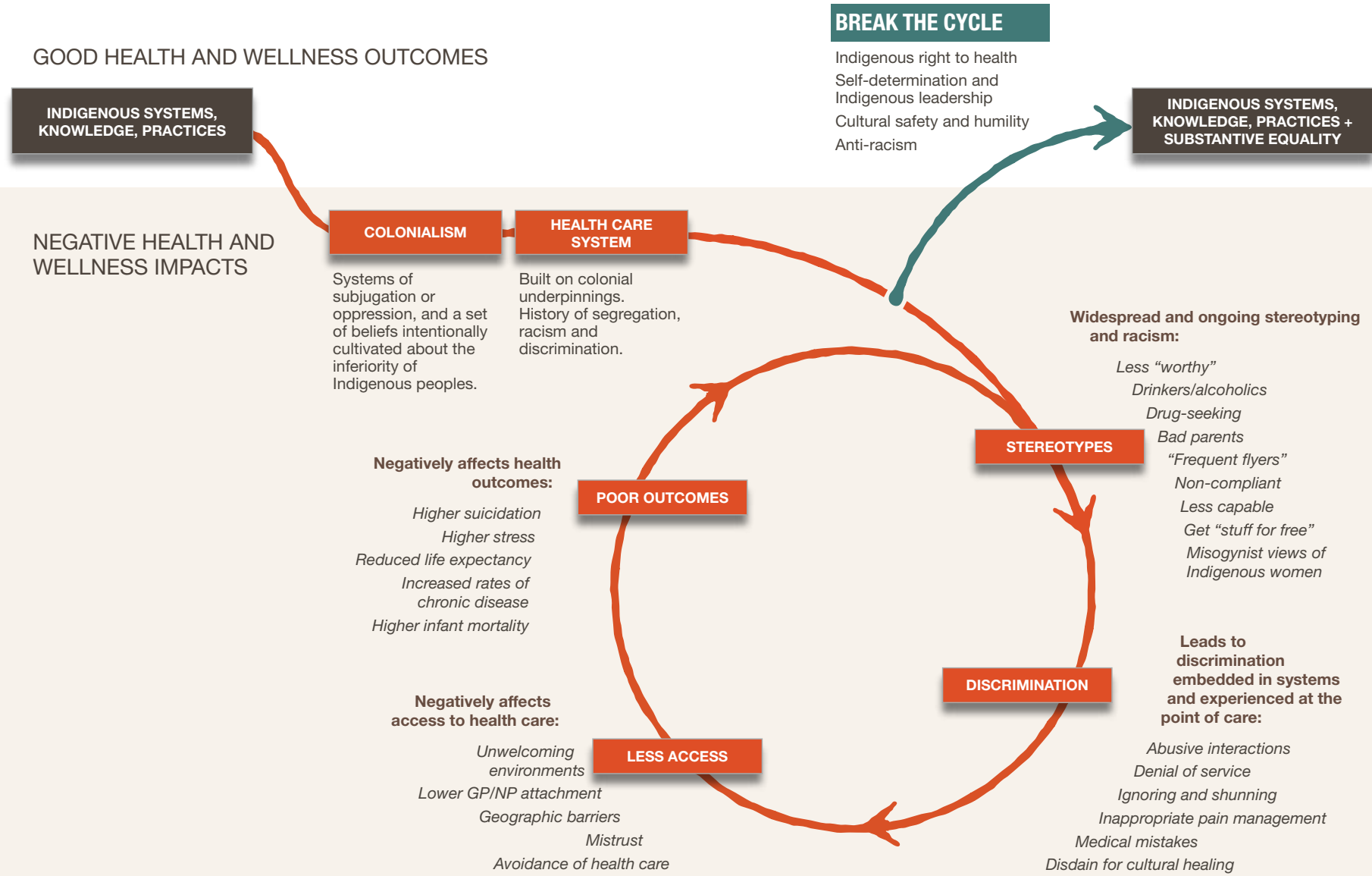
It must be stressed that the focus of this report is health system performance for Indigenous peoples, and its role as a contributor to health outcomes as measured by that system. The data, as will be shown in this report, point to inherent deficits in the system, not amongst Indigenous peoples and, due to this emphasis on health system performance, do not include the many measures of health and wellness that matter to Indigenous peoples.¹

This data report offers further evidence in support of the conclusions, findings and Recommendations described in the Review's first volume of reports. Taken together, these three reports clearly demonstrate the need for immediate, principled and comprehensive efforts to eliminate all forms of prejudice and discrimination against Indigenous peoples in the B.C. health care system. They provide the pathway to follow in creating an accessible and effective health care system. Finally, these reports establish the baseline measures that can assess progress in reaching a state of substantive equality in health care and outcomes for Indigenous peoples that adequately address the legacy of colonialism in health care and enable the expression and enjoyment of Indigenous human rights and improved quality of life.

These Review reports speak to the value of data to inform evidence-based solutions, and clearly demonstrate that accessing and producing this data in a timely manner is possible – and is now, in fact, imperative to driving positive change. The health system and Indigenous organizations are strongly urged to routinely produce timely data to underpin and inform policy decisions, assure accountability for improvement in health system performance for Indigenous peoples, and make data available to Nations and mandated First Nations and Métis organizations to drive improvement locally, regionally and provincially.

¹ The reader is directed to excellent resources that consider strength-based measures of Indigenous wellness, such as the Population Health and Wellness Agenda, which is a collaboration of the First Nations Health Authority (FNHA) and Office of Provincial Health Officer (OPHO), and the B.C. First Nations *Regional Health Survey* reports available from the FNHA.

In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care



Summary Report: <https://engage.gov.bc.ca/app/uploads/sites/613/2021/11/In-Plain-Sight-Summary-Report.pdf>
Full Report: <https://engage.gov.bc.ca/app/uploads/sites/613/2021/11/In-Plain-Sight-Full-Report.pdf>



2. Terminology



The lexicon of Indigeneity is dynamic and complex, spanning individual and Nation preferences, government legislation, policy and practices, and emerging social norms and understandings.

In this report, 'Indigenous' is used preferentially as the overall descriptor of the population who are the focus of the Review, and encompassing First Nations, Métis and Inuit. B.C.'s *Declaration on the Rights of Indigenous Peoples Act (DRIPA)* defines 'Indigenous' the same way the federal *Constitution Act, 1982* defines 'Aboriginal'.

From a data perspective, the term of choice within many government databases is 'Aboriginal'. 'Aboriginal' is used in the federal census and B.C. data collection policies. Where the originating data source uses the term 'Aboriginal', this usage is carried over into this report. It is also used with respect to the Interior region of B.C. based on the preference of First Nations and Métis peoples in that area.

The federal government also continues to use the terminology 'Registered or Treaty Indian', 'Indian reserves', and 'Indian Status' in its documentation – a by-product of the *Indian Act*. However, in this report, these terms are only used to accurately identify a data's original descriptors. 'First Nations', with the subset 'non-status First Nations' are otherwise used. The report also uses the terms 'Métis' and 'Inuit' consistent with contemporary practice.

These aggregate terms fail to capture the tremendous linguistic, cultural and other social diversity of the vibrant self-determining Nations which predated settler colonialism and the establishment of Canada, and which continue to exist today.

3. Population Overview

In the 2016 Census, which is the last broad enumeration of the Indigenous population in B.C., 5.9 per cent of the provincial population, or 270,585 persons, identified as Aboriginal. This represents a five-year growth of 16.5 per cent from the 2011 Census, and is related to relatively high fertility rates in the Aboriginal population as well as a trend to increasing numbers of individuals who are reporting Aboriginal identity in the Census.²

For B.C. specifically, 64.8 per cent (172,520) of the Aboriginal population further identified as First Nations (North American Indian), 33.0 per cent (89,405) as Métis and 0.6 per cent (1,615) as Inuit. The remaining 1.6 per cent were individuals who identified as having multiple Aboriginal identities.³

Of the 125,635 First Nations people with Registered or Treaty Indian status (72.8 per cent) in 2016, 40.1 per cent lived in one of B.C.'s First Nations communities, while the rest lived off reserve. Approximately 30.3 per cent of Aboriginal peoples in B.C. lived in rural areas, which was a higher proportion than the overall population. Vancouver had the largest Aboriginal population among Census metropolitan areas and Census agglomerations. Twenty-three per cent of B.C.'s Aboriginal population (61,455 persons) lived in Vancouver in 2016. Victoria had the second largest Aboriginal population (17,245 persons).⁴

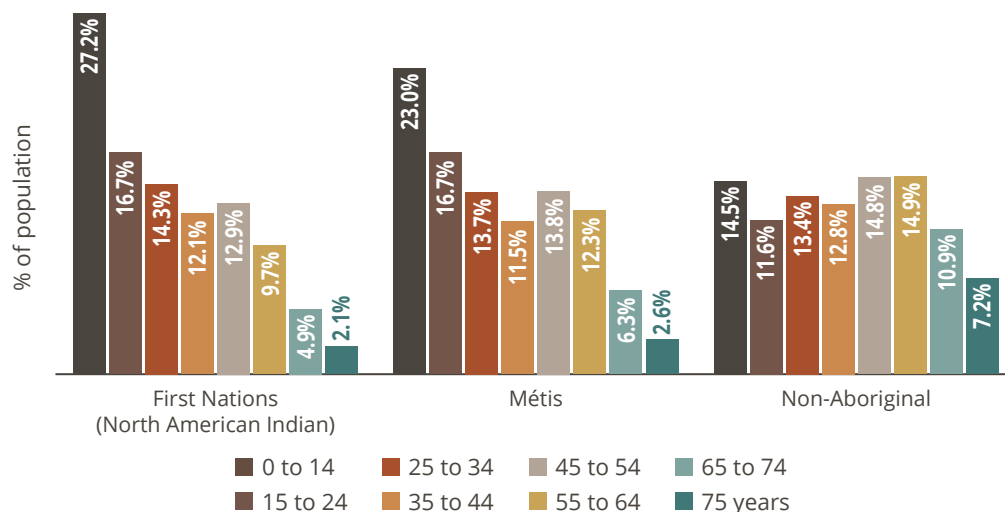
When compared to the non-Aboriginal B.C. population, both First Nations and Métis populations were more youthful in 2016, particularly seen with those under 25 years of age. In general, Indigenous peoples have not experienced the effects of population aging to the extent seen in the non-Indigenous population. Population aging is defined as an increasing median age of a population or an alteration in the age structure of a population, with the result that elderly persons are increasingly represented within a country's overall age structure. This aging-related difference is evident in Figure 1 of the First Nations, Métis and non-Aboriginal populations, starting at age groups older than 34 years, and culminating in the 75-plus years age group, where there is an approximately three fold difference between the First Nations and Métis proportions of the population ages 75-plus and that seen in the non-Aboriginal population.

² <https://www150.statcan.gc.ca/n1/daily-quotidien/171025/dq171025a-eng.htm>

³ The Census has a degree of under-reporting, as some First Nations communities choose to not participate. As well, other groups may similarly choose non-participation, such as homeless persons and Aboriginal persons who do not accept the jurisdiction and/or mandate of the Census.

⁴ <https://www2.gov.bc.ca/gov/content/data/statistics/infoline/infoline-2017/17-138-2016-census-indigenous-people-canada>

Figure 1: Age Distribution, 2016 Census, B.C.



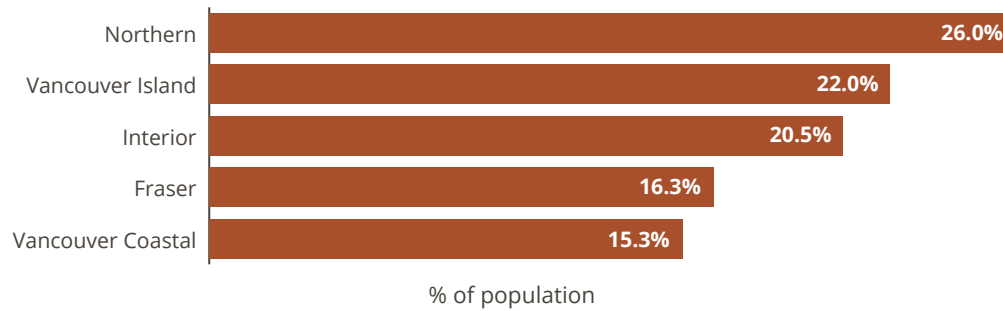
Much of the health status and health service utilization data which follow in this report are based on a subset of First Nations and Métis populations – those that are identifiable in First Nations and Métis population registries which can then be matched with health administrative databases.^{5, 6} The difference is fairly small between the First Nations population which can be analyzed in a health study (e.g., First Nations with registered status), and those who are missed (First Nations who do not have registered status – approximately 10 per cent in the Census). With respect to the Métis, the existence of a registry of their population which can be used to identify health data is fairly recent, and approximately 20,500 Métis individuals are currently registered.

Regions

For First Nations, the most populous region in B.C. in 2016/17 was Northern (26.0% of the total First Nations population), and the least populated was Vancouver Coastal (15.3%). These were also the two regions where there was a very slight majority of male First Nations (50.4%); in the other regions, the female population ranged from 50.7 per cent to 51.6 per cent.

⁵ The Métis are self-identified in the Canadian Census. In B.C., Métis Nation British Columbia (MNBC) administers a voluntary citizenship application process. As part of the application, Métis individuals can provide approval for their health data to be used in data linkages with provincial health databases.

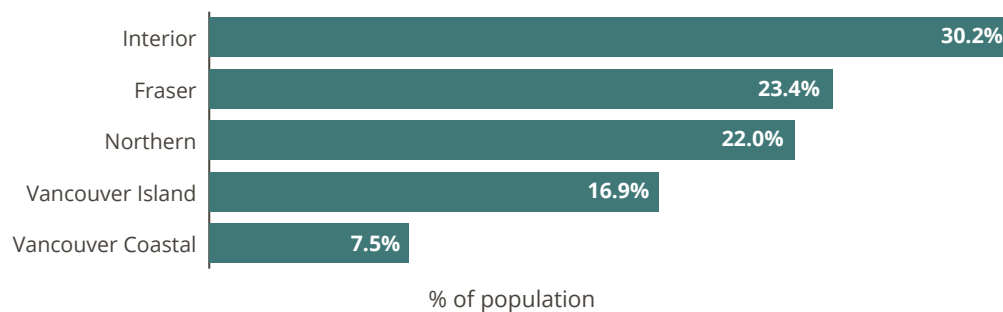
⁶ The First Nations Client File (FNCF) is a repository of demographic information for B.C. resident First Nations who are registered under the *Indian Act*.

Figure 2: First Nations Population by Region, 2016/17

FNCF, 2016/17

Over a 10-year period (2008/09 to 2016/17), the highest annual growth was in Fraser (1.3%) and Vancouver Island (1.0%), followed by Interior (0.5%), and Northern (0.3%). There was minimal change in the Vancouver Coastal First Nations population (0.1%).⁷

In contrast to First Nations people who are more likely to reside in regions that are northerly and remote, the regions with the highest Métis population were Interior (30.2%) and Fraser (23.4%) in 2017/18.⁸

Figure 3: Métis Population by Region, 2017/18

MCR, 2020

⁷ FNHA. 2020.

⁸ Review. 2020.

4. Data Sources and Methodology

The Review placed a strong emphasis on prioritizing the direct input and collecting the voices of Indigenous people who use the health care system and on gathering the experiences of health care workers in B.C. Including surveys, email and toll-free phone submissions, and stakeholder interviews, nearly 9,000 voices helped shape the Review findings. The Review Team also completed extensive qualitative and quantitative analysis of existing data related to health system performance for more than 185,000 Indigenous individuals. The Review engaged both Indigenous and non-Indigenous methodologies in data collection and analysis, included multiple quantitative and qualitative data sources, and followed established Indigenous data governance principles and processes.⁹

4.1 Data Sources Created by the Review

The sources of information created in this Review and covered in this report include:

- Indigenous Peoples' Survey (IPS)
- Health Workers' Survey (HWS)
- Intake file created through individual histories submitted to a toll-free phone number and email address.

Indigenous Peoples' Survey¹⁰

The IPS was established as a way to capture the experience of Indigenous people in B.C. related to racism or discrimination in the B.C. health care system; even so, it was open to the general public. It was launched on July 9, 2020 as a primarily online survey (hard copy written responses were also accepted) and was open for responses over a five-week period. (Survey, Appendix 1; Survey

⁹ The Review Team was headed by two Indigenous women – the Independent Reviewer and the Executive Director. The team included a combination of Indigenous and non-Indigenous members with public health and direct clinical experience, included physicians and nurses and public health leaders, and those with extensive knowledge of the health care system and expertise in conducting complex investigations, interpreting data, and Indigenous rights and anti-racism. The Review engaged external Indigenous reviewers with strong data and data governance backgrounds and training, and followed governance protocols of FNHA and MNBC with respect to accessing and publishing data.

¹⁰ The IPS was developed by the Review Team based on an instrument designed by PHSA, and reviewed and finalized in consultation with stakeholders and Indigenous leadership. The survey was hosted and managed by the Public Engagement Team at the Ministry of Citizens' Services on behalf of the Review. Analysis was conducted by an independent research firm under the close direction of the Review Team.

approach and methodology, Appendix 2). The IPS was heavily promoted through the Review's social media channels, on its website, through the networks of Indigenous and non-Indigenous health care organizations, and via traditional media coverage.

The IPS solicited the following from respondents:

- Feelings of safety or lack of safety in the health system
- Perspectives on the care received
- How Indigenous people utilize systems established to address complaints
- How Indigenous-specific racism might be best addressed.

The final number of surveys available for analysis was 2,780 (full and partial completions). Sixty-five per cent of respondents identified as First Nations, 10 per cent as Métis, and five per cent as Inuit or another Indigenous people from outside of B.C. – for a total of 80 per cent Indigenous respondents.

Health Workers' Survey¹¹

The HWS was launched online on July 30, 2020 and remained open until Aug. 27, 2020. (Survey, Appendix 3; Survey approach and methodology, Appendix 2). It was designed to seek feedback on the issue of Indigenous-specific discrimination in the health care workplace, and was expanded to solicit the views of the non-Indigenous racialized population on this topic. The HWS was heavily promoted through the Review's social media channels, on its website, through the networks of health regulators and via traditional media coverage.

The HWS solicited the following from respondents:

- Experience of racism towards health care users, and in health care settings
- Experiences of racism among health workers
- The responsiveness of the health care system to dealing with discrimination
- Presence of relevant training in health workers' education
- Cultural safety in the workplace

¹¹ The HWS was developed by the Review Team based on an instrument designed by Fraser Health, and was reviewed and finalized in consultation with stakeholders and Indigenous leadership. As with the IPS, the HWS was hosted and managed by the Public Engagement Team at the Ministry of Citizens' Services on behalf of the Review and analysis was conducted by an independent research firm with direction from the Review Team.

- Improvement of cultural safety in health care for both users and health workers.

The final number of HWS surveys available for analysis was 5,440 (full and partial completions). Just over 70 per cent of respondents were non-Indigenous and not from a racialized population (NINR); 22 per cent identified as racialized; and seven per cent were Indigenous (4% First Nations, 3% Métis and 1% Inuit). Eighty per cent of respondents were female (a similar percentage to what is seen in the provincial health care system), and the majority had worked in health care for more than 10 years.

Toll-free Telephone and Email Submissions

A toll-free telephone line and email inbox collected histories from both Indigenous and non-Indigenous respondents, including patients, family members and caregivers, health care workers, third-party witnesses and others.

The toll-free line and email inbox were both launched on July 9, 2020. Callers utilizing the toll-free line were prompted to record a submission of up to 20 minutes in length, or leave contact information for a member of the Review Team to return their call and take their submission by telephone. All submissions were recorded on a spreadsheet that included 28 categories, ranging from the health authority in which the incident occurred, to the health care provider(s) involved, to the outcome for the patient. The spreadsheet also included an open text field where key details of specific cases were logged.

4.2 External Data Sources

The Review collected large amounts of data from a number of sources. As the Independent Reviewer and a small number of team members were provided delegation under the *Ministry of Health Act*, confidential complaints and other row-level data from various sources were available to be examined.

Data Linkages

Much of the quantitative Indigenous-specific data in this report related to health system utilization and health outcomes have been sourced from databases which were linked to population registries that are specific to B.C. First Nations or Métis populations:

- The FNCF: a cohort of B.C. resident First Nations people registered under the *Indian Act*, and their unregistered descendants for whom entitlement-to-register can be determined, linkable through their B.C. Ministry of Health Personal Health Number (PHN).

- The MNBC Métis Citizenship Registry (MCR): a database of all those people who apply and meet MNBC criteria to be considered Métis citizens, and who have agreed to have their information, including PHN, used for data linkages purposes.

Linked databases which are included in this report are:

a) Health System Matrix

The Health System Matrix (HSM) is a provincial database that summarizes how people use provincial health services every year. The HSM divides the B.C. population into population groups according to their utilization of available sources of health services and includes approximately 70 per cent of all provincial health expenditures for individuals who have chosen/been able to access health services.

b) B.C. Chronic Disease Registry

The B.C. Chronic Disease Registry uses a standardized methodology based on administrative data, mainly from hospital and physician records, to estimate the prevalence rate of individual chronic conditions in a population.

c) Canadian Institute for Health Information (CIHI) Population Grouper (PG)

CIHI's Population Grouping Methodology uses data from multiple sectors to create clinical profiles and to predict the entire population's current and future morbidity burden and health care utilization. The population grouping methodology starts with everyone who is eligible for health care, including those who have not interacted with the health care system. It uses diagnosis information from hospital and physician services over a two-year period to create health profiles of 227 health conditions.

d) Perinatal Services BC (PSBC)

PSBC collects and analyzes data on delivery, postpartum transfer/readmission, newborn, and newborn transfer/readmission records submitted to PSBC's British Columbia Perinatal Data Registry. The registry captures >99 per cent of deliveries and births that occur in the province. Records used to generate this report meet the following conditions:

- Mother delivery and baby newborn records are linked. Unlinked mother delivery or newborn records are excluded (<0.2 per cent of babies are not linked to a mother)
- Complete late terminations are excluded from all indicators except the crude stillbirth rate; pregnancies involving selective fetal reduction are retained.

e) Opioid

Illicit drug toxicity overdose death data is obtained from the BC Coroners Service, Drug and Poison Information Centre, BC Emergency Health Services/Ambulance Service and Emergency Department (ED) visits at hospitals across B.C. It includes confirmed and suspected illicit toxicity deaths. The illicit drug toxicity category includes the following:

- Street drugs (controlled and illegal drugs: heroin, cocaine, MDMA, methamphetamine, illicit fentanyl, etc.)
- Medications not prescribed to the decedent but obtained/purchased on the street, from unknown means or where origin of drug not known
- Combinations of the above with prescribed medications.

The Provincial Overdose Cohort is a collection of linked administrative data on overdose events that are combined with data about prescription medications, social assistance programs, mental health service utilization, provincial incarceration history, and overall health care use. It includes information on a 20 per cent random sample of the general B.C. population, and a 65 per cent random sample of First Nations persons.

f) COVID-19

First Nations and Métis data on COVID-19 cases are obtained via data linkages with COVID-19 data, which is collected by the BC Centre for Disease Control from all health authorities.

g) Supplemental Data

Additional data were obtained through linkages with the Discharge Abstract Database (DAD), National Ambulatory Care Reporting System (NACRS) and Medical Services Plan (MSP) billings for defined indicators.

Regional Health Survey

The *Regional Health Survey (RHS)* is a national survey that is collected, controlled and shared by First Nations. It captures the self-reported health and wellness status of at-home First Nations peoples in B.C. The *RHS* has been completed nationally three times: Phase 1 in 2002-03, Phase 2 in 2008-10 and Phase 3 in 2015-17. It is regionally (i.e., provincially) administered by representative First Nations organizations (FNHA in B.C.) who steward the data on behalf of participating communities.

The data collection methodology uses randomly selected status individuals on the band list of a First Nation community who are living in that community at

the time of the survey. These selected individuals are all First Nations. In the third survey cycle, over 5,700 First Nations (including 3,026 adults) participated from 122 B.C. First Nations communities.

Patient-Reported Experiences Measurement Survey

Since 2003, the Ministry of Health and regional health authorities have implemented a program to measure the self-reported experience of patients in a range of health care sectors using Patient-Reported Experience Measurement Surveys (PREMS). The surveys are conducted province-wide and in a number of health care sectors including acute inpatient (IP) hospitals, EDs, outpatient cancer care services, mental health in-patients and long-term care facility residents. Patient-reported experience measures surveys include Indigenous self-identifier variables.

San'yas Indigenous Cultural Training Program

The San'yas Indigenous Cultural Safety training is an online training course provided through the PHSA to health providers in B.C. One component of the training is a discussion board to which participants are asked to contribute their perspective on stereotyping of Indigenous people. Almost 40,000 responses were received by the Review to the following questions in the discussion board:

- a. Have you ever encountered negative stereotyping of Indigenous people? If so, describe. If not, extend yourself beyond the work setting and think of any examples of negative stereotyping you might have encountered elsewhere.
- b. How did it impact the service the Indigenous person received?

BC Patient Safety and Learning System

Each of the five regional health authorities (and the PHSA) have a Patient Care Quality Office (PCQO) that serves as a point of contact to investigate concerns about services delivered through the health authority. PHSA houses the BC Patient Safety & Learning System (BCPSLS) and is responsible for maintaining the web-based tool that PCQO staff in the health authorities use to log complaints, and managing the subsequent data that are created. A search was undertaken by BCPSLS to identify complaint records from 2016 to 2020 that involved Indigenous patients, and were provided to the Review for analysis.

FNHA

Patient complaints which were received by the FNHA since its inception in 2013 were forwarded to the Review. These complaints were from various health service sectors – FNHA-administered services, band-administered services and provincial health services.

Regulated Health Colleges

The College of Physicians and Surgeons of BC, College of Dental Surgeons of BC, B.C. College of Nurses and Midwives, and the College of Psychologists of BC provided records relating to complaints which were identifiable as involving an Indigenous patient or health worker.

4.3 Limitations of the Data

This Review has taken place during a world-wide pandemic, with significant government and societal measures imposed to protect the health of the population. The work undertaken by the Review Team has been largely through virtual means.

Due to the urgency of the issue of racism and discrimination within the health care system, and its potential for deleterious effects on patients and others interacting with these services, the Review had a short and ambitious time frame, with the period between its initiation and the submission of initial reports only five months.

Undoubtedly, a longer time frame would have resulted in a larger sample size from the surveys and toll-free/email streams. If the Review had the benefit of engaging in direct interviewing with Indigenous peoples, especially Elders, a more complete picture may have emerged of their experiences. Due to the limitations of COVID-19, there were restrictions that required the Review team to use technology and engage effectively through organizations and in collaboration with service providers and Indigenous organizations.

It was hoped by the Review Team that First Nations and Métis experiences from the IPS could be reported separately. The small number of Métis respondents (10% of the total), and extremely few representatives of Inuit and other Indigenous peoples from outside of B.C. (5%) meant that it was not possible to undertake meaningful analyses due to the low numbers which resulted within and across questions. It was necessary to combine all Indigenous groups together (total of 80% Indigenous) to create a large enough population to allow for statistical analyses, despite their significant cultural, historical and linguistic differences.

The comparatively low numbers of Métis in B.C. have also limited Métis-specific analysis of other data sources in this Review which describe health service utilization and health outcomes. The MCR used for data linkages includes only a portion of the total Métis population. The Other Resident population of B.C. in the Métis analysis included First Nations and the Métis who are not part of the MCR, thus limiting the interpretation of any observed differences in rates between Métis and Other Residents.

The surveys were hosted by the B.C. government's Ministry of Citizens' Services, and this peripheral government involvement might have been seen as a barrier to some Indigenous peoples, even though the Review was fully independent and no information or findings were shared.

While the Review undertook efforts to raise awareness of its surveys and make them as accessible as possible to anyone who wanted to participate, it is important to note that these samples were self-selected and should not be interpreted as being representative of the B.C. population, or the population of health care workers in the province. As such, the findings cannot be interpreted as fully indicative of either Indigenous people or health care workers in B.C. as a whole. The findings have been made utilizing the surveys along with many other data sets and lines of inquiry.

Other limitations which are specific to the data analysis have been included in Appendix 4.

4.4 Privacy and Data Governance

All data and information arising from the Review, including surveys, individual incidents and testimonials, interviews, submissions and analysis of pre-existing sources of information, were subject to rigorous privacy protections.

The Independent Reviewer is the data steward and custodian of all data created as a result of this Review, on behalf of the Indigenous peoples of B.C. who own the data collectively. All members of the Review Team provided written undertakings of confidentiality prior to their involvement.

Data and other materials collected through surveys, interviews, telephone and email have been held securely by the Review Team. The data linkage products created for the use of the Review will be destroyed six months after the conclusion of the Review. All other materials will subsequently be sealed, and will not be available for any use, including further analysis, editing, research or publication.

4.5 Statistical and Analytical Tools

Metrics

The statistical measures used in this report are generally based on rates; e.g., the number of respondents to a question (e.g., number answering a question/total number of respondents), the number of users of a service (e.g., # users per 100 population), the number of cases of hospitalization (# cases per 1,000 population), the number of encounters of a user (e.g., # visits per user), and the prevalence rate of registrants in a health condition registry or database (# registrants per 100 population).

Confidence Intervals

Throughout this report, the difference between First Nations and Other Residents or between fiscal years, has been expressed through observation of rates (e.g., #users of a service per 100 population). Confidence Intervals (CIs) have been used to determine if a real change in rates has occurred or if the observed change is due to chance alone. A CI is a statistical technique that measures the range of population values. A 95 per cent CI means that 19 times out of 20, the true value lies within the range of values established by the CI (e.g., 0.75 ± 0.08 , meaning a range of 0.67 to 0.83). If, for example, when comparing a First Nations rate with a non-First Nations rate, the intervals of these two rates do not intersect, then real change has occurred with 95 per cent confidence. (Note: this is a conservative application of CIs, as the technique cannot establish with certainty, non-significance with respect to rates in some situations where a certain degree of intersection is observed.)¹²

Chi Square

The chi-square statistic compares the size of any discrepancies between expected results and the actual results, given the size of the sample and the number of variables in the relationship. In this report, significance has been concluded for p values < .05. In particular, it has been used to assess the association between responses to a question on racism, and the same survey's responses to questions on health and well-being, and to assess significance of other selected indicators (e.g., opioid).

¹² In the Review survey analyses, the analysts noted that overlap of CIs does not guarantee non-significance; it largely depends on the size of the overlap. The size of this overlap was assessed by a p value estimate. For example, if the upper 1% CI of one point estimate overlaps with the lower 1% CI of another point estimate, there could be a significant chance that the true means for both of these point estimates are the same (about a 1 in 3,600 chance). There was a concern that applying a more conservative test to this particular research may be perceived as requiring a higher standard of evidence from Indigenous voices than the general population. For this reason, the Review survey responses' CIs were further assessed using p values, and significance ($p < .05$) determined on this basis.

Age Standardization

In all comparisons between two populations (e.g., First Nations and Other Residents, or Métis and Other Residents) which have been based on the total population, rates have been age-standardized (a/s) to the Canadian population, unless otherwise noted.

Small Cell Values

This report has followed the Review's policy on privacy to ensure confidentiality of reported data and limit the possibility of small cell counts leading to unreliable estimates of the true measures in a population. Accordingly, all data have been suppressed if the observations are below 11 (or 21, if referring to the population from which the observations were drawn) to reduce the potential for identification and increase reliability of analyses.

Qualitative Analysis

The qualitative analyses of Review Intake, San'yas discussion board, and complaint data were completed using NVIVO software. For larger data sets, a representative sampling of the data was undertaken. The analysis began with detailed inductive coding of a sample of each data holding. Each narrative was read several times before being closely coded to reflect core content and concepts. Sub-themes were developed from these codes through an iterative process of comparing and contrasting similarities, differences and relationships between and within codes. These sub-themes were then grouped into broad themes. The relevance and fit of these themes and some sub-themes were confirmed with the Review Team. The resulting coding structure was then applied to the summaries of the remaining cases and informed the analysis of the other qualitative data sets, which utilized a combined inductive and deductive approach.

5. Findings: Surveys and Qualitative Data Sources

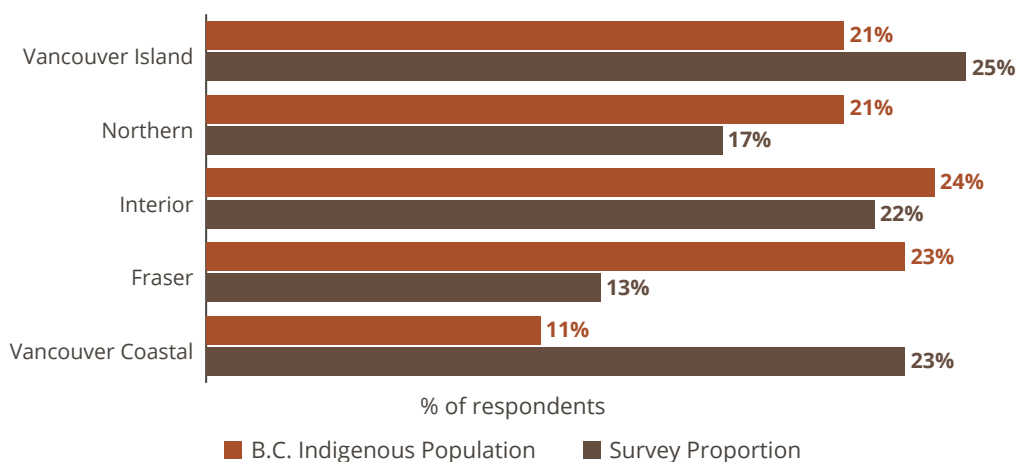


5.1 Indigenous Peoples' Survey

Profile of Respondents

- Figure 4 below illustrates the sample and population breakdown for Indigenous people in B.C., by region. In three regions, the Indigenous proportion of the B.C. population was greater than their proportion of survey respondents. The largest differences were in Fraser region (population was under-represented in survey respondents) and Vancouver Coastal region (over-represented).¹³
- A majority of Indigenous respondents reported living in an urban area (59%), while 33 per cent reported living in a rural or small rural area. A small minority reported living in a remote area (8%). Indigenous respondents were more likely to report living in a small rural or remote area than non-Indigenous respondents, and also were less likely to live in urban areas.

Figure 4: Respondents by Region



Review, 2020

- Among Indigenous respondents, 15 per cent were 29-years-old or younger, while 44 per cent were 30- to 49-years-old, and 42 per cent were 50 years or older. While age categories are not strictly comparable with the Census of the B.C. Indigenous population, overall it appears that young Indigenous people (under 30-years-old) were under-represented among survey respondents, while older Indigenous people (ages 50 and over) were over-represented.

¹³ Source: Statistics Canada 2016 Census Population Data. Retrieved from <https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/search-recherche/change-geo.cfm?Lang=E&Geo1=HR&Code1=5911&Geo2=PR&Code2=59&SearchText=East%20Kootenay%20Health%20Service%20Delivery%20Area&SearchType=Begins&SearchPR=01&B1=Aboriginal%20peoples&TABID=1&G=1&type=0>

This may reflect the fact that, as people age, they have more interactions with the health care system and therefore may have been more motivated to participate in this survey.

- Indigenous respondents were more likely to visit the ED, and less likely to visit general practitioners compared to non-Indigenous respondents.

Feelings of Safety

The first questions of the survey delved into how safe Indigenous people feel in health care settings, with providers and when receiving services. Respondents could answer “*completely safe*,” “*somewhat safe*,” “*somewhat unsafe*,” or “*not at all safe*.” In general:

- Indigenous respondents were significantly more likely to report feeling unsafe, and significantly less likely to report feeling safe, in the health care system compared to non-Indigenous respondents. This was a fairly consistent trend that was found across a variety of health care settings, services and providers.
- Gender had a significant impact on feelings of safety among Indigenous respondents. Women were the least likely to report feeling “*completely safe*” in most health care settings, services and providers, while two-spirit, non-binary and other-gendered individuals were most likely to report feeling “*completely safe*”.
- Age and region of residence did not have significant impacts on feelings of safety among Indigenous respondents.

Health Care Settings

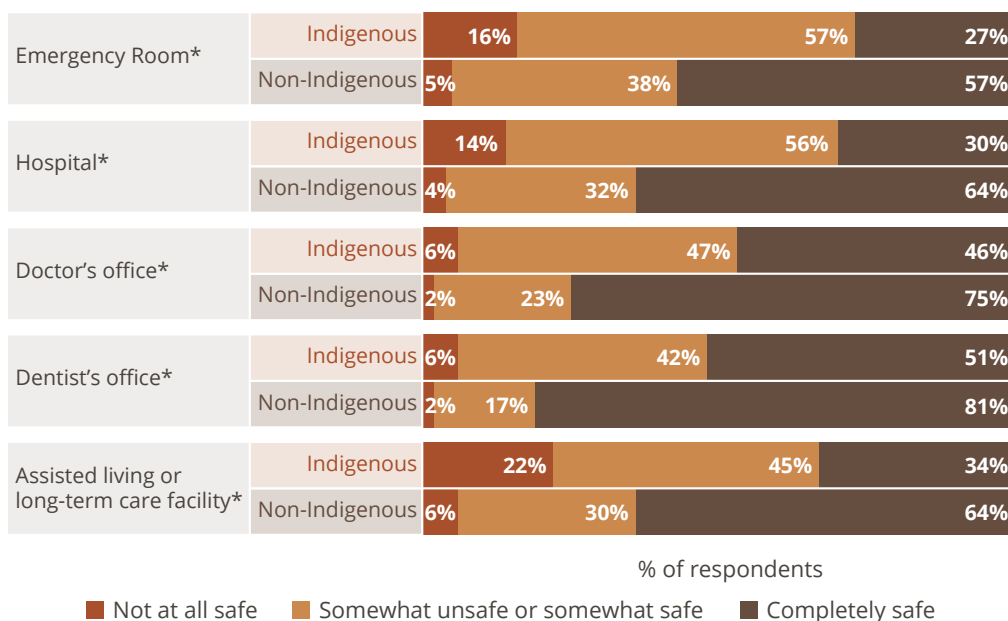
Indigenous respondents were significantly more likely to report feeling “*not at all safe*” and significantly less likely to report feeling “*completely safe*” in all health care settings included in the survey: EDs, hospitals, doctors’ offices, dentists’ offices, mental health clinics and assisted living or long-term care facilities. In most settings, Indigenous respondents were three to four times more likely to report feeling “*not at all safe*” than non-Indigenous respondents (Figure 5), with rates as high as 22 to 23 per cent for assisted living and long-term care facilities, and mental health facilities.¹⁴

Feelings of being “*completely safe*” varied from 27 per cent (ED) of Indigenous respondents to 51 per cent (dentist’s office); even so, the disparity with non-Indigenous respondents was large across all settings.

Interactions with social workers or Ministry of Children and Family Development (MCFD) representatives were noted by multiple Indigenous respondents as something they and/or their families are particularly fearful of when visiting hospitals or giving birth due to fears that their children will be apprehended.

¹⁴ Throughout this report, asterisks in figures denote statistically significant differences.

Figure 5: Feelings of Safety in Health Care Settings



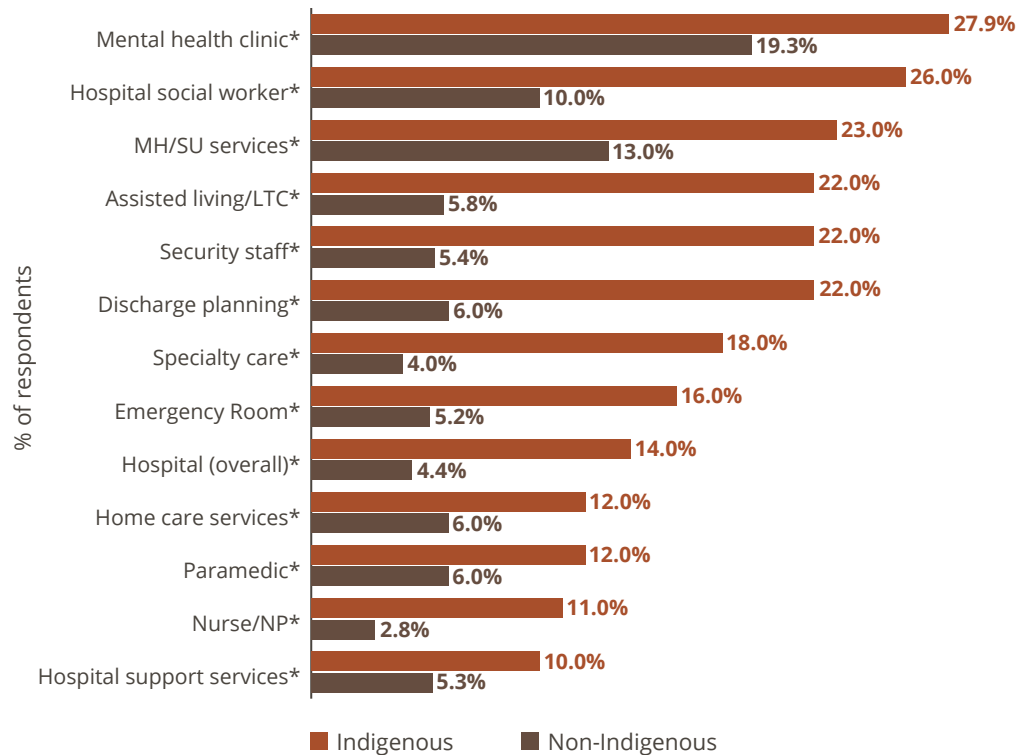
*Statistically significant differences between Indigenous and non-Indigenous rates
Review, 2020

Health Care Providers and Services

This same trend was noted among health providers and health services: Indigenous respondents were significantly more likely to feel unsafe, and less likely to feel safe, when interacting with and receiving services from a variety of health care workers. More than one in five Indigenous respondents were likely to feel “not at all safe” when interacting with hospital social workers (26%) and security staff (22%), and when using mental health or substance use services (23%) and discharge planning services (22%).

Again, similar to the views on the safety of health care settings, while the majority of non-Indigenous respondents felt “completely safe” with the identified health care providers, with the exception of family doctor and dental care provider, no health care provider was rated as “completely safe” by the majority of Indigenous respondents. When considering safety among various health care services, even among services with the highest reported rates of feeling “completely safe,” – fewer than one-half of Indigenous respondents felt “completely safe” when using these services.

Figure 6 summarizes the disparity between Indigenous and non-Indigenous responses for those settings, providers and services which had rates of 10 per cent or higher for feelings of not being safe. The biggest differences were seen in specialty care (4.5X higher rate among Indigenous respondents), security staff (4.1X), nurses/nurse practitioners (3.9X), assisted living and long-term care settings (3.8X), and discharge planning (3.7X).

Figure 6: “Not at all Safe” Responses, Indigenous, 10% or greater

*Statistically significant differences between Indigenous and non-Indigenous rates
 MH=mental health; SU=substance use; LTC=long-term care; NP=nurse practitioner
 Review, 2020

Gender

Further analysis looked at the impact of gender on feelings of safety. Among Indigenous respondents, a pattern emerged regarding feelings of safety in health care settings, providers and services: females were significantly less likely than males to report feeling “*completely safe*” in these settings, while males in turn were significantly less likely than two-spirit, non-binary and other-gendered individuals to report feeling “*completely safe*” in these settings.

Analyses were undertaken to assess the extent to which perceptions of health safety differed on the basis of gender. In general, the results of the survey suggest that overall, Indigenous females were less likely to feel safe in almost all health situations as compared to males. However, it is interesting to note that two-spirit, non-binary, and other-gendered respondents generally felt safer than either male respondents or female respondents in the identical health care settings and/or interactions with health professionals.

Age

All age groups within Indigenous respondents indicated similar patterns of feeling “*completely safe*” and “*completely unsafe*” in various health care

settings. Across all age groups, respondents felt least safe in mental health facilities, when interacting with hospital social workers and security staff at health care facilities, and when using mental health services and discharge planning services. Again, across all age groups, respondents felt most safe with traditional healers, and when receiving home care services, public health services, and hospital support services.

There was one notable difference among age groups regarding feelings of safety. Younger respondents (ages 29 and younger) reported that assisted living facilities and long-term care homes are among the places they feel most safe (59% reported feeling “*completely safe*”) while this setting was one of the places that older Indigenous respondents (30 to 49 years, and 50 years and older) felt least safe. The sample size for young people commenting on feelings of safety in these facilities was small (n=56), likely due to limited exposure to these settings among younger people, which may have influenced their perceptions of these facilities as well as the statistical power of the sample available in this data set.

Region

There were very few significant differences in feelings of safety among Indigenous respondents by region residence, and no trends that stood out within the data. Across all regions, Indigenous respondents reported feeling least safe in mental health facilities and long-term care facilities, when interacting with hospital social workers and building security staff, and when receiving mental health or substance use services, and discharge planning services. In contrast, across most regions, Indigenous respondents felt most safe: at First Nations or Métis health care clinics and other health offices; when interacting with traditional healers, family doctors or dentists; and when using public health services and hospital support services.

Care Experiences

A series of survey questions asked respondents about their experiences when receiving health care (i.e., how staff interact with respondents).

Multiple survey comments mentioned they had overheard themselves being referred to as “*frequent flyers*” among health care workers.

Respondents were asked a series of subjective experience questions, such as how often respondents felt that they were treated with respect and courtesy, involved in care decisions, insulted or harassed, treated with disrespect, or other issues related to the care they received at the time. Across most of these items, there were large and statistically significant differences between Indigenous and non-Indigenous respondents. Indigenous respondents were significantly more likely to report:

- “Never” being treated with the same respect and courtesy as other people (7%) and “never” being included in care decisions (11%)
- “Always” receiving poorer service than other people (23%), being treated as though they are dishonest (24%), being insulted or harassed (8%), being treated as if they are drunk or being asked about substance use (26%), being treated as though they are bad parents (14%), and having health staff stare, whisper, or point (13%).

Many survey respondents reported that health care staff assumed they were drunk or high when presenting to an Emergency Room or a paramedic. They also reported being asked repeatedly about drug and alcohol use within a single visit, with negative answers being disbelieved or ignored.

Although the percentages of Indigenous respondents who reported “always” having adverse experiences was variable, the proportional differences between Indigenous and non-Indigenous respondents were large and ranged from four to eight times more likely across all items for Indigenous respondents. Figure 7 illustrates these differences.

Gender

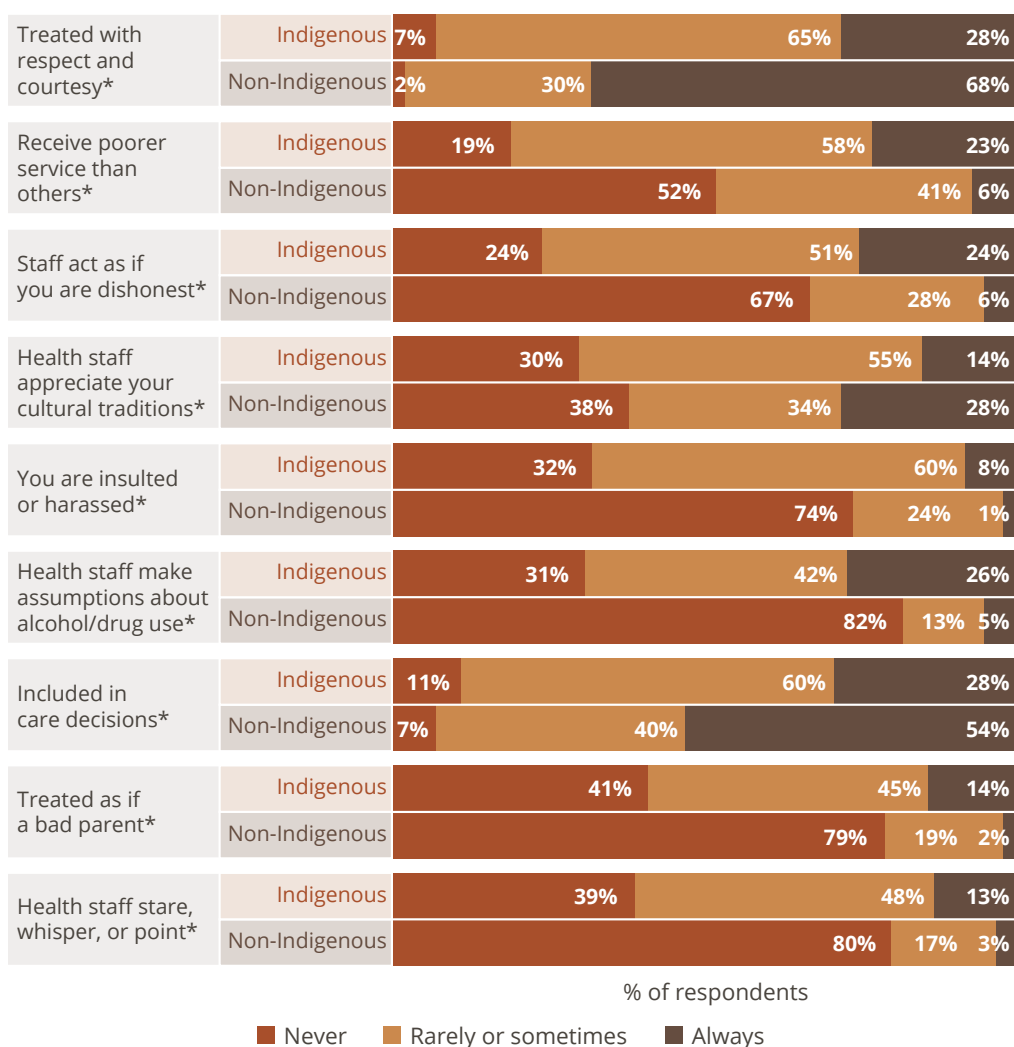
Among Indigenous respondents, gender was significantly associated with care experiences. A consistent trend emerged from the data:

- Female respondents were less likely to report positive experiences than males, and more likely to report negative experiences than males
- Two-spirit, non-binary and other-gendered respondents appeared to have the most positive experiences, being most likely to report “always” having positive experiences and “never” having negative ones.

Even among the most positive experiences, comparatively low proportions of Indigenous respondents reported experiencing these outcomes. Among females, the top Indigenous response – “always” feeling involved in their care decisions – was only 23 per cent.

Age

Overall, younger respondents (those ages 29 and younger) tended to be more likely to report “always” having positive care experiences, and “never” having negative care experiences, compared to middle-aged respondents (ages 30 to 49). There were no trends or significant differences among older respondents (ages 50 and over); this group did not differ significantly from the other age groups.

Figure 7: Subjective Experiences of Receiving Care

*Statistically significant differences between Indigenous and non-Indigenous rates
Review, 2020

Region

In most of these items, all regions had similar results to the province-wide analysis. Some region-specific differences were noted in:

- Being significantly more likely to report receiving poorer service than others at least occasionally (“rarely”, “sometimes”, or “always”)
- Being significantly more likely to report being treated as though they are dishonest at least occasionally (“rarely”, “sometimes”, or “always”)
- Being significantly more likely to report having staff make assumptions about alcohol or drug use at least occasionally (“rarely”, “sometimes”, or “always”).

Care Outcomes

Respondents were asked about the outcomes they typically experience from their health service interactions. Indigenous respondents were significantly less likely to report positive care outcomes when receiving health care compared to non-Indigenous respondents, with rates for “*always*” experiencing various positive care outcomes varying from 17 per cent to 36 per cent, compared to a range of 31 per cent to 71 per cent for non-Indigenous respondents. Specifically, Indigenous respondents were:

- Significantly less likely to report “*always*” receiving a proper diagnosis, getting medication when needed or requested, waiting the same length of time as anyone else to be seen by health staff, receiving a proper referral, receiving a thorough discharge process, feeling like their needs were taken seriously, receiving permission to practise traditional medicine, and receiving overall great care
- Significantly more likely to report “*never*” to the following statements: receiving medication when needed or requested, waiting the same length of time as anyone else to receive care, receiving a proper referral, receiving a thorough discharge process, feeling like their needs were taken seriously, receiving agreement to practise traditional medicine, and receiving great overall care.

Whereas the majority of non-Indigenous respondents indicated that for almost all interactions, they “*always*” received appropriate service (with the exception of a proper diagnosis), there was not one issue where the majority of Indigenous respondents felt that they “*always*” received the appropriate service. In fact, in most cases, less than one-third of Indigenous respondents felt they “*always*” received the appropriate service.

Multiple Indigenous respondents shared stories of family members’ symptoms not taken seriously by health care staff.

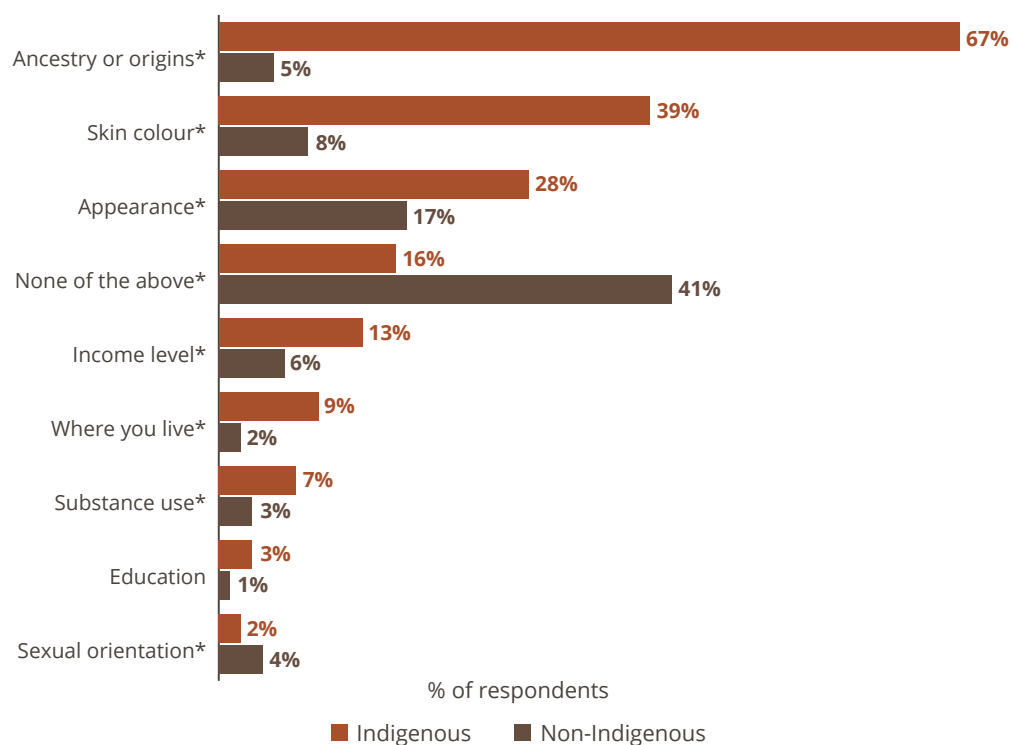
Two-spirit, non-binary and other-gendered respondents were most likely to report “*always*” receiving positive outcomes, at rates which were about two times higher than female respondents. Male respondent rates were midway between the female respondents and two-spirit, non-binary and other-gendered respondents.

Age also showed differences in the outcome data. Older respondents (50-plus years) were most likely to report “*always*” experiencing a variety of positive outcomes, at a significantly higher rate than middle-age respondents (30 to 49 years).

Interactions with Health Care Workers

Indigenous survey respondents were significantly more likely to report having experienced or witnessed racism against Indigenous people in the B.C. health care system. Further, 67 per cent of Indigenous respondents reported that they had experienced discrimination from B.C. health care staff in the past based on ancestry or origin, compared to just five per cent of non-Indigenous respondents. Other top factors attributable to discriminatory behaviour were skin colour (39%), appearance (28%) and income level (13%).¹⁵ (Figure 8)

Figure 8: Experiences of Discrimination Based on Different Factors, Indigenous Compared to Non-Indigenous



* Statistically significant differences between Indigenous and non-Indigenous rates
Review, 2020

Perceptions of Equity

In response to a question on perceptions of equity in health care, Indigenous respondents were:

- Significantly more likely to report that Indigenous people are “never” treated fairly in the health system, providers “never” want to work with or provide quality, safe care for Indigenous people, providers are “never” open to hearing about traditional medicine, there are “never” enough Indigenous

¹⁵ Respondents were asked to select their top three experiences related to discriminatory behaviour.

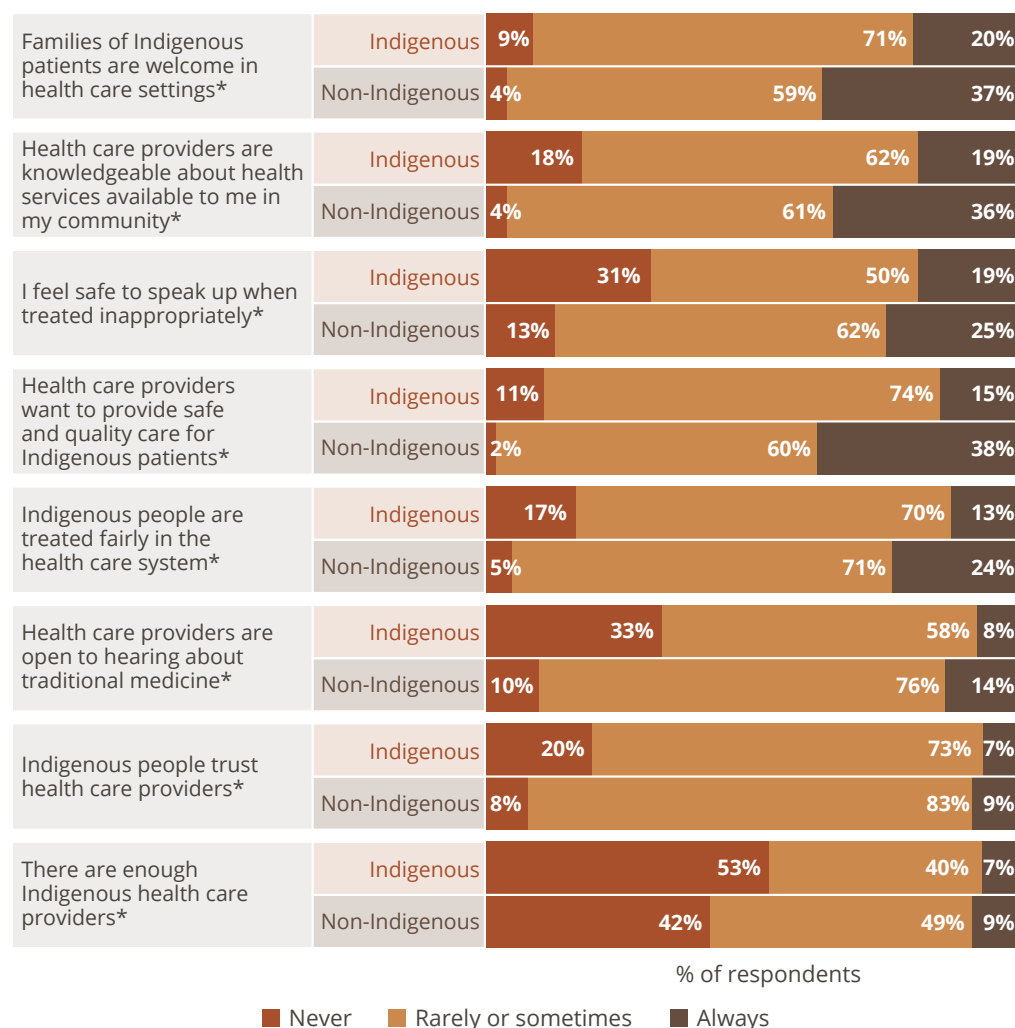
health care providers, and Indigenous families are “never” welcome in health care settings

- Significantly more likely to report “never” feeling safe to speak up when they are being treated inappropriately by a health care provider, and that health care providers are “never” knowledgeable about health care options in the community that are available to them.

Overall, the top three issues among Indigenous respondents included:

- Not having Indigenous health care providers
- Openness of health care providers to hearing about traditional medicine
- Feeling safe to speak up when treated inappropriately. (Figure 9)

Figure 9: Perceptions of Equity in Health Care, Indigenous Compared to Non-Indigenous



*Statistically significant differences between Indigenous and non-Indigenous rates
Review, 2020

Gender

Female respondents had very low perceptions of equity in the health care system, compared to male and other-gendered respondents.

Among Indigenous respondents, female respondents were significantly less likely than male respondents to positively rate equity for Indigenous people in the health care system. In turn, male respondents rated equity in the health care system significantly poorer than two-spirit, non-binary or other-gendered respondents.

Strikingly, less than 10 per cent of Indigenous female respondents believed that:

- Indigenous people are “*always*” treated fairly in the health care system
- Health care workers “*always*” want to work with and provide quality, safe care for Indigenous people
- Health care providers are “*always*” open to hearing about traditional medicine
- Indigenous people “*always*” trust health care providers
- There are “*always*” enough Indigenous health care providers.

Female Indigenous respondents were significantly more likely than males and other-gendered respondents to report having been discriminated against by health care workers on the basis of their ancestry or origins, their age, their skin colour, and their appearance. Females and two-spirit, non-binary or other-gendered respondents were equally likely to report having been discriminated against on the basis of their gender, and two-spirit, non-binary and other-gendered respondents were significantly more likely than males or females to report having been discriminated against on the basis of their sexual orientation.

Age

Age had a significant impact on only a few items related to perceptions of equity in the health care system among Indigenous respondents. In general, respondents in the middle age group (30 to 49 years) were least likely to report positive perceptions of equity. This age group was least likely to agree that:

- Indigenous people are “*always*” treated fairly in the health care system
- Health care providers “*always*” want to work with and provide quality, safe care to Indigenous people

- Indigenous people “always” trust health care providers
- Respondents “always” feel safe to speak up when they are being mistreated by health care workers.

Age also had some significant impacts on experiences of discrimination in the health care system. Younger respondents (ages 29 and younger) were significantly less likely to report that they had been discriminated against based on a variety of factors, including their ancestry or origins, disability, skin colour, or appearance. However, this younger cohort was more likely to report experiencing discrimination based on their gender, age, or substance use.

Region

There were some differences in perceptions of care equity and experiences of discrimination among Indigenous respondents by region.

For the most part, similar proportions of respondents reported “always” having equitable experiences in the health care system across different regions. On most items, however, respondents from the Fraser region were significantly more likely to report “always” seeing equitable treatment compared to respondents from Northern and/or Vancouver Island regions. This was true for the following items:

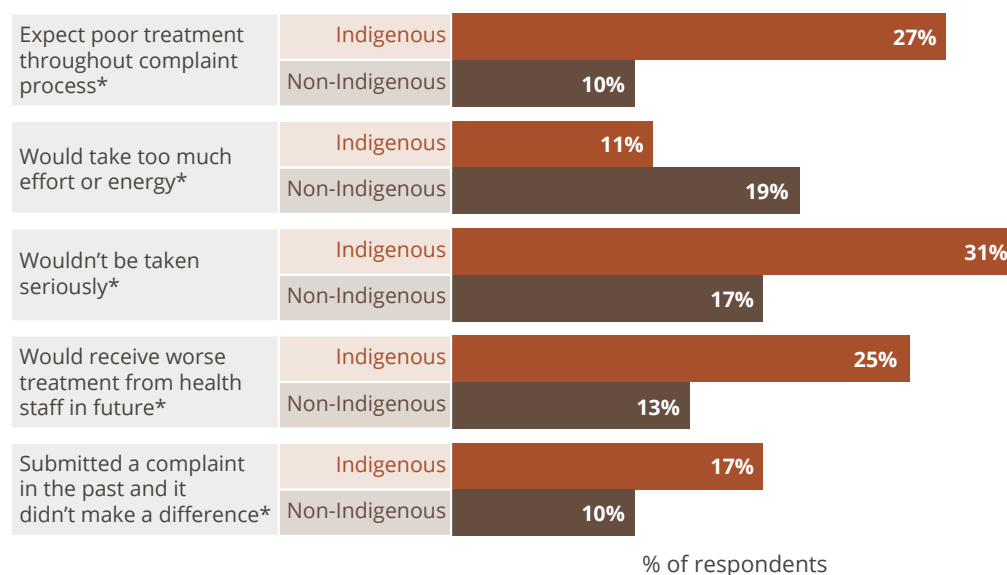
- Indigenous people are treated fairly in the health care system
- Health care providers want to work with, and provide safe quality care for, Indigenous people
- Health care providers are open to hearing about traditional medicine
- Indigenous people trust health care providers
- There are enough Indigenous health care providers
- Respondents feel safe to speak up about mistreatment by health care staff
- Families of Indigenous patients are welcome in health care settings.

Respondents from the Fraser region were significantly less likely than those from Northern and Vancouver Island regions to report having been discriminated against on the basis of their ancestry or origins, and significantly more likely to report “never” having experienced any discrimination based on the 15 factors listed in the survey.

Making Complaints

When asked about making complaints regarding poor treatment in the health care system, Indigenous respondents were significantly less likely to report being willing to make complaints, and significantly more likely to cite a number of barriers to filing a complaint if they had grounds to do so (Figure 10).

Figure 10: Barriers to Making a Complaint



**Statistically significant differences between Indigenous and non-Indigenous rates Review, 2020*

While there were some significant differences by gender in willingness to make a complaint if treated poorly (women less likely than other gender groups) and by age (respondents age 50 and older more likely than other age groups), there were no major differences in barriers to making complaints. Across all group types, Indigenous respondents encountered similar barriers. The three biggest barriers to making a complaint when one is warranted were: believing one would not be taken seriously or believed; expecting to be treated poorly or unfairly throughout the complaint process; and thinking it would not make a difference.

Region residence had no significant impact on Indigenous respondents' likelihood to make a complaint if they experienced poor treatment in the health care system. Across all regions, approximately 40 per cent of respondents reported they were "very likely" to make a complaint in such a circumstance.

Region also had no significant impacts on barriers to making complaints. Across all regions, similar issues were cited as among the top barriers to making a complaint when one is warranted: believing it would not make a

difference; expecting to be disbelieved or not taken seriously; and expecting to receive poor treatment throughout the complaint process.

Strategies to Improve Health Care for Indigenous People

Survey respondents were asked to rate the relative importance of various interventions or strategies in efforts to improve health care for Indigenous people in B.C. Across nearly all items or potential strategies listed, Indigenous respondents were significantly more likely to rate the items as *“very important”* and significantly less likely to rate the items as *“not at all important”*. There was one item for which both Indigenous and non-Indigenous respondents were similarly supportive: 41 per cent of non-Indigenous respondents, and 48 per cent of Indigenous respondents (differences not statistically significant) believed it was *“very important”* to collect data on Indigenous people, such as asking patients to self-identify as Indigenous. (Figure 11)

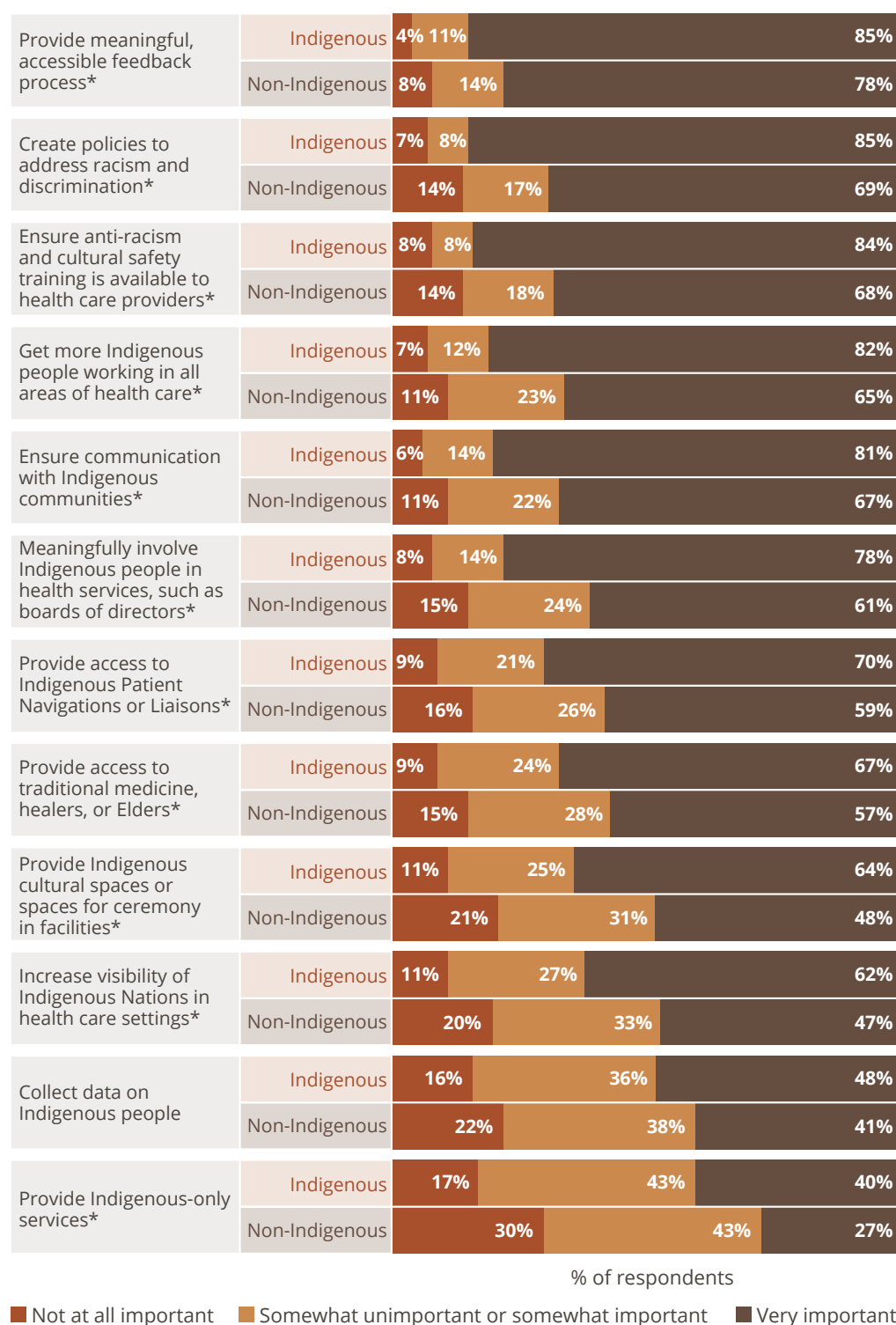
Further, large majorities of Indigenous respondents rated all strategies as *“very important”* (support ranged from 62% for increased visibility of Indigenous Nations in hospitals and health offices, to 85% for providing accessible, meaningful and safe feedback processes and creating policies to address racism and discrimination), with the exception of two items. As noted above, fewer than one-half of all respondents (Indigenous and non-Indigenous) believed that collecting data on Indigenous patients was important to improving health care for Indigenous people in B.C. In addition, fewer than one-half of all Indigenous respondents (40%), and approximately one-quarter of non-Indigenous respondents (27%) felt that providing Indigenous-only services was *“very important”* in improving health care experiences for Indigenous people. Non-Indigenous respondents were also significantly more likely, across all strategies listed, to rate interventions as *“not at all important”* compared to Indigenous respondents, with non-Indigenous respondents being most likely to rate visible signs of Indigenous people or culture (i.e., Indigenous cultural spaces, Indigenous-only services and visibility of Indigenous culture in health care settings) as *“not at all important”* compared to the majority of other items listed.

Gender and Age

All genders and ages had similar responses to the suggested strategies for improvement in the B.C. health care system, with *“very important”* rates from 60 per cent to 85 per cent supporting the need for cultural safety training, greater Indigenous representation in health care, anti racism/discrimination policies, Indigenous navigators, access to traditional medicine, meaningful involvement in health services, cultural spaces and other cultural expressions

in health services, and a safe and accessible feedback process. There was lesser support for Indigenous-only services and the collection of data on Indigenous people.

Across all age groups, non-Indigenous respondents were significantly more likely than Indigenous respondents, across all strategies listed, to rate interventions as *“not at all important”*, with the highest non-Indigenous rates for actions which refer to visible signs of Indigenous people or culture (i.e., Indigenous cultural spaces, Indigenous-only services and visibility of Indigenous culture in health care settings).

Figure 11: Importance of Various Strategies to Improve Health Care for Indigenous People, Indigenous Compared to Non-Indigenous

*Statistically significant differences between Indigenous and non-Indigenous rates

Review, 2020

Survey respondents were asked two open-ended questions regarding racism and Indigenous experiences in the health care system. The first question asked respondents what needs to change in the B.C. health care system to help Indigenous people feel safe.

The most common recommendations in these comments, from Indigenous and non-Indigenous respondents, were:

- Health care staff need to treat Indigenous patients with professionalism, and treat them as equal to any other patients (27% of Indigenous respondents, 20% of non-Indigenous respondents)¹⁶
- Health care staff need to provide compassionate and understanding treatment to Indigenous patients (21% of Indigenous respondents, 19% of non-Indigenous respondents)
- Health care staff need to undergo enhanced and/or mandatory cultural safety training to learn how to better engage with Indigenous patients (17% of Indigenous respondents, 19% of non-Indigenous respondents).

Indigenous respondents also identified other areas where health care could be improved to be safer for them. These included:

- Providing training to health care workers to counteract stereotypes and beliefs about addiction and pain tolerance among Indigenous patients (16%)
- Providing training to health care workers to counteract a tendency towards disbelieving or dismissing symptoms shared by Indigenous patients seeking care (13%)
- Integrating Indigenous practices into health care settings (12%)
- Providing additional resources to Indigenous patients to help them navigate the health care system (10%)
- Increasing responsiveness and consequences for health care staff who behave in discriminatory or abusive ways towards Indigenous patients, such as enhanced reporting and investigation mechanisms and more severe sanctions (10%).

Many Indigenous survey respondents had personal stories to tell about assumptions of addiction and under-treatment of pain. Women, in particular, reported receiving insufficient pain medication. Some reported that doctors were reluctant to prescribe any kind of opiate pain medication, even for serious injury and illness.

The second open-ended question asked respondents to share any other information they felt was important for understanding the experiences of Indigenous people in B.C.'s health care system. Many of the same themes were repeated: the need for better anti-racism and cultural safety training; the

¹⁶ Percentages in this section are based on the number of total respondents who answered the open-ended questions.

importance of compassionate and kind treatment; and pervasive patterns of health care workers disbelieving or minimizing Indigenous patients' concerns, and/or making assumptions about addictions and substance use.

Summary

Common Indigenous Experiences

- Few Indigenous people were able to report consistently positive experiences with the health care system related to their feeling of safety, interactions with health workers and care outcomes. Benchmarked against the non-Indigenous respondents, Indigenous respondents were more likely to report negatively on almost every measure included in the survey, with differences that were statistically significant.
- More than 10 per cent of Indigenous respondents reported in the open-ended questions that generally their medical concerns and symptoms were not taken seriously by health care workers. Another theme in the open-ended questions concerned poor or insufficient care, either experienced or witnessed, from health care workers directly related to assumptions about addictions and substance use. The impacts of these assumptions ranged from being asked the same question about their use of substances during a visit, to under-medicating pain due to assumptions about addictions, to taking concerns and symptoms less seriously based on the assumption that the patient was exaggerating in an attempt to get access to opioid pain medication.
- Across nearly all survey items, female Indigenous respondents reported experiencing poorer treatment and outcomes, and feeling less safe in health care settings, than Indigenous male and/or two-spirit, non-binary, and other-gendered respondents.
- While there were some differences among age groups and regions on these outcomes, there were no major trends that were consistent across a large number of survey items. This suggests that, while there may be some differences in care experiences by age or region, these differences do not represent a pervasive pattern of differential treatment and outcomes; but rather support their system-wide prevalence.

Racist Attitudes and Behaviours

- Indigenous people reported frequently encountering racism and discrimination in the B.C. health care system. Only 16 per cent of all Indigenous respondents reported never having been discriminated against for any reason listed while receiving health care.

- The large discrepancies between Indigenous and non-Indigenous patients in their reported experiences of care (e.g., being treated with respect, staff assuming drug or alcohol use) appear to corroborate these perceptions of anti-Indigenous discrimination in the health care system in B.C.

Quality of Care

- Approximately one-third of all Indigenous respondents reported “*always*” receiving the care they needed, such as: receiving a proper referral (36%); receiving needed medication (35%); receiving a thorough discharge process (31%); receiving a proper diagnosis (28%); and overall receiving great care (24%). Not only are these poor outcomes for Indigenous patients in and of themselves, but they are significantly worse than those reported by non-Indigenous respondents.

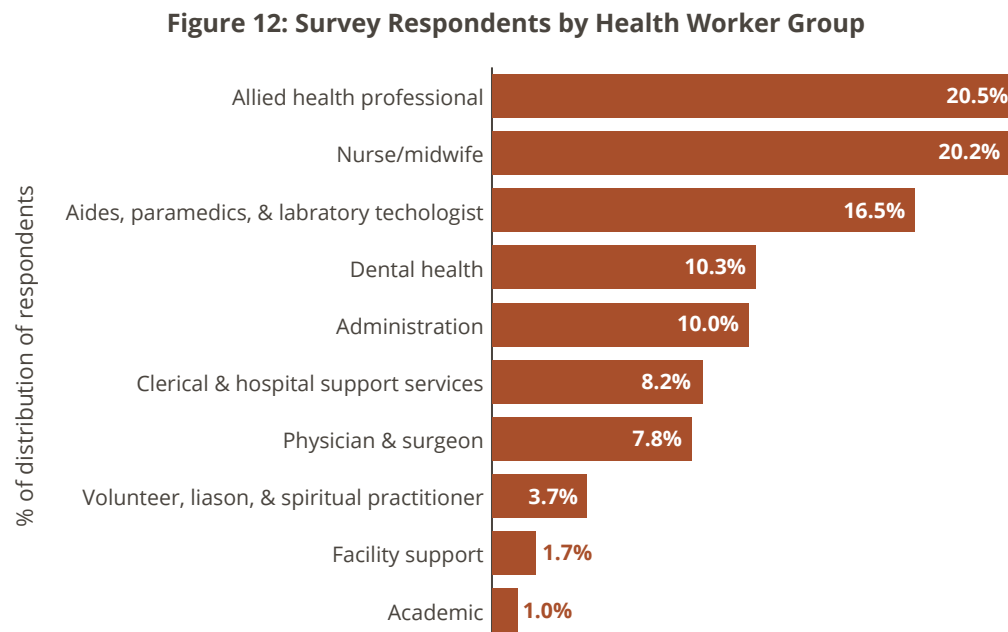
Achieving Change

- Eighty-five per cent of Indigenous respondents indicated that an accessible, meaningful and safe feedback process regarding health care experiences was “*very important*” to improving health care for Indigenous people in B.C. Among comments received in the open-ended fields, the most common themes heard from Indigenous respondents included a desire to be treated with professionalism, compassion and respect.
- Overall, Indigenous respondents tended to rate most approaches to improving Indigenous peoples’ health care experiences in B.C. as very important. The strong support for a wide variety of approaches should be interpreted as a need for a broad-ranging and wholistic approach to addressing the widespread feelings of racism in B.C. health care among Indigenous respondents who participated in this survey.
- Both Indigenous and non-Indigenous respondents emphasized the importance of providing anti-racism and cultural safety training in the workplace to counteract problems among health care workers regarding:
 - Stereotypes of Indigenous people having substance abuse issues and addictions
 - A general tendency to minimize and disbelieve health care concerns and symptoms of Indigenous people.

5.2 Health Workers' Survey

Profile of Respondents

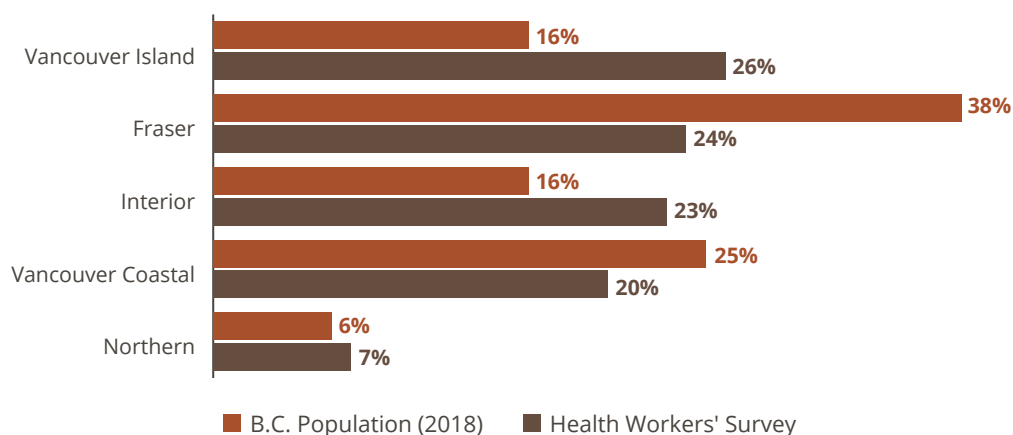
- The majority (80%) of HWS respondents were female and the remaining identified as men (19%), and as other identities (i.e., two-spirit, non-binary, transgender) (1%).
- The majority of respondents were working the health system (92%) at the time of the survey; of these respondents, 75 per cent were employed full-time and 25 per cent were employed part-time. A small proportion of survey respondents reported that they worked outside the health system (2%) or that they were students in a health professional program (3%; 59% full-time and 61% part-time). A small number of respondents reported being retired but back in the workforce (1%), currently on leave (1%), not currently working or studying (<1%), or working as a volunteer (<1%).
- The most commonly reported health worker group among survey respondents was allied health professionals (21%), followed by nurses or midwives (20%), and aides, paramedics and laboratory technologists (17%). Figure 12 provides a complete summary of survey respondents by health worker group.
- Most respondents had worked in health care for more than 10 years (63%). The remaining respondents reported working in the health system for six to 10 years (15%), three to five years (13%), or one to two years (6%). A small proportion of survey respondents had worked in the health system for less than one year (2%).



Review, 2020

- Survey respondents indicated that their work primarily occurred at a hospital or health centre, including EDs (48%), followed by a family practice setting, dental office, or community health office (15%), and long-term care (11%). Numerous other health settings were represented in the survey data, at lesser proportions.
- By region, Vancouver Island and the Interior were over-represented in the survey compared to their proportion of the B.C. population; whereas Fraser and Vancouver Coastal were under-represented. (Figure 13)

Figure 13: Survey Respondents by Health Region Compared to B.C. Population by Region



Review, 2020

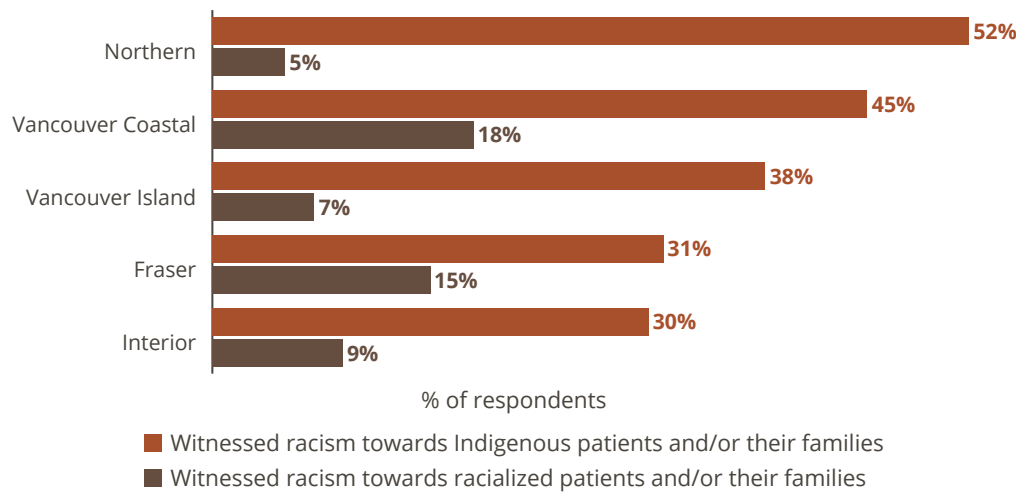
Witnessing Discrimination

Thirty-five per cent of survey respondents indicated that they had witnessed interpersonal racism or discrimination directed to Indigenous patients or their family and friends. This increased to 59 per cent for Indigenous respondents only.

Regions

NINR respondents from Vancouver Coastal and the Northern regions were more likely than respondents from other regions to indicate that they had witnessed racism or discrimination directed at Indigenous patients. Respondents from Vancouver Coastal and Fraser were more likely than respondents from other regions to indicate that they had witnessed racism or discrimination towards racialized patients. (Figure 14)

Figure 14: Rates of Witnessing of Interpersonal Racism or Discrimination by NINR Respondents, by Region



Review, 2020

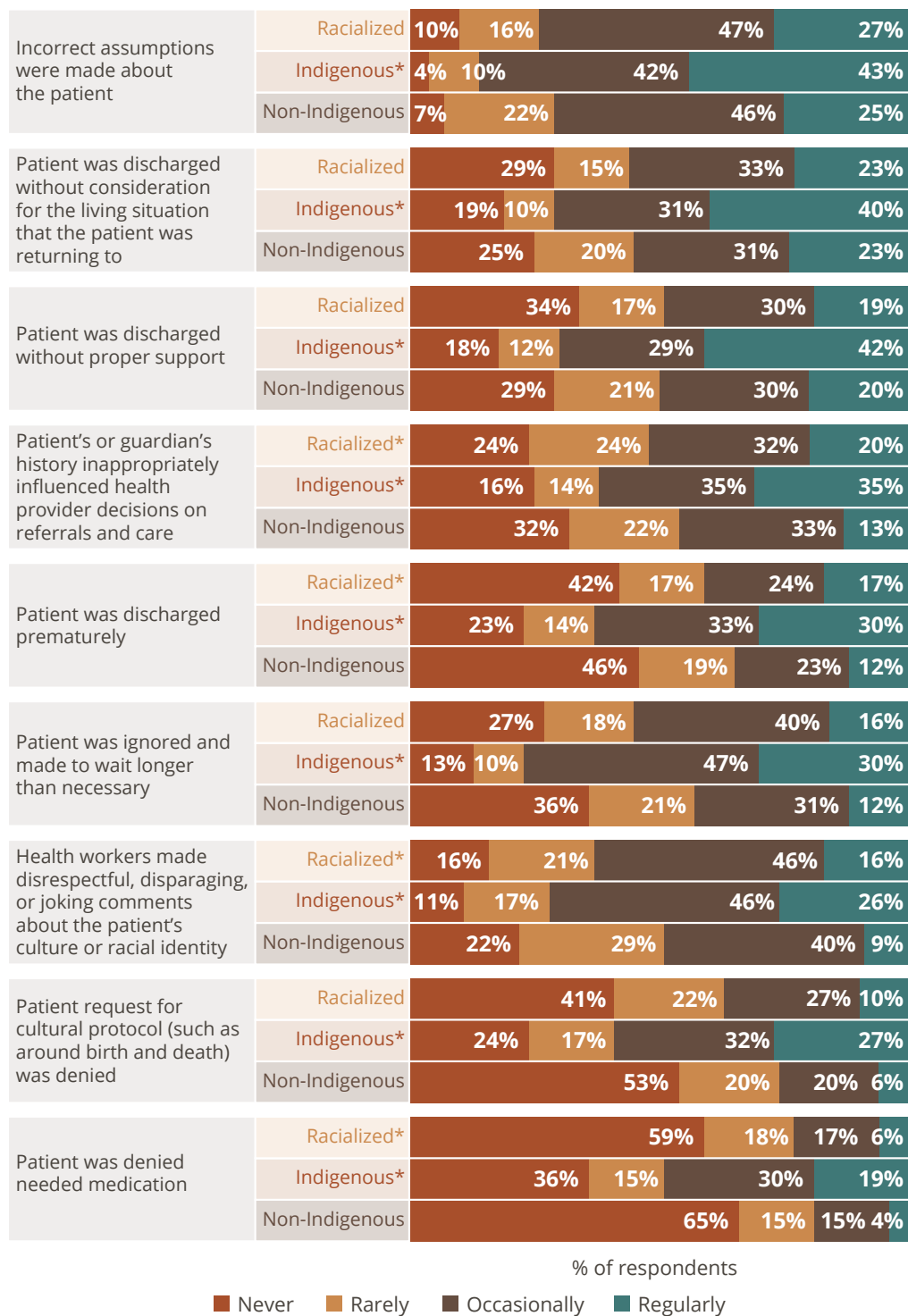
Respondents who had witnessed racism or discrimination were asked to review statements describing examples of such behaviour against patients, and had the option of choosing “never,” “rarely,” “occasionally,” or “regularly.” Indigenous respondents reported “regularly” at significantly higher rates than NINR respondents across all nine statements which were provided. (Figure 15) The three highest rates of Indigenous respondents “regularly” witnessing incidents were:

- incorrect assumptions being made about the patient (43%)
- a patient being discharged without proper support (42%)
- a patient being discharged without consideration for the living situation they were returning to (40%).

In addition:

- almost one in five Indigenous respondents reported that they “regularly” saw patients being denied needed medication
- more than one in four reported “regularly” witnessing denial of cultural protocols associated with birth and death, inappropriate inclusion of a patient’s history into care decisions, disrespectful comments being made by health workers, Indigenous people waiting longer, and being discharged prematurely.

When “occasionally” rates were combined with “regularly” rates, response rates of between 49 per cent and 85 per cent were received from Indigenous respondents across these statements.

Figure 15: Respondent Witnessed Incidents of Racism or Discrimination

*Statistically significant differences with the non-Indigenous rates

Review, 2020

On all statements, NINR respondents (i.e., those who had witnessed discrimination) had significantly lower rates; however, it should be noted, that if “*occasionally*” and “*regularly*” responses are combined, 50 per cent or more of NINR witnessed the three highest Indigenous reported statements above.

The least commonly-observed behaviour was a patient being denied needed medication. However, nearly one-quarter of all respondents indicated that they witnessed this behaviour “*occasionally*” or “*regularly*” (23%). One-quarter is a sizeable portion of the sample considering the nature of the behaviours being witnessed and the serious, treatment- and care-altering outcomes of these behaviours.

Among the most-regularly witnessed, racially-motivated behaviours reported by respondents, respondents from Northern and Vancouver Coastal regions were approximately 1½ to two times more likely to report these behaviours than respondents from other health regions. It is possible that this difference is due to differences in the proportions of Indigenous and other racialized respondents. Compared to other regions, respondents from the Northern region were more likely to be Indigenous and respondents from Vancouver Coastal were more likely to report a racialized identity. While there were differences in the proportions of respondents from each region reporting that they regularly witnessed a specific type of racism, the top three regularly witnessed events/behaviours were similar across regions as to those noted above.

Health Workers

Some differences emerged when the health worker group was considered. The lowest rates of having witnessed these behaviours were found among dental health professionals, aides, paramedics, lab technologists, and clerical and hospital support staff. The highest rates of having witnessed these behaviours were obtained from academics, and the combined group of volunteers, liaisons and spiritual practitioners, which are health workers less associated with direct clinical care. Three of these health worker groups were relatively low contributors to the survey: 10 per cent (dental), four per cent (academic) and two per cent (volunteer, liaison and spiritual practitioner). In general, while there were differences in the proportion of respondents from each health worker group reporting that they “*regularly*” witnessed a specific behaviour or type of racism, the top three most-regularly witnessed events/behaviours are largely similar across health worker groups and similar to the top three behaviours identified above.

Systemic Racism in the Workplace

When asked about systemic racism in the workplace, 84 per cent (NINR) and 93 per cent (Indigenous) respondents reported it to be “*somewhat*,” “*very*,” or “*extremely*” prevalent or were unsure.¹⁷ The balance said it was non-existent. Extreme prevalence of racism was noted by 14 per cent of Indigenous respondents and by 12 per cent of those identifying as racialized, with four per cent of NINR respondents acknowledging an extreme prevalence.

Academics and physicians & surgeons were the most likely, compared to all other health worker groups, to report that systemic racism was “*extremely prevalent*” in their workplace. Dental health providers were most likely to report that systemic racism was “*non-existent*” in their workplace, compared to all other health worker groups.

The most commonly reported reasons, among all respondents, of why systemic or organizational racism exist were: staff not willing to stand up and call out racially prejudiced behaviour (47%); staff not regularly reminded of the many ways discriminatory behaviour can occur (38%); under-representation of Indigenous personnel at all levels of the organization (37%); and lack of accountability by leadership to stop these behaviors (36%). The highest reason for systemic racism infers an onus on staff to “police” their colleagues and, combined with the second reason – that there is an under-representation of Indigenous personnel – suggests a cultural loading of responsibility on the Indigenous workforce to deal with discrimination in the workplace.

Regions

Across all regions, except Vancouver Coastal, the most commonly reported reason that systemic racism existed within a workplace was because staff were not willing to stand up and call out the racially prejudiced behaviour of their peers. Within Vancouver Coastal, respondents most often reported that under-representation of Indigenous personnel at all levels of the organization was the reason why systemic racism existed in their organization. The difference in explanations reported by health workers can illustrate fundamentally different ways of thinking about racism and racially prejudiced behaviour. Within Vancouver Coastal, health workers most commonly identified a systemic cause of racism (i.e., the under-representation of Indigenous personnel at all levels of the organization) while health workers from other regions most commonly identified a lack of policing peer behaviour or a lack of bystander intervention (i.e., staff not willing to stand up and call out racially prejudiced behaviour). The latter places the onus on staff and bystanders to monitor and correct peer behaviour rather than on leadership and training to ensure the behaviour does not occur in the first place. That said, respondents from three of five health regions also felt that under-representation of Indigenous personnel was a reason why systemic or organizational racism existed in

¹⁷ Unsure respondents: 16% (NINR); 7% (Indigenous).

their organization and respondents from all five regions identified that their employer or professional college could have provided more/better training on cultural safety and/or education that could help staff to understand the Indigenous experience.

Personal Experiences of Racism by Health Workers

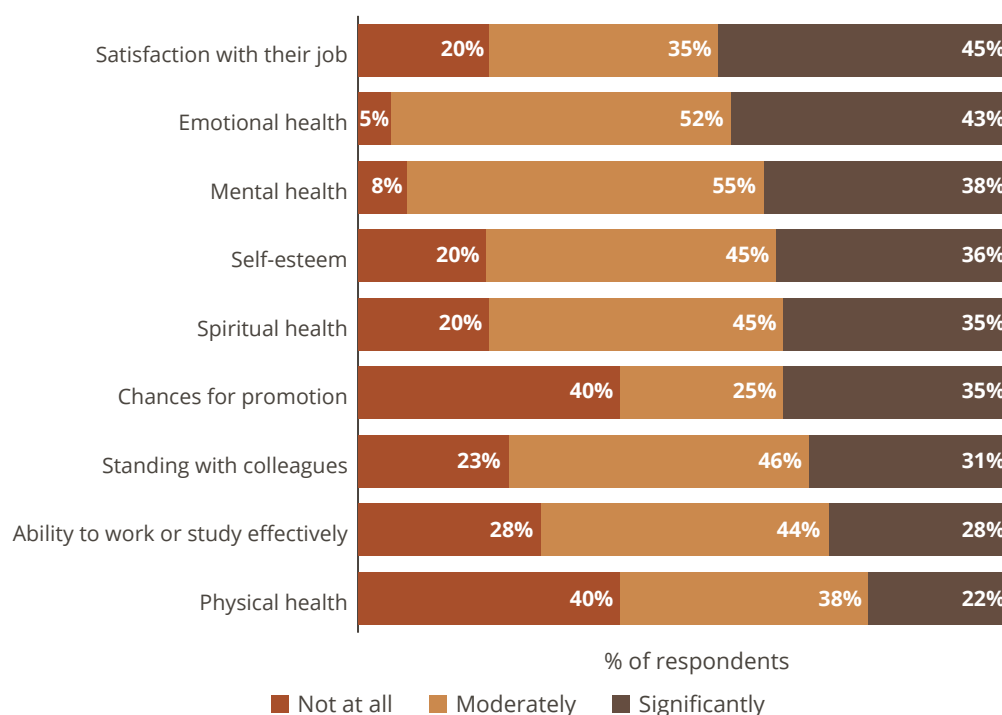
Forty-two per cent of NINR respondents reported witnessing racial prejudice or discrimination, based on culture, ethnicity or heritage, towards other health workers. This was lower than the more than one-half of Indigenous respondents who reported that they had personally experienced racial prejudice or discrimination at work because of their Indigenous identity/heritage (52%). With the Indigenous respondents, the most commonly reported experience was colleagues saying discriminatory or hurtful comments about Indigenous patients or Indigenous culture (59%). Racism was expressed through ignorance of the presence of different Indigenous groups (41%), tokenism on committees (35%), resentment – e.g., perceptions that Indigenous education was free (32%), social isolation (25%), and targeting Indigenous staff to care for Indigenous patients (14%). About 10 per cent of Indigenous respondents also reported effects directly on their job duties and career potential.

There were no significant differences in responses by region or health worker group.

Indigenous respondents who reported experiencing racial prejudice or discrimination at work indicated that it most often came from a colleague or fellow student (74%), or from an individual in a position of authority over them (58%). Respondents also reported that the prejudice or discrimination came from individuals in another department (33%), a patient or resident (30%) or from family members or visitors of patients or residents (22%).

Nearly all of these respondents reported that the racial prejudice or discrimination they experienced affected them personally, in a negative way. Indigenous respondents indicated that the racial prejudice or discrimination they experienced “moderately” or “significantly” negatively impacted their emotional health (95%), mental health (92%), self-esteem (81%), job satisfaction (80%), spiritual health (80%) and other aspects of their well-being at work and in their personal lives. Notably, 72 per cent reported moderate or significant impacts on their ability to work or study effectively, showing that the effects of discrimination extend past personal well-being to directly affect work performance. (Figure 16)

Figure 16: Reported Effects of Racial Discrimination at Work by Indigenous Respondents



Review, 2020

Responsiveness of Health Care and Education Settings to Discrimination

One-half of all respondents indicated that, if they felt it was necessary, they would place a complaint. This dropped to 29 per cent when considering Indigenous respondents only.

Indigenous and NINR respondents were similar in the top three reasons/barriers which would stop them from placing a complaint with their supervisor about racism or discrimination they experienced, and also had similar rates of response. The most commonly reported barriers were: potential that it could adversely affect the respondent's relationship with colleagues in the future (45% of Indigenous respondents); the respondent did not think making a complaint would change the behaviour (42%); and the respondent had seen complaints submitted in the past and it did not make a difference in their workplace (35%).

A second series of questions asked about placing a complaint with a B.C. regulated health profession college or registrar. Smaller proportions of Indigenous respondents compared to NINR respondents would place such a complaint if necessary.

Higher proportions of Indigenous respondents reported barriers to college or registrar complaints compared to NINR respondents. Again, there was consistency with respect to the top three barriers chosen by both groups: the respondent was concerned that nothing would happen (56% of Indigenous respondents); concerns that the review body would not have the sensitivity or awareness to understand the prejudiced behaviour underlying the complaint (46%); and concern that the identity of the respondent would be made known to the person the complaint was against (41%).

Regions

There were few differences in responses by region. Respondents from Interior (58%) and Vancouver Island (52%) were most likely to report that they would place a complaint with a college or registrar if they felt it was necessary, compared to respondents from other health regions (42%). No differences in barriers to placing a complaint were observed by health region.

Health Workers

The highest proportion of respondents reporting that they would place a complaint with a college or registrar if they felt it was necessary came from dental health providers (65%). This was significantly higher than other health worker groups (33% for academics to 53% for physicians and surgeons). No significant differences in barriers to placing a complaint with a college or registrar were observed when comparing health worker groups.

Education and Training

Respondents were asked to comment on whether their training and education included various components that could help them to deliver culturally safe and appropriate care. Compared to NINR respondents, Indigenous respondents were less likely to agree with the following statements related to their training and education:

- instructors and mentors were positive role models in culturally safe care (8% *“strongly disagreed”*)
- it was safe to register concerns regarding discriminatory comments seen (15% *“strongly disagreed”*)
- Indigenous patients received the same level of care as other patients (15% *“strongly disagreed”*).

Nurses, midwives, volunteers, liaisons and spiritual practitioners were more likely than other health provider groups to “strongly agree” that they learned about the impacts and influences of colonialism, and about systemic bias and racism in Canadian society.

A sizable proportion of all respondents recognized disparity in the level of care received by Indigenous compared to non-Indigenous patients. Less than one-half strongly agreed that during their training and education they learned about the impacts of colonialism (33% to 38%, depending on the respondent group) and/or that cultural sensitivity training was integrated into all aspects of the curriculum (17% to 19%).

Regions

A larger proportion of respondents from the Interior and Vancouver Island, compared Vancouver Coastal, agreed that they felt safe to register a concern regarding discriminatory actions they saw, and were more likely to agree that Indigenous patients receive the same level of care as other patients.

Health Workers

By health worker group, the main findings were: (1) dental health professionals and facility support workers were consistently more likely to “strongly disagree” with positive statements about how their training prepared them to provide culturally safe care; and (2) nurses and midwives, volunteers, liaisons and spiritual practitioners were more likely to “strongly agree” with these statements. These findings suggest that perhaps training for dental health professionals and facility support workers provides less opportunity for learning about the impact of colonialism and providing culturally safe care

Cultural Safety in the Workplace

Volunteers, liaisons and spiritual practitioners, allied health professionals, academics, and nurses and midwives tended to be more likely than other health worker groups to consider a variety of interventions as a “high priority”.

Health care workers overall agreed that there is a need for change in health care settings to improve cultural safety for Indigenous patients. Strongest support was for interventions focused on leadership, policies and practices, and training or education for staff, while support was lowest for creating dedicated cultural spaces for Indigenous ceremonies in health facilities, and for creating peer support networks to implement cultural safety practices in workplaces (Figure 17). In all of the interventions, only four per cent to 12 per cent of respondents noted these were not a priority, and 70 per cent or greater classed the actions as a medium or high priority.

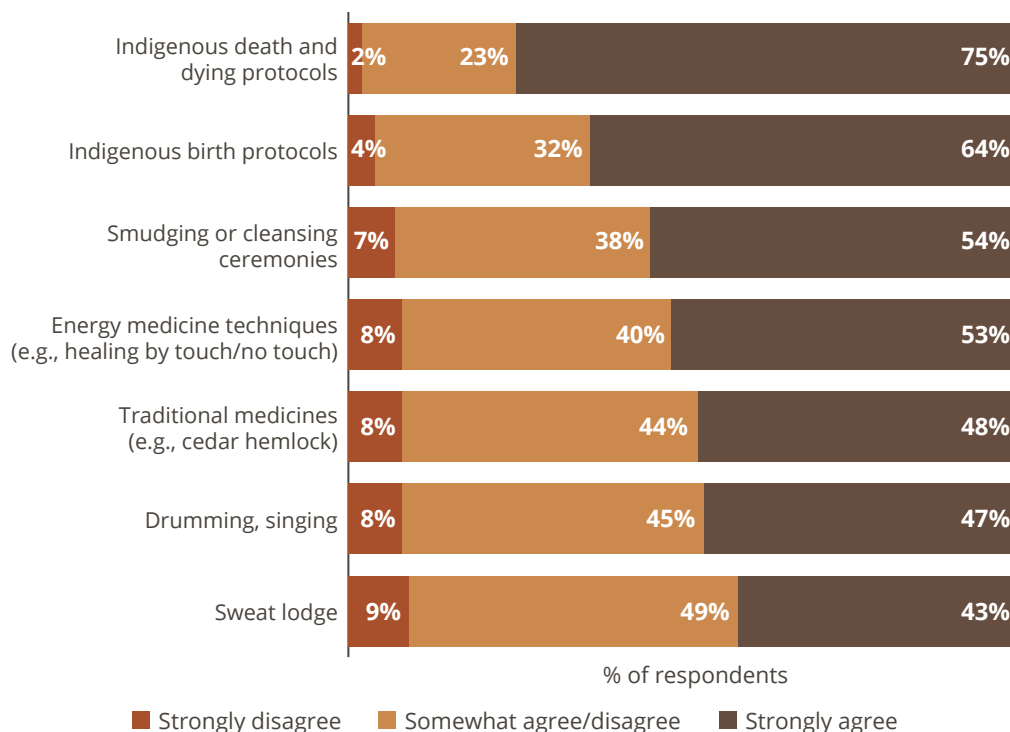
Figure 17: Respondents' Priority Ratings of Indigenous-Related Cultural Actions

Review, 2020

Survey respondents were asked to rate their agreement with the inclusions of various traditional Indigenous practices into Indigenous patients' care plans. Across all items, large majorities of survey respondents reported that they "somewhat" or "strongly" agree with the inclusion of each practice in care plans for Indigenous patients. When combining "somewhat agree" and "strongly agree," the majority of respondents supported the inclusion of all of the traditional Indigenous practices in patient care plans shown in Figure 18. Support as evidenced by "strongly agree" was highest for death and dying protocols (75%), followed by birth protocols (64%).

Nurses, midwives and allied health professionals tended to be more supportive of these traditional Indigenous practices compared to other health groups, while physicians, surgeons and dental health providers were the least supportive.

Figure 18: Support for Various Indigenous Practices Included in Care Plans



Review, 2020

What Needs to Change?

Three open-ended questions at the end of the survey asked survey respondents for other feedback related to improving cultural safety for Indigenous patients and staff in the health care system. Overall, 46 per cent of all survey respondents provided at least one comment in the final three open-ended response fields (n=2,557). Indigenous respondents were more likely to leave a comment, with 59 per cent of all Indigenous respondents doing so. Other racialized respondents were less likely to leave comments, with 41 per cent doing so. NINR respondents aligned with the average, with 47 per cent leaving at least one comment in these fields.¹⁸

Need for cultural and institutional changes

Across all three open-ended questions, the most common themes found in comments tended to emphasize the need for systemic change in institutional structures, policies and workplace cultures.

Two of the open-ended questions asked respondents to identify what changes were needed to make the health care system safer for Indigenous patients

¹⁸ Percentages in this section are based on the total number of respondents who answered the open-ended questions, unless otherwise noted.

or for Indigenous health care workers. Themes from the comments provided included the following:

- A need to listen to and prioritize Indigenous voices in making improvements to the health care system (22% for Indigenous patients, 9% for Indigenous health care workers)
- A need for increased Indigenous representation in health care (19% for Indigenous staff, 11% for Indigenous patients)
- A need for changes to organizational cultures and structures to promote decolonization and reconciliation (17% for Indigenous staff, 16% for Indigenous patients)
- A need for health care workers, particularly front-line health care workers, to make cultural changes (15% for Indigenous patients).

The last two issues have different perspectives – the former emphasized culture from the top-down, starting at management; the latter emphasized the more specific, somewhat more insular, culture that forms among front-line health care workers such as in hospital settings.

These themes reiterate the highest-priority items identified in the closed-ended survey questions regarding improving cultural safety in the health care system: ensuring health leadership strongly address racism (supported by 64% of respondents) and reviewing policies and procedures through anti-racist, health equity lenses (supported by 63% of respondents).

Training and education for health care workers

Training and education were noted by respondents in all three open-ended questions in the survey; this theme was one of the most frequently cited issues across all questions. These comments tended to discuss the need for more training and education opportunities to be made available to staff, the need for increased quality in those opportunities, and the need for more staff to be required to take these courses.

It is also worth noting that, in the final question of the survey asking respondents to provide any other information they felt was important, 13 per cent of respondents indicated that their workplace's current approaches to cultural safety are insufficient. Among these respondents, some comments noted that the training opportunities available were not resulting in change in staff members' practices, due to the insufficiency or shallowness of training, the lack of institutional support to implement lessons learned, or a general attitude of "not taking seriously" the importance of the training sessions and treating them instead as a box to check off on a list.

Other themes or issues raised

A number of other issues or themes were raised in open-ended comments, although less frequently than those discussed in the subsections above. These additional themes included:

- Calls for additional supports for Indigenous patients and workers
- Calls for increased accountability for health care staff when it comes to racist or discriminatory behaviour
- Belief that Indigenous people, not health care workers, should be the ones commenting on how to make the health care system safer
- Belief that general kindness, compassion and treating everyone as equals will be sufficient to redress Indigenous-targeted racism
- Comments saying that respondents simply don't know how to address racism in the health care system.

Finally, one concerning trend among open-ended responses was the prevalence of discriminatory views towards Indigenous people, or antagonism towards the purpose of this Review. A number of related themes were identified, such as denial of racism in the health care system, expectations that Indigenous people should do more to adapt to the health care system, objections to the focus on Indigenous-specific racism as well as generally negative comments. Overall, 13 per cent (531)¹⁹ of all NINR respondents expressed some form of discriminatory view towards Indigenous people or antagonistic comment about the Review.

Summary

Interpersonal racism and discrimination in B.C. health care

- Over one-third of survey respondents reported that they had witnessed interpersonal racism or discrimination directed to Indigenous patients (59% for Indigenous respondents only). The most commonly reported behaviours that were “regularly” witnessed by health workers who responded to the survey were incorrect assumptions being made about a patient, followed by a patient being discharged without consideration for the living situation they were returning to, and a patient being discharged without proper support. These behaviours have significant implications for patient well-being and treatment and could lead to negative care or recovery outcomes.

¹⁹ Percentage calculation is based on total NINR respondents to the survey.

Systemic racism in B.C. health care

- About one-third of health workers surveyed felt that systemic or organizational racism was “*somewhat prevalent*” in their workplace. A larger proportion of Indigenous and racialized respondents, compared to non-Indigenous, non-racialized respondents, reported that systemic racism was “*extremely prevalent*” in their workplace. This may be because Indigenous and racialized respondents are better able to recognize and identify a behaviour as racist or discriminatory compared to non-Indigenous and non-racialized respondents who do not have the first-hand lived experience of racism.
- The most commonly reported reasons why systemic or organizational racism exist were: staff not willing to stand up and call out racially prejudiced behaviour; staff not regularly reminded of the many ways discriminatory behaviour can occur; and under-representation of Indigenous personnel at all levels of the organization. The most commonly reported reasons were largely consistent by region and by health worker groups, again suggesting that this is a system-wide problem.

Health workers’ experiences of racism

- More than one-half of Indigenous or racialized respondents reported that they had experienced racial prejudice or discrimination at work because of their identity/heritage. The most commonly reported experience was colleagues saying discriminatory or hurtful comments about patients of the same identity, heritage or culture as the respondent. Indigenous respondents reported that this behaviour was often from a colleague or fellow student or a person in a position of authority over them.
- Nearly all respondents who reported that they had experienced racial prejudice or discrimination at work reported that the behaviour had a negative impact on them personally. When assessing moderate and significant impacts together, the most common negative impacts reported by Indigenous respondents who had experienced workplace discrimination were on their mental health and emotional health.

Barriers to reporting racism in B.C. health care settings

- Nearly one-half of health workers who responded to the survey reported that they would place a complaint with their supervisor at their workplace or with a B.C. regulated health professional college or registrar if they felt it was necessary. Smaller proportions of Indigenous and racialized respondents, compared to non-Indigenous and non-racialized respondents, reported that they would place a complaint if they thought it was necessary. This finding potentially highlights Indigenous and racialized respondents’ mistrust of the

system, as they are less likely to file complaints but more likely to witness a behaviour and label it as racist and/or prejudiced and discriminatory compared to non-Indigenous and non-racialized respondents.

- Across all groups, health workers' most commonly reported barrier to placing a complaint with their supervisor was the potential that it could adversely affect the respondent's relationship with colleagues in the future. The most commonly reported barrier to filing a complaint with a health professional colleague was the concern that the complaint would be ineffective and nothing would happen.
- While a large proportion of respondents recognized disparity in the level of care received by Indigenous and non-Indigenous patients, fewer than one-half *"strongly agreed"* that during their training and education they learned about the impacts of colonialism and that cultural sensitivity training was integrated into all aspects of the curriculum. This finding potentially points to a gap in training for health care workers.
- Dental health professionals and facility support workers were least likely to report that their training included learning about the impact of colonialism and had culturally sensitivity training integrated into all aspects of the curriculum, while nurses and midwives were most likely to report this. This suggests that perhaps the training and education of nurses and midwives provides more opportunity for learning about the impact on colonialism and providing culturally safe care.

Suggestions for how to improve cultural safety for Indigenous people in B.C. health care

- Health workers who responded to the survey tended to agree that there is a need for change in health care settings to improve cultural safety for Indigenous patients. Respondents were most likely to support interventions that focused on leadership, policies and practices, and training or education for staff. While there was considerable support for various interventions and changes to the health care system that would make it safer for Indigenous patients, the open-ended comments also suggest that there is considerable work to be done with some denying that change is needed. Some health care workers made comments that illustrated their belief that racial prejudice and discrimination does not exist in the health care system, which indicated they may be resistant to efforts to correct a problem that they do not believe exists.

- When asked about specific Indigenous practices, respondents supported the inclusion of all listed traditional Indigenous practices in patient care plans. Support was highest for death and dying protocols, followed closely by birth protocols. The significant differences seen by health providers in support for various Indigenous traditional health and wellness practices could be useful in identifying health care professional groups where one is most likely to find “champions” or peer leaders for inclusion of traditional practices in Indigenous patient care plans, and where additional cultural safety training and supports may be needed.

5.3 Review Intake Data

Introduction

This report summarizes contributions made by members of the public who contacted the Review through the toll-free number or email. Over twice as many people identified as Indigenous than those who identified as non-Indigenous.²⁰ The overwhelming majority of respondents discussed the experiences of Indigenous patients, reflecting the Review’s intended focus. While most had experienced the health care system as service users or witnesses to the experiences of service users, over one-third of the contributions came from people working within the health system. Each person contacting the Review contributed their unique history and perspective. Together, they provided a picture of the health care system characterized by six broad themes. Four themes described ways in which Indigenous-specific racism and discrimination were enacted in the health care system, one described their impact and another described their extent.

Methodology

All calls and emails coming into the Review were logged by a member of the Review Team. When a respondent wished to tell their history or otherwise contribute to the Review, a team member followed up with them before writing a summary of the information they provided.

An Excel spreadsheet was created to document the summaries and to categorize the following information:

- The respondent’s identity as Indigenous or non-Indigenous
- The respondent’s role in relation to the incident(s) described (e.g., patient, caregiver or family member, health worker, etc.)

²⁰ This analysis was completed on a subset (549) of all submissions received.

- The scope of the incident(s) described (e.g., personal experience, observation of a single event, multiple or systemic concerns, third-party report)
- The region or health authority involved in the incident(s) described
- The health care location where the incident(s) occurred (e.g., hospital, ED, multiple locations, etc.)
- The identity as Indigenous or non-Indigenous of the patient involved in the incident(s) described.

For the quantitative analysis, the number and percentage of responses in each category were calculated. Cross-tabulations were conducted to describe relationships between the categories. It was necessary to collapse some categories to enable cross-tabulations to be performed. Due to their small number, for example, racialized respondents and patients were included in the categories of non-Indigenous respondents and patients. If there was no response logged in a specific category, it was counted as unknown.

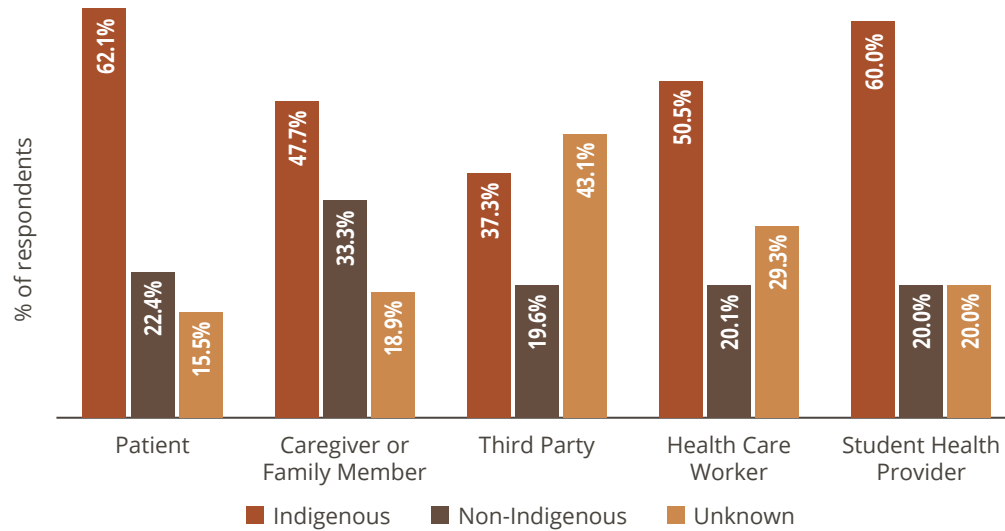
Description of Respondents

More than half (53%) of the respondents in the Intake file identified as Indigenous, 22 per cent identified as non-Indigenous and 25 per cent did not share this information.

The role of respondents in relation to the incident(s) they described was classified into one of five categories. Thirty-four per cent of respondents worked within the health care system as staff or students and, of these, 57 per cent of health care workers talked about their own personal experience. Thirty-two per cent of respondents identified as the patient at the center of the history shared, 19 per cent were caregivers or family members and nine per cent were third parties to the incident.²¹

The proportion of respondents who identified as Indigenous or non-Indigenous across the five roles (patient, caregiver/family member, third party, health care worker, and health care student) is illustrated in Figure 19. The lowest proportion of Indigenous respondents was in the third-party group who reported the histories of other people (37%). Indigenous people made up the highest proportion, however, of all other role groups.

²¹ 5% unknown.

Figure 19: Respondent Role by Indigenous Identity

Review, 2020

Over 40 per cent of the health care worker respondents were from the nursing profession and 13 per cent were physicians (Table 1).

Table 1: Health Provider Respondents by Occupation

Occupation	% Responses
Nurse professional	43%
Other*	18%
Physician	13%
Social worker	6%
Allied health professional	4%
Care aid	4%
Clerical staff (e.g., ward clerk, office assistant)	3%
Mental health or addictions worker	3%
Lab & Imaging	2%
Non-clinical staff (e.g., food, cleaning)	2%
Paramedic	2%

**Note: Other includes occupations not covered in the categories (e.g., administration, dental, security)*

Description of Histories Shared

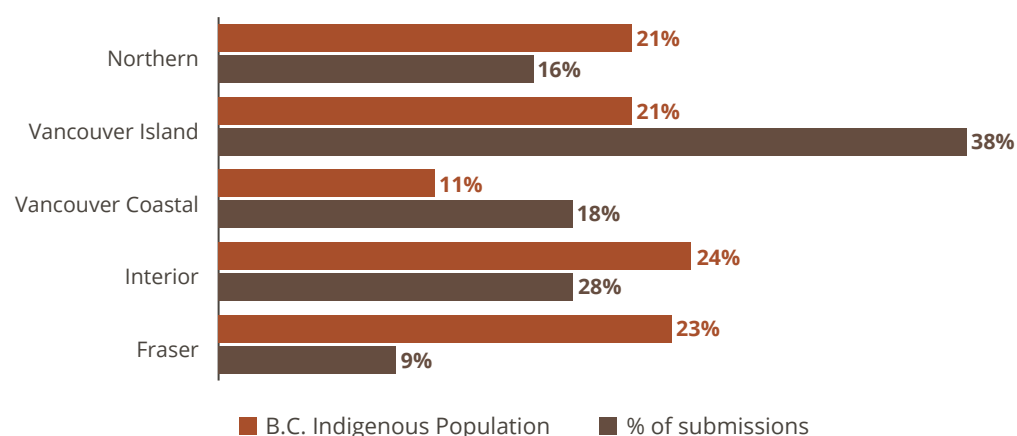
The scope of each history shared captured whether the respondent was reporting their own experience, something they had witnessed happen to another person, second-hand knowledge that they had neither witnessed nor

experienced, or general systemic concerns. More than half of respondents spoke from personal experience (54%), and 26 per cent talked of multiple or systemic concerns. Eight per cent were a single, witnessed event.

Seventy-eight per cent of respondents identified the health authority in which the incident or concerns had occurred. While every health authority was represented, the greatest number of respondent reports (36%) were related to Vancouver Island, and the lowest reportable number was from Providence Health Care (4%). The data from the FNHA and PHSA are not reportable due to their small numbers in the Intake file.

Figure 20 looks specifically at those cases which occurred in one of the five geographic regions. Both Vancouver Island and Vancouver Coastal had a higher proportion of cases than might be expected based on the distribution of Indigenous peoples across these five regions. The largest difference was Fraser with nine per cent of cases, even though this region is home to 23 per cent of the Indigenous population.

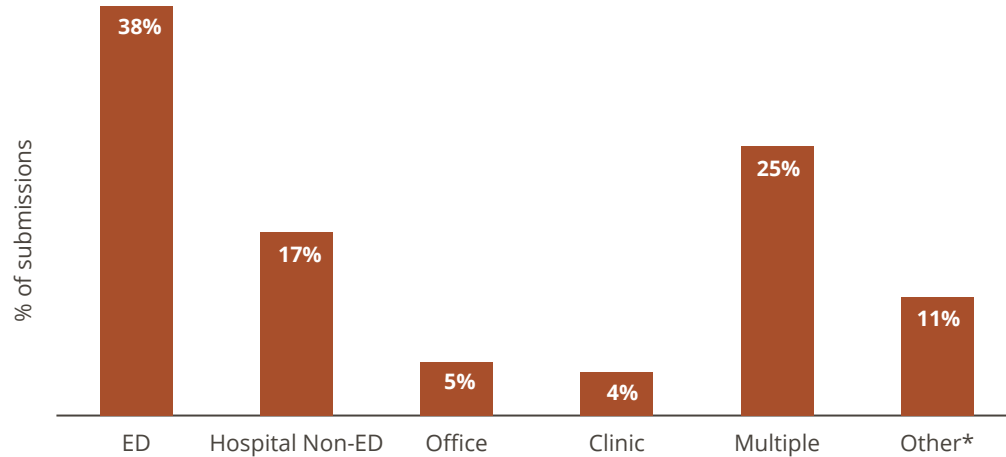
Figure 20: Distribution of B.C. Indigenous Population & Submissions Across Regions



Review, 2020

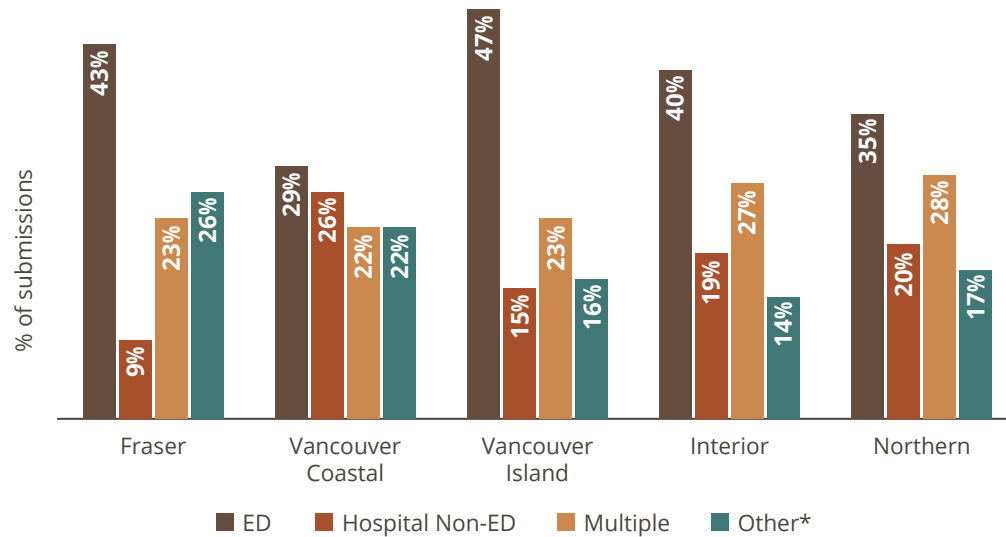
Of the responses where the racial or cultural identity of the patient was provided, 88 per cent were Indigenous, while the remaining 12 per cent of patients were identified as non-Indigenous. By region, 57 per cent of submissions in Fraser to 86 per cent in Interior were related to an Indigenous patient.

The experiences reported to the Review happened in a range of health care settings, with the ED being most common. One-quarter of respondents reported incidents or concerns that took place in more than one location. (Figure 21)

Figure 21: Response by Health Care Location

**Incident occurred at another health care location or outside the health care system Review, 2020*

The ED was the most-identified location of concern for the five regions (Figure 22). Concerns related to EDs may also have been captured in the “multiple” location designation. Providence Health Care was not displayed given the small number of locations identified in the Intake file.

Figure 22: Location of Incident by Health Authority

**Incident occurred at another location – Health Care Office and Clinic are included in this Review, 2020*

Themes Across the Histories Shared

There were six primary themes that ran through the histories shared with the Review. Four themes described the ways in which Indigenous-specific racism and/or discrimination showed up in the health system. These were:

- *Stereotyping* by health care professionals (discussed by 45% of respondents). The most frequently referenced stereotype was of Indigenous people being “less worthy” of care, reflected in a range of attitudes and acts that devalued Indigenous personhood, culture, history and experiences. Other common stereotypes included that of Indigenous people being alcohol users, drug-seekers and inadequate parents.
- *Restricted access* (40%). This described the experience of being shut out of care, made to wait for care or seeing Indigenous people receive demonstrably less access to quality care than non-Indigenous people.
- *Unacceptable personal interactions* (38%). These were interactions with health care professionals that were characterized by verbal abuse, disrespect for patients’ physical bodies, a cold or harsh demeanor or a failure to listen, believe and take seriously.
- *Medical (mis)treatment* (25%). This took the form of inappropriate pain management, misdiagnoses and medical mistakes.

The remaining two themes were:

- *Negative impacts* (28%). These described the consequences of the reported incidents on the lives of those involved. Impacts included death, long-lasting physical debilitation, trauma, emotional distress and avoidance of the health system.
- *Breadth of the problem* (43%). Respondents spoke of Indigenous-specific racism and/or discrimination as being endemic to the health care system, demonstrated in multiple locations and through the poor treatment of Indigenous staff and a lack of Indigenous staff, resources, training, effective leadership and willingness to challenge racism when it occurred. This theme also addressed other forms of oppression within the system and the ineffectiveness of complaints processes.

In addition, 25 people shared with the Review their positive experiences with the health care system. This is a relatively small group, but some of their comments speak to a theme that surfaced in the Review’s analysis of the San’yas data; that of health professionals “doing the right thing”, giving good care and staging individual acts of resistance to racism against Indigenous people.

Detailed Description of Themes

The six themes were comprised of the following:

1. Stereotyping

Indigenous people reported being stereotyped during their interaction with the health system, and often these stereotypes appeared to shape the care provided or not provided. The following were the primary stereotypes described:

a. “Less Worthy” of Care

Respondents talked about patients being treated poorly simply because they were Indigenous. There were a wide range of comments and actions attributed to health care providers that suggested patients were perceived as a homogenous group that was less entitled to care and respect. This included Indigenous people being described or treated as living in poverty, being dirty, sexually promiscuous, inclined to criminal behaviour, unable to attend appointments on time or comply with instructions. There were disparaging and “othering” references to Indigenous languages, communities and economic arrangements, and a lack of respect paid to cultural practices, historical experiences and family relationships.

b. Alcohol User

Respondents described the common assumption by health providers that their health condition was related to alcohol use. Patients were assumed to be drunk when their presentation was due to other causes – this was described as leading to their medical needs going unassessed or untreated. There are many examples of the first, sometimes repeated, and often apparently unwarranted question being *“how much have you had to drink?”*

c. Drug-seeker

Respondents gave examples of Indigenous people being assumed to be presenting to the health system in order to get drugs. They were commonly denied pain medication due to this stereotype. Sometimes this assumption was explicitly related to the idea that the person was a street drug user and led to patients being asked about their regular drug use without apparent reason.

d. Inadequate Parent

Indigenous patients were assumed to be inadequate, neglectful or undeserving parents. While described by fewer respondents than the stereotypes above, this stereotype could have significant impact, as it was associated with actions to involve child welfare social workers. Some respondents were explicit that social work involvement was for no reason other than that the patient was Indigenous.

2. Restricted Access

Respondents talked about a range of ways in which health providers impeded access to care for Indigenous people. These included being:

Shut Out

Respondents discussed many incidents of being shut out of care, from being physically locked out of buildings, to being sent home without expected assessment, treatment or planning. Being shut out included examples of patients being declined help, tests, treatment, specialist referrals and aftercare. This left some patients making repeated attempts to access service.

Made to Wait

Respondents who were able to access care were made to wait for long periods. Some people described feeling that they had been deliberately responded to slowly or “*put to bottom of the wait list*” and waiting while non-Indigenous patients were seen first. Isolation was a particularly impactful element of some peoples’ experience; they were left to wait alone, in empty rooms or away from others.

Treated Differently

Respondents described examples of situations in which Indigenous people were treated differently in direct comparison to non-Indigenous people. They waited longer, saw appointments or resources go to others, or received less access to quality care than non-Indigenous people in the same situation. Some described accessing appropriate care only after a non-Indigenous person intervened; being accompanied by a non-Indigenous person was described by several people as a strategy to secure access.

3. Unacceptable Personal Interactions

Respondents identified a range of incidents in which individual health providers engaged in personal interactions with Indigenous people that were abusive, disrespectful, demeaning or showed a lack of caring and humanity. They included providers being:

Disrespectful of patients’ physical bodies

Disrespect for patients’ physical bodies showed up in two ways. The first was in examples of patients being physically manhandled or treated roughly. Some of these incidents were described as feeling like assaults, and some led to physical injury. The second way was in a failure to meet patients’ basic needs for food, warmth or proper hygiene. Respondents described incidents in which health providers failed to provide them adequate food or liquids, ignored their bathroom and hygiene needs, and left them without clothing or blankets.

Verbally Abusive

There were many descriptions of health providers making racist or rude comments. Such comments might be said directly to a patient, be overheard by the patient, written about the patient, or said to other staff. Staff were described as making fun of or mocking Indigenous patients and in some cases “yelling” at them or talking about their personal information in an inappropriately loud voice.

Cold and Harsh

There were multiple instances of health providers interacting with patients in ways that were explicitly described as lacking a sense of compassion, caring and humanity. “Cold” and “harsh” were the words most used to describe these interactions, although respondents also used words like “angry”, “dismissive”, “insensitive”, and “disdainful”.

Disbelieving

A shared feature of some respondents’ histories was that health providers held a disbelieving stance towards them. The interaction with the health provider was characterized as one in which the provider minimized their concerns, opinions or choices. Sometimes this was described as a passive act: a failure to listen to them or take them seriously. Sometimes it was more aggressive, with some patients being explicitly accused of “faking” or being manipulative.

4. Medical (Mis)treatment

Respondents discussed the main ways in which the health system failed to treat their specific medical issues. These were through:

Inappropriate Pain Management

Respondents discussed widespread inappropriate pain management for Indigenous patients and described ways in which the pain of specific Indigenous patients had been ignored or minimized. At times, pain was acknowledged but treatment was withheld, sometimes with an explicit reference to the stereotype that Indigenous people were drug-seeking or felt pain differently. At other times, the pain management offered was simply ineffective.

Misdiagnoses and Medical Mistakes

Respondents described examples of mistakes being made in the medical treatment of Indigenous patients, including specific medical conditions being missed or misdiagnosed. Strokes and heart attacks were the medical conditions most commonly discussed. In some examples, the failure to recognize and treat symptoms appropriately was explicitly connected to stereotyping, with symptoms assumed to be alcohol- or drug-related.

Negative Impacts

Respondents described negative experiences with the health system as having profound and often lasting impacts on the person involved. These impacts included:

Physical Harm

The physical health of patients was negatively impacted by their interactions with the health system. These interactions were described as inducing chronic pain and broken bones, brain injury and excessive scarring. The failure to diagnose or treat symptoms led to the need for future hospitalization or the worsening of chronic conditions. Some respondents attributed patient deaths or near-death experiences to the poor service received.

Emotional Harm

Respondents described interactions with the health system leaving patients feeling *“terrified,” “scared,” “angry,” “frustrated,” “embarrassed,” “humiliated,” “ashamed”* and *“distressed”*. Some patients remained traumatized, depressed, or brought to tears by the memory of their experiences long after the event.

“Stay Home and Suffer”

A common response to the care received was to get away and stay away. This might mean choosing to leave hospital early, or not returning in the event of future pain or need for treatment. Some patients avoided a particular health care setting, while others sought to avoid the health system altogether.

5. The Breadth of the Problem

There were three main ways in which respondents discussed the health system as being characterized by widespread problems. They identified that:

Racism is systemic

Respondents described Indigenous-specific racism as happening in multiple settings or were explicit that this was a problem throughout the health system. EDs, interactions with paramedics and prenatal, delivery and postnatal care appeared most frequently in respondents’ experiences as the location for racist or discriminatory treatment. Respondents talked about the lack of Indigenous staff and of racist behaviour against Indigenous staff. They also talked about a lack of resources and health services for Indigenous people. There were examples of a passive acceptance of Indigenous-specific racism by staff, descriptions of a failure of leadership and political accountability to address the issue, and calls for more or better training.

The health system discriminates in other ways, too

Respondents identified a range of ways apart from Indigenous-specific racism in which they felt the health system discriminates against groups of people. After racism against non-Indigenous people, the most discussed issues were discrimination against people with mental health and substance use issues, ageism and classism.

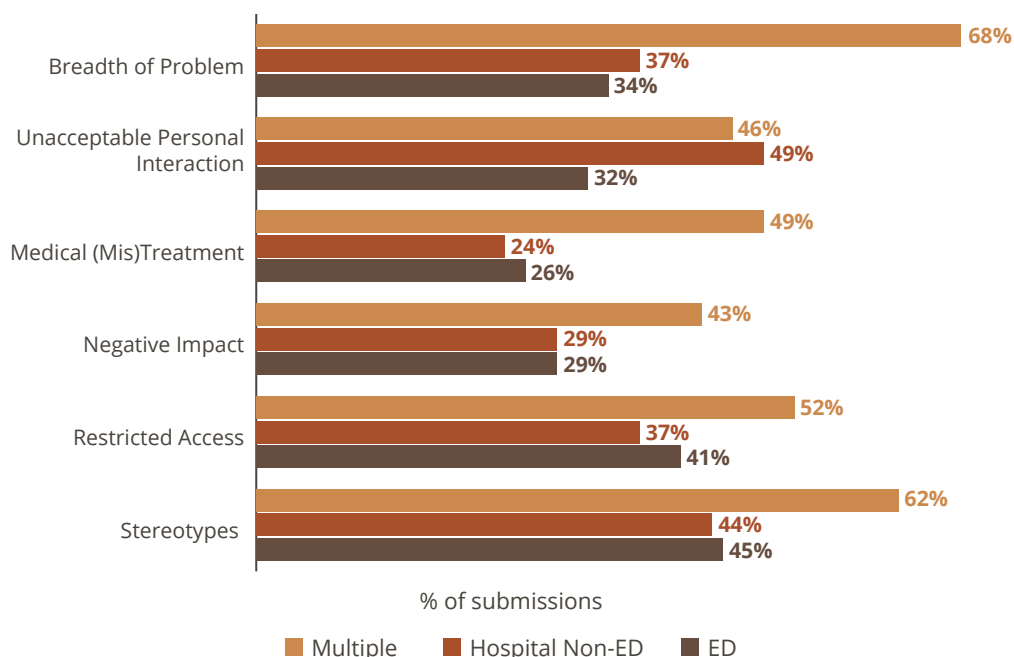
Complaining does not help

Some respondents described attempting and failing to find resolution to their concerns by making a complaint. The most common message about the complaints system was that *“nothing was ever done”* in response to their complaint. There were also examples of retaliation, and descriptions of a culture of fear that prevented complaints from being made.

Distribution of Themes

There was a great deal of consistency in the frequency with which these six themes were discussed across all groups who contributed to the Review and in relation to all regions and health service locations. This suggests that racism against Indigenous people should be seen as the concern of the entire health system and not one that is limited to a few “bad apples” among health professionals, workplaces or regions. The widespread nature of stereotyping, restricted access, unacceptable personal interactions, medical mistreatment and incidents causing harm is discernible from the two figures that follow. While EDs were a location for oppression, so too were other hospital departments, as shown by a similar frequency across the themes in Figure 23 and the common inclusion of multiple health settings in respondent histories.

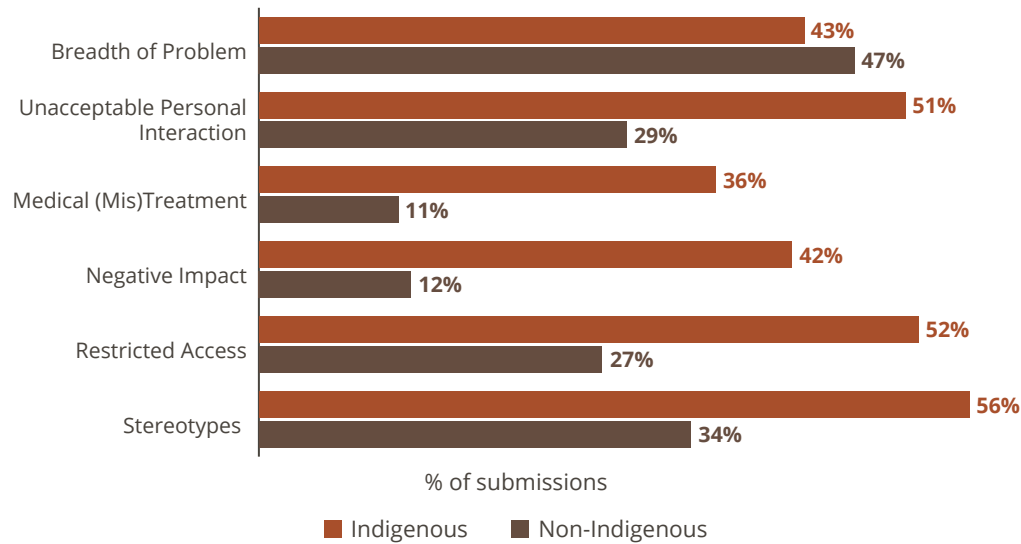
Figure 23: Themes by Location



Review, 2020

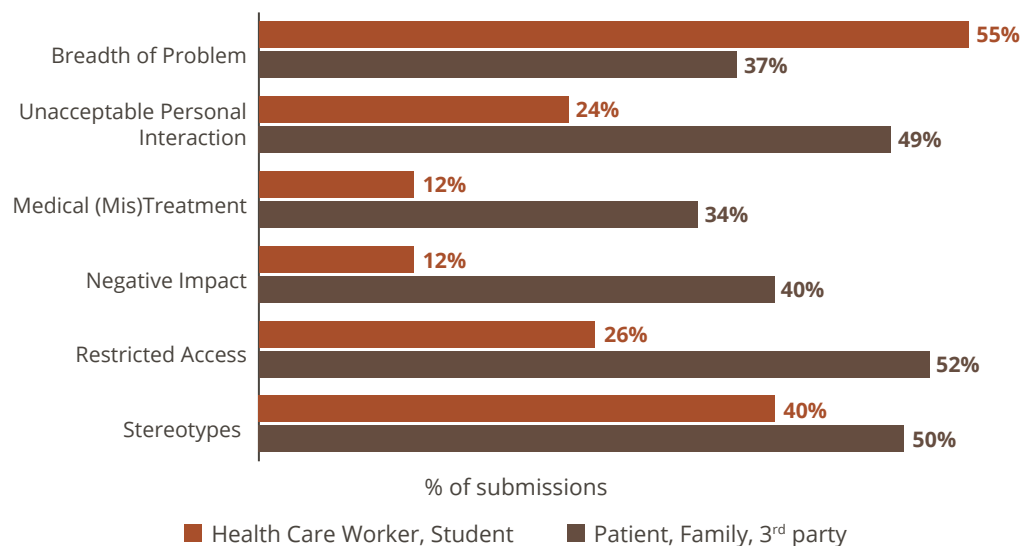
The distribution of themes shown at a provincial level were replicated in each of the regions.

It is striking that more than half of all Indigenous respondents talked about each of the themes of stereotyping, restricted access and unacceptable personal interactions (Figure 24). A smaller proportion of non-Indigenous respondents raised these issues, but the greatest difference in contributions made by Indigenous and non-Indigenous respondents came with the issues of medical (mis)treatment and the negative impacts of the service received. These two themes were the least present in non-Indigenous contributions, perhaps indicating that these issues can remain hidden to those not directly involved.

Figure 24: Themes by Indigenous/Non-Indigenous Respondent

Review, 2020

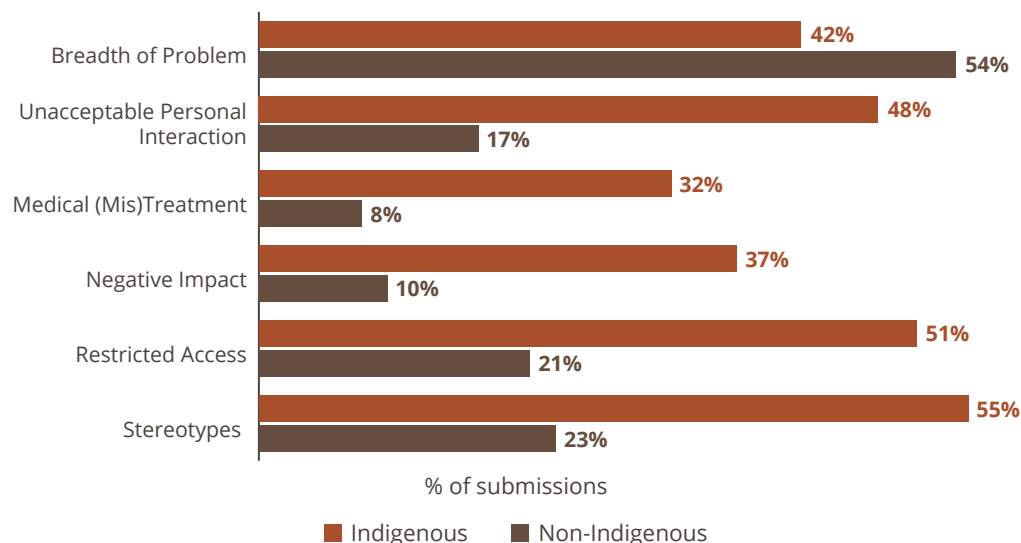
A similar pattern was evident when comparing the accounts of those who might be broadly seen as “service recipients and observers” with the accounts of “service providers”. (Figure 25) Well over half the health workers and students who contacted the Review spoke to the breadth of the problem, suggesting there is widespread acknowledgement within the system of the need for change.

Figure 25: Themes by Respondent Role

Review, 2020

Stereotyping, restricted access, unacceptable personal interactions, medical (mis)treatment and the profound negative impacts all these issues have were primarily discussed in relation to Indigenous patients (Figure 26). In a smaller number of contributions, however, they were discussed as an issue for non-Indigenous patients. Some people discussed non-Indigenous patients suffering from other forms of discrimination, while others spoke of being “*presumed Indigenous*” due to their physical appearance and treated poorly as a result.

Figure 26: Themes by Indigenous/Non-Indigenous Patients



Review, 2020

Summary

The histories shared with the Review in large part were by people who identified as Indigenous and they were overwhelmingly about the experiences of Indigenous patients. While some respondents spoke about positive experiences, the main picture presented was one of significant and widespread Indigenous-specific racism and discrimination in B.C.’s health system.

Common stereotypes of Indigenous people as being “*less worthy*” of care, alcohol users, drug-seekers and inadequate parents manifested in restricted access to care for Indigenous patients, a range of disrespectful, disbelieving and verbally abusive interactions and a lack of warmth and caring from health professionals. In some histories, they led directly to incidents of medical mistreatment, as Indigenous people were intentionally left in unmedicated pain and serious medical conditions went undiagnosed. Indigenous patients and those who cared about them paid a heavy price in emotional and physical suffering, with many choosing to avoid the health system in response.

Perhaps the most striking finding to date is the consistency of this picture. Indigenous-specific racism and discrimination showed up in all four of its primary forms (stereotyping, restricted access, unacceptable personal interactions and medical (mis)treatment) across all the regions and in multiple health settings. It was reported by Indigenous and non-Indigenous respondents and both by people working within the health system as service providers and those who interacted with it as service recipients. Many spoke about the breadth of the problem; this is an issue that manifests not only in the direct interactions between health professionals and those seeking their help, but in complaints, training, resource allocation and accountability processes that are clearly in need of development if Indigenous-specific racism is to be adequately addressed.

5.4 San'yas Thematic Analysis

Introduction

The San'yas Indigenous Cultural Safety training is an online course provided through the PHSA to health providers in B.C. One component of the training is a discussion board to which participants are asked to contribute their perspective on stereotyping of Indigenous people. While offered in response to questions about stereotyping in the health system, the contributions provide broader insights into health provider perspectives and ways in which Indigenous people are served by the health system.

PHSA provided an Excel spreadsheet containing information for 39,576 participants who had taken San'yas training between 2009 and 2020. This dataset contained participant responses to the following discussion board questions:

- a. Have you ever encountered negative stereotyping of Indigenous people? If so, describe. If not, extend yourself beyond the work setting and think of any examples of negative stereotyping you might have encountered elsewhere.
- b. How did it impact the service the Indigenous person received?

The dataset also included the following information about each respondent: year of participation in the San'yas training; health authority; job category; ancestry; age group; education level and gender.

A random sample of 30 Indigenous respondents and 30 non-Indigenous respondents was drawn from each of the five geographic regions, FNHA and an "other" category which initially consisted primarily of PHSA settings and MCFD

(total of 420). With the exception of the Indigenous subset of the Vancouver Coastal sample, this was taken from the population of respondents who had participated in the training in 2019 or 2020. To complete the Vancouver Coastal sample, it was necessary to go back to 2016 to identify 30 Indigenous people who had participated in the training.

To ensure that the qualitative analysis was focused on the health system, the following two changes were made in the sampling:

1. Forty-four respondents from across the health authority categories were removed and replaced with respondents from the same health authority and ancestry category when the following criteria were met:
 - The respondent's stereotyping example was clearly not from the health system
 - The respondent made no mention of any aspect of their work or the health care system.
2. All MCFD respondents in the "other" health authority category were removed and randomly replaced with non-MCFD respondents.

Thematic Structure

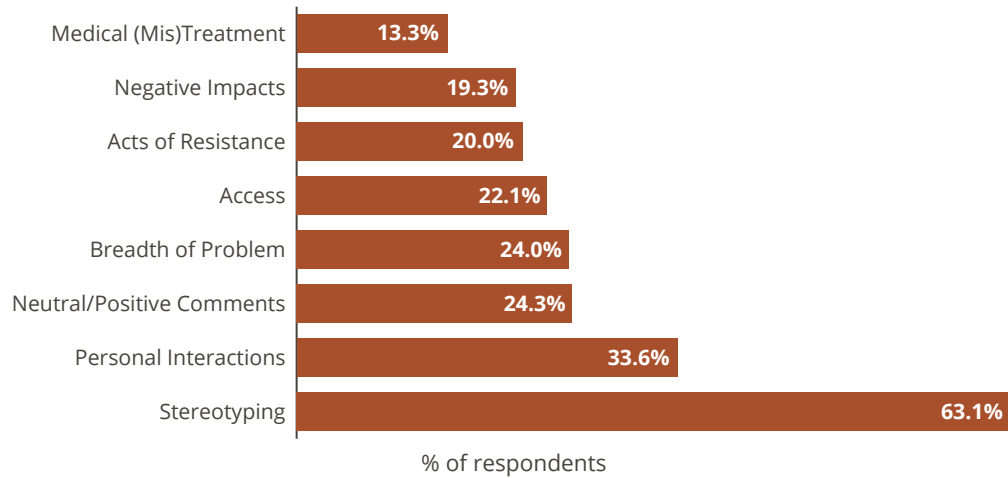
The six major themes that were developed during the Review Intake analysis remained relevant to the San'yas data. These themes were stereotyping; restricted access; unacceptable personal interactions; medical (mis)treatment; negative impacts; and breadth of the problem.

In addition, three new themes were identified:

- acts of resistance
- neutral/positive comments about the health system
- related areas of provider uncertainty.

The first two of these new themes were identified at the beginning of the San'yas analysis and included in frequency calculations. The third was identified as the analysis progressed, meaning that frequencies could not be reliably calculated.

The frequency with which the primary themes was discussed is illustrated in Figure 27.

Figure 27: Per cent of Respondents Discussing Each Theme

PHSA, 2020

Several new sub-themes were also developed. Falling under the ‘Unacceptable Personal Interactions’ theme were:

- Failure to respect culture
- Disengagement
- Failure to inform.

Falling under the ‘Stereotyping’ theme were:

- *“Looking Indigenous”*
- Pan-Indigenous.

Falling under the ‘Neutral/positive Comments about the Health System’ was:

- Comments about San’yas.

Falling under the ‘Related Areas of Provider Uncertainty’ theme were:

- *“Frequent flyers”*
- Substance users
- Determinants of health.

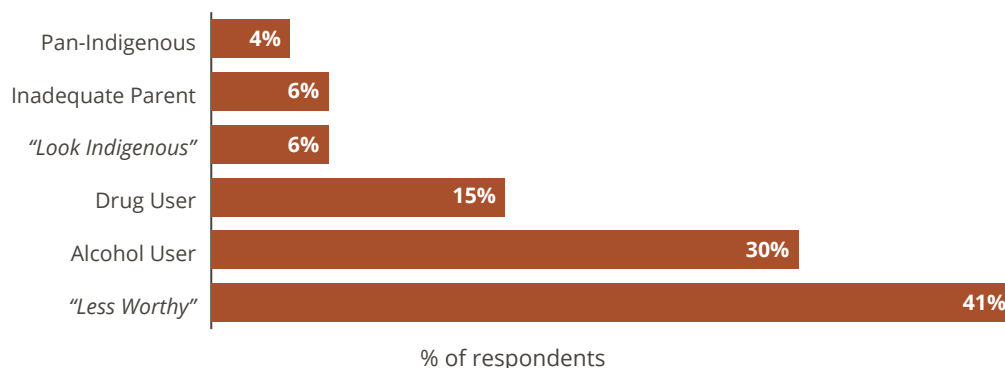
Description and Frequency of Themes

Themes are presented below in the order of the frequency with which they were discussed.

1. Stereotyping (n=265)

In light of the questions prompting the discussion board responses, it was not surprising that nearly two-thirds of responses described stereotyping of Indigenous people in the health system. They discussed six broad stereotypes with the frequency illustrated in Figure 28.²²

Figure 28: Stereotypes



PHSA, 2020

The primary stereotypes were discussed as follows:

a. "Less Worthy" of Care (n=174)

Forty-one per cent of respondents referenced the broad stereotype that Indigenous people were "less worthy" of care. This included a range of attitudes suggesting that Indigenous people formed a homogenous group and were less respectable, competent and valuable than others. Respondents talked of situations in which health workers stereotyped Indigenous people as being lazy, poorly educated, violent or frightening, dirty, thieving and unable to be on time. Living in Indigenous communities was presented as being inherently problematic. For some, poor treatment by health providers was provided for no reason other than that the person on the receiving end was Indigenous.

Within this broad category there were a number of specific stereotypes.

The one cited by most respondents (56), was that Indigenous people "get things for free". It was connected to the idea that Indigenous people were less deserving of support, and included references to education, taxation and medication.

Twenty-nine respondents talked about the stereotype that Indigenous people did not care about or take care of their health. This was linked to

²² Percentages in this section are based on the total number of respondents (420).

another stereotype, discussed by 28 people, that Indigenous people were “non-compliant” or “difficult”. In a number of examples, these stereotypes informed decisions by health workers not to “waste time” by referring Indigenous patients on for further treatment or specialist services.

b. Alcohol User (n=127)

A stereotype described by 30 per cent of respondents was that Indigenous people were problematic alcohol users. Respondents reported many experiences in which Indigenous patients were assumed to be drunk or sick as a result of alcohol use. These accounts sometimes included the detail that the patient had never drunk alcohol or had not drunk it in many years. Respondents also reported experiences where people who were drunk or alcoholics were assumed to be Indigenous.

c. Drug User (n=62)

Fifteen per cent of respondents described the stereotype that Indigenous people were drug users. Stereotyping regarding drug use was often linked to alcohol use; Indigenous people were broadly painted as having “*drug and alcohol issues*”. A small number of respondents described situations in which pain medication was withheld as a result of the belief that Indigenous patients were inappropriately drug-seeking.

The stereotype related to drug use showed up slightly differently in this dataset in comparison to the Review Intake data. Intake respondents had talked primarily about the stereotype that Indigenous people were drug-seeking and attempting to access medication without justification. In the San'yas data, drugs were discussed more in the context of general addictions.

d. “Looking Indigenous” (n=26)

Six per cent of respondents talked about health provider responses being informed by whether a person fit with a physical stereotype of an Indigenous person. People with darker skin were automatically assumed to be Indigenous and to fit one of the stereotypes described in this section. There was discussion about lighter skin enabling respondents to “pass” as non-Indigenous, meaning that they avoided Indigenous-specific racism and discrimination until the moment that their Indigenous identity became clear.

e. Inadequate Parent (n=24)

Six per cent of respondents spoke of the stereotype that Indigenous people are inadequate parents. This distinct stereotype was linked not only to poor treatment from health professionals, but also to the intervention of child welfare services.

f. Pan-Indigenous (n=18)

Although only raised by four per cent of respondents, this described a distinct way of stereotyping. Indigenous people were presented as a homogenous

group warranting responses that disregarded the specific culture, beliefs, needs and preferences of the person involved. Respondents described the practice of making automatic referrals for Indigenous or cultural services and of being asked to speak on behalf of all Indigenous people. Sometimes this stereotyping was attached to apparently positive traits, for example with assertions that all Indigenous people were spiritual, deserving of reverence and family oriented.

2. Unacceptable Personal Interactions (n=141)

Thirty-four per cent of respondents described health providers interacting with Indigenous people in a problematic way. These personal interactions took the following primary forms:

a. Verbally Abusive (n=65)

This primarily involved health providers making rude or racist comments which were made directly to a patient, overheard by the patient, or said to other staff. Staff were sometimes described as “*laughing at*” the person, and comments were accompanied by disrespectful gestures such as eye-rolling.

b. Failure to Respect Culture (n=31)

Respondents discussed a demonstrated lack of respect for Indigenous values and cultural practices in the interactions between health providers and those they served. This appeared to be rooted in a lack of understanding about the nature and importance of these values and practices. It showed up mainly in a failure to appreciate the roles taken by family and/or community members in the lives of Indigenous patients. Health providers were described as being intolerant of family members visiting relatives in hospital, and this appeared to be a particular issue when members of the patient’s circle gathered to mark a birth or a patient passing. This theme also included examples of health providers failing to recognize or value the importance of smudging, drumming, song, history, languages, names and hair care for particular Indigenous patients.

c. Disbelieving (n=27)

Respondents talked about staff holding a disbelieving stance towards them. The interaction with the health provider was characterized as one in which the provider minimized their concerns, opinions or choices. Most often, this was described as a passive act: a failure to listen to them or take them seriously. In a small number of responses, it was more aggressive, with some patients being explicitly accused of “*faking*”, exaggerating or being manipulative.

d. Cold and Harsh (n=22)

Respondents discussed the general demeanour of staff as lacking a sense of compassion, caring and humanity. As one respondent commented, nothing derogatory needed to be said when this general demeanour could convey so much of staff hostility and disrespect.

e. Disrespect for Patients' Physical Bodies (n=11)

Disrespect for patients' physical bodies showed up in two ways. The first was in examples of patients being physically manhandled or treated roughly. The second way was in a failure to meet patients' basic needs for food, warmth or proper hygiene.

Disrespect for patients' physical bodies – and, in particular, incidents of physical manhandling – was considerably less obvious in the San'yas responses than in the Intake data.

3. Neutral or Positive Comments (n=102)

Twenty-four per cent of respondents made comments that reflected positively on the health system. Some respondents complimented the work being done by particular health professionals. Two distinct sub-themes were:

a. No Negative Stereotyping at my Work (n=54)

Thirteen per cent of respondents claimed that they had not seen negative stereotyping of Indigenous people in their workplace. These claims may well reflect the fact that some workplaces have addressed this issue more effectively than others, although some respondents acknowledged that they might also lack the insight to recognize this stereotyping.

Just over a quarter of respondents offered examples of stereotyping that were clearly not from the health system. In many cases, they were childhood memories and involved Indigenous people being mistreated in retail stores or at school. The stereotypes reflected those shared by respondents who did provide health-related examples.

b. Positive Comments about San'yas (n=35)

These comments about the San'yas training were overwhelmingly positive, related to the ways in which the training had prompted reflection and led to new learning. The discussion format and ability to learn from others and recall past experiences was particularly valued.

4. The Breadth of the Problem (n=101)

Twenty-four per cent of respondents discussed Indigenous-specific racism and discrimination as being a widespread and/or systemic problem within the health system. Three sub-themes could be identified in their contributions on the issue:

a. Racism is systemic (n=68)

Respondents discussed Indigenous-specific racism and discrimination as an embedded problem in the health care delivery system. While 50 respondents identified the ED as the location of stereotyping and other

The ineffectiveness of complaints processes was discussed by only three respondents and was far less prominent than it had been in the Intake data. This may simply be because respondents had not been asked to reflect on this issue or had little direct experience with the complaints process.

oppressive behaviour, the same number described it happening in multiple settings, or on multiple occasions, or were explicit that this was a problem throughout the health system. In addition, respondents talked about systemic issues like a lack of Indigenous staff, training, resources for Indigenous people and a failure of leadership and political accountability.

b. Staff Remain Silent (n=26)

Respondents discussed situations in which they or other health providers stayed silent in the face of Indigenous-specific racism or discrimination. Some respondents talked about not knowing how to speak up or of lacking courage at moments when they felt they should have challenged oppressive behaviour. Others described in more general terms the difficulties of speaking up in a system in which there was complacency and 'group think'.

c. Racism Against Indigenous Staff (n=18)

Respondents discussed being the recipients of Indigenous-specific racism or discrimination at work. Similar to patients stereotyped as "*less worthy*" of care, they described being seen as less educated, sober, and capable of competent and professional conduct than non-Indigenous colleagues.

The health system discriminates in other ways as well

Twenty-one respondents identified ways in which they felt the health system discriminates against groups of people other than Indigenous people. Unlike in the Intake data analysis, these responses were not included in the 'breadth of the problem' theme, so as to keep the focus clearly on Indigenous-specific discrimination.

5. Restricted Access (n=93)

One of the ways in which Indigenous patients were discriminated against in the health system was by restrictions on their access to care.

a. Shut Out (n=64)

Respondents discussed being shut out of care. This included being turned away when they sought help, often leading to repeated attempts to access service. It also included reports of Indigenous people being sent home without the expected assessment, treatment or planning. Access to tests appeared as a particular issue, with health providers failing to make or request appropriate and timely assessments due to stereotyping. There were accounts of negative health provider attitudes shifting abruptly once test results came in. Being shut out also included examples of patients being declined help, treatment, specialist referrals and aftercare.

b. Made to Wait (n=28)

Respondents discussed Indigenous patients having delayed care and being made to wait for services. Several attributed the delays specifically to the patients' Indigenous identity and related stereotyping.

c. Treated Differently (n=11)

Respondents described examples of situations in which Indigenous people were treated differently in direct comparison to non-Indigenous people. Several talked of Indigenous people having their turn in line taken by non-Indigenous people, with health providers being explicit that this was due to patients being stereotyped. Others talked of Indigenous patients being given less access to quality care than non-Indigenous patients in the same situation.

While being 'made to wait' was a common theme across the Intake and San'yas data, the particularly distressing elements of being isolated or waiting alone was not discussed by San'yas respondents. This may indicate that some health providers are unaware of the particularly powerful impact this isolation may have on some Indigenous patients.

6. Acts of Resistance: (n=84)

Twenty per cent of respondents described individual acts of resistance in response to the Indigenous-specific racist or discriminatory treatment they witnessed in the health system. They resisted by either going out of their way to show compassion to the Indigenous person involved or challenging and educating the staff who were being oppressive. Respondents primarily talked about their own behaviour, and some Indigenous respondents spoke of a responsibility to teach others or to speak up about these issues.

7. Negative Impacts (n=81)

The negative impacts of Indigenous-specific racism and discrimination were evident in 19 per cent of respondent accounts. They included:

a. Emotional Harm (n=39)

The most common impact described was emotional harm. Respondents described interactions with the health system leaving patients with distressing feelings including hurt, anger, shame, sadness, humiliation and distress. Several respondents gave accounts of patients losing trust in health professionals as a result of their experiences.

San'yas respondents tended to describe immediate and short-term emotional impacts of interactions with health providers. Few described the kind of long-lasting, emotional harm that was apparent in the Intake data.

b. Avoid the Health System (n=36)

Another common response to the care received was to change behaviour to avoid future interactions with the health system. This might mean choosing to leave hospital early, or not returning in the event of future pain or need for treatment. Some patients avoided a particular health setting, while others sought to avoid the health system altogether.

c. Physical Harm (n=26)

Respondents described ways in which the physical health of patients was negatively impacted by their interactions with the health system. Just over half of this group gave examples that led to the patient's death. While specific examples were given of patients needing emergency admission to surgery or intensive care, most other respondents made general connections between the poor treatment received by Indigenous people leading to the worsening of their conditions, delayed healing and chronic disease.

8. Medical (Mis)Treatment (n=56)

Thirteen per cent of respondents described stereotyping leading to incidents of medical mistreatment.

a. Medical Misdiagnoses and Mistakes (n=44)

The outcome of stereotyping was, in the accounts of 10 per cent of respondents, medical misdiagnoses and mistakes. This was discussed most often in relation to falls; there were reports that staff assumed patients who had fallen must be Indigenous and of failing to diagnose concussions, tumours and head injuries because the Indigenous patient was believed to be under the influence of alcohol or drugs. Liver conditions, including lethal liver failure, were also missed in the medical treatment of a number of patients or were misattributed to alcohol use. Stereotyping was reported to lead to the symptoms of stroke and diabetes being misinterpreted and seizure-inducing conditions, like brain haemorrhage and Parkinson's disease, being missed.

Inappropriate pain management was not as evident in the San'yas data as it had been in the Review Intake histories. This may reflect the fact that the mismanagement of pain is clearest to the patient experiencing it, and San'yas respondents typically discussed their experiences as health providers rather than as patients. It may also be because the histories provided by Intake respondents reflected the more egregious examples of medical (mis)treatment.

In several accounts, patients who were conscious or semi-conscious were mistakenly assumed to be drunk or high and their medical needs were left unattended. On a related note, one professional commented that stereotypes were more overtly shared between staff when the patient was unconscious.

b. Inappropriate Pain Management (n=13)

While it was reported only by three per cent of the San'yas sample respondents, this is a distinct issue that was reported to have significant consequences. It was associated by some with the denial of pain medication due to the stereotype that the medication would be misused or was inappropriate for Indigenous people.

9. Related Areas of Provider Uncertainty

This theme describes issues about which respondents described or demonstrated a particular lack of knowledge, competence or confidence and which clearly informed, but were not limited to, the treatment of Indigenous people. Sub-themes included two categories of patient that respondents appeared to have particular difficulty in treating effectively and with compassion. Indigenous people might fall within one of these groups without any stereotyping taking place, or they might be placed in such a group as a result of stereotyping.

a. “Frequent Flyers”

The term “*frequent flyer*” was used several times to describe people who attended health care settings, and in particular the ED, on a regular basis. Professionals presented as being frustrated by their repeated attendance, and at a loss to know how to address them. This sub-theme was linked to the sub-theme of being “shut out”; the typical response was for the patient to be told to leave or otherwise denied service, contributing to the cycle of repeated visits.

b. Substance Users

Patients who were alcohol and drug users were presented as being particularly difficult to manage. Health providers appeared challenged to keep motivated to provide good care for people with addictions.

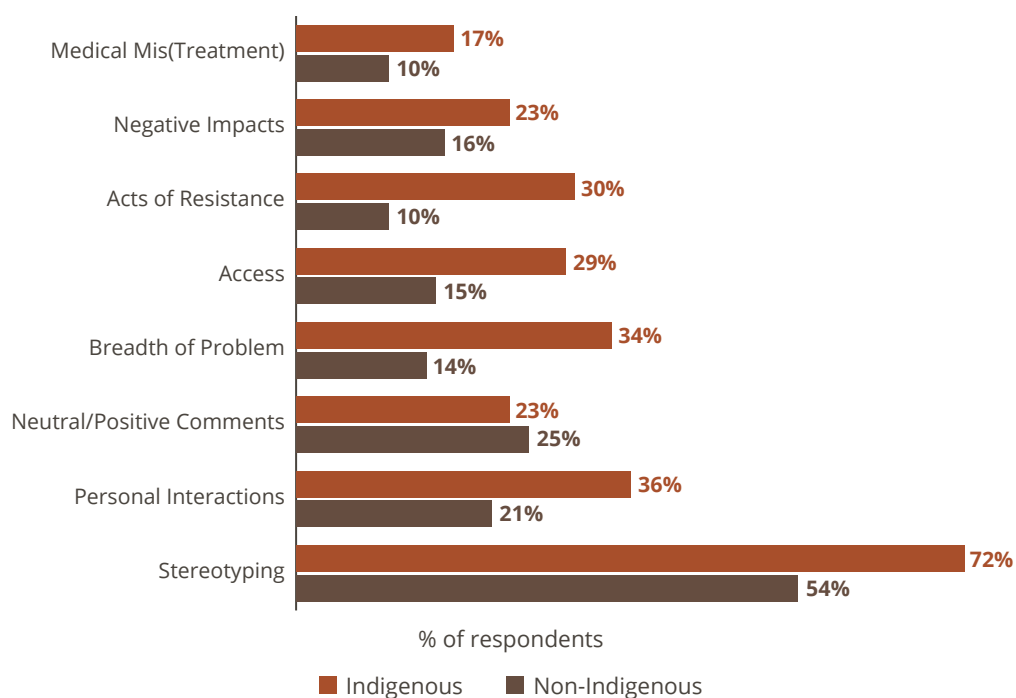
c. Determinants of Health

Respondents discussed issues related to the interplay of individual and social determinants of health. Questions were raised as to how to use knowledge about the social determinants of health without stereotyping, and about the value of risk factors and population-level information in informing equitable individual care. It was suggested that the health, and health education, systems tended to frame societal injustices as issues of cultural or individual pathology.

Distribution of Themes by Indigenous Identity

There were noticeable differences in the numbers of Indigenous and non-Indigenous respondents who discussed each theme, as illustrated in Figure 29. The greatest differences were seen in the ‘breadth of the problem,’ and ‘acts of resistance’ themes. Notably, the only theme where non-Indigenous respondents had a higher response rate was neutral/positive comments about the health system.

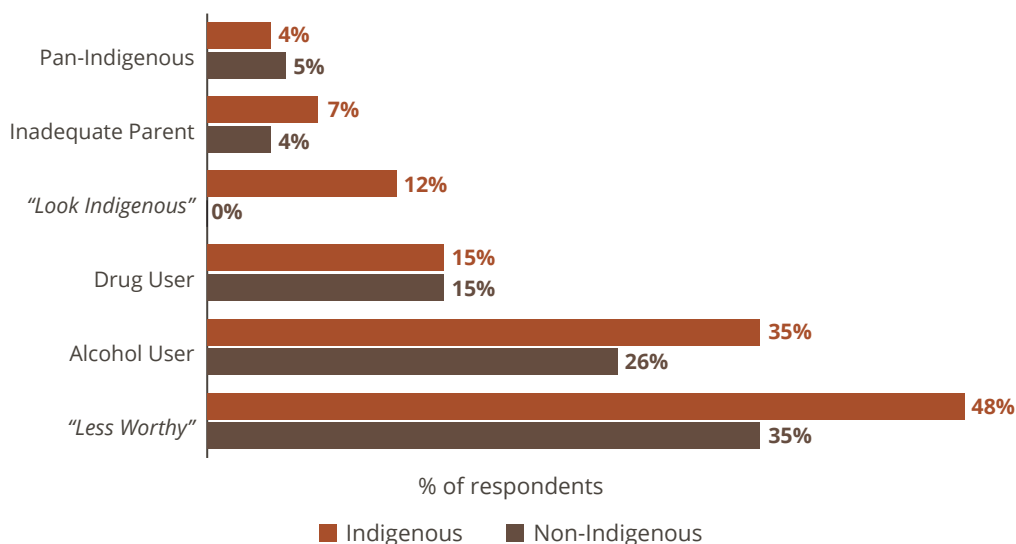
Figure 29: Discussion of Themes by Respondent Type



PHSA, 2020

Figure 30 provides the frequency of reporting common stereotypes by respondent type. Nearly 50 per cent of non-Indigenous respondents could not offer a work-related example of stereotyping. The most common stereotypes reported by both groups were alcohol user and “less worthy”.

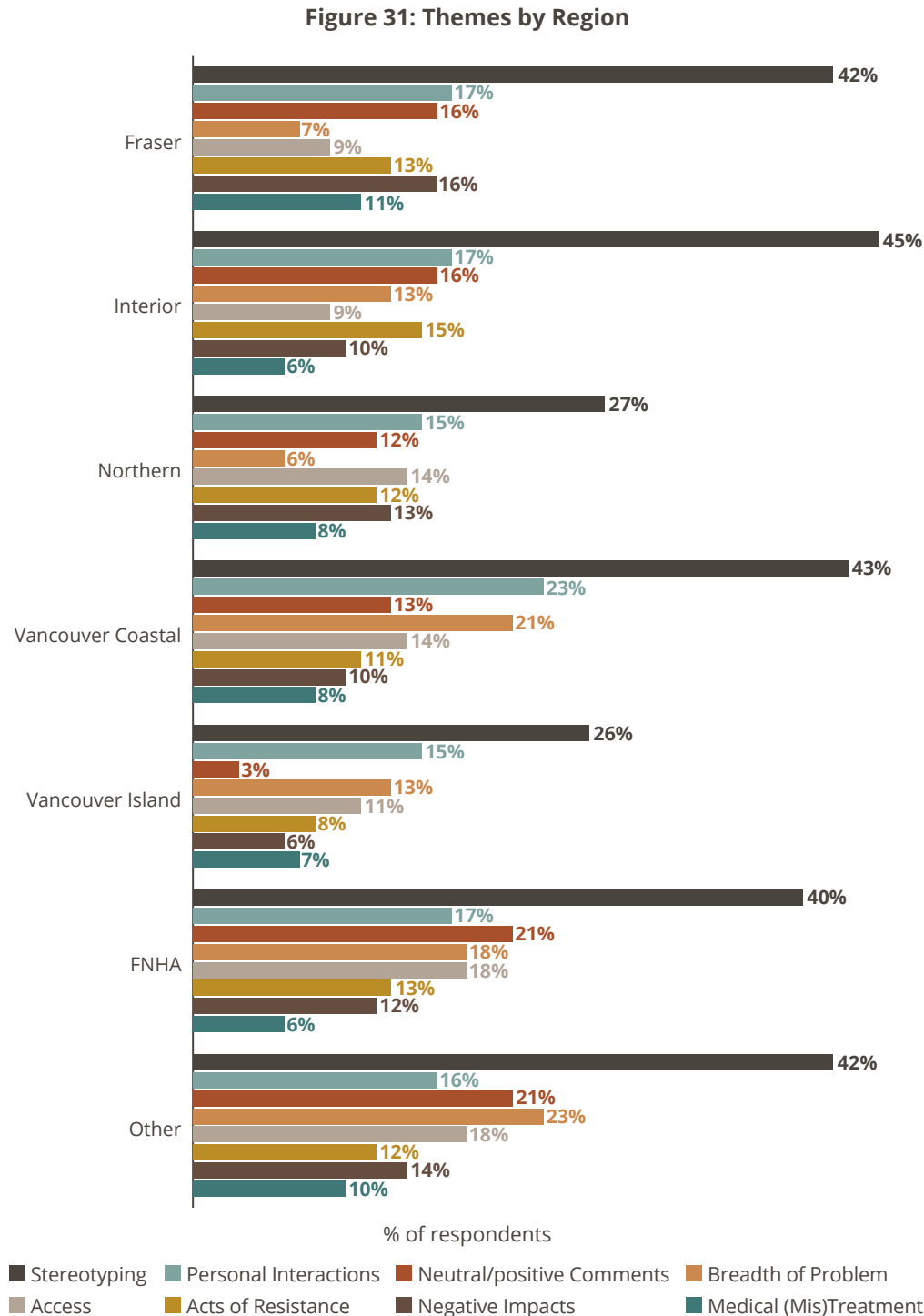
Figure 30: Identification of Stereotypes by Respondent Type



PHSA, 2020

Distribution of Themes by Region

Figure 31 provides a perspective on the frequency with which each of the primary themes was discussed across the regions. It should come as no surprise that stereotyping was the main focus of discussion in every region, in light of the fact that respondents had been prompted to contribute stereotyping examples.



PHSA, 2020

There are some visible differences between the regions. Within this sample, for instance, Vancouver Island respondents provided a low number of neutral/positive comments, and a relatively high number of Vancouver Coastal respondents discussed personal interactions. It is difficult to interpret these differences; a particular issue may be discussed more within a particular region because it is more present, and/or because staff are more insightful about it. Perhaps the clearest conclusion to be drawn from these frequencies is that Indigenous-specific discrimination and racism is an issue across every health authority.

Summary

The six major themes that were developed during the Review Intake analysis remained relevant to the San'yas data. These themes were stereotyping; restricted access; unacceptable personal interactions; medical (mis)treatment; negative impacts; and breadth of the problem. In addition, three new themes were identified: acts of resistance, neutral/positive comments about the health system and related areas of provider uncertainty.

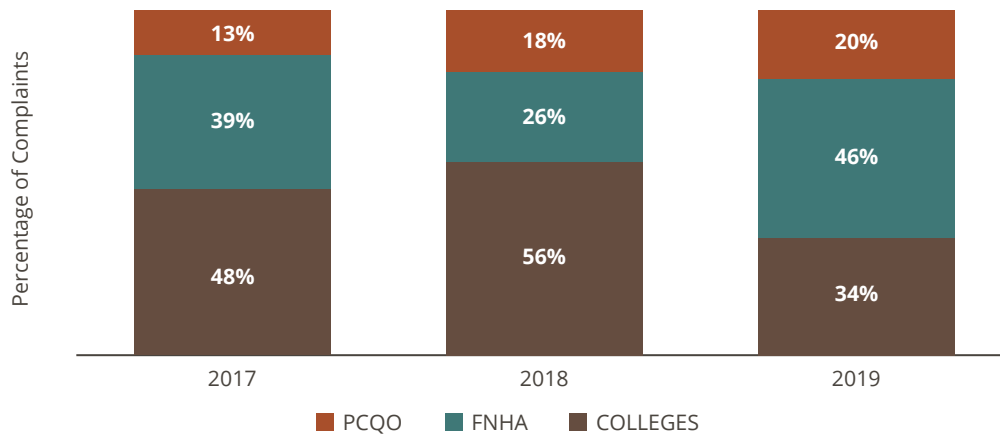
Considerably more Indigenous people talked about each of the different manifestations of Indigenous-specific racism and discrimination, while non-Indigenous respondents outstripped Indigenous respondents only on neutral/positive comments about the health system. This suggests a clear difference in the level of insight into, and direct experience of, this type of oppression. The fact that 'acts of resistance' were discussed by three times more Indigenous respondents than non-Indigenous respondents, and most examples were of the respondent or an Indigenous person challenging the oppressive behaviour, supports the conclusion that Indigenous staff in the health system shoulder a significant and disproportionate burden for standing up against Indigenous-specific discrimination and racism.

It is striking that even when explicitly prompted, nearly 50 per cent of non-Indigenous respondents could not offer a work-related example of stereotyping. Those who did were overwhelmingly silent on an issue raised by a significant number of Indigenous participants: that of being treated according to a stereotype of "*looking Indigenous*". It is notable, too, that the only stereotyping sub-theme to be identified in more non-Indigenous responses than Indigenous responses was "*Pan-Indigenous*", and this appeared to reflect a lack of understanding on the part of some non-Indigenous respondents as to differences between Indigenous people, cultures and communities.

5.5 Indigenous-Specific Complaints

The Review gathered and analyzed data regarding the use of health authorities' and regulated health professional colleges' complaints processes by Indigenous peoples. Between 2017 and 2019, 355 complaints involving Indigenous people were identifiable when searching complaints data from health authority PCQOs, FNHA Quality Care and Safety office, and the regulatory colleges for dentists, nurses and midwives, physicians and surgeons, and psychologists in B.C. (Figure 32) This three-year total amounts to an annual average of roughly 118 complaints.

Figure 32: Indigenous Complaints by Source



Review, 2020

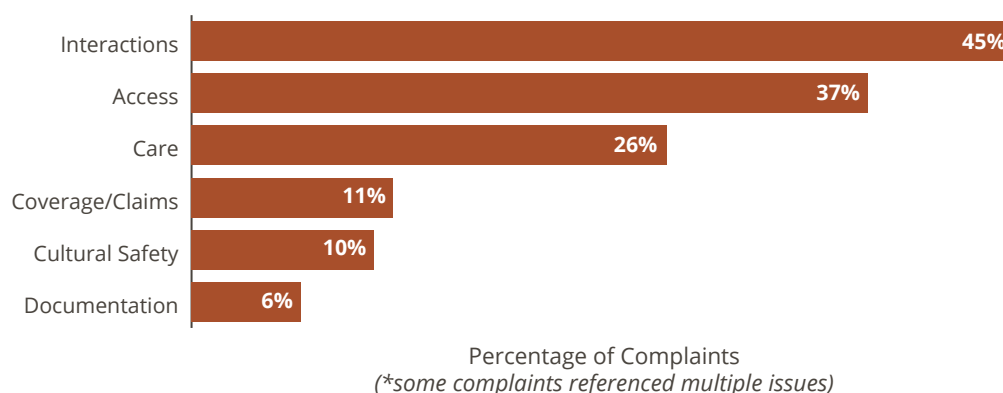
The Review qualitatively analyzed a sample of complaints received from PCQOs, FNHA and regulatory colleges spanning the period of 2011 to 2020 (n=431) and identified common concerns regarding health care provision. (Figure 33) The three most common complaints related to individual interactions, restricted access and poor care:

- 1. Individual interactions.** Complainants described interactions with health providers as being disrespectful, rude, informed by stereotypes, and lacking in compassion and warmth. Many felt they were not listened to or believed and described staff failing to acknowledge their presence, explain important information, obtain their consent or take them seriously. Complainants spoke of being lied to, mocked and yelled at. Some providers were described as aggressive, controlling, transgressing professional boundaries and engaging in physically rough or assaultive behaviour.
- 2. Restricted access** to timely appropriate care. Patient histories included being turned away from the hospital, denied treatment and not receiving appropriate assessments or referrals. Many spoke of being discharged

early or without enough planning and support. There were concerns about delays in receiving service and the lack of access to physicians, specialists, Indigenous support workers and Elders. Complainants also described breakdowns in travel arrangements to access care, including a general lack of support for travel for patients and family, changes to transportation arrangements, delayed payment of claims and substandard accommodation while away.

3. Poor care that failed to meet practice standards or patient expectations. These complaints included misdiagnoses, missed diagnoses and errors in assessments and the administration of medication and vaccinations. They also included concerns about prescribing practices and the mismanagement of pain.

Figure 33: Types of Complaints Issues



Review, 2020

The next most common complaints issues tended to be directed to a particular complaints process. The colleges received nearly all the complaints about absent, inaccurate or mismanaged documentation. The overwhelming majority of complaints regarding financial coverage and claims for medicine, equipment and services were received by FNHA. The health authorities received the majority of complaints about culturally unsafe care, the exclusion of family members and specific cultural practices, knowledge or ceremony.

An explicit link between Indigenous identity and the problematic health care received was made by complainants and documented by complaints officers for between 11 per cent and 82 per cent of complaints across all sources analyzed. This considerable variation may reflect differences in the extent to which complaints officers and processes had awareness and understanding of these issues.

When the link between poor care and the patient's Indigenous identity was formally recognized during the intake stage, there was little documented evidence that the responding body explicitly addressed or considered this issue in its response to the complainant. Conversely, disposition of reports of disrespectful, racist or discriminatory behaviour included a reference to the provider's 'true' intentions, and were met with broad statements of the responding body's commitment to cultural safety, or were found to be unverifiable because they were not reflected in the health provider's written account of their own behaviour in patient records – on which many complaints investigations heavily rely. It is not surprising that a common message from those who shared their patient histories with the Review was that making a complaint achieved little.

The regulatory colleges appear similarly ill-equipped to address the complexity of Indigenous patient experiences when they involved other health providers, multiple settings or systemic discrimination or racism. Complaints to health regulators related to Indigenous patients resulted in a critical finding against the professional more often when the complaint was made by another health provider, and less often when it was made by a patient or their family member. These complaints often focused on issues such as the quality of documentation rather than problematic interactions and access that were commonly the focus of complaints made by Indigenous patients and their families.

Summary

There were three main themes in the review of Indigenous-specific complaints received by health authorities and regulatory colleges: negative experiences/interactions with individual health providers, having access to care restricted or denied, and care which did not meet practice standards or patient expectations.

The Review's analysis found that the complaint processes used by these organizations are not easily accessible to Indigenous people, do not include space for Indigenous processes and methods, and can reinforce experiences of racism and stereotyping. The end result is that Indigenous people may be left with little recourse for poor treatment. This has the effect of reinforcing for Indigenous individuals, and more generally for some Indigenous communities, that within the health system one may experience injustices without any opportunity for those wrongs to be addressed. This reproduces past harms and trauma that have been part of the experience of colonialism in the health care system and contributes to a lack of access and poorer health outcomes.

6. Findings: Quantitative Data Sources



6.1 Data Associations Between Racism and Wellness

One goal of this Review was to bring together the data that exists in B.C. that demonstrate the connection between racism, reduced access to health care and poorer health outcomes, and to supplement that data with additional insights and information gathered through the Review. The connection between racism and lower health and well-being has been well-documented in the literature. In 2012, one study surveyed over 250 publications which examined racism as a determinant of mental and physical health and/or health behaviours. This extensive research reveals the strong association between self-reported racism and ill-health among minority groups in many developed countries. Racism tends to precede ill-health rather than vice versa, and does in both mental ill-health and physical disease.^{23,24} This relationship has been explored through the work of the Review using data from the first, and only, national First Nations health survey of its kind, the *First Nations Regional Health Survey (RHS)*, which periodically collects wide-ranging information about First Nations on reserve and Northern communities based on western and traditional understandings of health and well-being.^{25,26} Examination of the *RHS* data has demonstrated this same connection between the experiences of racism and many other determinants of health. These results do not independently establish causation between racism and well-being, but the associations between the *RHS* responses to experiences of racism and the many determinants of health showcased below strongly supports the extensive body of research noted above.²⁷

²³ Paradies YC and J Cunningham. The DRUID study: racism and self-assessed health status in an Indigenous population. *BMC Public Health* 2012, 12:131.

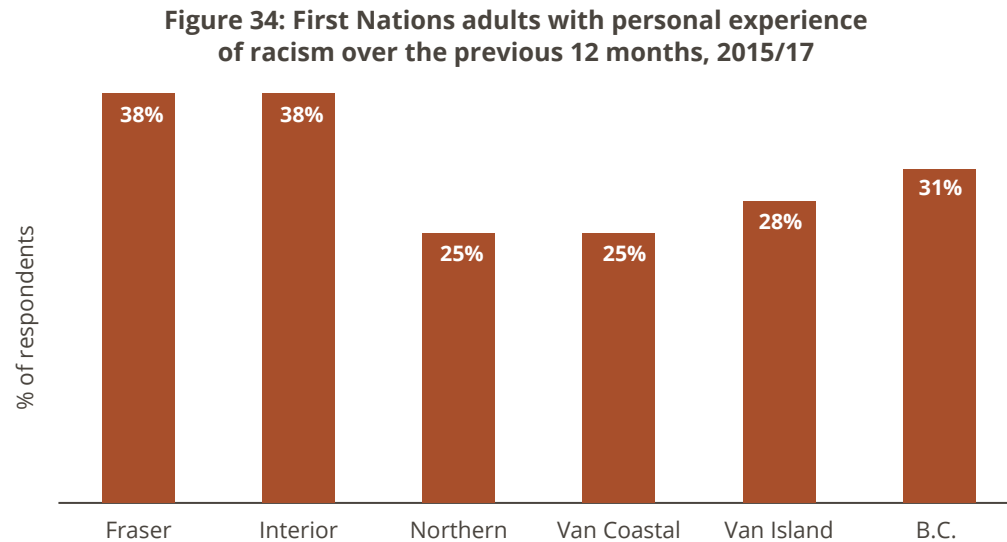
²⁴ Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaheer, M., & Gee, G. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PloS one*, 10(9), e0138511. <https://doi.org/10.1371/journal.pone.0138511>

²⁵ The *First Nations Regional Health Survey (RHS)* is a First Nations-governed, national health survey in Canada which is administered in all regions.

²⁶ FNHA. 2019a. B.C. *First Nations Regional Health Survey*, 2015-17.

²⁷ The *RHS* has been validated by evaluation teams from Harvard University (in 2006) and Johns Hopkins University (in 2012), who praised the survey methodology as “outstanding” and “first-rate” and concluded that the execution of the *RHS* was “excellent overall and superb along many dimensions.” <https://fnigc.ca/first-nations-regional-health-survey.html>.

In the most recent round of the B.C. *RHS* (2015-17), one of the survey questions addressed racism specifically. Thirty-one per cent of First Nations adults indicated that they had personally experienced racism in the previous 12 months.²⁸ (Figure 34) The responses to this question on racism have been investigated below against health and well-being questions in the *RHS*, including stress/distress, suicidation, lifestyle choices and health outcomes.



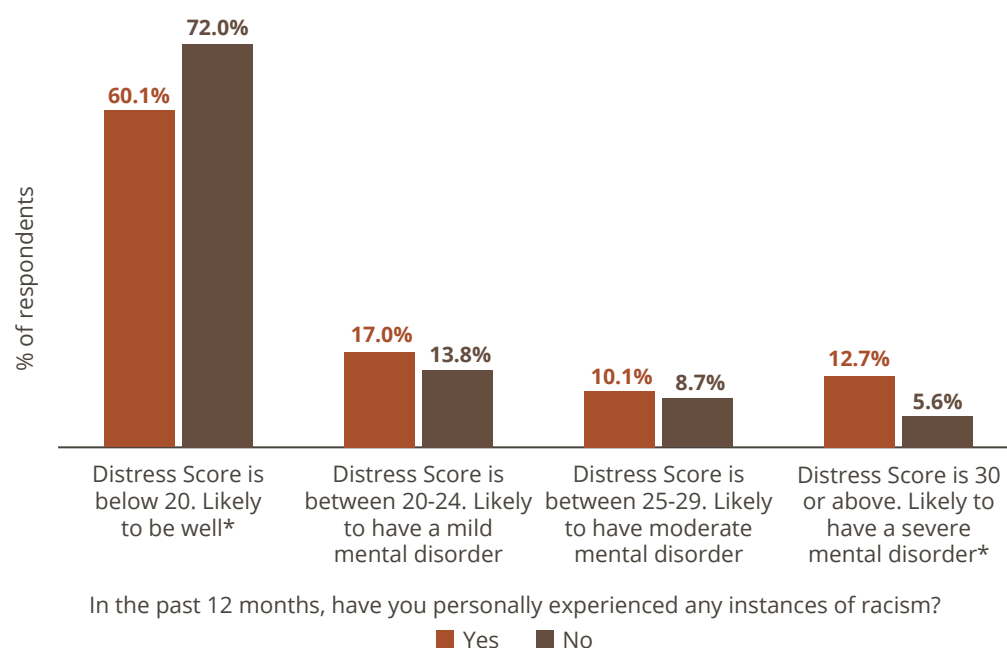
FNHA (*RHS*), 2020

²⁸ In Section 6 Findings: Quantitative Data Sources, all rates reported are age standardized (a/s) unless otherwise noted or represent an age group. Differences between populations are noted in the text if there is a statistically significant difference evaluated by chi square analysis or confidence interval measurement as appropriate. In the figures, significant differences are identified with an asterisk.

Distress and Stress

The *RHS* incorporated the Kessler Psychological Distress Scale (K10) as a global measure of distress of respondents based on questions about anxiety and depressive symptoms. The results indicated that persons who scored in the well range of the scale (<20) were less likely to have personally experienced racism over the past 12 months, and those who had an extreme distress score (>30) were more likely to have experienced this racism. (Figure 35)

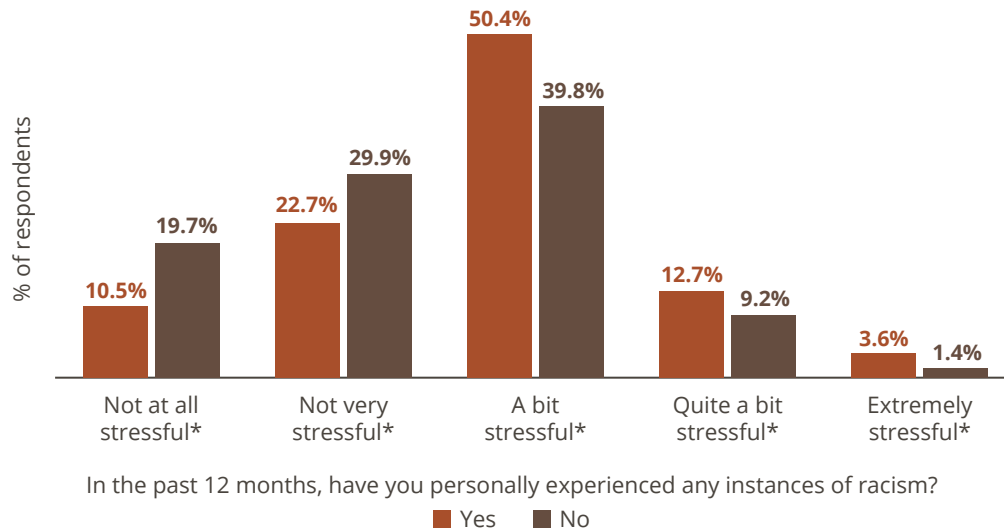
Figure 35: First Nations adults who personally experienced instances of racism, by distress, 2015/17



**Significantly different
FNHA (RHS), 2020*

Respondents were asked about the level of stress they experienced on most days. The percentage of individuals who answered yes to experiencing racism was significantly higher than those who answered no for the following responses about their level of stress: “a bit stressful”, “quite a bit stressful,” and “extremely stressful.” The only response where respondents were more likely to have answered no to a previous racism experience was “not at all stressful.” (Figure 36)

Figure 36: First Nations adults who personally experienced instances of racism, by stress level, 2015/17



**Significantly different*

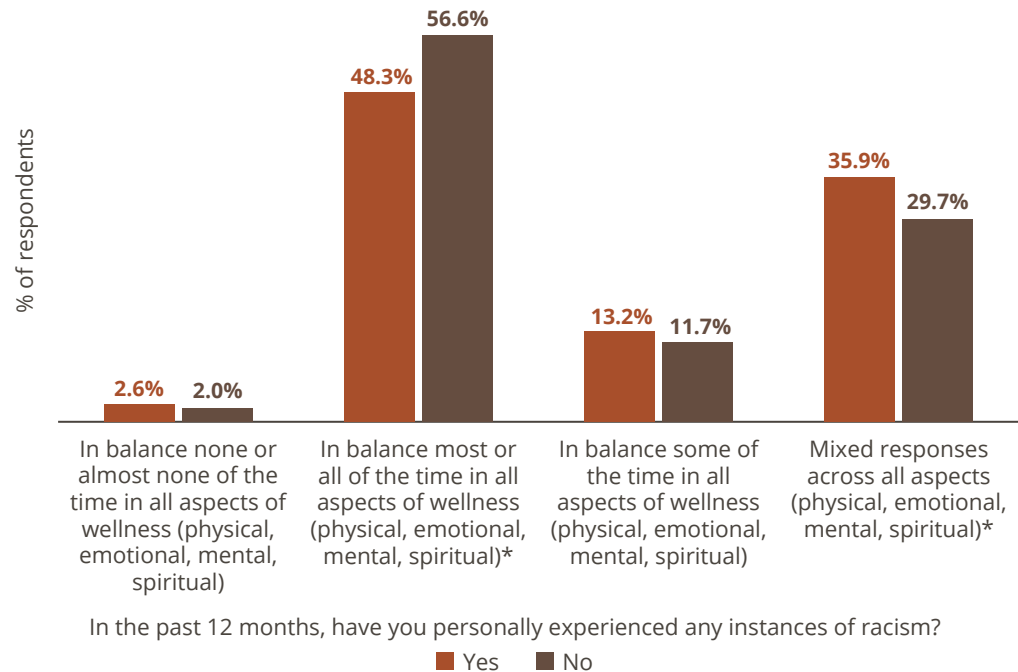
Moderate variability in the 'extremely stressful' results. Interpret with caution.

FNHA (RHS), 2020

Overall Balance

Respondents were asked how often they felt that they were in balance in the four aspects of their life: physically, emotionally, mentally and spiritually. There were very few respondents who answered that they were in balance none or almost none of the time (<3%). Those who answered that they were in balance most or all of the time were less likely to have experienced racism in the previous 12 months, whereas those who had a mixed response across the four aspects of balance were more likely to have experienced racism. (Figure 37)

Figure 37: First Nations adults who personally experienced instances of racism, by degree of balance, 2015/17



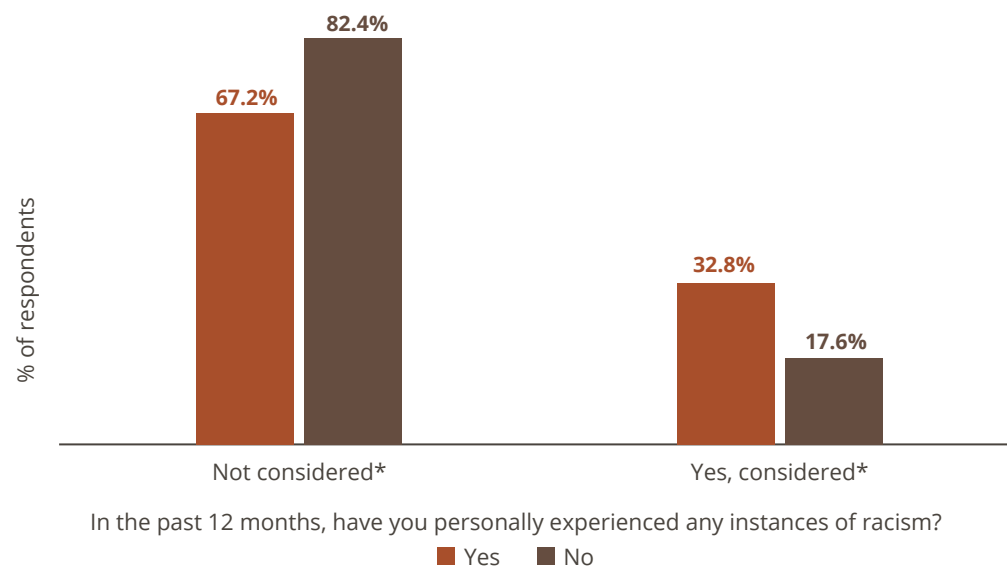
**Significantly different
FNHA (RHS), 2020*

Suicidation

When asked “Have you ever seriously considered suicide?” the percentage of individuals who answered yes was 32.8 per cent among those who had experienced racism in the last 12 months, which was significantly higher than the 17.6 per cent rate from individuals who had not experienced racism. Those persons who answered that they had not ever considered suicide within that time frame were less likely to have experienced racism. (Figure 38)

A similar pattern of findings was obtained from the question “Have you ever attempted suicide?”

Figure 38: First Nations adults who personally experienced instances of racism, by degree of consideration of suicide, 2015/17



**Significantly different*

FNHA (RHS), 2020

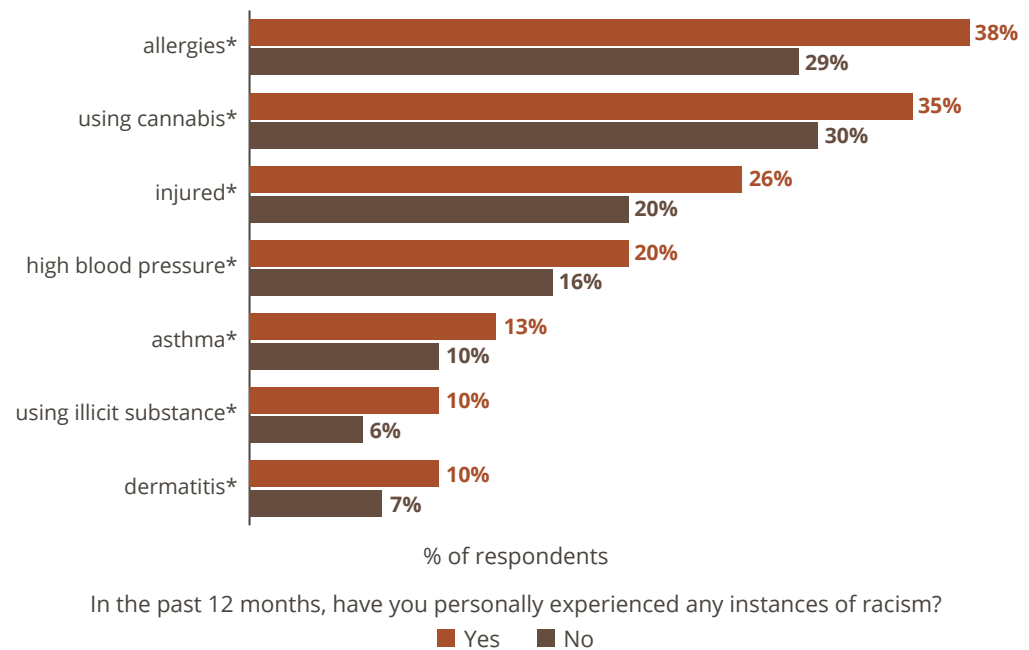
Health Status & Life Experiences

The experience of racism was analyzed in conjunction with a variety of health status indicators and life experiences. Persons who had experienced racism had higher rates for allergies, high blood pressure, asthma, dermatitis and injury (Figure 39). They also had a greater use of use of cannabis or illicit substances. On average, the rates for persons who had experienced racism were about 20 per cent to 40 per cent higher than those without these health outcomes or experiences. It should be noted that the connection between racism and health outcomes can be multifactorial and complex, as an increasing level of morbidity in itself can result in more needs for health services, which then provides for a greater opportunity to be exposed to racism.

Persons who had experienced racism also had higher rates for experiencing aggression, cyberbullying, and anxiety and mood disorders. These rates were 60 per cent or more higher than those without this experience of racism for aggression and mental disorders, and 3X greater for cyberbullying.

Also associated with a previous racist experience was a greater likelihood of having a high school diploma and working for pay, suggesting that these situations may provide more opportunities to be exposed to racist environments or structural racism.

Figure 39: First Nations adults who personally experienced racism, by health outcomes and use of mood altering substance, 2015-17



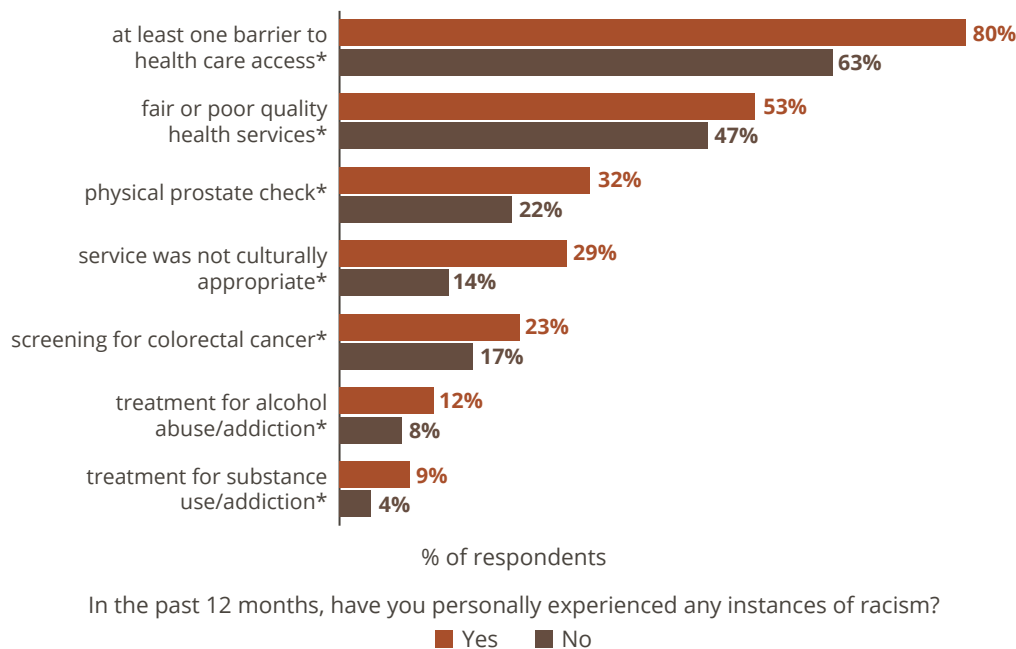
**Significantly different*

FNHA (RHS), 2020

Health Services

Significant differences were obtained between respondents who did and did not experience racism across a variety of health service indicators. Persons who reported a racist experience were more likely to have had at least one barrier to health care access, evaluate health services as fair or poor, or as not culturally appropriate, and have accessed prostate and colorectal screening services. (Figure 40)

Figure 40: First Nations adults who personally experienced racism, by health service access and utilization, 2015-17



**Significantly different*

Moderate variability in the results for "treatment for alcohol use/addiction" and "treatment for substance use/addiction." Interpret with caution.

FNHA (RHS), 2020

Mental Health

Because of the dynamic interplay between racism, mental wellness and health outcomes, the *RHS* data was looked at from the perspective of mental wellness, not only experiential racism. The *RHS* mental wellness data showed a similar pattern of results as seen with the racism question above, whereby persons who self-evaluated as having fair or poor mental health had higher rates for distress, stress, lack of balance and suicidation considerations/attempts than those who self-evaluated as having good/very good/excellent mental health. Although this analysis cannot substantiate causation – that racism causes

mental illness and issues with physical health and wellness – the data does suggest that there can be a dual association of racism and lack of mental wellness in diverse health outcomes. It also is compatible with the published findings noted above that racism tends to precede ill-health for both mental ill-health and physical disease.

In the *RHS*, there was a higher percentage of respondents reporting the following conditions, treatment or issues who also self-evaluated as having fair/poor mental health, compared to those who reported good/very good/excellent mental health:

- phobia, obsessive-compulsive disorder or a panic disorder (26% fair/poor vs 8% good/very good/excellent)
- depression, bipolar disorder, mania or dysthymia (29% vs 7%)
- cyberbullying in the past 12 months (16% vs 7%)
- physical or verbal aggression (55% vs 42%)
- asthma (14% vs 11%)
- chronic back pain excluding arthritis (30% vs 17%)
- dermatitis/atopic eczema (13% vs 7%)
- high blood pressure (23% vs 16%)
- quality of health care services as fair/poor (61% vs 47%)
- at least one barrier to health care access (77% vs 67%)
- health care service not culturally appropriate (24% vs 18%)
- treatment for alcohol abuse/alcohol addiction (14% vs 8%)
- at least one use of illicit substance in the past 12 months (12% vs 7%)
- treatment for substance abuse/substance addiction (12% vs 4%)
- injured in the past 12 months (27% vs 21%)

Three indicators (high school diploma, working at a job for pay, and able to meet all the basic living requirements) were reported by a higher percentage of people who self-evaluated as having good/very good/excellent mental health than those who reported fair/poor mental health.

6.2 Population Segments

One way of assessing the health needs of a population is to group individuals with similar health status together as a tool for health system performance reporting. In B.C., this is accomplished through 14 population segments, extending from non-users of services to the highest severity of disease (end of life population segment). This grouping is exclusive – an individual may be in only one population segment, which is the one which represents their highest acuity of disease during the year. The assignment into groups is primarily based on utilization of hospital and physician services. Appendix 5 provides a description of these population segments (PS01 – PS14).

Using this population segmentation, 14.3 per cent of the First Nations population were non-users (PS01) of health care in 2017/18, a slightly lower rate than seen with Other Residents. First Nations were also less likely to be categorized in the healthy population segment (PS02) compared to Other Residents (30.8% versus 37.3%). The healthy population segment includes people who are low users of the health system.

Whereas the proportion of the First Nations population who were “healthy” was fairly consistent across health regions (30% to 32%), the Other Resident population showed differences (about 34.2% in the Northern up to 39.9% in Vancouver Coastal regions). Regardless, “healthy” First Nations were a lower percentage of the population than Other Residents in all regions, with the largest disparity in Vancouver Coastal, and the smallest in the Northern region.

When compared to Other Residents, First Nations had higher proportions in the population segments that were related to the levels of chronic condition complexity, severe mental health and substance use (PS06, MHSU), and child and youth major conditions (PS04). After the healthy segment (30.8%), the highest proportion for First Nations was in low complexity of chronic diseases (PS05 LCC) (27.1%), followed by medium complexity of chronic diseases (PS06 MCC) (10.0%).

Rates were similar between First Nations and Other Residents for maternity and healthy newborns (PS08), and for frail in residential care (PS13).

The differences seen in chronic conditions, cancer (PS12) and MHSU at the provincial level were observed across all regions, except that First Nations in the Northern region had a similar proportion of LCC as Other Residents, and Interior, Fraser and Vancouver Island had similar proportions of the cancer population segment as Other Residents.²⁹

²⁹ FNHA (HSM). 2020. Note: FNHA data is referenced by its source database: Health System Matrix (HSM), Perinatal Services B.C. (PSBC), Population Grouper (PG), opioid and COVID-19.

Table 2: Distribution of Population Segments, First Nations and Other Residents, 2017/18

Population Segment		% of pop
PS01 Non User**	First Nations	14.3%
	Other Residents	15.0%
PS02 Healthy**	First Nations	30.8%
	Other Residents	37.3%
PS03 Adult Major Age 18+**	First Nations	2.6%
	Other Residents	3.1%
PS04 Child and Youth Major <18 years*	First Nations	1.2%
	Other Residents	0.7%
PS05 Low Chronic Conditions*	First Nations	27.1%
	Other Residents	24.9%
PS06 Medium Chronic Conditions*	First Nations	10.0%
	Other Residents	8.2%
PS07 Severe Mental Health & Substance Use*	First Nations	3.2%
	Other Residents	1.8%
PS08 Maternity & Healthy Newborns	First Nations	2.0%
	Other Residents	2.1%
PS10 High Chronic Conditions*	First Nations	7.1%
	Other Residents	4.4%
PS12 Cancer**	First Nations	1.3%
	Other Residents	1.4%
PS13 Frail in Residential Care	First Nations	0.7%
	Other Residents	0.7%
PS14 End of Life**	First Nations	0.3%
	Other Residents	0.4%

All rates are a/s, except for PS04, PS08 and PS14, which are crude and are highly age group-specific.

*First Nations rate significantly higher than the Other Resident rate

**First Nations rate significantly lower than the Other Resident rate

6.3 Mortality

A common measure of the health of a population is its life expectancy – how long might a person be expected to live, based on the population's current patterns of mortality by age group and condition. In B.C., the life expectancy at birth for First Nations decreased from 75.9 years in 2011 to 73.4 years in

2017, with the decline in part attributable to the opioid health emergency.³⁰ This life expectancy is almost nine years less than that of the B.C. population (82.2 years in 2016-2018).³¹

The mortality rate provides not just a way of measuring lives lost; it also allows a measurement of the potential years of life lost (PYLL) in a population. The First Nations all-cause age-standardized mortality rate has been increasing since 2013, and in 2017 was 116.2 per 10,000 population or a cumulative total of 244.8 PYLL per 1,000 population.³² For Other Residents in B.C.,³³ the ASMR was just over half of the First Nations rate, at 63.3 per 10,000 population in 2015, and the PYLL was 104.9 per 1,000 population.³⁴

Suicide is a significant factor in this data. Hospitalization rates for intentional injury were four times higher among First Nations (2017/18-2019/20) compared to Other Residents, with little differences between sexes.³⁵ Over the past two decades, the data has marginally changed with an overall decline in the youth suicide rate among First Nations in B.C.; still, this improvement has been tempered by an increase starting in 2011-15. In 2013-17, the First Nations rate was 3.3 per 10,000 population, four times higher than the corresponding rate in the Other Resident population.³⁶

Infant mortality (in the first year of life) has historically affected First Nations to a larger extent than the general population, both within B.C. and nationally. Lack of supports and services is a recognized contributor to excess post neonatal deaths. B.C. First Nations infant mortality for the five-year time period (2013-2017) declined to 5.8 deaths per 1,000 live births, after a consistent increase in the four previous reporting periods. Even so, the gap with Other Residents in the 2013-17 data was almost twofold.³⁷

³⁰ FNHA and OPHO. 2020. <https://www.fnha.ca/Documents/FNHA-PHO-First-Nations-Population-Health-and-Wellness-Agenda-Summary-of-Findings.pdf> (Other Resident ASMR and PYLL rates received from FNHA)

³¹ Statistics Canada. Table 13-10-0114-01 Life expectancy and other elements of the life table, Canada, all provinces except Prince Edward Island. DOI: <https://doi.org/10.25318/1310011401-eng>

³² FNHA and OPHO. 2020.

³³ The term Other Residents is used to describe the residual B.C. population after a First Nations and/or Métis data linkage has been completed.

³⁴ B.C. Vital Statistics Agency. 2015 Annual Report: Selected Vital Statistics and Health Status Indicators. <https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/statistics-reports/annual-reports/2015/pdf/annual-report-2015.pdf>

³⁵ Review. 2020.

³⁶ FNHA and OPHO. 2020.

³⁷ FNHA and OPHO. 2020.

Regions

Infant mortality rates varied across the regions and appeared to have no relationship to urbanization or remoteness. This variability in large part may be attributable to the small numbers of deaths reported by region.³⁸ Within these regions, there can be further variability (e.g., south versus north).

Table 3: First Nations Infant Mortality Rate, by Region 2013/17

	Rate per 1,000 live births
Fraser	5.5
Interior	2.1
Northern	5.3
Vancouver Coastal	6.1
Vancouver Island	9.0

6.4 Births

Perinatal Services BC provides data on live births, still births, neonatal mortality, very-preterm and preterm births, as well as birthweight indicators. The health of a newborn can be influenced by the physical, mental, emotional and spiritual wellness of the mother during pregnancy, the socio economic environment she is in (from food security to housing, employment and a stable living condition), her access to wellness care, screening and nutritional support, as well as the birth experience itself including the quality of health care received.

Over the 2015/16 to 2017/18 time period, First Nations birth rates exceeded those of Other Residents by about 43 per cent (2017/18: 12.4 versus 8.7 births per 1,000 population). Of all First Nations births in 2017/18, 0.7 per cent were stillborn, which was a similar rate to that seen among Other Residents. There was no statistical difference between these populations for singleton versus multiple births. First Nations had a significantly higher neonatal mortality rate (deaths before 28 days of age), with 2.4 deaths per 1,000 live births, compared to a rate of 1.7 for Other Residents. This rate was variable in both populations between the 2011/12-2017/18 time period examined.³⁹

First Nations were twice as likely to have very-preterm (gestational age <32 weeks) and preterm (<37 weeks gestational age) births compared to Other Residents in 2017/18, with no appreciable change to these rates since 2011/12.⁴⁰ (Figure 41) There are numerous medical conditions and other risk

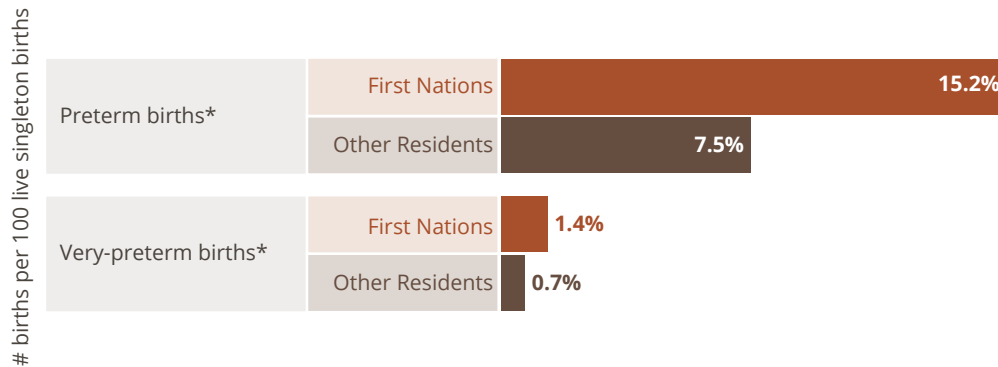
³⁸ FNHA and OPHO. 2020. (Supplemental data from FNHA.)

³⁹ FNHA (PSBC) 2020.

⁴⁰ FNHA (PSBC) 2020.

factors for preterm delivery, including a history of high blood pressure, being underweight or obese before pregnancy, diabetes, late or no health care during pregnancy, smoking, alcohol consumption, using illegal drugs, domestic violence, stress and lack of social support.⁴¹ For very-preterm births, there can be significant impacts on the growing child due to this early exposure to stress and pain, including issues with visual memory (such as remembering pictures), poor planning skills, and symptoms of anxiety and depression.⁴²

Figure 41: Premature Births, First Nations and Other Residents, 2017/18



**First Nations rate significantly higher than the Other Residents rate
FNHA (PSBC), 2020*

6.5 Primary Care Services

When looked at in totality, the pattern of how First Nations navigate health services points to serious accessibility issues, particularly for preventative, primary care. Health administrative data were analyzed to examine utilization of health services in the B.C. population in the areas of physician services, continuity of care, screening for cancers, oral health and use of the ED.

In 2017/18, the First Nations user rate for physician services was 76.1 per cent, meaning they had visited a physician at least once during the year. Other Residents in the province had a 3.3 per cent higher rate for physician utilization, and a 1.8 per cent higher rate for accessing laboratory and diagnostic testing as an outpatient.⁴³ For the First Nations population with demonstrated greater health needs, as is discussed below, these rates for accessing basic primary care would be expected to be considerably higher, not lower. Lower access to physician services may be reflected in a higher burden of disease, or simply reflect that access is insufficient to meet the health needs of the population.

⁴¹ What are the risk factors for preterm labor and birth? (accessed Sept 21, 2020) https://www.nichd.nih.gov/health/topics/preterm/conditioninfo/who_risk

⁴² The Long-Lasting Effects of Preterm Birth. (accessed Sept 21, 2020) <https://www.nichd.nih.gov/newsroom/resources/spotlight/012612-effects-preterm-birth>

⁴³ FNHA (HSM), 2020.

This pattern of lesser use of physician services by First Nations was seen across all age groups and both sexes, except for females ages 30 to 64 years, where there was no difference in the rates. First Nations children ages five years and younger showed the greatest disparity, as their rate of accessing paediatric physician services was 80 per cent of that seen with Other Resident children of the same age.⁴⁴ First Nations males of all ages, particularly younger than 17, had lower access to lab and diagnostic testing compared to Other Residents. With First Nations females, the disparity in access to testing was less, and disappeared for those ages 18 to 49 years.⁴⁵

Attachment

This pervasive reduced access by First Nations is reinforced by lower rates of continuity of care. An ongoing relationship with a health practitioner can facilitate individuals receiving a spectrum of services which can link to treatment and promote a return to healthy living. Continuity of care has been associated with better quality of care and with improved patient adherence and self-management, improved outcomes, and lower health care utilization and costs.⁴⁶ One of the available measures of continuity of care in the B.C. primary health care system is whether an individual generally sees the same primary care provider for their health care needs, as measured through attachment to general practitioners and nurse practitioners. The Ministry of Health considers an individual to be attached if at least 50% of their visits are with the same practitioner or within the practitioner's family practice.⁴⁷

Among the First Nations population in 2017/18, 77 per cent were attached by this definition, indicating that they had consistency in their primary care provider. The rate of First Nations attachment increased with age, reaching 90.2 per cent for those 65 years and older in 2017/18.

First Nations of all age groups had lower attachment rates compared to Other Residents, which resulted in comparatively higher non-attachment rates. With respect to First Nations who were non-attached, the greatest disparity was in the 65-and-older age group, where the First Nations rate for non-attachment was 88.5 per cent higher than the Other Resident rate. (Figure 42)

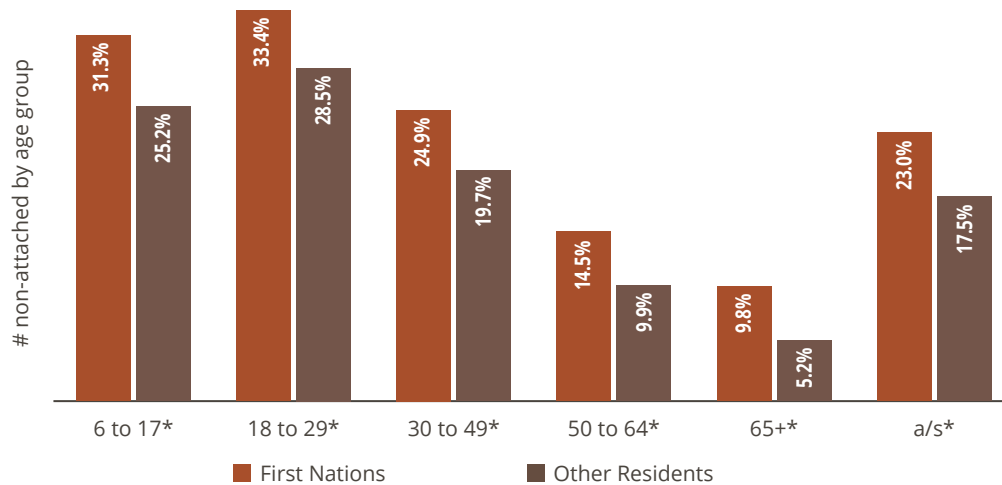
⁴⁴ 2016/17 data.

⁴⁵ FNHA (HSM). 2020.

⁴⁶ Review of the continuity of care literature undertaken by: Shin DW, Cho J, Yang HK, et al. Impact of continuity of care on mortality and health care costs: a nationwide cohort study in Korea. *Ann Fam Med*. 2014;12(6):534-541. doi:10.1370/afm.1685

⁴⁷ If less than 5 visits are found in a fiscal year, then up to 10 previous years are included to find at least 5 visits.

Figure 42: Non-attachment rate, First Nations and Other Residents, by age group, 2017/18



**First Nations rate significantly higher than Other Residents rate.*

FNHA (HSM), 2020

Regions

Regions were variable in the proportion of the First Nations population who were considered to be attached to a primary care practitioner, with the lowest attachment in Fraser, and the highest attachment in the Northern (all age groups).

In all except the Northern regions, where First Nations had comparable attachment rates to Other Residents, First Nations had higher rates of non-attachment in 2017/18 than Other Residents, from 1.3X to 1.6X higher (Table 4). Similar differences were seen on an age-specific basis.

Table 4: Non-attachment rate, by regions, 2017/18

	First Nations	Other Residents	Rate Ratio
Interior	23.7%*	17.4%	1.36
Fraser	29.0%*	18.2%	1.60
Vancouver Coastal	20.4%*	15.3%	1.33
Vancouver Island	24.4%*	18.7%	1.30
North	18.8%	18.6%	

**First Nations rate significantly higher than the Other Resident rate*

In the First Nations population, persons who were non-attached had a lower rate of using physician, lab and diagnostic services, and were more likely to visit the ED and be hospitalized compared to attached persons. This pattern was seen in all age groups, sexes and across health regions.

Sex-related differences were also seen within attachment groups. For example, *non-attached* First Nations males had the lowest utilization rates in primary care services, at 20 percentage points less for lab and diagnostic services, 15 percentage points less for physician services and five percentage points less for ED use when contrasted with non-attached First Nations females. Again, all regions showed similar differences.

Screening

Screening for early detection of cancers and pre-cancerous conditions is a key disease prevention strategy in primary care. The Review examined Pap and FIT⁴⁸ testing in both First Nations and Métis populations in 2017/18. Although the Métis did not show significant differences with the Other Resident rates in Pap testing for cervical cancer detection, in all age groups First Nations women had lower rates of accessing Pap testing compared to Other Residents, with an overall rate of 5.3 per cent, which was 68 per cent of the rate in the Other Resident population.⁴⁹ (Figure 43)

With respect to FIT testing, which screens for colorectal cancer, the First Nations rate (5.5%) was 76 per cent of the Other Resident populations' rate in this year. There was one notable exception when looking at age groups. Both First Nations and Métis FIT testing rates for the 30 to 49 age group were higher than Other Residents.^{50, 51} (Figure 44)

These lower rates of screening among First Nations exists despite this population having a 1.6X higher prevalence rate of cervical cancer and a 1.3X higher prevalence rate of colorectal cancer in 2017/18, again in comparison with Other Residents.⁵²

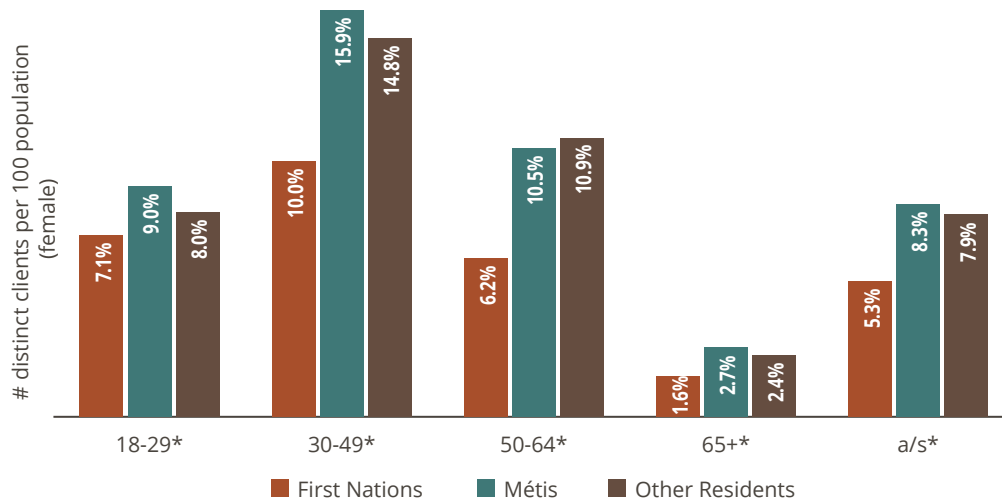
⁴⁸ fecal immunochemical test

⁴⁹ Review. 2020.

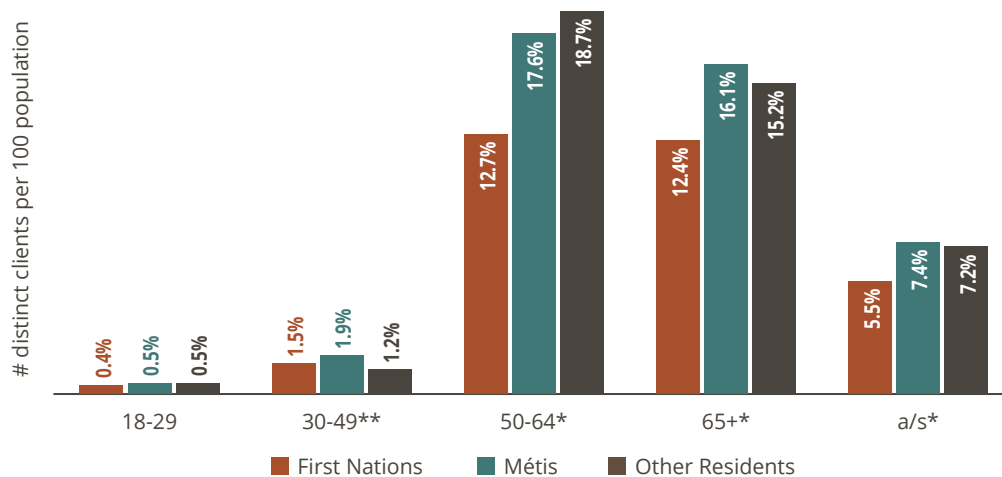
⁵⁰ There was no difference between the Métis and Other Residents a/s rates for Pap and FIT testing.

⁵¹ Review. 2020.

⁵² FNHA (HSM). 2020.

Figure 43: Pap testing rate, First Nations, Métis and Other Residents, 2017/18

* First Nations rate significantly lower than the Other Resident rate
Review, 2020

Figure 44: FIT testing rate, First Nations, Métis and Other Residents, 2017/18

* First Nations rate is significantly lower than the Other Resident rate
 ** First Nations and Métis rates are significantly higher than the Other Resident rate
 Review, 2020

Regions

In the First Nations Pap utilization data, differences in the total population rates were seen by region:

- Northern and Interior screening rates were higher than Vancouver Coastal and Vancouver Island
- In terms of the gap with Other Resident Pap screening rates, the largest difference was seen in Vancouver Coastal (First Nations rate was 59% of the Other Resident rate) and the least disparity was in Fraser (81%).

With FIT testing, region variation was also observed:

- Vancouver Island and Fraser rates were higher than Vancouver Coastal, Northern and Interior. (Note: Interior's rates were lower than the four other regions)
- As with the Pap rates, the greatest difference between First Nation and Other Resident FIT testing was seen in Vancouver Coastal, where the First Nations rate was 68 per cent of the Other Resident rate. The least disparity was in Fraser and Vancouver Island where the First Nations rates were 83 per cent and 87 per cent, respectively, of the Other Resident rates in these regions
- The only difference on a regional basis with the Métis data was seen with the 'bookend' rates: Interior's screening rate was significantly lower than Fraser's screening rate. There were no statistical differences between the Métis and Other Resident data on a regional basis.

Table 5: Pap & FIT Testing Rates by Region, 2017/18

	First Nations		Métis	
	Pap	FIT	Pap	FIT
Interior	6.1%	4.6%	7.7%	6.3%
Fraser	5.9%	6.5%	9.1%	8.3%
Vancouver Coastal	5.3%	5.3%	7.9%	ISD
Vancouver Island	5.2%	6.7%	7.2%	7.6%
Northern	6.0%	4.8%	8.1%	6.8%

See text for statistical differences

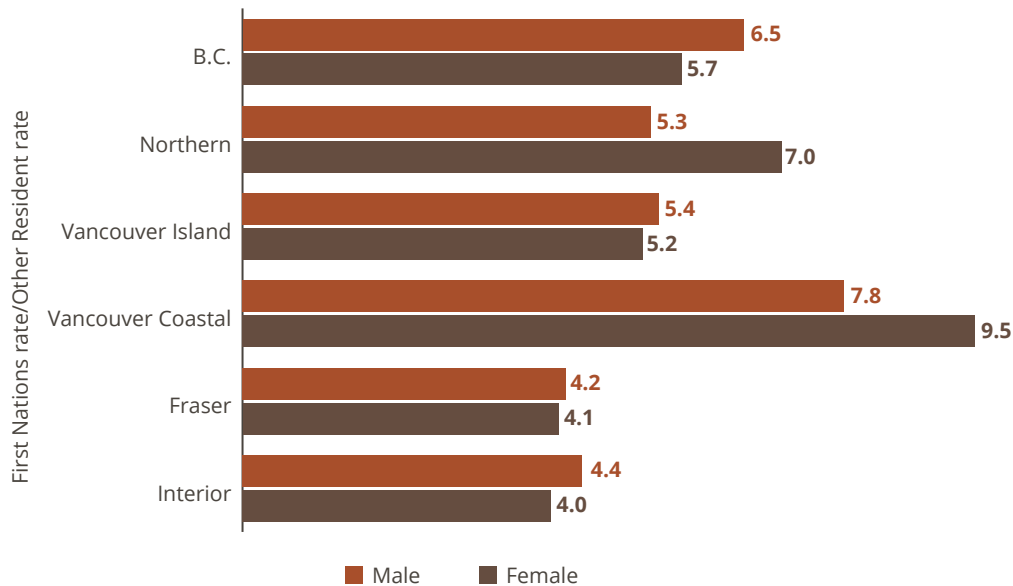
Oral Health

Access to preventative primary care was examined from the perspective of the consequences of inadequate oral care and/or dental hygiene in children. Young children may require day hospitalization to treat dental caries due to their need for anaesthesia. In 2019/20, 6.4 per cent of First Nations children ages one to five years were hospitalized for this reason, with a boys' hospitalization rate of 6.5 per cent and a girls' rate of 6.3 per cent. For those ages six to nine years, the rate dropped off to 2.5 per cent, again with little difference between the sexes (2.4% males; 2.6% females).

The disparity in dental hospitalizations between First Nations and Other Residents is one of the highest in all commonly evaluated health indicators. For girls ages one to five years, the difference ranged from 4.0 times higher

in Interior to 9.5 times higher in Vancouver Coastal. A slightly narrower range was seen with boys of that age. (Figure 45)

Figure 45: Dental Caries Hospitalization - Rate Ratio, First Nations/Other Residents, 1-5 years, 2019/20

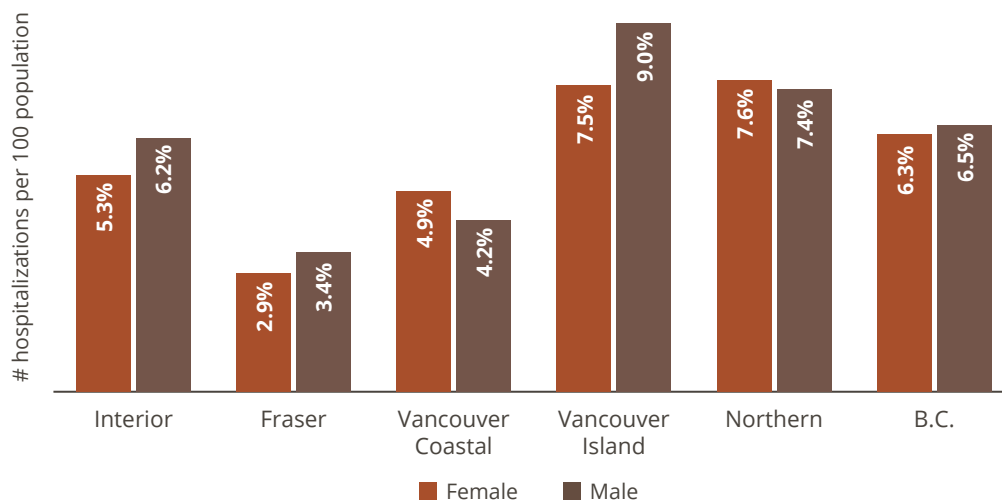


Review, 2020

Regions

There was moderate variability on a regional basis between the sexes in the First Nations one- to 5-year-old rate for dental hospitalizations in 2019/20. (Figure 46)⁵³

Figure 46: Dental Caries Hospitalizations, 1-5 years, First Nations by sex, 2019/20



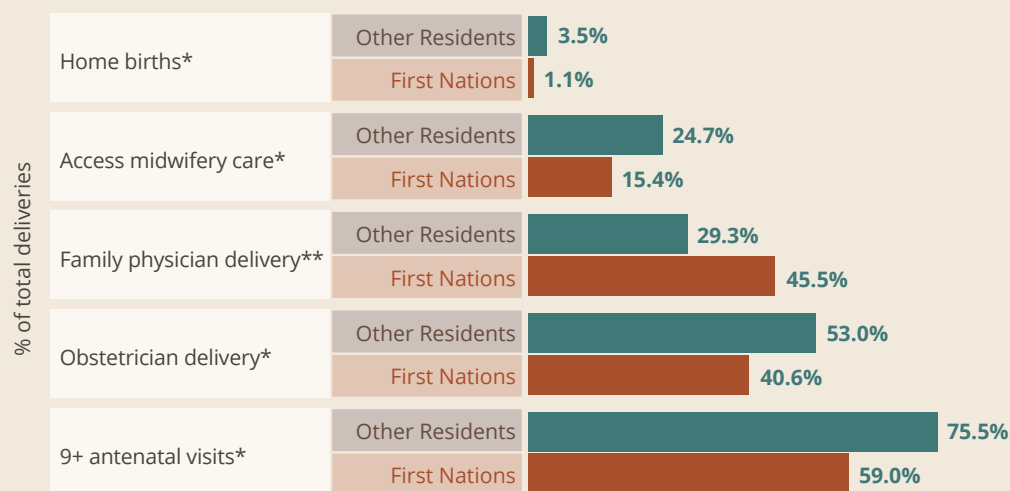
Review, 2020

⁵³ Review, 2020.

Perinatal and Child Services

In 2016/17, access to pediatrician care for First Nations ages 0 to five years was 80 per cent that of Other Residents.¹ This lower access to care begins prior to birth. In 2017/18, First Nations expectant mothers received fewer antenatal visits than Other Residents, and as well were less likely to access midwifery care, have an obstetrician present during delivery, or deliver at home.² In contrast to Other Residents, the First Nations rate of Caesarian section delivery was closer to the World Health Organization (WHO) recommended target for this procedure than was the Other Resident rate.³

Figure 47: Access to Perinatal Services, First Nations and Other Residents, 2017/18



* First Nations rate significantly lower than the Other Resident rate

** First Nations rate significantly higher than the Other Resident rate

FNHA (PSBC), 2020

Differences in maternal residence are factors in accessibility to services. Twenty per cent of First Nations women who gave birth in 2017/18 lived at least one hour travel time from the delivery facility (and almost one-half lived at least two hours away), whereas 3.5 per cent of Other Resident women had this geographic challenge. This is reflective of the rurality of the maternal residence: remote (9.6% of First Nations deliveries vs 0.3% of Other Resident deliveries); rural (29.3% vs 13.3%).

First Nations mothers are also younger on average. In 2017/18, 4.0 per cent of First Nations women who gave birth were less than 18 years of age (Other Residents: 0.4%), whereas 10.9 per cent of First Nations women were 35 years or older (Other Residents: 25.6%).²

One of the measures of infant health is birthweight adjusted to the infant's gestational age. There are a number of health conditions associated with both extremes of this indicator – being too small for gestational age and being too large. Small for gestational age means that the birthweight is below the 10th percentile for gestational age, and large for gestational age signifies that the birthweight is above the 90th percentile for gestational age. On this measure, First Nations infants were more likely to be large for gestational age compared to Other Residents, at a greater than twofold higher rate (25.2% versus 11.9%), and less likely to be small for gestational age.⁴

¹ FNHA (HSM) 2020.

² FNHA (PSBC) 2020.

³ The WHO has recommended a Caesarian section rate of 10% to 15%. In 2017/18, the First Nations rate was 23.3%, compared to the Other Resident rate of 33.0%.

⁴ FNHA (PSBC) 2020.

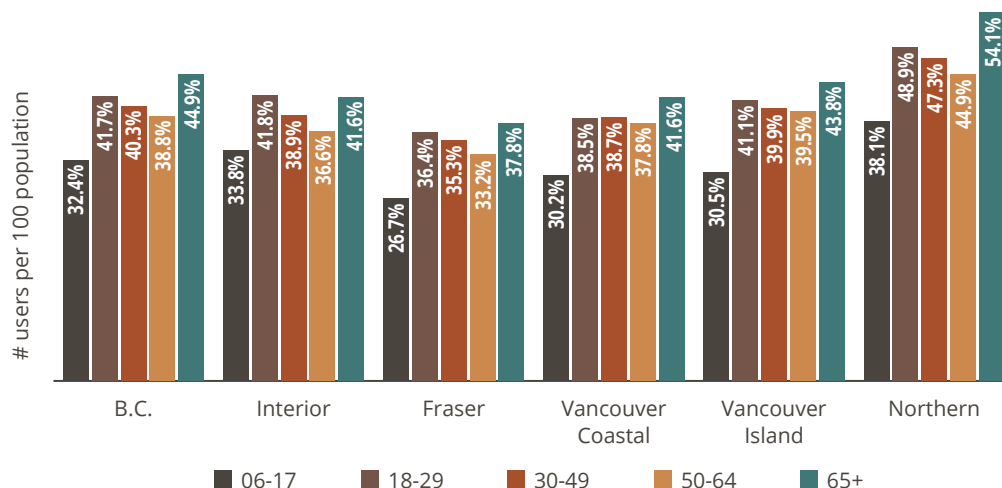
6.6 Hospital Services

Emergency Department

A relatively small difference in accessing physician services can have much larger effects in other areas of the health system, as health needs become more acute. Decreased access to general practitioners, not having a family doctor, inability to book an appointment and transportation in a timely manner, poorer health status, and delay in seeking care are all contributors to the comparatively greater demand for ED use by First Nations in B.C. In addition, in some locations, physicians may use the ED as the most convenient place to see their patients, thereby increasing ED utilization. In a survey of the Surrey Memorial Hospital, the reason for having more than one visit in the past six months was analyzed, pointing to additional factors driving ED use. Having more than one visit was significantly associated, not just with being Indigenous, but also with having stayed in a shelter in the past year, finding it at least somewhat difficult to live on their income, being treated with less respect in daily life, being treated with less courtesy in daily life, and having English as a first language.⁵⁴

Based on physician records, 40.3 per cent of First Nations visited the ED at least once in 2017/18, with a range of 34.9 per cent in Fraser region to 47.8 per cent in Northern region. In all regions, the First Nations age group least likely to require ED care was six- to 17-year-olds. Both zero to five and 65+ age groups were uniformly high users, with user rates exceeding 50 per cent in Northern. (Figure 48)⁵⁵

Figure 48: ED Utilization, First Nations, 2017/18 by Age and Region



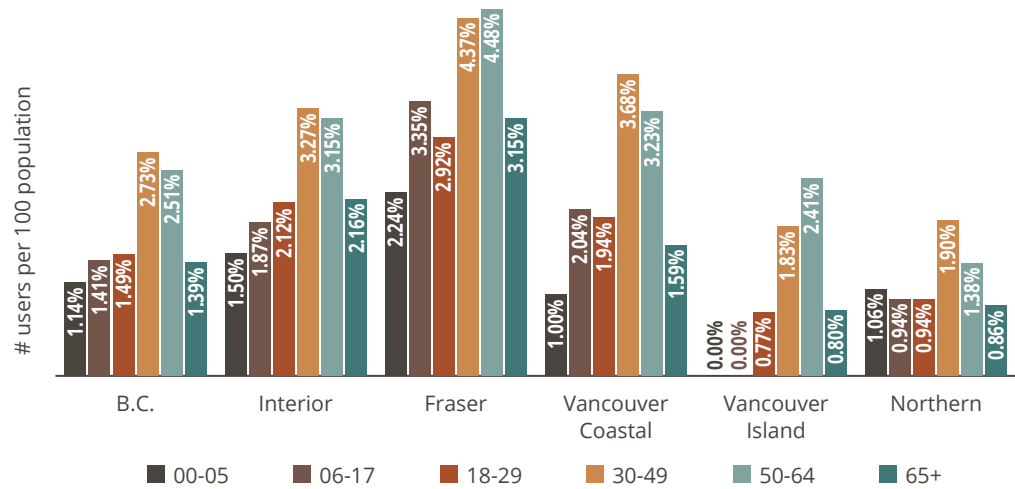
FNHA (HSM), 2020

⁵⁴ Surrey Memorial Hospital (SMH): EQUIP Baseline Data Highlights. May 2020. Data collection undertaken in 2018 on 664 patients at SMH E.D.

⁵⁵ Unless otherwise cited, ED data were sourced from FNHA (HSM) 2020.

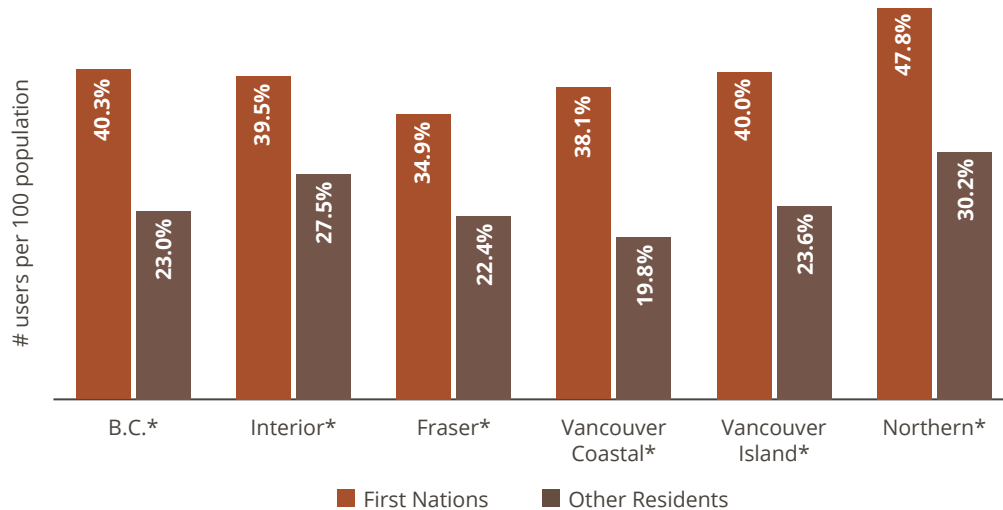
In general, First Nations ED service use increased between 2008/09 and 2017/18 across most age groups and regions. Fraser, with the lowest ED rates in all age groups, saw the highest average annual change (AAC) in First Nations utilization of the ED, ranging from a two per cent to three per cent increase annually for children, youth and young adults, and in excess of four per cent annually for those ages 30 to 64 years. Northern, with the highest ED utilization, was the most stable, showing lesser growth of one per cent to two per cent annually across age groups. (Figure 49)

Figure 49: AAC, ED Utilization, First Nations, 2008/09 to 2017/18, by Age and Region



FNHA (HSM), 2020

First Nations, on average, were 75 per cent more likely to visit the ED in 2017/18 than Other Residents, with the greatest difference in Vancouver Coastal (1.9X higher). (Figure 50) On an age-specific basis, the greatest difference between First Nations and Other Resident rates was with those ages 18 through 64 years, where the First Nations rate was approximately two times greater (data not shown).

Figure 50: ED Utilization, First Nations and Other Residents, 2017/18

* First Nations rate significantly higher than the Other Resident rate
 FNHA (HSM), 2020

First Nations females were more likely to visit the ED compared to First Nations males in 2017/18. Both female and male First Nations had higher rates of ED utilization compared to Other Residents; however, the First Nations female rates' disparity was greater. (Figure 51)

Figure 51: ED Utilization, First Nations and Other Residents, 2017/18

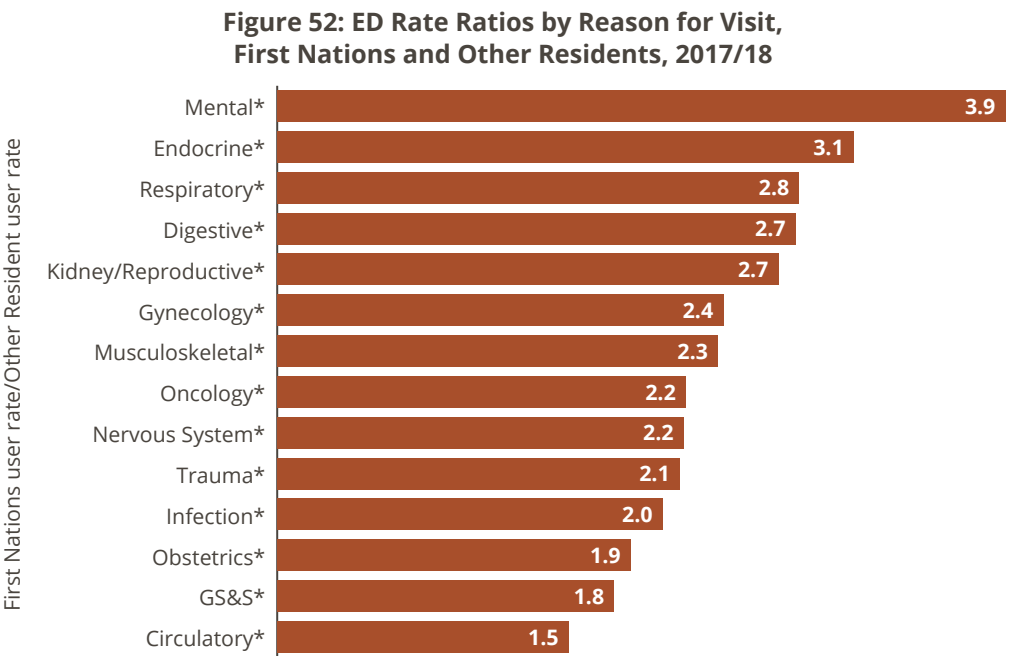
*First Nations female rate significantly higher than First Nations male rate and Other Resident female rate; First Nations male rate significantly higher than Other Resident male rate.

FNHA (HSM), 2020

Reason for ED Visit

In 2017/18, the most common reason for a First Nations person to visit the ED was general signs and symptoms (GS&S) (14.1%), meaning that the underlying cause of the person’s health condition could not be determined by the ED visit. The second most common reason was for treatment of trauma (12.7%), followed by respiratory (7.3%) and digestive (4.6%) reasons.

In all conditions, First Nations total population rates were greater than that of Other Residents. In all but circulatory, GS&S and obstetrical reasons for visiting the ED, the difference was greater than 2X. First Nations were 3.9X more likely to visit the ED for mental health issues, and they were 3.1X more likely to visit for endocrine reasons, which include diabetes. (Figure 52)



** First Nations rate is significantly higher than the Other Resident rate
FNHA (HSM), 2020*

Regions

Generally, these First Nations/Other Resident differences were replicated across regions, with varying levels of disparity between the two populations. In 10 of the 14 subspecialties, total population ED user rates in all regions were higher in the non-attached First Nations population than the non-attached Other Resident population: digestive, kidney/reproductive, infection, mental, musculoskeletal, trauma, general signs & symptoms, obstetrics, gynecology and respiratory. Other subspecialties such as endocrine and nervous systems had mixed results across the regions, or the numbers were too small for analysis (e.g., oncology).

ED Utilization over Time

Between 2008/09 and 2017/18, the greatest increase in First Nations utilization of the ED by reason for visit was:

- 6.9 per cent annually for oncology (with the proviso that the rate was low at 0.38% in 2017/18, and low rates can fluctuate from year to year)
- 6.8 per cent annually for mental disorders. This was the one category where a high level of annual increase was seen in all age groups from six years and older to 65+ (range of 4.8% to 7.8% annually)
- 6.0 per cent annually for endocrine disorders
- 4.3 per cent annually for kidney/reproductive conditions.

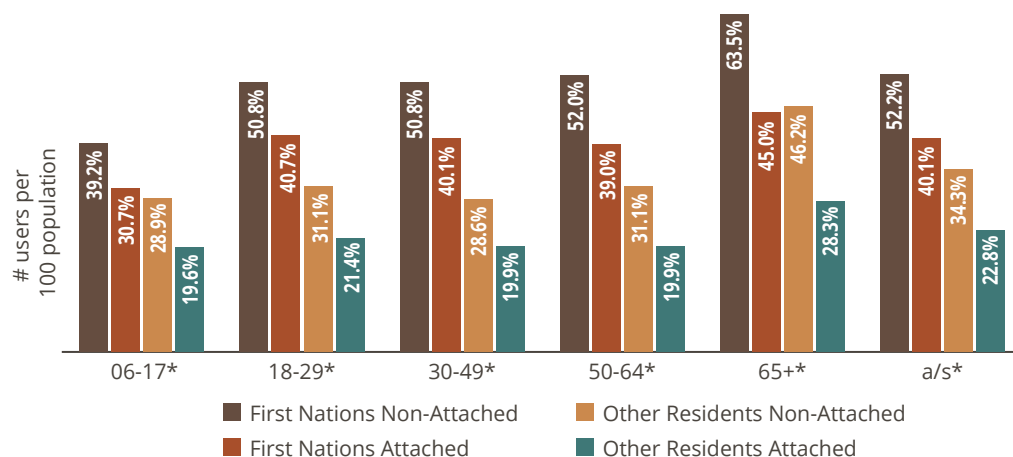
Regions

When looked at by individual regions, for many subspecialties, First Nations rates increased or remained stable between 2008/09 and 2017/18. Often, the stability was due to smaller numbers at the regional level, which prevented an assessment of rate change.

Attachment & ED Utilization

Among all health care users in B.C., those who are non-attached had a higher need for services from the ED; however, disparities in access to physicians, regardless of attachment status, serve to magnify this need in the First Nations population. In 2017/18, non-attached First Nations ED user rates were eight to 15 percentage points higher than attached First Nations, depending on the age group. The largest difference in user rates was seen in the elderly (63.5% non-attached; 45.0% attached). Although First Nations who are attached have a lesser need for services from the ED than those who are not attached, their lower ED user rate is still far greater than the 28.3 per cent user rate seen with attached Other Residents. (Figure 53)

Figure 53: ED Utilization by Attachment, First Nations and Other Residents, 2017/18



**First Nations non-attached rates significantly higher than First Nations attached and Other Resident rates*
 FNHA (HSM), 2020

In the First Nations *non-attached* population, the greatest differences in ED usage (2.5X difference or greater) compared to Other Residents were largely in the 30 to 49 and 50 to 64 population, where chronic conditions are establishing and increasing in severity, particularly in First Nations: ⁵⁶

- Nervous system (50-64)
- Respiratory system (30-49 and 50-64)
- Digestive (30-49 and 50-64)
- Endocrine (18-29; 30-49; and 50-64)
- Kidney/reproductive (50-64)
- Mental disorders (6-17; 18-29; 30-49; and 50-64)
- Oncology (18-29) [note: low rates increase variability]
- Obstetrics (18-29).

⁵⁶ A closer look at the progression of chronic conditions in the First Nations population is included in the Chronic Condition section.

ED Encounters

Due to the aggregated format in which HSM data was received by the FNHA, formal statistical comparison of rates was not possible for the calculation of average number of encounters per user.⁵⁷ On average, First Nations who used the ED in 2017/18 visited between two and three times. The First Nations data shows:

- The average number of ED encounters per First Nations user ranged from 1.71 among six- to 17-year-olds on Vancouver Island up to 3.14 among 65+ in Northern.
- In general across categories describing reasons for visits, the average annual ED encounters per user were greater than two.
- The total population average number of ED encounters per user overall and in the mental health subspecialty increased between 2008/09 and 2017/18 across regions in B.C.
- The difference between First Nations and Other Residents age groups in their average number of overall ED encounters per user was less than one encounter (First Nations > Other Residents). In the majority of categories describing reason for visits, this difference was marginal.

Understanding First Nations' Increased Need for ED Services

PREMS provides a view into understanding the increased use of the ED by Indigenous peoples. In the 2018 ED version of the survey, a greater proportion of self-identified Aboriginal respondents noted that they did not have a doctor's office, clinic or other place to go, other than the ED, for check-ups/medical advice or when sick or hurt (8.8% versus 5.0% among all survey respondents). Further to this, 36.9 per cent of Aboriginal respondents noted that they had visited the ED for an ongoing health condition or concern, which was higher than the 28.5 per cent reported by non-Aboriginal respondents.⁵⁸ This finding corresponds to other observations in the same survey whereby a lower percentage of Aboriginal respondents were assessed as having an urgent need (30.1% versus 44.1%) using Canadian Triage & Acuity Scale (CTAS) scoring.⁵⁹ It should be noted that CTAS is a rapid assessment upon presentation to the ED,

⁵⁷ Interpretation of these rates should be considered cautiously.

⁵⁸ FNHA, 2019b. *Evaluation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance*

⁵⁹ The CTAS score is assigned to each patient when presenting to the ED and is based on the type and severity of the presenting signs and symptoms: 1: resuscitation (e.g., cardiac or respiratory arrest, major trauma); 2: emergent (e.g., chest pain, severe abdominal pain, sudden severe headache); 3: urgent (e.g., shortness of breath, hypertension, vomiting/nausea); 4: less urgent (e.g., confusion, urinary tract infections); 5: non-urgent (e.g., diarrhoea, dressing changes, medication request).

and could be affected by unacknowledged bias, whereby Aboriginal patients may be assumed to be “*frequent flyers*,” not validly seeking care, intoxicated or having other stereotypes which have been identified in this Review and which would lower the urgency in a CTAS score.

This difference can also be related to the profile of persons who self-identified as Aboriginal in the PREMS. An analysis by Interior Health Authority found that self-identified Aboriginal persons had lesser differences with the Other Resident population in their utilization of the ED for urgent reasons than what the PREMS data showed.^{60 61}

An analysis was undertaken by the Review in the 30 EDs in B.C. where data are collected in the National Ambulatory Care Reporting System (NACRS), in the key areas of time to physician assessment, length of stay, admission to hospital, and return rate after discharge from the ED.⁶² Both First Nations and Métis data were available; however, the small numbers in the Métis data have precluded any meaningful analysis. There are many factors that can affect wait times and admission decisions, including:

- Triage level by CTAS: which reflects the severity/urgency of the presenting condition, keeping in mind that there may be some conditions that are assessed as CTAS 1, for example an allergic reaction, that may not require admission after treatment
- Facility characteristics: staffing levels, geographic density, and physical capacity affect a facility’s ability to respond to patient flows
- Reason for visit: for example, the presenting complaint or discharge diagnosis, can reflect important clinical differences between patients arriving in the ED
- Age of the patient: which may affect the acuity of the patient or their susceptibility to complications.

In a length of stay analysis, a significant factor for admitted patients is the time waiting for an inpatient bed, which is dependent on congestion in the hospital’s inpatient wards. At a provincial level, First Nations’ lengths of stay were higher than Other Residents, for all CTAS levels (1/2, 3 and 4/5 aggregations), from resuscitation/emergent needs to non-urgent care, with the exception of all CTAS levels for those ages 65+ and CTAS 4/5 levels for the 0 to 29 age groups.

⁶⁰ In the Interior data: CTAS 1/2: 12.3% Aboriginal, 14.6% general population; CTAS 3: 36.6%, 39.1%; CTAS 4/5: 46.6%, 43.5%

⁶¹ Interior Health Authority. 2020. *Acute Care Services Utilized by Self-Identified Aboriginal People*.

⁶² Review. 2020.

By region, First Nations' length of stays were higher for all CTAS levels in Vancouver Coastal, and lower for all levels in Vancouver Island. The other regions had variable results.

In admission data, the CTAS level, facility, time of day and day of week are important for understanding differences in ED admissions. The premise of higher need for ED care among First Nations as a reflection of inadequate access to primary care appears to be supported by 2018/19 data, which shows First Nations in all age groups except 65+ having higher hospital admissions from the ED across all the CTAS levels including less urgent/non-urgent (1.2X to 1.7X). These higher admission rates, which were 50 per cent to 70 per cent higher for less urgent/non-urgent visits, provide context for the PREMS finding that First Nations were more likely to visit the ED for a non-urgent need, and again draw into question implicit biases in initial triaging at entry into the ED whereby First Nations may be incorrectly judged to be *"frequent flyers,"* intoxicated or drug-seeking.

Admission rate comparisons were variable by region. In Vancouver Island, First Nations were less likely to be admitted to the hospital across all CTAS levels and in Fraser for CTAS 1-3, whereas the results were mixed in the other regions.

A regression analysis of provincial ED admission data found that First Nations overall had admission rates higher than others of the same age, triage level, presenting complaint, health history and other available properties. In this analysis, the First Nations admit rate from the ED was 12.7 per cent compared to 12.1 per cent for Other Residents. First Nations/Other Resident admission rates showed that three presenting complaints had odds ratios of greater than 1.5 (skin, ophthalmology, and ear, nose and throat), eight had odds ratios between 1.1 and 1.4 (environmental, gastrointestinal, genitourinary, neurologic, orthopedic, respiratory, trauma and minor/general) and one showed no difference (cardiovascular). There were three presenting complaints where the odds ratios were significantly less than one (mental health at 0.80; substance use at 0.80 and obstetric/gynecology at 0.71). Given the higher utilization of the health system by First Nations for MHSU and the higher First Nations premature birth rate, the fact that First Nations are less likely to be admitted for these reasons is not easily explained with the available data.

For time to physician initial assessment (TPIA), the facility, CTAS and time of day are important drivers. At the provincial level, First Nations 18 years and older had shorter wait times to be seen by a physician compared to Other Residents.⁶³

TPIA was lower for First Nations across all CTAS levels in Vancouver Coastal and Vancouver Island, with mixed results in other regions.

Return rates for non-admitted ED patients can be dependent on the initial admit rates for a given facility/condition. In the 2018/19 ED provincial data, First Nations compared to Other Residents, were more likely to be readmitted within 48 hours after discharge from the ED. All age groups and CTAS levels show this trend; however, the rates were low, meaning that the underlying numbers were small, and a statistical confidence could not always validate a higher observed First Nations rate. In the following categories, First Nations readmittance rates were assessed as significantly higher by statistical analysis: zero to 17 years, resuscitation/emergent (1.6X); 18 to 29 years, urgent (1.6X); 30 to 49 years, urgent (1.4X), and 30 to 49 years less/non-urgent (1.7X).

Inpatient and Day Procedure Services

Hospitalization admissions in Canada are broadly divided between inpatient (IP) and day procedures (DP). Data is available for both cases (the number of total admissions in the population) and users (which refers to the number of persons who required care).⁶⁴

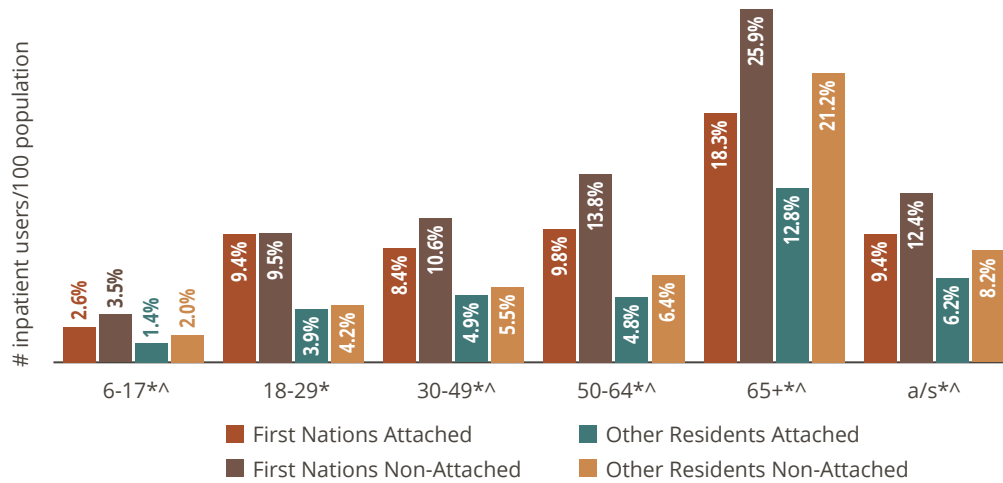
User Rates

As seen with ED utilization, not only did First Nations have higher rates of IP admissions (users per 100 population) compared to Other Residents, the highest user rates were seen with those who were not attached to a primary care practitioner. One-quarter of all non-attached First Nations ages 65 and older had at least one IP admission compared to 18.3 per cent of those who were attached, and significant differences in the First Nations attached/non-attached user rates were also seen in the six to 17 years and 30+ populations. (Figure 54)

⁶³ With one exception, CTAS 4/5 for First Nation ages 50-64 years.

⁶⁴ Unless otherwise cited, hospital data were sourced from FNHA (HSM) 2020.

Figure 54: IP Hospital Utilization by Attachment, First Nations and Other Residents, 2017/18

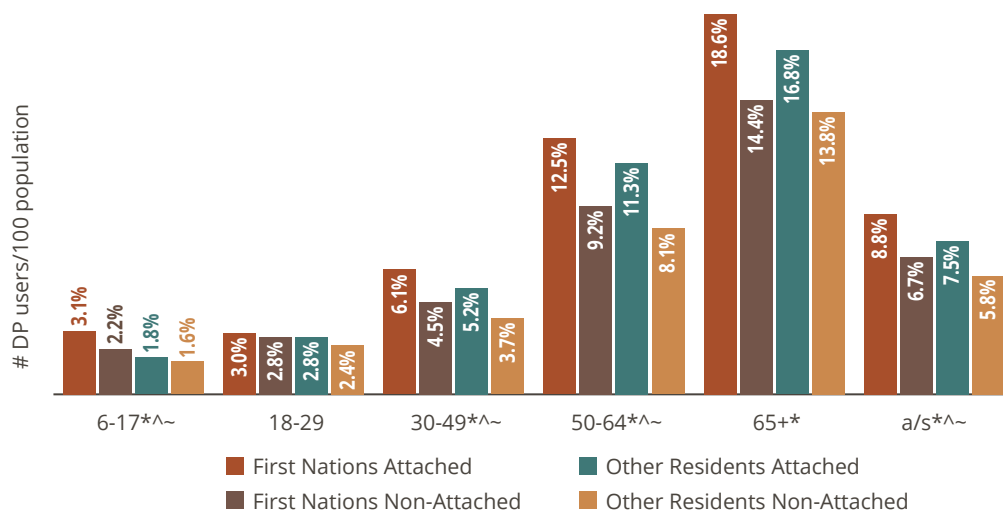


**First Nations rate significantly higher than the Other Resident rate, both attached and non-attached, except 6-17 attached*

^ First Nations non-attached rate significantly higher than the First Nations attached rate FNHA (HSM), 2020

In contrast to the IP user data, First Nations who were attached had higher rates of DPs than non-attached in all age groups except 18 to 29 years, suggesting that continuity of care is a driver towards hospital care not requiring an overnight stay, or that non-attached First Nations for other reasons were more likely to find DP options to be not accessible. DP rates increased across the life course, with an overall rate in the First Nations population of 8.8 per cent attached and 6.7 per cent non-attached. (Figure 55)

Figure 55: DP Utilization by Attachment, First Nations and Other Residents, 2017/18



** First Nations attached rate significantly higher than the Other Resident attached rate*

^ First Nations attached rate significantly higher than the First Nations non-attached rate

~ First Nations non-attached rate significantly higher than the Other Resident non-attached rate

FNHA (HSM), 2020

First Nations IP user rates decreased between 2008/09 and 2017/18; whereas DS user rates increased. In both metrics, the change was seen provincially and in Interior, Vancouver Island and Northern regions.

Case Rates

In the case rate data, First Nations compared to Other Residents had a higher proportion of all hospitalizations as IPs (62.0% versus 52.3%) in 2017/18, and a correspondingly lower proportion as DPs (38.0% versus 48.8%).⁶⁵ This difference could have multiple possible reasons – the difficulties of transportation, particularly for DPs, which can occupy an entire day at a hospital, lower referral rates for DPs, and higher acuity of disease necessitating IP care.

In 2017/18, the First Nations case rate for IPs was 15.5 cases per 100 population, which was 80 per cent higher than the Other Resident rate (8.8 cases per 100 population). An elevated First Nations rate was seen in all age groups older than five years.

⁶⁵ Data from Interior Health Authority on the self-identified Aboriginal population support the increased emphasis on IP admissions, as Aboriginal patients were 6.6% of all inpatient cases and 4.1% of all surgical daycare cases. IHA. 2020.

The metric of average cases per user provides a view into how frequently individuals may need hospitalization during a year. Due to the format in which the HSM data was received, the statistical significance of comparisons involving average cases per user cannot be evaluated.⁶⁶ However, the data are supportive of the First Nations population having a higher need for IP care on an average individual basis:

- slightly more average IP cases per user among First Nations than Other Residents, provincially and across regions
- similar average DS cases per user among First Nations and Other Residents, provincially and across regions
- slightly more average IP cases per user than average DS cases per user among First Nations.

There were slight increases in both the average IP cases per user and DS cases per First Nations user over the life course.

Over the time period 2008/09 through 2017/18:

- in general, changes in the average number of cases per user of DS and IP hospital services were small in magnitude among First Nations, across age groups and regions between 2008/09 and 2017/18
- increases were noted in the average number of DS cases per user in Northern and Fraser regions, with average annual changes (AACs) of 0.45 per cent to 0.47 per cent, respectively
- increases were noted in the average number of IP cases per user in Interior and Vancouver Coastal regions, with AACs of 0.36 per cent to 0.60 per cent, respectively.

Inpatient cases can be further divided into acute rehab, intensive care and alternate level of care (ALC) days. ALC days occur when individuals occupying a hospital bed are waiting to be discharged to a more appropriate setting and no longer require the intensity of services provided in acute care. The First Nations percentage of IP days comprised of ALC days was higher than the Other Resident percentage, for all age groups older than 18, and also overall (7.8% versus 6.9%). This First Nations ALC rate was stable between 2008/09 and 2017/18. Attachment was examined on a total population level for the province, and showed that First Nations who were attached to a primary care practitioner had a lower ALC rate than those who were non-attached.

⁶⁶ Interpretation of these findings should be considered cautiously.

Significant differences between populations at an age-specific level were mixed among the regions, partially due to the small number of ALC patients, limiting statistical confidence measures.

- The percentage of ALC days was higher among First Nations 30 to 49, compared to Other Residents in all regions except Vancouver Island where the data was insufficient for analysis
- The percentage of ALC days was higher among First Nations 50 to 64, compared to Other Residents in Interior, Vancouver Coastal and Northern Region. This First Nations rate was comparatively lower in Fraser
- The percentage of ALC days was higher among First Nations, 65+, compared to Other Residents in Interior and Vancouver Island. This First Nations rate was comparatively lower in Fraser, Vancouver Coastal and Northern.

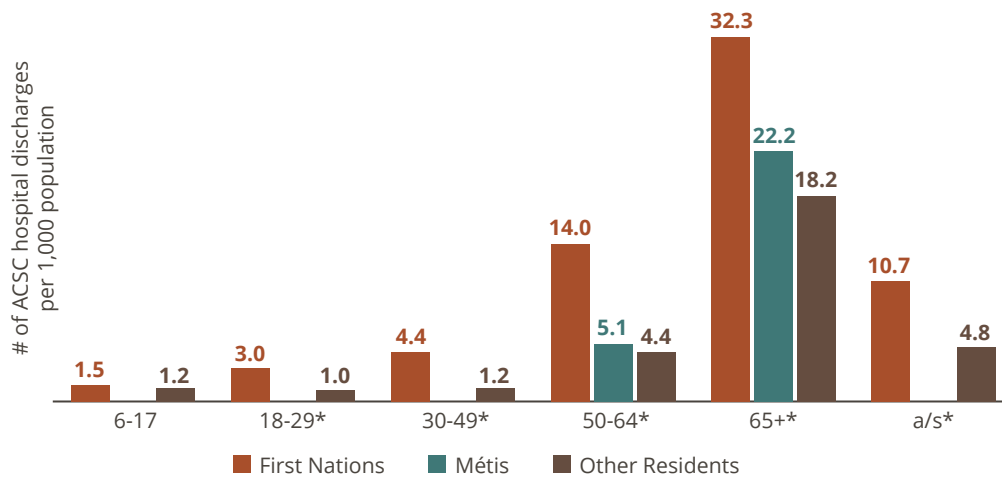
The percentage of days spent in ICU as a proportion of total IP days was similar between First Nations (6.6%) and Other Residents, and showed stability over the 2008/09 to 2017/18 time period. Similarly to the ALC data, First Nations who were attached had a lower number of IP days spent in ICU compared to those who were non-attached. This observation was seen provincially and in Interior and Vancouver Island regions.

Avoidable Hospitalizations

Higher rates of avoidable hospitalizations among First Nations residents can be a barometer of inadequate access to primary health services. Ambulatory care sensitive conditions (ACSCs) are a group of chronic medical conditions (e.g., asthma, diabetes, hypertension and angina, among others), which if treated appropriately in a primary care setting, should not lead to hospitalization, and thus hospitalization is considered avoidable or preventable. The hospitalization rate for ACSCs among First Nations was over two times higher than among Other Residents in 2017/18, and was reflected in all adult age groups. Métis rates for those 50 years and older were available for analysis, and showed no significant differences with Other Residents rates.⁶⁷ (Figure 56)

⁶⁷ FNHA (HSM) 2020 & Review 2020.

**Figure 56: ACSC Hospitalization Rate,
First Nations, Métis and Other Residents, 2017/18**



**First Nations rate significantly higher than the Other Resident rate*

FNHA (HSM) 2020 & Review 2020

Readmissions

All Cause Readmissions

The Review examined 30-day readmissions to hospital (all cause). In 2019/20, 14.3 per cent of First Nations who had been discharged were readmitted within 30 days for the same reason, which was 1.3 times the rate of Other Residents (9.7%). First Nations female and male readmission rates were fairly similar (13.8% and 15.3%, respectively); however, First Nations females showed a greater gap with the relevant Other Resident population, as their readmission rate was 1.4 times higher, whereas the male First Nations readmission rate was 1.2 times higher.

Métis readmission data were statistically similar to that of Other Residents overall: 9.3% Métis, compared with 9.7% Other Residents. By sex, there was one difference: the Métis male rate was 10.0%, which was .80X that of Other Residents (11.8%); whereas there was not a statistical difference with Métis females: 9.2% Métis vs 8.5% Other Residents.

Regions

The higher First Nations readmission rates were seen across regions overall and by sex.

**Table 6: All Cause Readmission Rates,
First Nations and Other Residents, 2019/20**

	First Nations	Other Residents
B.C.*	14.3%	9.7%
Interior*	12.5%	9.7%
Fraser*	13.3%	9.1%
Vancouver Coastal*	17.2%	9.6%
Vancouver Island*	14.4%	9.6%
Northern*	12.1%	8.9%

**First Nations rate significantly higher than Other Resident rate.*

Mental Health Readmissions

Readmission rate ratios in the categories of all mental health illnesses, anxiety disorders, mood/affective disorders, schizophrenia, and substance-related reasons are shown in Table 7. In 2019/20, First Nations, when compared to Other Residents, had increased rates of readmission (total population) for mental health overall (1.3 times), schizophrenia (1.5 times) and substance-related reasons (1.2 times). They were less likely to be readmitted for mood affective disorders (0.5 times). Sex-specific data is provided; however, the numbers underlying these rates may have been too small to confirm rate differences for males and females in some instances.

Regions

In three regions, the First Nations rate for total mental illness readmissions was greater than Other Residents, up to 40 per cent higher in Vancouver Island. (Table 7)

**Table 7: Readmissions for Mental Health Illnesses,
First Nations/Other Resident Rate Ratios, 2019/20**

	Total Population	Female	Male
All mental health illnesses			
- B.C.	1.25	1.30	1.22
- Fraser	1.35	1.49	
- Interior	1.32	1.44	
- Vancouver Island	1.40		1.48
Schizophrenia			
- B.C.	1.46	1.7	
Substance-related			
- B.C.	1.17		
Mood affective disorders			
- B.C.	0.50		

Leaving Against Medical Advice

A measure of quality and confidence in the health system is the rate by which individuals leave the hospital against medical advice. Evidence indicates that patients discharged against medical advice have an increased risk of hospital readmission and potentially death.⁶⁸

When compared to other patients, First Nations who had non-overdose related encounters were more than twice as likely to leave B.C. hospitals against medical advice in the years 2015-18. In 2018, the rate of First Nations patients leaving against medical advice (LAMA) was 3.7 per cent; compared to a 1.4 per cent rate for other patients. Overall, there were 10 hospitals in the province where the First Nations LAMA rate was greater than five per cent and, in nine hospitals, this rate was higher than the Other Resident rate. In the one specialty women's hospital in the province, First Nations women in 2017/18 left the hospital against medical advice at a rate which was 11 times greater than that seen with Other Residents.^{69 70}

⁶⁸ Glasgow JM, Vaughn-Sarrazin M, Kaboli PJ. Leaving against medical advice (AMA): risk of 30-day mortality and hospital readmission. *J Gen Intern Med.* 2010;25(9):926-9

⁶⁹ FNHA. 2020. Data on patients leaving against medical advice was sourced from the DAD via the Provincial Overdose Cohort (2015-2018). This cohort database contains a broad range of information on a 20% random sample of the general B.C. population, and a 65% random sample of First Nations persons.

⁷⁰ Opioid-related admissions are a small subset of total admissions. LAMA findings appear similar for opioid-related admissions; however, the gap between First Nations and Other Residents was not as large and number of admissions were small. As a result, significant differences could not be established.

Interior Health Authority has a voluntary self-identification option for Indigenous peoples which allows Indigenous-specific analyses to be undertaken of their hospital data. Elevated rates of leaving the ED without being seen were reported by the health authority in its 2019/20 data. For self-identified Aboriginal patients who visited the health authority's EDs, the rate of leaving without being seen was 4.5 per cent, compared to 2.8 per cent for the general population.⁷¹

6.7 Chronic Conditions

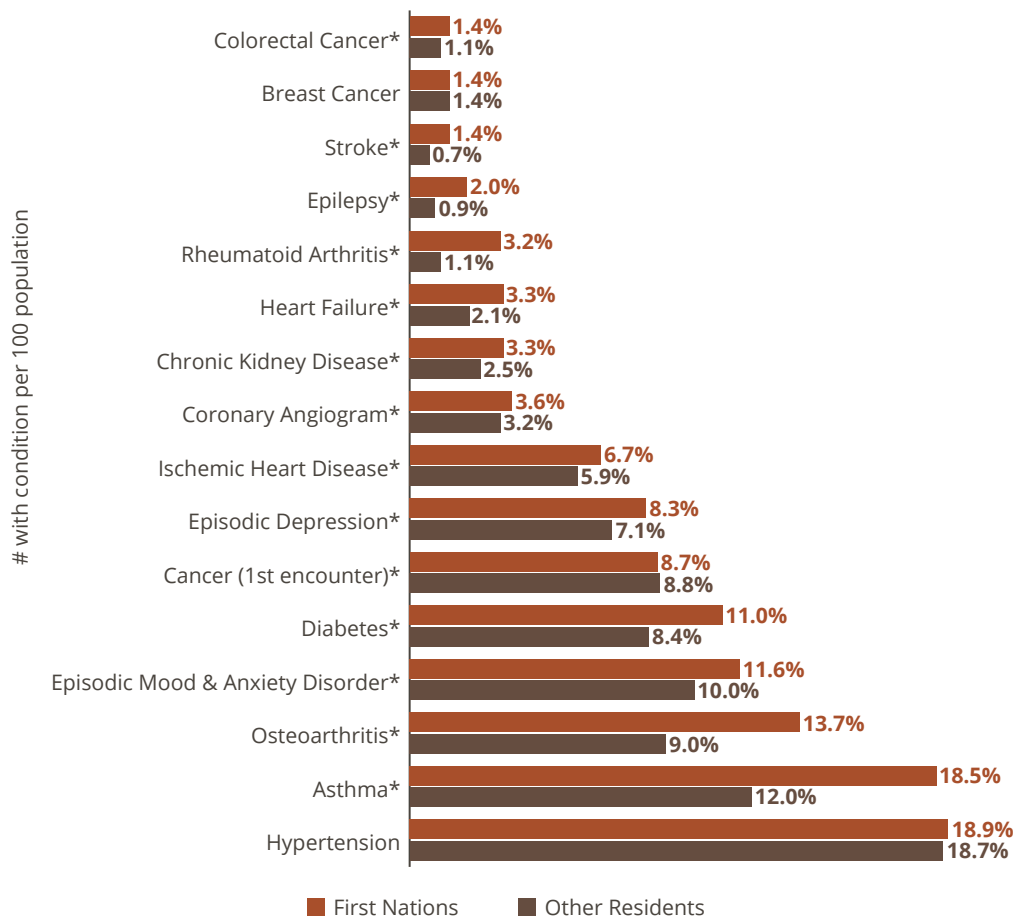
Data analyzed in the Review confirmed the increased rate of chronic diseases experienced by Indigenous people in B.C. and the diverse multiple health conditions which impact individuals simultaneously. It also revealed that chronic conditions affect Indigenous people earlier in the life course.

Chronic conditions in B.C. are monitored through the Chronic Disease Registry, which is a combination of conditions, events and interventions associated with chronic disease. Inclusion of an individual in the registry is based on a history of physician and/or hospital visits associated with a chronic condition or intervention. By individual chronic condition, the highest prevalence rates among First Nations were seen in 2017/18 with hypertension (18.9%) and asthma (18.5%), followed by osteoarthritis, mood & anxiety disorder, diabetes, cancer (the year of diagnosis only), and depression. Of the 16 conditions with prevalence rates of greater than one per cent in the First Nations population, all but cancer (year of diagnosis), breast cancer, and hypertension rates were higher in the First Nations population compared to the Other Resident population. In four of these conditions, the First Nations prevalence rate was at least 50 per cent greater than the Other Residents rate. This includes rheumatoid arthritis (2.9X), epilepsy (2.2X), stroke (2.0X), osteoarthritis (1.5X), and asthma (1.5X). (Figure 57)⁷²

⁷¹ IHA. 2020.

⁷² Chronic condition data in this section is from FNHA (HSM) and FNHA (PG) 2020 unless otherwise cited.

**Figure 57: Chronic Condition Prevalence Rate,
First Nations & Other Residents, 2017/18
(First Nations rates >1%)**



*First Nation rate is significantly higher than the Other Residents rate.

Figure includes chronic conditions with a/s prevalence rates >1%.

FNHA (HSM), 2020

The Review extended the chronic condition analysis to include kidney transplantation. In 2018/19, 1.1 persons per 10,000 First Nations received a kidney transplant, which was almost double the rate of Other Residents. The rate of dialysis was also over two times higher for First Nations.

A similar rate of kidney transplants was seen in the Métis population. Statistical validation of a difference with the Other Resident rate was not possible, due to the small numbers of persons receiving this treatment. No statistical comparisons were possible with access to dialysis treatment.⁷³

Seven chronic conditions with rates of five per cent or greater were analyzed for sex-specific differences. (Figure 58) The prevalence in the female First Nations

⁷³ Review, 2020.

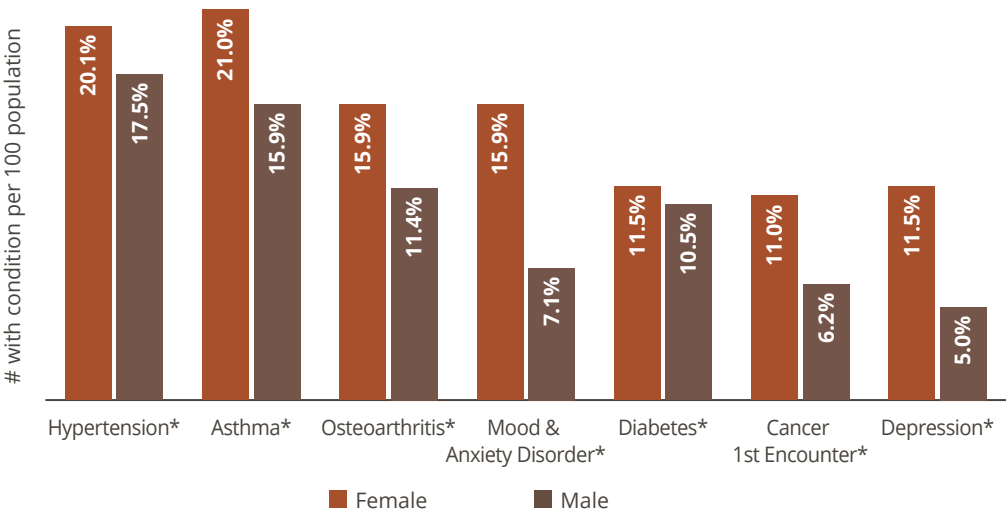
Cardiovascular Conditions

The data on cardiovascular conditions illustrate that First Nations were more likely to be diagnosed with one of these conditions at rates which were considerably higher than the Other Residents: stroke (2.0X); heart failure (1.6X), acute myocardial infarction 65+ years (1.3X) and angina 65+ years (1.2X). Interestingly, interventions associated with treating or preventing these conditions were not similarly elevated to reflect this increased risk: coronary artery bypass graft (no difference) and percutaneous transluminal coronary angioplasty (no difference). There can be a number of reasons to explain this difference, including increased First Nations mortality following a cardiovascular event, different patterns of how disease is expressed between populations, barriers to accessing these interventions (e.g., referral rates, wait time, transportation issues, among others) and avoidance of treatment.

population was higher than the male population, with differences of greater than two times higher for mental health conditions, 1.8X for cancer first encounter, 1.4X for osteoarthritis, and 1.3X for asthma. This higher burden of chronic disease borne by females was evident in most chronic conditions, except those related to cardiovascular disorders.

The greatest growth in the prevalence rate of these seven profiled conditions between 2008/09 and 2017/18 was in asthma (AAC: 2.7% female; 3.3% male) and cancer first encounter (3.5% female; 2.4% male); with male rates increasing faster in conditions associated with mental health: depression (0% females; 2.0% males); and mood & anxiety disorders (1.1% females; 2.5% males).

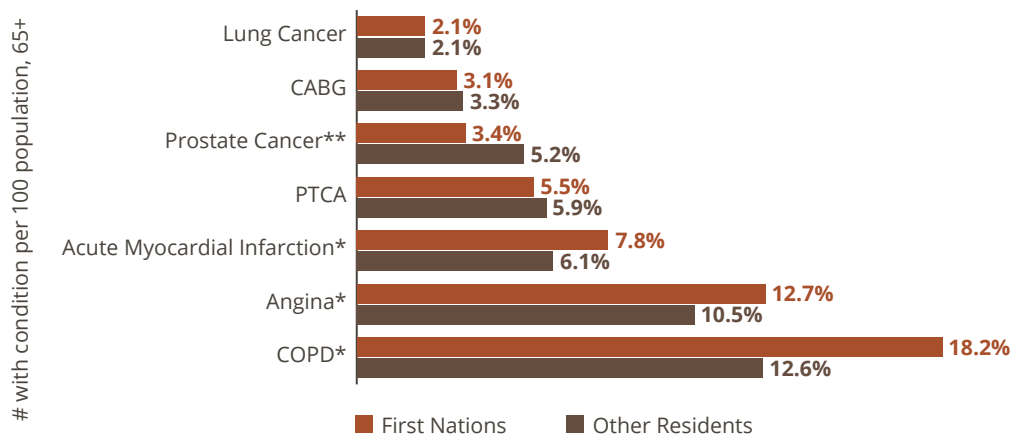
Figure 58: Chronic Condition Prevalence, First Nations by sex, 2017/18



*First Nations female rate significantly higher than First Nations male rate
FNHA (HSM), 2020

There were seven conditions or interventions where disease is heavily focused on the older age groups and age standardization was not possible on the total population. For those ages 65+ years, First Nations prevalence was higher in three of these conditions: chronic obstructive pulmonary disorder (COPD), angina, and acute myocardial infarction, and lower in prostate cancer. (Figure 59)

Figure 59: Chronic Condition Prevalence, 65+ years, First Nations and Other Residents, 2017/18



*First Nations rate is statistically higher than the Other Resident rate

**First Nations rate is statistically lower than the Other Resident rate

CABG=coronary artery bypass graft; PTCA=percutaneous transluminal coronary angioplasty

FNHA (HSM), 2020

There are four conditions in the Chronic Disease Registry with sufficient data for statistical comparison in the child and youth population: asthma, depression, epilepsy and mood & anxiety disorders. First Nations prevalence rates for these conditions in the six- to 17-year-old population were higher than Other Residents, from 1.3X for mood & anxiety disorders, to 2.3X for epilepsy. (Table 7)

Table 8: Chronic Conditions, 6-17 years, 2017/18

	Asthma*	Depression* (episodic)	Epilepsy*	Mood and Anxiety Disorders* (episodic)
First Nations	20.4%	2.9%	1.5%	4.4%
Other Residents	14.2%	1.9%	0.6%	3.5%
Rate Ratio	1.4	1.5	2.3	1.3

*First Nations rate significantly higher than the Other Residents rate

In Table 9, 21 chronic conditions rates were examined amongst First Nations by the age group most affected, the age group where the greatest difference with the Other Resident rate exists, and also the change in rates relative to the Other Resident population. In most instances, the age group most affected is 65+ (exceptions being mental health disorders and epilepsy). However, the greatest gap between First Nations and Other Resident Rates often is for those age groups younger than age 65. Commonly, disparities are evident starting at 30 years, with notable exceptions. For example, the First Nations all-service

user rate for hypertension was 1.3X higher than the Other Resident population in the 18 to 29 age group, with no significant increase in those over 50 years of age, and significant differences in the younger age group user rates were seen with asthma (0-5 years, 2.2X), depression (6-29 years, 1.4-1.5X), diabetes (18-49 years, 1.4-1.5X), cancer (0-17 years, 1.3X) and epilepsy (0-5 years, 4.4X).

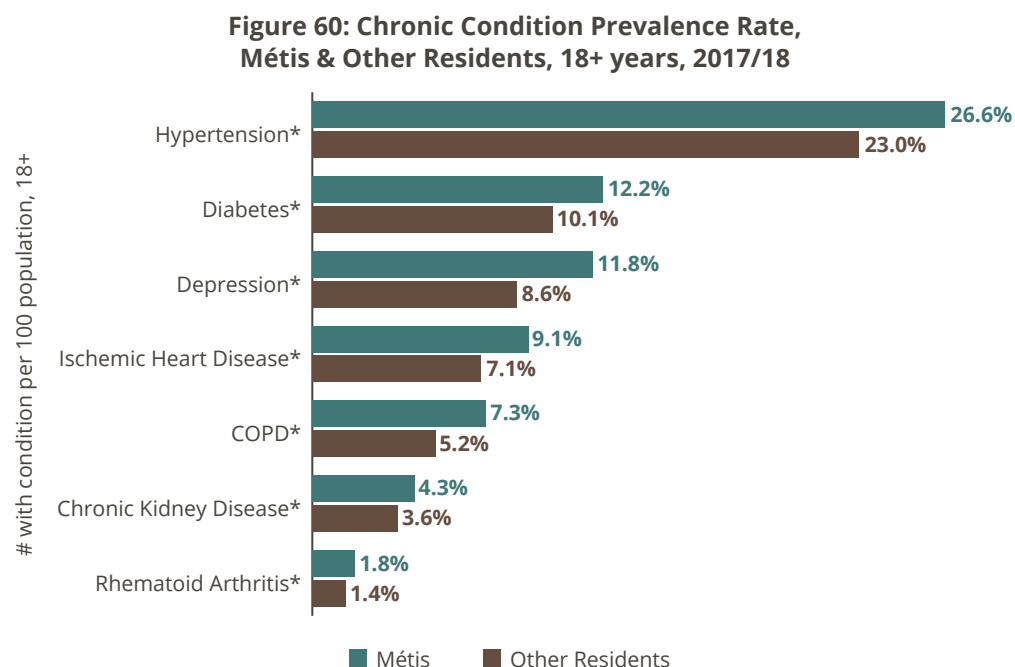
With respect to a change in the prevalence rates between 2008/09 and 2017/18, in 12 conditions, the First Nations AAC was greater than the Other Resident AAC. In four conditions, the reverse was observed. (Table 9)

Regions

Table 9 also highlights the largest differences between First Nations and Other Residents by age group and region, and illustrates the broad reach of disparities across all regions.

Métis

Métis prevalence rates (based on the 18+ population) in common chronic conditions were also higher than Other Residents in 2017/18. The greatest disparity was seen with depression and COPD (both 1.4X higher). (Figure 60)



*Métis rate significantly higher than the Other Residents rate
 MNBC, 2020.

**Table 9: Chronic Condition Prevalence Rates and Average Annual Change (AAC),
First Nations and Other Residents, 2017/18**

Condition	First Nations Data		First Nations/Other Resident Comparison			Average Annual Change	
	<i>FN a/s prevalence[^]</i>	<i>FN Age Group most affected</i>	<i>Rate Ratio: a/s FN/OR Comparison</i>	<i>FN/OR Greatest Difference by Age Group</i>		<i>FN Annual Change (Crude)</i>	<i>AAC: a/s FN/OR Comparison</i>
	<i>Provincial</i>	<i>Provincial</i>		<i>Provincial</i>	<i>Regions</i>	<i>Provincial</i>	<i>Provincial</i>
Cardiovascular							
Hypertension	18.9%*	65+: 61.7%	-	18-29: 1.3X	18-29: VC (1.8X); 30-49: VC (1.4X)	3.9%	FN higher
Ischemic Heart Disease	6.7%**	65+: 26.3%	1.1X	30-64: 1.2X-1.4X	30-49: across regions except I (1.3X-2.1X)	3.7%	FN higher
Coronary Angiogram	3.6%**	65+: 14.1%	1.1X	6-17: 1.6X 30-49: 1.5X	18-29: F (2.5X); 30-49: VC (2.3X)	5.4%	FN higher
Heart Failure	3.3%**	65+: 14.0%	1.5X	18-29: 2.6X 30-49: 2.9X	18-29: VC (2.9X); VI and N (3.1X) 30-49: across regions (2.2X-4.3X) 50-64: across regions (1.5X-2.6)	5.1%	FN higher
Stroke	1.4%	65+: 5.6%	2.0X	30-64: 2.6X-2.7X	30+: 1.5X-3.6X, except 30-49 F.	4.7%	FN higher
Angina	65+: 12.7%	65+: 12.7%	65+: 1.2X	30+: 1.2X-1.4X	50-64: F (1.3X); VC&VI (1.8X); N (1.2X) 65+: F (1.2X); VC (1.8X); VI (1.4X); N (1.2X)	1.2%	--
AMI	65+: 7.8%	65+: 7.8%	65+: 1.3	30-64: 1.4X	30-49: VC (3.2X); VI (1.9X) 50+: F, VC and VI from 1.4X – 1.9X	5.2%	FN higher ~
PTCA	65+: 5.5%	65+: 5.5%	65+: -	-	Only difference: 65+: I (.73X); VC (1.3X); 50-64: N (.74X)	6.1%	FN lower~
CABG	65+: 3.1%	65+: 3.1%	65+: -	-	65+: I (0.74X) 50-64: VC (0.59X)	1.6%	ISD~
Respiratory							
Asthma	18.5%*	6+: 16%-20%	1.6X	0-5: 2.2X	0-5: VI (3.2X); I: (2.5X); N: (2.3X)	3.1%	FN higher
COPD	65+: 18.2%	65+: 18.2%	65+: 1.4X	30-64: 2.0X-2.2X	30-49: F, VC, VI (1.9X-2.9X) 50-64: across regions (1.2X-2.6X)	2.3%	--

6. Findings: Quantitative Data Sources

Mental Wellness							
Episodic Mood & Anxiety Disorder	11.6%*	18-64: 14%-16%	1.2X	18-49: 1.3X	6-64: F and VC (1.3X-1.8X)	2.6%	FN higher
Episodic Depression	8.3%*	18-64: 10%-12%	1.2X	6-29: 1.4X-1.5X	6-49: F (1.5X-1.9X) and VC (1.8X-2.1X)	1.7%	FN higher
Diabetes and Related							
Diabetes	11.0%*	65+: 33.4%	1.3X	18-49: 1.4X-1.5X	18-49: VC (2.0X) and 30-49: VI (2.0X)	4.4%	FN lower
Chronic Kidney Disease	3.3%*	65+: 12.6%	1.3X	30-49: 2.1X	30-49: VC (2.8X), VI (2.5X) 50-64: VC (2.2X), VI (2.0X)	7.4%	FN lower
Dialysis	0.9%	65+: 2.4%	2.6X	30-49: 4.2X Other age groups: 1.9X – 3.0X	30-49: 2.9X-7.7X 50-64: 1.8X-4.1X	4.6%	FN higher
Other							
Osteoarthritis	13.7%*	65+: 43.0%	1.5X	30-49: 2.2X	30-49: across regions (1.4X-2.9X) 50-64: across regions (1.2X-2.1X)	3.5%	FN lower
Cancer (1 st encounter)	8.7%*	65+: 23.9%	-	0-17: 1.3X 18-29: 1.2X	6-29: VC (1.4X-1.7X)	5.5%	FN higher
Rheumatoid Arthritis	3.2%*	65+: 8.4%	2.8X	30-49: 3.6X 60-64: 3.0X	18-29: 1.0X-3.0X; 30-49: 2.2X-5.0X 50-64: 1.9X-4.2X Highest ratios in VI and N	2.7%	FN lower
Epilepsy	2.0%**	30+: 2.0%-2.7%	2.4X	0-5: 4.4X; other age groups 2X or greater	0-5: VI (4.3X); N (4.5X) 6+: across regions (2X-3X)	3.4%	FN higher

F=Fraser; I=Interior; N=Northern; VC=Vancouver Coastal; VI = Vancouver Island

^ if ISD for calculation of an a/s rate, the highest age group's rate (65+ year) is displayed.

~ based on 65+ population average annual change.

*First Nations female rate is higher than the male rate.

**First Nations female rate is lower than the male rate.

AMI: acute myocardial infarction; CABG: coronary artery bypass graft; COPD: chronic obstructive pulmonary disorder;

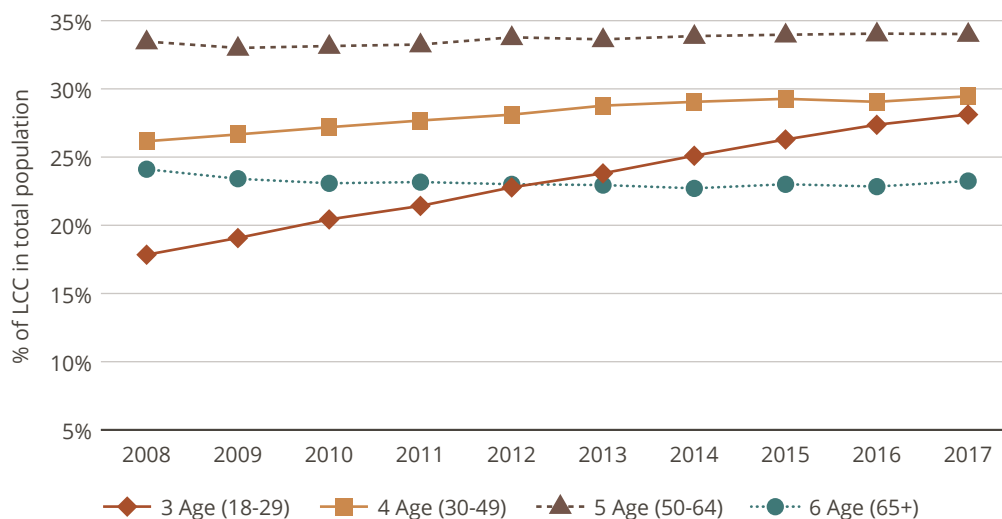
ISD = insufficient data; PTCA: percutaneous transluminal coronary angioplasty

Progression of Chronic Disease

As described above, there are three population segments that specifically address chronic conditions, and which are analogous to increasing complexity of conditions from low, to medium, to high. For example, diabetes is in the LCC population segment; uncontrolled diabetes can progress to pre-dialysis kidney disease (MCC) and finally to dialysis/organ transplant (a high chronic condition or HCC). A second example of the progression of these population segments is cardiovascular disease: from hypertension (LCC) to angina (MCC) to heart failure or stroke (HCC).

Between 2008/09 and 2017/18, proportionately more First Nations were diagnosed with a LCC or a HCC. The increase was from 22.9 per cent to 27.2 per cent for LCC and 2.8 per cent to 4.5 per cent for HCC.⁷⁴ The LCC increase was driven by 18- to 29-year-olds, who saw an average of five per cent growth annually to reach 28.1 per cent in 2017/18, meaning that in this year almost three in 10 of this age group were diagnosed with asthma, mood/anxiety disorder (including depression), diabetes, epilepsy, hypertension, osteoarthritis, and/or osteoporosis. (Figure 61)

Figure 61: Prevalence of LCC, First Nations, 2008/09-2017/18



FNHA (HSM), 2020

Looking at the number of individuals *newly entered* into one of these three chronic condition population segments during 2017/18 can be helpful in determining trends. In 2017/18, most First Nations newly diagnosed with either a low or medium complexity condition were in the 18 to 29 and 30 to 49 age groups. Differences are apparent when compared against Other Residents, as

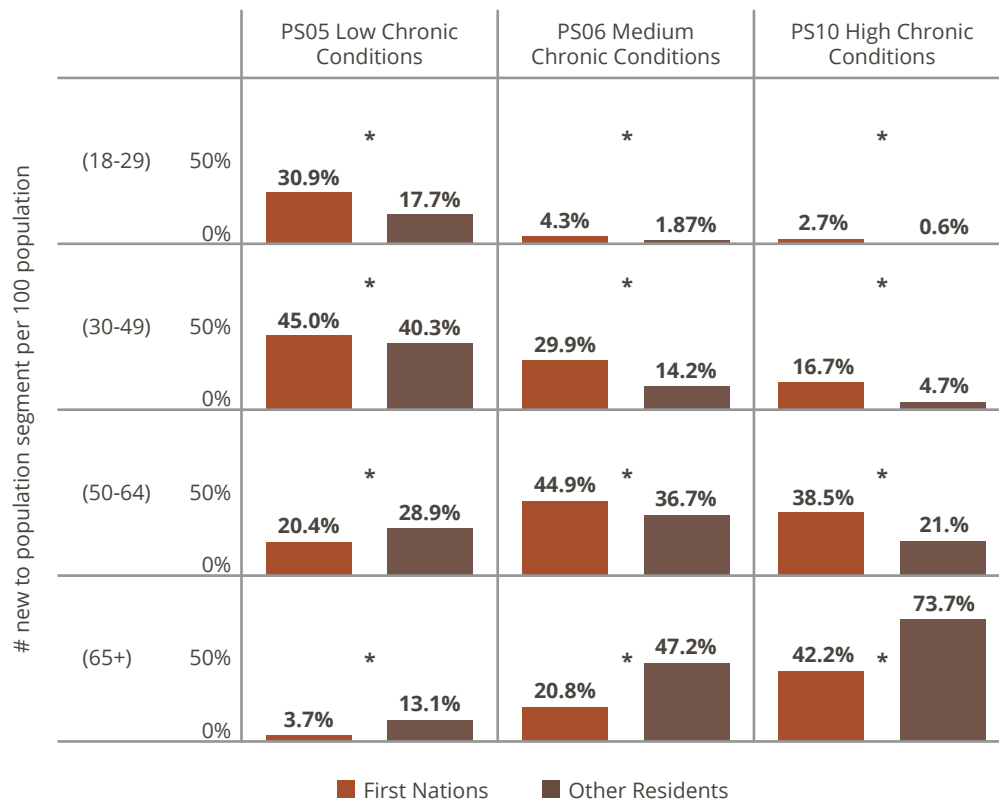
⁷⁴ Note: not age standardized; represents the true percentage in the population.

First Nations were more likely to be entered into LCC when they were 18 to 29 and 30 to 49 years of age, and comparatively less likely to be entered when older (50-64 and 65+ years), demonstrating that chronic conditions impact First Nations earlier in life than they do for the rest of the population. (Figure 62)

This pattern is repeated in the MCC group but, in this case, First Nations were more likely than Other Residents to be newly entered in MCC for all age groups younger than 65 years, with a comparatively smaller proportion being diagnosed with a medium complexity condition later in life (65+ years).

This acceleration of chronic conditions is ultimately expressed in the HCC entrants, as 58 per cent of First Nations who are diagnosed with the highest severity of chronic conditions are entrants to HCC *prior* to reaching the age of 65, compared to 26 per cent of new Other Resident entrants, and is further evidence of how First Nations experience more serious disease earlier in life. In 2017/18, the rate of new First Nations entrants ages 30 to 49 years into HCC (16.7%) was 3.6 times higher, and the rate for 50- to 64-year-olds (38.5%) was 1.8 times higher, than the Other Residents' rates. By contrast, Other Residents ages 65+ were more likely to be new entrants to HCC than First Nations of the same age.

**Figure 62: New to Population Segment,
First Nations and Other Residents by age, 2017/18**



* First Nations rate statistically different from Other Resident rate
FNHA (HSM), 2020

Attachment

Table 10 provides data on the difference of utilization of services between those with a condition who are attached and those non-attached. For many service indicators, non-attachment user rates are marginally different than attached user rates, albeit statistically significant. In order to focus on conditions/age groups with the most serious attachment gaps, results have been displayed in Table 10 if significantly different rate ratios were less than .90 or greater than 1.14. In 13 of 14 conditions, non-attached First Nations had a higher rate of using physician and/or hospital services in at least one age group, a trend which was seen to a lesser extent with MHSU admissions and MHSU physician visits. The exception to this pattern was access to laboratory and diagnostic services. In eight conditions, the non-attachment rate was less than 90 per cent of the rate for those attached. This finding is surprising given the observed greater use of non-attached individuals in the ED, and draws into question whether there may be differences in physician referrals to speciality care (which often require lab and diagnostic testing) between these two groups.

Table 10: Non-Attached/Attached User Rate Ratios ("X") by Major Service Line, First Nations, 2017/18 based on user rates (persons using a service at least once)

Chronic Condition	Total ER	Total Hospital	Lab & Diagnostic Services	MHSU (hospital)	MHSU (physician)
AMI	50+: 1.2X-1.4X	65+: 1.4X	30-49: .86X		
Angina	50+: 1.3X-1.4X				
Asthma	All ages: 1.2X-1.4X	65+: 1.2X	6-64: .84X-.86X	18-49: 1.8X; 50-64: 3.0X; 65+: 6.7X	6-49: .73X-.84X
CABG			65+: .88X		
Cancer (1st)	All age groups: 1.3X-1.6X	65+: 1.2X	50-64: .84X	30-64: 3.1X-3.7X	
CKD	30+: 1.3X-1.4X	65+: 1.3X		Total crude rate: 2.3X	30+: 1.3X-1.4X
COPD	30+ 1.3X-1.4X	30-49: 1.6X; 65+: 1.3X		50-64: 3.5X	30+: 1.3-1.4
Diabetes	18+: 1.3-1.5	30+: 1.2X-1.4X		30-64: 2.9X-4.0X	
Heart Failure	6+ (except 18-29): 1.2X-1.7X	30+: 1.4X-1.5X		Total crude rate: 3.1X	Total crude rate: 1.3X
Hypertension	18+: 1.4X-1.6X	30+: 1.2X-1.4X	30-64: .87X - .89X	30+: 2.4X-3.5X	50+: 1.2X
M&A Disorder	6+: 1.3X-1.5X	6-64: 1.3X-1.6X		6-64: 1.9X-3.1X	
Osteoarthritis	30+: 1.4X-1.5X	50+: 1.2X	30-64: .87X-.88X	50+: 2.8X-3.3X	65+: 1.3X
Osteoporosis	50+: 1.3X-1.4X	65+: 1.3X	50-64: .89X	Total crude rate: 3.6X	
PCTA	50+: 1.4X	65+: 1.4X			
Rh Arthritis	30+: 1.3X-1.4X		18-29: .58X	50-64: 4.6X	
Stroke	65+: 1.4X	65+: 1.4X			65+: 1.5X

Note: For many indicators, non-attachment user rates are marginally different than attached user rates, albeit statistically significant. In order to focus on conditions/age groups with the most serious attachment gaps, results are displayed above if significantly different ratios are less than .90 or greater than 1.14; total crude rate results are shown if age groups are 1SD.

6.8 Mental Health and Substance Use

In 2017/18, 3.2 per cent of First Nations were categorized in the Severe MHSU population segment; a rate which was 1.8 times higher than that of Other Residents.⁷⁵ Prevalence and health service utilization data provide a lens into the population needs for MHSU:

Mental health needs

- The First Nations prevalence rate for depression in 2017/18 was 8.3 per cent compared to 7.1 per cent for Other Residents and, for mood and anxiety disorders, the rates were 11.6 per cent and 10.0 per cent, respectively. The disparity in depression was greatest for First Nations ages 18 to 29 years, as their prevalence of this condition was 40 per cent higher than Other Residents. In the same year, the Métis depression prevalence rate for those ages 18 years and older was also 40 per cent higher.
- With mental health services, First Nations user rates were 1.1 times (physician) and 1.9 times (hospital) greater than Other Residents.

Substance use needs

- The rate of deaths attributed to alcohol among First Nations has been increasing since 2011, up to 14.2 per 10,000 in 2015, a rate that was three times higher than the rate for Other Residents.⁷⁶
- A comparable difference was seen in access to physician services for substance use (3.4X) in 2017/18 data. Hospital utilization validates this increased need, with the First Nations hospitalization rate being 5.6X higher for substance use.
- Attachment to a primary care practitioner provides the opportunity for a higher intensity of care. However, this focus is not available for many First Nations people who do not benefit from a consistent care provider. Even First Nations people who are attached to a primary care practitioner are at a disadvantage comparatively. For example, although First Nations individuals ages 18 to 29 and 30 to 49 years had 10 more visits annually, on average, if they had access to a consistent physician or family practice for their addictions needs (compared to First Nations who were non-attached), this was still a lower intensity of visits than Other Residents who were attached.

⁷⁵ Data in this section is from FNHA (HSM) 2020 unless otherwise cited.

⁷⁶ FNHA and OPHO. 2020.

Youth

- In 2013-2017, the First Nations youth suicide rate was 3.3 per 10,000 population, four times higher than the corresponding rate in the Other Resident population.⁷⁷
- The B.C. Adolescent Health Survey of Grades 7 to 12 in 2013 reported that, in comparison to their non-Aboriginal peers, Aboriginal youth were more likely to report extreme stress or despair, self-harm, suicide ideation or attempts, and to have forgone needed mental health services. In the survey's community consultations, youth said that they did not seek needed mental health services, partly because they were worried about being judged or bullied by peers and partly because they were worried about how their parents might react. Lack of services, long wait lists, and transportation were also cited as barriers in smaller communities.⁷⁸
- First Nations ages six to 17 had a 1.3 times higher mood and anxiety prevalence rate and a 1.5 times higher depression prevalence rate compared to Other Residents in 2017/18. In terms of utilization of health services, nine per cent of First Nations of the same age visited a physician for severe mental health issues in 2018/19. The rates for both mood and anxiety disorder prevalence and physician mental illness services showed steady growth from 2008/09, with the latter increasing at 4.5 per cent annually on average.

6.9 Multi-Morbidity

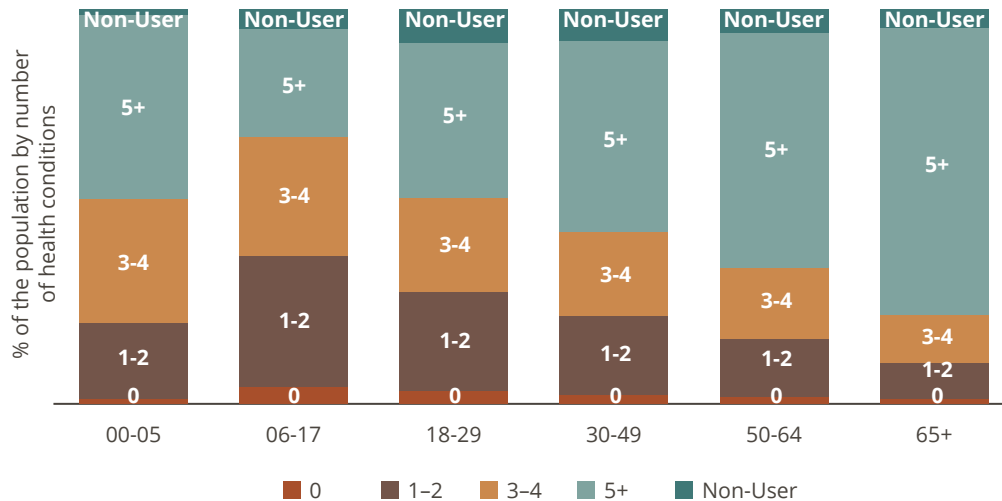
The increased health burden experienced by Indigenous people extends past chronic disease to include diverse health conditions. In an analysis of 227 health conditions encompassing all aspects of disease which are treated in the health system, both First Nations and Métis populations were examined from the lens of utilization of hospital and physician services.⁷⁹

Multi morbidities are present in all age groups, including the very young. In Figure 63, First Nations data is presented; however, Métis rates were similar, with both populations showing the increasing burden of multi-morbidities with age. (Figure 63)

⁷⁷ FNHA and OPHO. 2020.

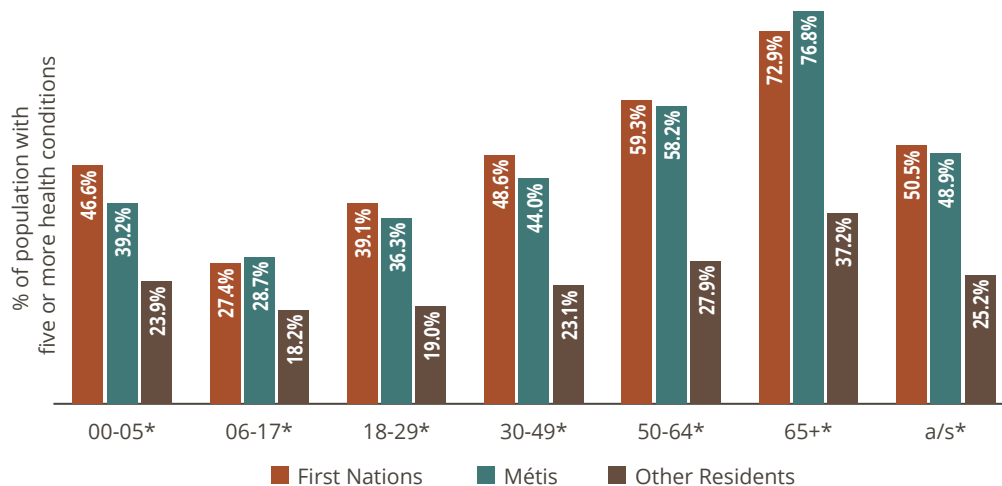
⁷⁸ McCreary Centre Society 2016. Raven's Children IV. Aboriginal Youth Health in B.C. https://www.mcs.bc.ca/pdf/ravens_children_iv.pdf

⁷⁹ These conditions are part of the Population Grouper (PG) database developed by the Canadian Institute of Health Information and housed in the B.C. Ministry of Health. They have been defined based on physician and hospital diagnostic groupings, and include both acute and chronic conditions.

Figure 63: Average number of health conditions by age, First Nations, 2017/18

FNHA (PG), 2020

In all age groups, First Nations and Métis were more likely to have five or more health conditions than Other Residents, typically at over two times higher rates for adults.⁸⁰ (Figure 64)

Figure 64: Five+ Health Conditions by age, First Nations, Métis and Other Residents, 2017/18

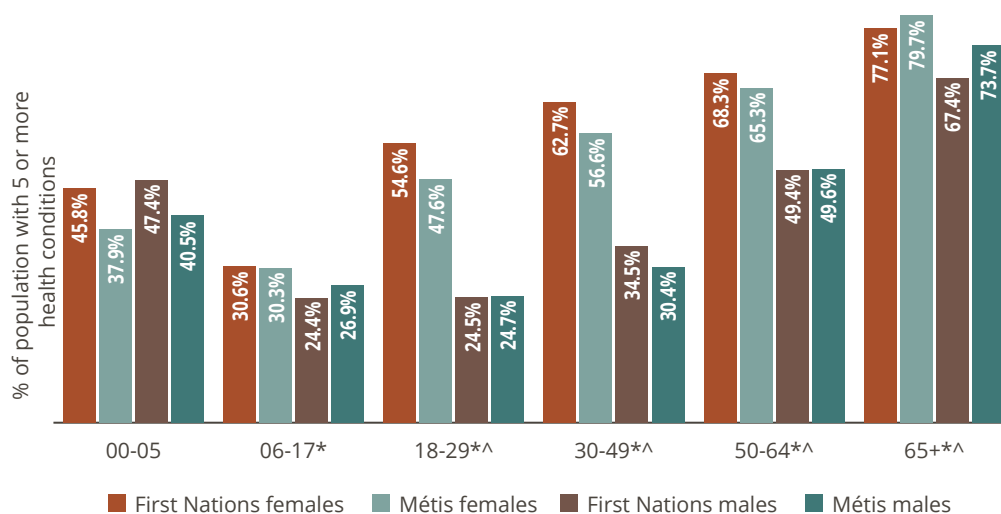
*Significant differences between First Nations and Other Resident rates, and Métis and Other Resident rates

FNHA (PG), 2020

In addition, First Nations and Métis adult females in all age groups experienced five or more conditions at greater levels than adult males, with the largest difference seen in the 18 to 29 and 30 to 49 populations. (Figure 65)

⁸⁰ Data in this section is from FNHA (PG) 2020 unless otherwise cited.

Figure 65: Five+ Health Conditions by age and sex, First Nations and Métis, 2017/18



*First Nations female rate significantly higher than First Nations male rate

^Métis female rate significantly higher than Métis male rate

FNHA (PG), 2020

The 227 chronic conditions data were used by the Review to customize 27 larger groupings, covering cerebrovascular, cardiovascular, neurodegenerative, respiratory, oral health, chronic respiratory, acute respiratory, gastrointestinal, liver/pancreas/gall bladder, endocrine, malnutrition, acute/chronic renal, HIV, TB, sepsis, mental illness, cancer, female reproductive health, and other groupings. Twenty-three of the 27 groupings included both male and female conditions and, of these, First Nations females had higher rates of hospital and physician utilization than did First Nations males in 10 groupings.

A large disparity was also evident when differences were explored within sexes, between First Nations and Other Residents. In 19 of the 23 conditions where both sexes could be considered, the difference between First Nations and Other Resident female utilization of services was greater than seen with their male counterparts. In Table 11, the largest disparities in the female comparison have been displayed. The rates of hospital and physician utilization for First Nations women ages 30 to 64 years compared to Other Resident women were up to 11X and 9X greater, respectively, for HIV disease, with large differences for sepsis, dental caries/gingivitis, respiratory infections, liver/pancreatic/gallbladder diseases and acute/chronic kidney disease. These disparities were not evident in the Métis data.

Table 11: Female First Nations/Other Resident rate ratios, service utilization by selected conditions, 2017/18

	Age	Hospital	Physician
HIV	30-49	11.2	8.7
	50-64	10.2	9.0
Sepsis	a/s	4.1	4.1
Dental caries/ gingivitis	0-5	6.4	6.3
	6-17	3.8	3.6
Acute and chronic kidney disease	a/s	2.1	2.0
Pneumonia/ acute infectious respiratory disease	a/s	2.1	1.9
Liver/pancreatic/ gallbladder diseases	a/s	2.1	1.7

6.10 Public Health Emergencies

The Review considered data from B.C.'s two public health emergencies – opioid overdoses and COVID-19, recognizing that these emergencies do not impact all populations in the same way. Disproportionate impacts are known to result from intersections with factors such as poverty, housing, education and geography, and their effects can be magnified in the Indigenous population already facing inadequate access to primary care and poorer health outcomes.

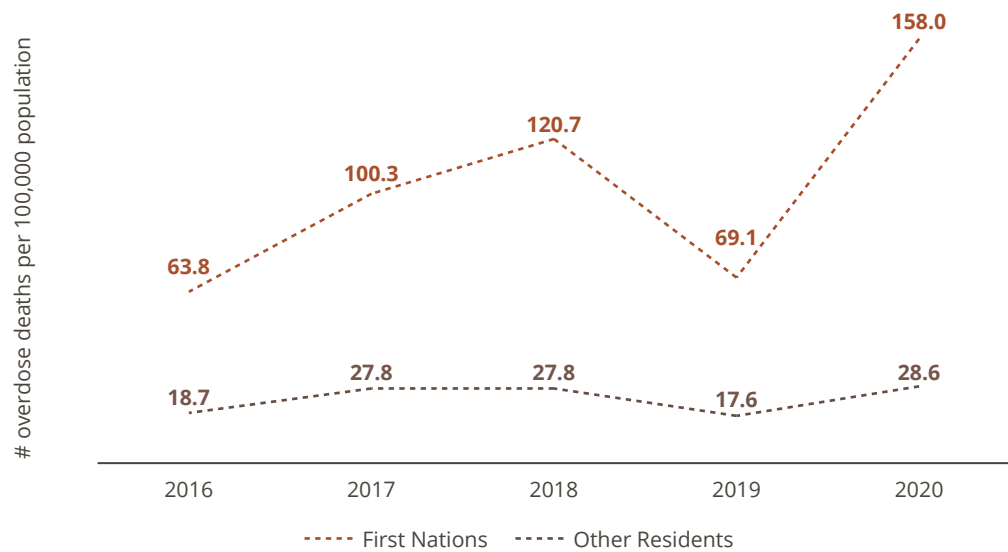
Illicit Drug Toxicity Mortality

Between January and October 2020, there were 215 First Nations deaths due to illicit drug toxicity, which were 15.5 per cent of the provincial total (1,386 deaths).⁸¹ More First Nations people died in the first 10 months of 2020 than in the whole of 2018 (202 deaths), previously the worst year to date since the opioid emergency was declared. In the 2020 time period, First Nations died from overdoses at a 5.5X higher rate than Other Residents (4.6X males; 10.1X females).

As Figure 66 shows, aside from 2019, when the number of opioid deaths declined in the province, the gap between the rate of First Nations dying from opioid overdose and that of Other Residents increased annually from 2016 to 2020.

⁸¹ All data in this section from FNHA (opioid). 2020.

**Figure 66: Illicit Drug Toxicity Mortality,
First Nations and Other Residents, 2016-2020**

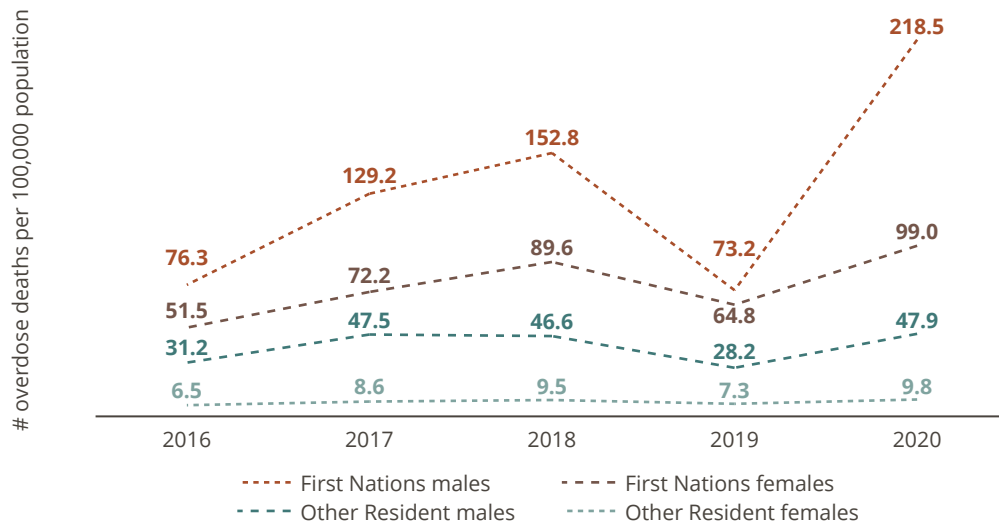


FNHA (opioid), 2020

In 2020, 32.6 per cent of First Nations deaths were among females, compared to 17.4 per cent among Other Residents. This difference of 1.9X is slightly lower than the first four years of the health emergency, when the First Nations female proportion of deaths ranged from 2.2X to 2.4X that of the Other Resident population.

Figure 67 provides the overdose mortality rate by sex between 2016 and 2020. Aside from the dip in rates in 2019, the data suggest that, among Other Residents, the mortality has leveled off whereas, with First Nations males in particular, there has been a steep rise in deaths, reaching 218.5 deaths per 100,000 in the first 10 months of 2020, which is an increase of 43 per cent from the previous peak in 2018.

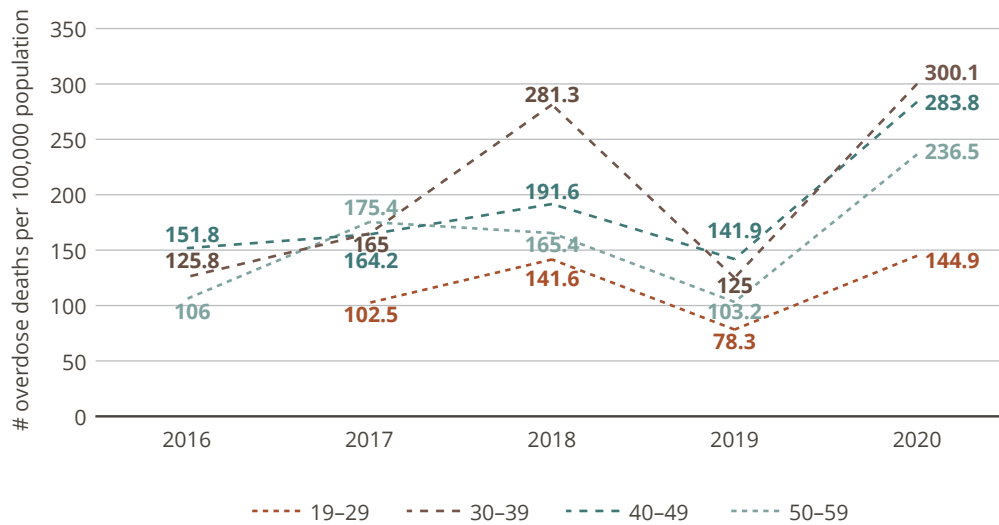
Figure 67: Illicit Drug Toxicity Mortality, First Nations and Other Residents, by sex, 2016-2020



FNHA (opioid), 2020

In the age groups 19 through 59 years, where sufficient First Nations data are available for analysis, the data show that, after the decline in overdose deaths in 2019, the age groups 40 to 49 and 50 to 59 had mortality rates rebounding to a greater extent than in the 19 to 29 and 30 to 39 age groups. (Figure 68)

Figure 68: Age-Specific Illicit Drug Toxicity Mortality, First Nations, 2016-2020



FNHA (opioid), 2020

Almost half of First Nations overdosed in private residences in 2020; however, if these data are looked at by region, Vancouver Coastal is an outlier with approximately one-quarter of overdoses occurring in this setting and most overdoses occurring in other residences.⁸²

COVID-19

First Nations in B.C. in the first 7½ months of the COVID-19 pandemic experienced a larger rate of infection than what has been seen in the general population of the province. The cumulative incidence of COVID-19 among First Nations as of Oct. 14, 2020 was 328.1 cases per 100,000, which was 56 per cent higher than the rate of Other Residents (210.2). The cumulative per cent positivity rose in the “second wave” of the pandemic to 4.57 per cent in the August to Oct. 14 time period, up from 1.79 per cent in the initial five months of the pandemic. (Figure 69)

Figure 69: COVID-19 Rate, First Nations, 2020

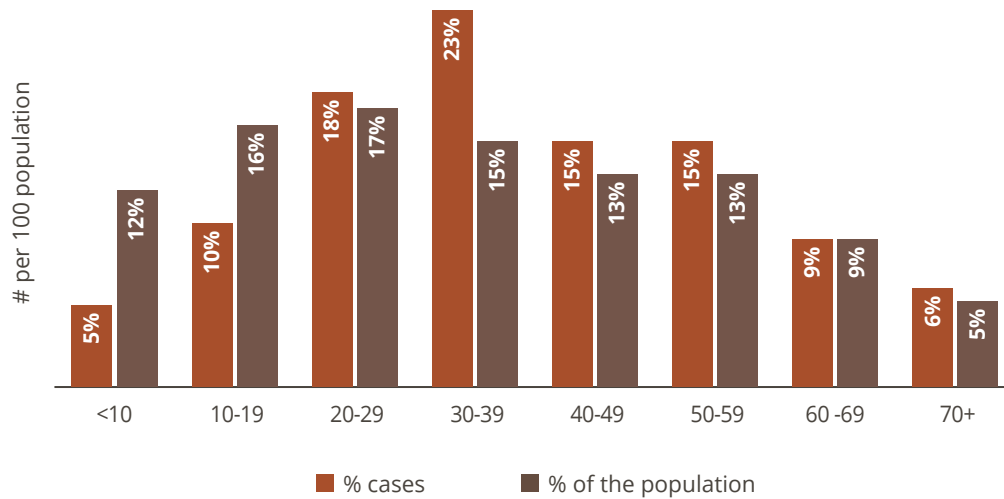


FNHA (COVID), 2020

First Nations females had a larger representation than males, at 56.1 per cent of total First Nations cases (range of 48.6% Interior to 57.9% Northern). By age group, the highest proportion of cases was in the 30- to 39-year-old population at 23 per cent, who have a higher rate than would be expected given their percentage of the total population. (Figure 70)

⁸² Other residence includes: single room occupancy hotel, social housing, group home, halfway home, homeless shelter, seniors residence, rooming house and safe house.

Figure 70: COVID-19 Case Rate and Population Distribution by Age, First Nations, 2020



FNHA (COVID), 2020

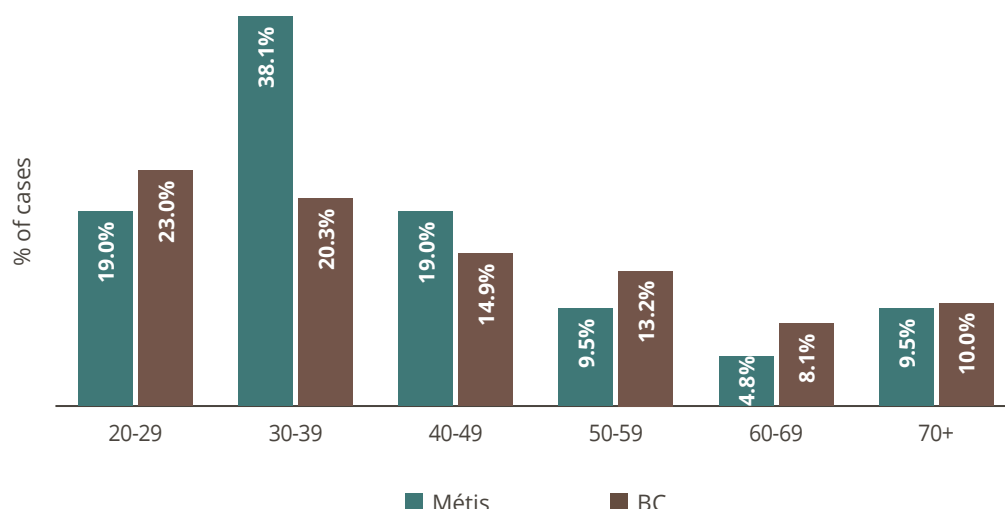
Twenty-nine per cent of First Nations who contracted the virus resided in or near their community. As of Oct. 14, 2020, half of the cases were reported in Vancouver Coastal, followed by Northern and Fraser Health Authorities, at approximately 20 per cent each.⁸³

Métis to date have a lower incidence of COVID-19 compared to Other Residents. Statistics to Oct. 20, 2020 show the case rate of those 18 years and older was 14.2 per 10,000 population, whereas the comparable rate for B.C. was 23.2. The highest percentage of Métis cases was in those ages 30 to 39 at 38.1 per cent, almost double the percentage seen in the B.C. population.⁸⁴ (Figure 71)

⁸³ FNHA (COVID-19). 2020.

⁸⁴ MNBC. 2020.

Figure 71: Per cent COVID-19 Cases by Age, Métis and Other Residents, 2020



MNBC (COVID), 2020

Unintended Consequences of the COVID-19 Pandemic

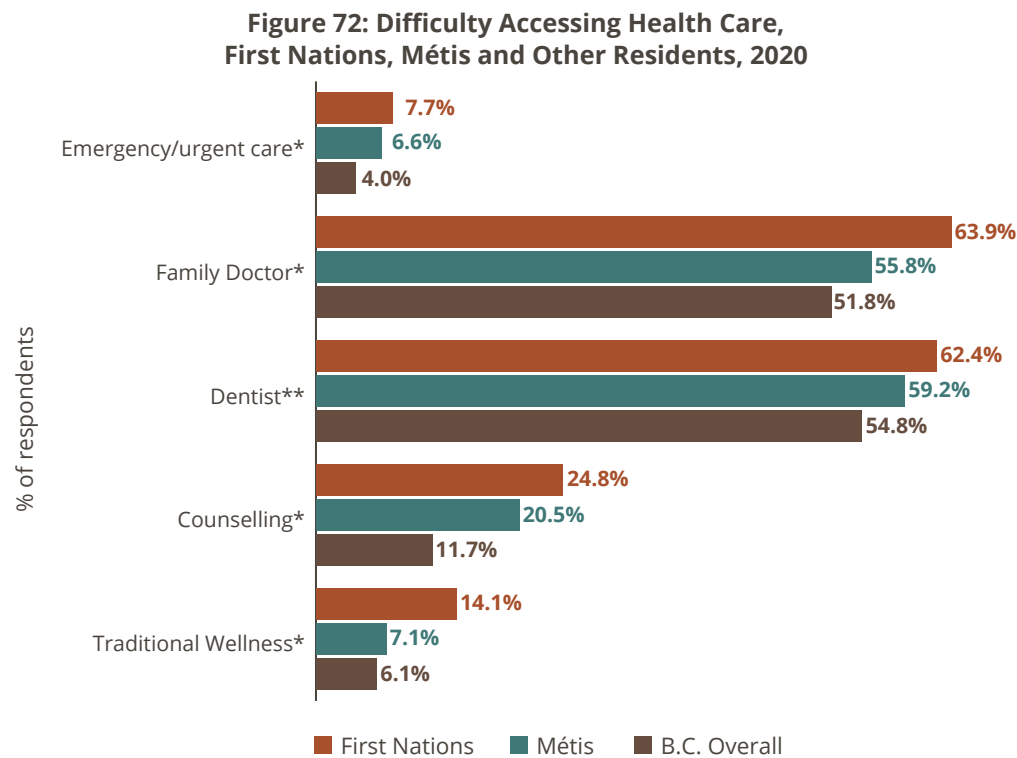
Compared to B.C.'s overall population, First Nations and Métis are more likely to experience stress from the confinement brought on by the COVID pandemic, with 26.7 per cent of First Nations and 25 per cent of Métis rating the amount of stress in their lives as quite or extremely significant (B.C.: 18.3%) in a B.C. survey of the unintended consequences of the pandemic.^{85, 86} They were also more likely to express concerns about the health of vulnerable family members and their ability to access the essential goods they needed. Furthermore, 50.3 per cent of First Nations and 52.1 per cent of Métis people rated their mental health as slightly or much worse than it was before the pandemic (B.C.: 46.4%).

Among the stressors on mental wellness due to the pandemic are income and food security. Forty-one per cent of First Nations and 38 per cent of Métis respondents said they were having increased difficulty meeting their household financial needs, compared to 32 per cent of the B.C. population. Related to this, 31 per cent of First Nations reported that they were worried that due to the pandemic, food would run out before they had money to buy more – which was twice the rate reported for B.C. overall. The Métis response (22.6%) was also higher than the rate reported for B.C. overall.

⁸⁵ B.C. Centre for Disease Control (BCCDC). 2020. COVID-19 Speak Survey. In the spring/early summer of 2020, the unintended consequences of the social isolation, economic disruption, decreased family connection and confinement associated with the COVID-19 pandemic response were explored in this survey. The survey included an opportunity for Indigenous respondents to self-identify as First Nations, Métis or Inuit (which cumulatively accounted for 6 per cent of total responses).

⁸⁶ Unless otherwise noted, all First Nations/B.C. and Métis/B.C. comparisons are statistically significant.

For the Indigenous population, which this Review has shown is challenged to receive primary health care services on a level equitable to the rest of the population, the pandemic has increased this disparity. A higher proportion of First Nations and Métis respondents reported that they had difficulties accessing emergency/urgent care and their family doctor. The greatest difference was with counselling services and traditional wellness, as First Nations were more than two times more likely to experience difficulty accessing these services than the overall B.C. population. (Figure 72).



* Both First Nations and Métis rates significantly higher than the overall B.C. rate

** First Nations rate significantly higher than the overall B.C. rate

BCCDC 2020. COVID-19 Speak Survey.

The survey explored care avoidance and found that 39 per cent of First Nations and Métis respondents were avoiding traditional wellness services, and their rates for emergency/urgent care avoidance (13% and 12%, respectively) were double that seen in the general population. First Nations were twice as likely as the B.C. population to avoid using counselling services (22% versus 11%).

6.11 Summary

In summary, the analyses presented in this quantitative data section have resulted in the following findings in the Indigenous data as they relate to health system performance and experience for Indigenous people:

Inadequate health system performance was seen in:

- Insufficient access to primary care services and lower attachment to primary care practitioners
- Lesser access to preventative care, such as screening for cancer detection, and a hypothesized lesser access to preventative oral health services as contributing to the large disparity in oral health hospitalizations
- Increased reliance on ED services across a broad spectrum of health conditions, and lower scores for patient experiences in the ED
- Increased admissions to hospital from the ED and a higher rate of avoidable hospitalizations
- A higher emphasis on IP admissions and lesser use of DP for treatment
- Increased rate of LAMA (from hospitals)
- Lesser access to common perinatal services.

Analysis of Indigenous health outcomes revealed:

- Increased adverse outcomes for infants
- Higher prevalence of chronic conditions, and an earlier progression to increased complexity of these conditions
- Higher prevalence of acute and chronic multi-morbidities
- Disproportionate impact on women's health across a wide variety of measures
- Greater impact of public health emergencies (opioid and COVID-19)
- Association between the experience of racism and poorer health and wellness indicators.



7. Discussion



The results of the two surveys convened by the Review, the submissions received from Indigenous people, the extensive key informant interviews and document reviews undertaken, and the history of Indigenous-specific complaints in the health system have led to the following conclusions about Indigenous-specific stereotyping, racism, profiling and discrimination in the B.C. health system:⁸⁷

- All forms of racism experienced by Indigenous peoples lead to avoidance of care in large part because Indigenous people seek to avoid being stereotyped, profiled, belittled and exposed to prejudice.
- Misinformed and prejudiced beliefs about the inferiority of Indigenous peoples represent a systemic problem that exists across all regions and health care settings, and which will require similar systemic and multi-layered solutions.
- Racism, whether it be commentary or other behaviours, towards Indigenous patients is tolerated in health care environments. Neither Indigenous patients nor health care workers have safe pathways for disclosure and resolution.
- Public education and awareness is limited on two fronts (1) the history of colonialism in health care and its present-day impacts; and (2) racism, accompanied by a lack of accessible anti-racism tools for health care workers.

This Review has demonstrated many disparities in Indigenous health outcomes and access to services as a result of insufficient and inadequate health system performance, which has been underpinned by structural, racist and discriminatory factors discussed at length in the Review's primary report. The very experience of racism in and of itself is associated with lower health and well-being, and is manifested through colonial health service structures and racial profiling that predispose and subject Indigenous peoples to poorer access to basic health services and perpetuate their inequitable health outcomes. The extensive amount of data describing utilization of health services and health outcomes has provided a view of Indigenous people receiving services in a health care environment which is skewed away from primary preventative care and towards secondary and tertiary care and treatment. Although at face value, First Nations' access to physician care does not seem to be too disparate with what is seen with Other Residents, when placed in the context of their

⁸⁷ An extensive discussion of the findings which underlie these conclusions may be found in the full report and summary report of: Addressing Racism Review. 2020. *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*. Please see Appendix 6 for the recommendations included in this report.

considerably higher burden of disease – which should necessitate enhanced access to primary health care providers – the inadequacy of the primary care system is apparent. In addition, this lesser access to physician services is magnified by lesser attachment to primary care practitioners, and points to the fact that there is not an optimal primary care system available to a high needs population.

First Nations screening rates for two common cancer detection tests, Pap and FIT, were approximately 70 per cent of that of Other Residents, and could in part be due to fewer First Nations having access to continuous care from a family physician or nurse practitioner as well as reluctance to engage with the health system unless absolutely necessary. In addition, the rates of pediatrician and obstetrician services were lower among First Nations, suggesting that comparatively more First Nations are relying on the primary care system for perinatal and child health instead of specialty maternal and child health services, despite evidence of higher rates of preterm and very-preterm births, increased rates of asthma, depression, mood and anxiety disorder and epilepsy, and poorer oral health outcomes in the child and youth population.

The locus of the ED for much of First Nations' health care is apparent, with adult ED user rates two times or more greater than Other Residents. EDs may be the only place that First Nations can be seen by a physician, or they may have increased needs for care which drive up the utilization rate. The adverse and racist experiences detailed in the two Review surveys and the histories submitted by individuals suggest that many First Nations may actually use the ED as a last resort. The analysis on hospital admissions from the ED which controlled for triage level, size of the facility, age profile and other factors found that First Nations had increased rates of admission from the ED for most presenting complaint categories which substantiates their higher needs. The only categories with lower First Nations rates were mental health (odds ratio 0.8), substance use (0.7) and obstetrics/gynecology (0.7). Given the higher First Nations utilization of MHSU services and the troubling indicators noted above for births, these lower admissions are not easily explained and should be subject to further study.

Women's Health

A pivotal finding of the Review is that Indigenous women have greater need for health care services and are more likely to feel unsafe in accessing those services. Indigenous women have a demonstrated higher need to receive health care services. At the same time, however, Indigenous women experience unique forms of racism within the health care system and feel

unsafe interacting with that system, resulting in less trust – and therefore avoidance of – discretionary health care services such as primary preventative care, which further contributes to health outcome disparities resulting in hospitalization.

First Nations and Métis women are disproportionately affected by poor health compared to their male counterparts and, as seen through the acute and chronic disease data provided in this report, carry a higher burden of disease.

The health disparities between Indigenous and non-Indigenous women is greater than that seen with males. This increased disparity is seen in a majority of acute and chronic conditions whereby the difference between the First Nations and Other Resident female rates of health service use were greater than the comparable difference with the male populations, and similarly greater in their utilization of the ED.

Indigenous women experience multiple health conditions (multi-morbidities) at a greater extent than do either their non-Indigenous counterparts or Indigenous males. By early adulthood, half of First Nations and Métis women experience five or more morbidities, which is over twice the rate seen with males or non-Indigenous females. Although this extreme difference disappears with Indigenous males in the older age groups, the two-fold difference in rates between Indigenous and non-Indigenous females continues.

A service gap between Indigenous and non-Indigenous women is evident when examining maternal and child health, with lower access by First Nations to health services from the prenatal period through to care of young children.

Indigenous women are overly impacted by public health emergencies. The disproportionate need of Indigenous women noted in health service utilization and health status data also continues in the context of public health emergencies, with the First Nations female share of deaths due to opioid overdoses in 2020 to date almost twice as high as the female Other Resident share. In the COVID-19 pandemic, First Nations females are over-represented in the number of confirmed First Nations cases.

The health system is often unsafe for Indigenous women. Paired with this greater need for health services is a deep experience of unsafety in accessing those services. The IPS responses were predominantly (70%) provided by Indigenous women sharing their experiences. The results clearly demonstrated that Indigenous women feel less safe than males when receiving health services, not just because of disrespectful and discourteous treatment, but because of fear – for example, that they are seen as bad parents, sexually available, or

that care providers will have less respect for their bodies. Interactions with social workers or MCFD representatives were noted by multiple Indigenous respondents as something they and/or their families are particularly fearful of when visiting hospitals or giving birth due to concerns that their children will be apprehended. This perceived lack of safety is also evidenced by the disproportionate rate at which Indigenous women left a women's hospital in B.C. against medical advice.

Going Forward

The work of FNHA and the Provincial Health Officer in designing aspirational, strength-based indicators will provide a valuable lens to understanding First Nations health going forward. Of the indicators in their collaborative inaugural report, the *Population Health and Wellness Agenda*, there were four in which a positive trend exists: cultural wellness, high school completion within eight years, reported patient experiences in health care, and reductions in smoking rates. There have been nominal or no change in indicators tracking food insecurity, acceptable housing, avoidable hospitalizations, healthy birthweights, infant mortality, children's oral health, mental and emotional well-being, physical activity, diabetes incidence and hospitalizations for serious injuries. Five indicators show a worsening trend, ranging from healthy childhood weights and youth suicide to life expectancy, mortality rate and alcohol attributable mortality.⁸⁸

A complementary set of indicators such as those outlined below will be necessary to track on an ongoing basis Indigenous health service utilization, probe for health status improvements and hold the health system to account. These will largely be deficit-based indicators but, as laid out in the Review report *In Plain Sight*, are needed at this point in time as visible measures of the outcome of racism and discrimination in health service settings. Currently there is no accountability for eliminating Indigenous-specific racism in the B.C. health care system, including system-wide data and monitoring of progress. A full discussion on the topic of data-based measurement is covered in the primary Review report *In Plain Sight*, and is available in Appendix 7. It sets forth principles to guide the improvement of the measurement of Indigenous-specific racism, including adherence to First Nations and Métis data governance principles, enhanced collection of Indigenous self-identification across the health system, accessibility of disaggregated data by First Nations and Métis governments and mandated health organizations which are recognized data stewards, and ultimate accountability by the Ministry of Health to monitor change in the issue of Indigenous-specific racism.

⁸⁸ FNHA & OPHO. 2020.

Health administrative indicators which are readily available through data linkages and which can assist in monitoring the progress towards equitable access and health outcomes for Indigenous peoples have been profiled in this report and include:

- Attachment to primary care practitioners: attachment is a primary strategy to improve the quality of health services and it shows there is a greater disparity in the First Nations population than simply the ability to access a physician
- Encounter rates: evaluation of the number of visits for various types of health needs will monitor not only if Indigenous people have access to care, but also if the intensity of care is equitable
- ED user rate: the ED should not be a substitute for primary preventative care, and ED utilization is a barometer of how effective the primary care system is in meeting the health needs of Indigenous people
- Leaving against medical advice: First Nations have been shown to leave care prematurely at greater rates than Other Residents. Turning around this indicator will require Indigenous people to have an improved perception of safety, trust and comfort in the health system
- Chronic conditions: in addition to monitoring the prevalence of chronic conditions, their progression from low to high complexity in the young and middle age adult population is a compelling indicator of the progression of poor health
- Multi-morbidities: tracking the average number of health conditions being treated in the health system per person is an expression of the burden of disease in a population
- Readmissions, such as 48-hour readmission after discharge from ED and 30-day readmission to hospital: In one review of the literature on hospitalizations, nine per cent to 48 per cent of all readmissions were judged to be preventable because they were associated with indicators of substandard care during the index hospitalization, such as poor resolution of the main problem, unstable therapy at discharge, and inadequate post-discharge care. Furthermore, randomized prospective trials have shown that 12 per cent to 75 per cent of all readmissions are preventable by patient education, pre-discharge assessment and aftercare
- Access to screening: equitable access to screening programs for cancer detection and other serious diseases is a key prevention strategy in primary care

- Maternal and infant health: the number of antenatal visits and the rate of premature/very-premature births are measures of both equitable access to services and substantively equitable outcomes. Related indicators include access to obstetricians and midwifery care.

Other health administrative indicators which have not been fully explored through data linkages include wait times (e.g., surgical wait times/wait lists, diagnostic testing), access to specialists, utilization of specialty testing (e.g., CT scans, MRIs, ultrasounds, genetic counselling, etc.), utilization of community programs such as mental health and public health, physician services not captured through fee for service data, health condition-specific mortality, and hospital/ED medical misdiagnosis/mistakes.

As noted earlier, this Review had an ambitious timeline. This schedule meant that the Review focused on providing a high-level perspective of health utilization and health outcome data for Indigenous peoples, provincially and regionally. Much important analysis remains to be done at finer geographic, gender and age-group levels to fully understand the impact of individual, structural and systemic racism.

The surveys undertaken in this Review have amply demonstrated the ongoing need for data collection on patient and worker experiences to evaluate impacts and progress of system improvements and cultivation of cultural humility and anti-racist mindsets in enhancing cultural safety in health care. These future surveys must continue to address the presence and impact of racism head-on to normalize these critical concepts and not metaphorically flinch against the posing of hard questions.

The *RHS* analysis contained in this report has provided associations between racism and wellness, and has demonstrated the value of extending surveys on racism in the health system to include health outcome measures, such as stress, suicidation and chronic disease, and indicators that ask respondents about perceived effectiveness of care received. Existing surveys such as PREMS should be evaluated for unconscious bias and could be reframed to be more reflective at understanding Indigenous-specific realities of racism and discrimination in the health system.

This report has shown that racism's impacts on health outcomes can only be fully understood through a broad ranging analysis of data across multiple domains – data which is all 'in plain sight' through the use of available mechanisms and survey instruments. Existing and planned data linkages and data explorations of Indigenous health in B.C. should be viewed through their contribution to an understanding of racism in health services, so that future work in this area can build on and enhance the knowledge base established through the Review.

Appendix 1

Indigenous Peoples' Survey Questions

This survey material has been provided as an open source document. Future users should be aware that the application of these questions and the results obtained will be highly situation dependent. This Review's survey findings are a product of the B.C. Indigenous experience and the B.C. health system, and may have been influenced by the survey's method of distribution, which took place during a world wide pandemic, and heightened interest from media coverage of events alluding to racism. For these and other reasons, other jurisdictions may obtain variations of these findings from a survey using similar questions.

Suggested citation: Indigenous Peoples' Survey, Addressing Indigenous-specific Racism and Discrimination in B.C.'s Health Care System, December 2020.

My age is:Please choose **only one** of the following:

- ☐ 18 years or younger
- ☐ 19-29 years
- ☐ 30-39 years
- ☐ 40- 49 years
- ☐ 50-59 years
- ☐ 60-69 years
- ☐ 70-79 years
- ☐ 80 years and older

In which province or territory do you live?Please choose **only one** of the following:

- ☐ Alberta
- ☐ British Columbia
- ☐ Manitoba
- ☐ New Brunswick
- ☐ Newfoundland and Labrador
- ☐ Northwest Territories
- ☐ Nova Scotia
- ☐ Nunavut
- ☐ Ontario
- ☐ Prince Edward Island
- ☐ Quebec
- ☐ Saskatchewan
- ☐ Yukon

In which health authority/region do you currently reside?Please choose **only one** of the following:

- ☐ Fraser Health
- ☐ Interior Health
- ☐ Northern Health
- ☐ Vancouver Coastal Health
- ☐ Island Health
- ☐ Prefer not to say
- ☐ I do not know but the city/town I live in or am closest to is _____

What best describes where you live?

Please choose **only one** of the following:

- ☐ Urban area
- ☐ Rural area
- ☐ Small Rural area
- ☐ Remote area

Which best describes your current gender identity?

Please choose **only one** of the following:

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Transfeminine
- ☐ Transmasculine
- ☐ Two-spirit
- ☐ Different identity
- ☐ Prefer not to answer

Do you identify yourself as an Indigenous person, that is, First Nations, Métis or Inuit?

Please choose **only one** of the following:

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

As you identify yourself as an Indigenous person, are you:

Please choose **only one** of the following:

- ☐ First Nations
- ☐ Métis
- ☐ Inuit
- ☐ Other North American Indigenous Nation
- ☐ Other Indigenous Nation
- ☐ Prefer not to answer

As you identify yourself as a First Nations person do you live on a First Nations reserve?

Please choose **only one** of the following:

- ☐ Yes
- ☐ No
- ☐ Not applicable
- ☐ Prefer not to answer

If you are an Indigenous child or youth (17 years and younger), where do you primarily live?

Please choose **only one** of the following:

- ☐ with your parent(s)
- ☐ with another family guardian (e.g., grandparent, aunt, uncle, etc.)
- ☐ with foster parents
- ☐ in a group home with adoptive parents
- ☐ Other _____

Please do not include any personally identifiable information about yourself or others in your responses.

How safe did you feel when you used or interacted in the past with the health service locations listed below?

Please choose the appropriate response for each item:

	Completely safe	Somewhat safe	Somewhat unsafe	Not at all safe	No opinion	I didn't use this service
Emergency room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital (admission as day patient or overnight)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doctor's office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dentist's office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other health care office, such as chiropractor, physiotherapist etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assisted living or long term care home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
First Nations or Métis health centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How safe did you feel when you used or interacted in the past with the health service providers listed below?

Please choose the appropriate response for each item:

	Completely safe	Somewhat safe	Somewhat unsafe	Not at all safe	No opinion	I didn't use this service
Family doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialist including surgeon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nurse or nurse practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traditional healer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paramedic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital social worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other health provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Security staff in hospital or building	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How safe did you feel when you used or interacted in the past with the health services listed below?

Please choose the appropriate response for each item:

	Completely safe	Somewhat safe	Somewhat unsafe	Not at all safe	No opinion	I didn't use this service
Mental health or substance use services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialty care (e.g. birthing & maternal care, cancer, palliative, pediatrics/child health, dialysis etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge planning before going home from the hospital or emergency room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public health services (e.g. vaccinations, stop smoking etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital support services (e.g. food service, cleaning etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I receive the majority of my care in the following location:

Please choose **only one** of the following:

- ☐ Doctor's office
- ☐ Walk in clinic
- ☐ Nurse practitioner run clinic
- ☐ Emergency Department
- ☐ First Nations or Métis community health clinic
- ☐ Other _____

Please do not include any personally identifiable information about yourself or others in your responses.

Where is this care located?

Please choose **only one** of the following:

- ☐ Urban area
- ☐ Rural area
- ☐ Small Rural area
- ☐ Remote area

When you use health care services (e.g., seeing a doctor, nurse or other health care provider or going to the hospital, using emergency services, etc.), how often do any of the following things happen to you?

Please choose the appropriate response for each item:

	Always	Sometimes	Rarely	Never	No opinion
I am treated with the same courtesy and respect as other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I receive poorer service than other people (e.g., I am ignored, or people don't hear what I say)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health staff act as if they think I am dishonest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health staff understand and appreciate my Indigenous culture and traditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am insulted or harassed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health staff act as if they think I am drunk or I am asked about substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health staff acknowledge that I care about my health and include me in decisions about my health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am treated as if I am a bad parent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health staff around me stare, whisper or point	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What do you think are the top *three* reasons for the negative experiences you may have had?

Please select at most 3 answers:

- ☐ My ancestry or origins – including culture, ethnicity, being Indigenous
- ☐ My income level
- ☐ My gender
- ☐ My education
- ☐ My sexual orientation
- ☐ Physical disability
- ☐ My age
- ☐ Substance use
- ☐ My religion/spirituality
- ☐ My mental health
- ☐ My skin colour
- ☐ Other health conditions
- ☐ My appearance (e.g., weight, height, clothing)
- ☐ The way I speak English or my accent
- ☐ Where I live
- ☐ None of the above
- ☐ Other _____

Please do not include any personally identifiable information about yourself or others in your responses.

In the past, when you used health care services (e.g., seeing a doctor or nurse, going to the hospital, having an x-ray or blood test taken, using emergency services, etc.), how often have the following things happened to you:

Please choose the appropriate response for each item:

	Always	Sometimes	Rarely	Never	No opinion
I was properly diagnosed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was given medication, including for pain, when I needed it or asked for it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I waited the same length of time as other people to be seen by a doctor or other health care provider, when it seemed I had the same need for health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I received a proper referral (e.g., to another doctor, a specialist, program or service)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My discharge process from the hospital was complete (e.g., I was given a follow up plan, I received home care services, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I felt like my needs and concerns were taken seriously (e.g., I received the care I needed in the emergency room, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My health providers agreed that I could practice traditional medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall, I received great care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thinking only about your last encounter with the health system, how would you rate your experience in this encounter?

Please choose **only one** of the following:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ No opinion

How likely would you be to express your concerns or make a complaint if you thought you were treated poorly or unfairly when using a health care service?

Please choose **only one** of the following:

- ☐ Very likely
- ☐ Somewhat likely
- ☐ Not at all likely

If you had a reason to make a complaint about health care that you or a loved one received, but did not, what was the reason you would not make a complaint?

Please select at most 3 answers:

- ☐ I don't think it would make a difference
- ☐ I would be treated poorly or unfairly throughout the process of complaining
- ☐ I don't know how to make a complaint or what the options are
- ☐ It would take too much energy or effort
- ☐ I wouldn't be taken seriously/no one would believe me
- ☐ I would be treated worse by health care staff in the future
- ☐ I submitted a complaint before, and it did not make a difference
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

Thinking back on your experience in the health system, how often would you *agree* with following statements?

Please choose the appropriate response for each item:

	Always	Sometimes	Rarely	Never	No opinion
Indigenous people are treated fairly in the health care system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care providers want to work with/provide quality, safe care for Indigenous people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health care providers are open to hearing about traditional medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigenous people trust health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are enough Indigenous health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel safe to speak up when I believe I am being treated inappropriately by health care staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Families of Indigenous patients are welcome in hospitals and health care settings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health providers are knowledgeable about health services in my community which are available to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To improve health care for Indigenous people, how important is each of the following:

Please choose the appropriate response for each item:

	Very important	Somewhat important	Somewhat unimportant	Not at all unimportant	Don't know or no opinion
Collecting data on Indigenous people, such as asking patients to self-identify as Indigenous or First Nations, Métis or Inuit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anti-racism and cultural safety training/education for health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More Indigenous people working in all areas of health care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Policies to address racism and discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigenous-only services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigenous Patient Navigators or Liaisons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to traditional medicine, healers or Elders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigenous cultural spaces or space for ceremony in hospitals/health care centres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigenous people meaningfully involved in health services, such as board of directors or high-level positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication between hospitals/health care organizations and Indigenous communities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visibility of Indigenous Nations in hospitals and health offices, such as art work, recognition of traditional territory, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A feedback process that is accessible, meaningful and safe to access regarding one's care/experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What needs to change for Indigenous people to feel safe when using health services? (Think about your experiences in the Emergency Room, with paramedics, with doctors or nurses, giving birth, etc.)

Please do not include any personally identifiable information about yourself or others in your responses.

Please write your answer here:

Please tell us anything else that you think might be helpful for understanding Indigenous peoples' experiences in health care.

Please do not include any personally identifiable information about yourself or others in your responses.

Please write your answer here:

Thank you very much for your participation in this survey.

Appendix 2

Survey Methodology

Approach and Methodology – Indigenous Peoples’ Survey and Health Workers’ Survey

Analysis of feedback obtained from the public engagement survey – hosted and managed by the Public Engagement Team at the Ministry of Citizens’ Services at the request of the Review – was conducted by an independent research company. Throughout the analysis and reporting process, this company reported to and conferred with a representative from the Review Team pursuant to the independent mandate of the Review.

The sub-sections below provide a summary of the approach utilized in the data analysis.

Coding of Open-Ended Responses

There were several open-ended questions in this survey. Responses to these open-ended fields were coded by research staff, according to coding frameworks developed for each question.

Coding frameworks were developed by taking a random sample of responses to each question (sample size varied based on the total number of responses available) and reviewing their content to identify themes. An inductive, iterative approach was used to develop the framework; when a new theme was identified, past comments were reviewed for the same or similar theme to ensure that themes were defined in a manner sufficiently broad to capture the variations on the sentiment, without being too broad to provide meaningful information.

Quantitative Analysis

The majority of survey responses were analyzed quantitatively. Summary statistics were used to develop an overall picture of responses to closed-ended questions. Open-ended text fields in the survey were coded thematically, as described above, and codes applied to comments were then also summarized using statistical methods.

Where appropriate, some cross-tabulations and comparisons of responses by group type (e.g., by region, health authority, gender, and other demographic variables of interest) were undertaken to identify whether the sub-groups

differed significantly in their responses. Demographic variables of interest for these comparisons were identified *a priori* by the Independent Reviewer's team, in consultation with the external contractor. Decisions were based on existing knowledge about these sub-groups and interest in better understanding diverging trends among them.

Limitations and Caveats

While the Independent Review and its partners undertook efforts to raise awareness of the survey and make it as accessible as possible to anyone who wanted to participate, it is important to remain aware that this sample from both surveys was self-selected and should not be interpreted as being representative of the B.C. population, or the population of Indigenous people in B.C.

The findings are illustrative of broad experiences in the B.C. health care system and are to be considered along with other lines of inquiry by the Review in understanding the presence and extent of Indigenous-specific discrimination in health care. Findings that indicate experience of racism, or difference in outcomes among different groups, should be taken as indicative of issues in the B.C. health care system, but not definitive accounts of group differences.

Finally, it is not possible to know if respondents were referencing recent experiences or if they based opinions on interactions they may have had some time in the past and thus findings presented in this report are not representative of a particular point in time.

Indigenous Peoples' Survey

Where analyses by Indigenous identity were undertaken (i.e., comparisons of Indigenous patients to those who reported no Indigenous identity, or did not provide information on their identity), it was necessary to combine all Indigenous groups together (total of 80% Indigenous) to create a large enough population to allow for statistical analyses, despite these groups' significant cultural, historical and linguistic differences.

Health Workers' Survey

The findings highlighted in this report should be interpreted with caution and not generalized to the larger population of health care workers in B.C. (i.e., finding should be considered non-representative) – it is not known if the experiences shared by respondents are common or representative of health care workers in B.C. as a whole, due to the self-selected nature of the sample.

Due to a survey programming issue, approximately one-half of all respondents who reported working in B.C. (n=2,799) were not asked which health authority/region they work in. Data for these respondents is missing and analysis of survey data by health authority/region includes only those individuals who were asked, and responded to, the question about which health authority/region they work in (n=2,423).

Appendix 3

Health Workers' Survey Questions

This survey material has been provided as an open source document. Future users should be aware that the application of these questions and the results obtained will be highly situation dependent. This Review's survey findings are a product of the B.C. Indigenous experience and the B.C. health system, and may have been influenced by the survey's method of distribution, which took place during a world wide pandemic, heightened interest from media coverage of events alluding to racism, and the survey's methodology relating to the flow of questions. For these and other reasons, other jurisdictions may obtain variations of these findings from a survey using similar questions.

Suggested citation: Health Workers' Survey, Addressing Indigenous-specific Racism and Discrimination in B.C.'s Health Care System, December 2020.

Section A: About you

Currently, with respect to my occupation, I am:

Check **all** that apply:

- ☐ Working full time in the health system
- ☐ Working part-time in the health system
- ☐ Working outside of the health system
- ☐ Studying in a health professional program (college or university) full-time
- ☐ Studying in a health professional program (college or university) part-time
- ☐ Working as an instructor, faculty or preceptor in a health professional program (college or university)
- ☐ Not working or studying
- ☐ Working as a volunteer
- ☐ Retired
- ☐ Retired but back in the health workforce
- ☐ On leave (e.g., medical, parental, etc.)
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

My primary role in the health system is (select the best answer):

Please choose **only one** of the following:

- ☐ Allied Health Professional (e.g., PT/OT/RT/SW/SLP/Dietitian/Psychologist, etc.)
- ☐ Clerical Support
- ☐ Administration
- ☐ Dental Health Provider
- ☐ Elder
- ☐ EMT/Paramedic
- ☐ Facilities Management/Trades
- ☐ Food Service
- ☐ Health Care Aide or Orderly (hospital)
- ☐ Home Care Aide or Home Support Worker
- ☐ Health Program Worker (e.g., mental health counsellor, community health representative, etc.)
- ☐ Housekeeping
- ☐ Instructor, Faculty, or Preceptor
- ☐ Lab Technician/Phlebotomist/Medical Imaging Technician
- ☐ Leadership/Management

- ☐ Licensed Practical Nurse
- ☐ Midwife
- ☐ Nurse Practitioner
- ☐ Patient Navigator or Liaison
- ☐ Physician and Surgeon (including Podiatric Surgeon)
- ☐ Registered Nurse
- ☐ Registered Psychiatric Nurse
- ☐ Security
- ☐ Spiritual Health Practitioner
- ☐ Student
- ☐ Volunteer
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

In which province or territory do you live?

Please choose **only one** of the following:

- ☐ British Columbia
- ☐ Alberta
- ☐ Manitoba
- ☐ New Brunswick
- ☐ Newfoundland and Labrador
- ☐ Northwest Territories
- ☐ Nova Scotia
- ☐ Nunavut
- ☐ Ontario
- ☐ Prince Edward Island
- ☐ Quebec
- ☐ Saskatchewan
- ☐ Yukon
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

In which health authority/region do you work or study?

Please choose **only one** of the following:

- ☐ Fraser Health
- ☐ Interior Health
- ☐ Northern Health
- ☐ Vancouver Coastal Health
- ☐ Island Health
- ☐ Prefer not to say
- ☐ Not applicable

What best describes where you live?

Please choose **only one** of the following:

- ☐ Urban area
- ☐ Rural area
- ☐ Small Rural area
- ☐ Remote area

The location of the majority of my work (including placements of students) is:

Please choose **only one** of the following:

- ☐ Hospital/health centre (excluding the Emergency Department)
- ☐ Hospital Emergency Department
- ☐ Family practice setting, dental office, community health centre
- ☐ Specialist office
- ☐ Walk in clinic
- ☐ Home health
- ☐ Long-term care/residential care
- ☐ Street outreach program
- ☐ Other emergency services (e.g., ambulance or medivac)
- ☐ First Nations or Métis community health clinic, service, or program
- ☐ Allied health professional clinic (e.g., PT, OT, etc.)
- ☐ Mental health or addictions centre
- ☐ Laboratory testing or medical imaging not located in a hospital or health centre
- ☐ Group home
- ☐ Halfway house or prison
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

Considering your entire career, how long have you worked in the health system?Please choose **only one** of the following:

- ☐ Less than 1 year
- ☐ 1 to 2 years
- ☐ 3 to 5 years
- ☐ 6 to 10 years
- ☐ More than 10 years

Which best describes your current gender identity?Please choose **only one** of the following:

- ☐ Female
- ☐ Male
- ☐ Non-binary
- ☐ Transfeminine
- ☐ Transmasculine
- ☐ Two-spirit
- ☐ Different identity
- ☐ Prefer not to answer

Do you identify yourself as an Indigenous person, that is, First Nations, Métis or Inuit?Please choose **only one** of the following:

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

As you identify yourself as an Indigenous person, are you:Please choose **only one** of the following:

- ☐ First Nations
- ☐ Métis
- ☐ Inuit
- ☐ Other North American Indigenous Nation
- ☐ Other Indigenous Nation
- ☐ Prefer not to answer
- ☐ Not applicable

Racialized people are those who are non-Caucasian in race or non-white in colour.

Do you identify as a racialized person?

Please choose **only one** of the following:

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

Second B: Witnessing racism or discrimination in Health Care

Discrimination is defined as through action or inaction, denying members of a particular social group access to goods, resources and services.

Racism is defined as a set of mistaken assumptions, opinions and actions resulting from the belief that one group of people categorized by colour or ancestry is inherently superior to another.

Racialized people are those who are non-Caucasian in race or non-white in colour.

Have you witnessed any kind of interpersonal racism or discrimination at work directed to Indigenous patients or their families/friends?

Please choose **only one** of the following:

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Prefer not to say

Have you witnessed any kind of interpersonal racism or discrimination at work directed to non-Indigenous racialized patients or their family/friends based on their appearance, ancestry or heritage?

Please choose **only one** of the following:

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Prefer not to say

Please review the statements below, and if applicable to the racism or discrimination you witnessed against patients, please indicate how often these were observed by you:

Please choose the appropriate response for each item:

	Regularly	Occasionally	Rarely	Never	Not applicable
The patient was ignored or made to wait longer than necessary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health workers made disrespectful, disparaging, or joking comments about the patient's cultural or racial identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient was denied needed medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incorrect assumptions were made about the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient was discharged prematurely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient's or guardian's history inappropriately influenced health provider decisions on referrals and care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient request to utilize traditional medicine was dismissed or ignored	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient's need for cultural protocols (such as surrounding death or birth) was denied	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient was discharged without proper support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The patient was discharged without consideration of the living situation that the patient was returning to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Organizational or systemic racism allows people to normalize, hide or disguise racism because of the acceptance of these behaviours in the environment of the health service, institution or society in general.

From your perspective, organizational or systemic racism in your workplace is:

Please choose **only one** of the following:

- ☐ Extremely prevalent
- ☐ Very prevalent
- ☐ Somewhat prevalent
- ☐ Non-existent
- ☐ No opinion
- ☐ Not sure
- ☐ Prefer not to say

If organizational or systemic racism exists in your work environment, why do you think that it has not been prevented?

Please select up to **three** responses.

- ☐ Staff are not regularly reminded about the many ways that discriminatory behaviour can occur
- ☐ Staff are not willing to stand up and call out racially prejudiced behavior of their peers
- ☐ Lack of accountability by leadership to stop discriminatory approaches or behaviours
- ☐ Absence of training, or inadequate preparation by professional colleges on cultural safety or cultural sensitivity
- ☐ No education provided by the employer which could help understand Indigenous experiences and the impacts of colonialism and colonial oppression
- ☐ Indigenous patient navigators or liaisons are not effectively promoted as a resource for patients or staff
- ☐ Indigenous personnel are underrepresented at all levels of the organization.
- ☐ Prefer not to say
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

Section C: Personal experiences of racism or discrimination

Do you feel that you have personally experienced racial prejudice or discrimination at work because of your Indigenous identity/heritage?

Please choose **only one** of the following:

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Prefer not to say

Please check the following examples of Indigenous-specific prejudice or discriminatory behaviour in the workplace that have been directed to you.

Please select up to **three** responses.

- ☐ I feel I am a token Indigenous person when invited to teams or committees
- ☐ Colleagues are resentful because they thought my education was free
- ☐ Colleagues say discriminatory or hurtful comments about Indigenous patients or Indigenous culture in front of me
- ☐ I am chosen to look after Indigenous patients, not because of my skills and expertise, but because I am Indigenous
- ☐ I am turned down for courses and other education that would further my skills and career, while other staff are allowed to participate
- ☐ I feel excluded or isolated from coworkers
- ☐ Information I need to do my job is deliberately withheld
- ☐ Colleagues do not understand that there are differences between Indigenous groups
- ☐ Prefer not to say
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

From whom did you experience racism or discrimination at work because of your Indigenous identity/heritage?

Check **all** that apply

- ☐ Individuals with authority over me
- ☐ Instructors or mentors
- ☐ Coworkers or fellow students
- ☐ Individuals working for me
- ☐ Individuals from other departments
- ☐ Volunteers or clergy
- ☐ Patients or residents
- ☐ Family members or visitors of patients or residents
- ☐ Prefer not to say
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

To what extent has the experience of racial discrimination at work affected you personally?

Please choose the appropriate response for each item:

	Significantly	Moderately	Not at all	Prefer not to say	Not applicable
My mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My emotional health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My spiritual health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My ability to work or study effectively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My standing with my colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My chances for promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My satisfaction with my job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (rate here and describe below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other (please write your answer here):

Please do not include any personally identifiable information about yourself or others in your responses.

Do you feel that you have personally experienced racial prejudice or discrimination at work because of your identity/heritage as a racialized person?

Please choose **only one** of the following:

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Not applicable
- ☐ Prefer not to say

Please check the following examples of racialized prejudice or discriminatory behaviour in the workplace that have been directed to you.

Please select up to **three** responses.

- ☐ I feel I am a token person when added to committees or teams
- ☐ Colleagues say discriminatory or hurtful comments about patients of my ancestry, heritage, or culture in front of me
- ☐ I am chosen to look after patients of my ancestry or heritage, not because of my skills and expertise, but because I am of the same ancestry or heritage
- ☐ I am turned down for courses and other education that would further my skills and career, while other staff are allowed to participate
- ☐ I feel excluded, or isolated from coworkers
- ☐ Information I need to do my job is deliberately withheld
- ☐ Prefer not to say
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

From whom did you experience racism or discrimination at work because you are a member of a visible/racialized population?

Check **all** that apply

- ☐ Individuals with authority over me
- ☐ Instructors or mentors
- ☐ Coworkers or fellow students
- ☐ Individuals working for me
- ☐ Individuals from other departments
- ☐ Volunteers or clergy

- ☐ Patients or residents
☐ Family members or visitors of patients or residents
☐ Prefer not to say
☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

To what extent has the experience of racial discrimination at work affected you personally?

Please choose the appropriate response for each item:

	Significantly	Moderately	Not at all	Prefer not to say	Not applicable
My mental health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My emotional health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My spiritual health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My ability to work or study effectively	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My standing with my colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My chances for promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My satisfaction with my job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (rate here and describe below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: (Please write your answer here) Please do not include any personally identifiable information about yourself or others in your responses.

Have you witnessed other health care workers/personnel experience racial prejudice or discrimination because of their culture, ethnicity or heritage?

Please choose **only one** of the following:

- ☐ Yes
- ☐ No
- ☐ Not sure
- ☐ Prefer not to say

Section D: Reporting Racism or Discrimination

From your perspective, what are the reasons that could stop you from placing a complaint with a supervisor in your place of work about racism or discrimination you may experience or witness?

Please select up to **three** responses.

- ☐ The health worker union would fight the complaint and any corrective action that came from it
- ☐ The supervisor also demonstrates racially prejudiced behaviour
- ☐ I don't want to jeopardize my employment and the potential for advancement
- ☐ It could adversely affect my relationship with my colleagues in the future
- ☐ I don't think it would change the behavior I saw
- ☐ I wouldn't be taken seriously / no one would believe me
- ☐ I have seen complaints submitted before, and it did not make a difference in the workplace
- ☐ I don't know what the process is for making complaints in my workplace
- ☐ Not applicable, I would make a complaint if I felt it was needed
- ☐ Prefer not to answer
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

What are the reasons that could stop you from placing a complaint with a B.C. regulated health profession college or registrar about racially prejudiced or discriminatory behaviour you may experience or witness?

Please select up to **three** responses.

- ☐ I would be afraid of being seen as a whistleblower
- ☐ In the past, the person who I was making a complaint about was involved in the complaint review process
- ☐ I would be concerned that nothing would happen
- ☐ I would be concerned that the review body would not have the cultural sensitivity or cultural awareness to understand the racially prejudiced behavior underlying the complaint
- ☐ I would be concerned that my identity would cause people to not take my complaint seriously
- ☐ I would be concerned that my identity would be made known to the person I made the complaint against
- ☐ Not applicable, I would make a complaint if I felt it was needed
- ☐ Prefer not to answer
- ☐ Other: _____

Please do not include any personally identifiable information about yourself or others in your responses.

Section E: Education and Training

Thinking of your education (either current or past) required for your position in health care, please indicate your agreement with the following about your training:

Please choose the appropriate response for each item:

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	No opinion	Prefer not to answer
I learned about the many ways that colonialism has impacted and continues to impact Indigenous health and wellbeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I learned how colonialism has influenced how Indigenous people may interact with the health care system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural sensitivity training (all cultures) was integrated into all aspects of the curriculum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I learned about systemic bias and racism in Canadian society and how to counteract this as a health professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During my education and training, I felt that Indigenous patients received the same level of care as other patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During my education and training, I felt safe to register concerns regarding discriminatory actions I saw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During my education and training, my instructors and mentors were positive role models in culturally safe care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section F: Cultural safety in the workplace

Please rate your agreement with the following statements.

Please choose the appropriate response for each item:

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	No opinion	Prefer not to answer
My workplace's disciplinary policies and practices to prevent discrimination are sufficient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with the way in which my workplace responds to matters related to discrimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The physical space I work in is welcoming to Indigenous staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel supported to raise concerns related to discrimination in my workplace	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My onboarding process was culturally safe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel safe to talk about my cultural background with my colleagues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My workplace effectively holds staff accountable in completing Indigenous-specific cultural safety training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My workplace is discrimination free	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To ensure safe, quality health care services for Indigenous people, how would you prioritize the following actions:

Please choose the appropriate response for each item:

	High Priority	Medium Priority	Low Priority	Not a Priority	No opinion	Prefer not to answer
Provide a variety of educational opportunities for health care staff to understand Indigenous peoples' past experiences and how these have impacted their health today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase the number of Indigenous people working in all areas of health care services, including senior management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ensure that all organizational policies and procedures are examined using anti-racism, cultural safety and health equity lens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Promote regular dialogue between health providers and traditional healers, Elders or knowledge keepers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Create Indigenous cultural spaces or designated spaces for ceremony in hospitals/health care centres	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ensure that health leadership strongly address racial prejudice and promote Indigenous cultural safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural safety training mandated as the minimum standard for all employees with a health care organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of peer support networks to help employees practice what they learn from cultural safety training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please rate your agreement that the following traditional, customary and/or ceremonial health practices should be options considered when developing a care plan for Indigenous patients.

Please choose the appropriate response for each item:

	Strongly Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree	No opinion	Prefer not to answer
Drumming, singing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy medicine techniques (e.g., healing by touch/no touch)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigenous birth protocols	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigenous death and dying protocols	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smudging or cleansing ceremony	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweat lodge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traditional medicines (e.g., cedar, hemlock)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What needs to change for Indigenous people to feel safe when using health care services?

Please write your answer here:

Please do not include any personally identifiable information about yourself or others in your responses.

What needs to change for Indigenous people working in the health system to feel safe in their workplace?

Please write your answer here:

Please do not include any personally identifiable information about yourself or others in your responses.

Please tell us anything else that you think might be helpful for understanding Indigenous-specific racism or discrimination in the health system.

Please write your answer here:

Please do not include any personally identifiable information about yourself or others in your responses.

Thank you very much for your participation in this survey.



Appendix 4

Data Limitations

Small Populations

One limitation which is common to all First Nations and Métis data sources is that their populations are comparatively small from a population health analysis perspective. When a database is segmented to look at gender, age, geography, disease condition and/or attachment, numbers can become very small. The Review's data governance protocol only allows the reporting of rates which have been derived from numerators of at least 11 or denominators of at least 21. Although larger numbers can be worked on and reported, in some cases such numbers can still be small in analytical terms, causing year-to-year fluctuations in rates, and an inability to derive statistical conclusions from the data in comparisons with other populations.

Data Linkages

The entire process of acquiring data through a data linkage process is laborious and lengthy, resulting in a continuous wait list for data linkages. The end result of this process is that data eventually received from a data linkage is often not timely. If there are immediate, urgent needs for data, the queue can be managed to accommodate this urgency, but to the detriment of other requestors who then experience longer delays. Furthermore, the FNHA relies heavily on data-linked databases, such as the HSM and Population Grouper, which must be created by the Ministry of Health, which in itself introduces a delay.

The data-linkage process uses a deterministic linkage with the FNCF to identify records of individuals who are First Nations with status through the Indian Register. It does not capture individuals who are non-status First Nations. The MCR includes only those individuals who have sought citizenship through MNBC and have agreed to have their data used in data linkages. As such, at the present time, it includes about a quarter of all Métis in B.C. who self-identified in the Canadian Census. It cannot be considered a random representation of this population, as individuals self-select to be included in the MCR. Assessments of MCR rates on a comparative basis must be tempered by the fact that the residual population for comparison, called Other Residents, in this case includes all First Nations, status and non-status, as well as Métis not in the MCR.

Due to late reporting of births in the Indian Register and/or a difference between when the FNCF was last updated and the data being linked, some infants will be included only if parents can be identified as registered/eligible First Nations.⁸⁹ This is an inherent limitation of all data linkages where the client files are updated on a yearly or longer basis, and a variation of it applies to the MCR as well.

The most recent HSM linkage with the FNCF has shown some anomalies with respect to the zero to five age group in 2017/18, which have not been adequately investigated by time of publication. For this reason, HSM age group-specific data for zero to five years has been drawn from 2016/17.

Existing privacy legislation in B.C. separates data in government/public institutions from non-governmental organizations and the private sector. Legislative barriers prevent FNHA and MNBC from receiving row level data from data linkages, as this is considered personal information governed by privacy legislation with no accommodation to share this data between public and private versions of the legislation. Data from data linkages must be provided in aggregate, which limits the statistical tests that can be accomplished, and makes data mining to completely understand the data and its initial findings impossible.

As with all data sources that are sequestered from other databases with no ability to conduct supplemental data linkages (due to the aggregate nature of the data), there is not a convenient mechanism to understand if shifts in health utilization or health status indicators represent changes in access to health providers or if they are representative of changes in the health of the population.

Health System Matrix

The HSM has built-in service lines from which to understand utilization of the health system. These service lines were developed for the B.C. population as a whole, and not tested for validity or appropriateness with the Indigenous population of the province.

Excluded from the HSM are:

- service utilization from First Nation community health services and FNHA-funded projects

⁸⁹ Theoretically, missing infants will affect both the numerator and denominator equally and therefore not affect a rate calculation. This is only true if there is not a systematic difference between infants who are registered right away/infants whose registered parents can be easily verified and infants who are registered late or whose parental information is incomplete.

- about 30 per cent of provincial expenditures such as population health programs, and community mental health programs
- physician services provided via salaried positions. The HSM does contain a portion of salaried/alternate payment plan physicians who shadow bill (submit fee codes corresponding to the patient's visit)
- data from B.C. Cancer Agency, B.C. Renal Agency and MCFD
- in the current version of the HSM, home care has been removed due to methodological issues.

Population Grouper

Similarly to the HSM, the Population Grouper has been built from selected data sources to develop patterns of health care utilization in the general population with no consideration of Indigenous or small populations. These patterns are based on Ontario and Alberta health utilization trends. Currently excluded from the Population Grouper are IP mental health stays, inpatient rehab, home care and long-term care.

Regional Health Survey

The survey is only able to reflect the experience of First Nation individuals living in community, and does not include complete coverage of all First Nations communities or the residents within.

PREMS

As a voluntary sample survey utilizing voluntary self-identification of Aboriginal ethnicity, it is unknown to what extent the survey findings reflect the experiences of all First Nations and Métis accessing the health system in B.C. The percentage of respondents identifying as Aboriginal varies between sector surveys.

Opioid

FNHA reporting covers all unintentional drug toxicity deaths among First Nations people in B.C. (accidental and undetermined) that occurred between Jan. 1, 2016 and Oct. 31, 2020, inclusive. It includes confirmed and suspected illicit toxicity deaths (inclusion criteria below). Data is subject to change as death investigations are concluded.

The illicit drug toxicity category includes the following:

- Street drugs (Controlled and illegal drugs: heroin, cocaine, MDMA, methamphetamine, illicit fentanyl, etc.).
- Medications not prescribed to the decedent but obtained/purchased on the street, from unknown means or where origin of drug not known.
- Combinations of the above with prescribed medications.

COVID-19

Cumulative incidence rates of COVID-19 for the First Nations population were calculated by FNHA from 2019 population estimates derived from 2018 version of FNCF. Use of a population estimate may result in slight over or underestimation of COVID-19 cumulative incidence rates for this reporting period. To calculate COVID-19 rates among other residents, the estimated First Nations population in 2019 (calculated as mentioned above) was subtracted from the total population of respective region in 2019 (via B.C. Stats 2015-19 population estimates) to estimate the Other Resident population size for 2019. This may result in slight over- or underestimation of rates.

Qualitative Analysis

Qualitative analysis is an inherently subjective process of meaning making. It is not possible to ascertain the extent to which the views and experiences of those included in the qualitative analysis represent the views and experience of those who were not included. The themes generated are no more than suggestive of possible patterns in the broader population. The analysis was conducted by a single analyst; interpretations were informed by their social location and limited by their perspective. With the exception of the Review Intake database, there was no consultation with database owners during the analysis process. This was intended to support the independence of the Review but may have limited the accuracy of some conclusions. There was considerable inconsistency in the depth and detail of the narrative provided for analysis. Missing and superficial data limited the potential for the analysis to reflect the complexities of lived experience. It was not possible to discern the extent to which missing or superficial data reflected real deficiencies in recording or gaps in practice. Review time constraints excluded the possibility of recoding all data after full development of a coding structure for each data set. This may have led to inaccurate frequency calculations, with errors most likely to involve under-counting.

Appendix 5

Population Segment Definitions

PS01 Non User	Non User B.C. residents who did not use publicly funded health services included in Health System Matrix.
PS02 Healthy	Healthy B.C. residents who were low users of publicly funded services and did not have any health conditions which would assign a person to a higher acuity population segment. They used up to \$1,500 of physician services and up to \$1,000 of prescription drugs (PharmaNet expenditures which includes both government paid and out-of-pocket/extended benefits prescription drugs); did not use any other health care services; and were alive at the end of the year.
PS03 Adult Major Age 18+	Adult Major Age 18+ B.C. residents age 18 years and older with major health conditions other than those which assign a person to a higher acuity population segment. They used more than \$1,500 of physician services; or used more than \$1,000 of prescription drugs (PharmaNet expenditures which includes both government paid and out-of-pocket/extended benefits prescription drugs); or used any other health care services; or died during the year.
PS04 Child and Youth Major <18 years	Child and Youth Major <18 years B.C. residents under the age of 18 with major health conditions other than those which assign a person to a higher acuity population segment. They used more than \$1,500 of physician services; or used more than \$1,000 of prescription drugs (PharmaNet expenditures which includes both government paid and out-of-pocket/extended benefits prescription drugs); or used any other health care services; or died during the year. The unhealthy newborns were included in this population segment.
PS05 Low Chronic Conditions	Low Chronic Conditions B.C. residents with one or more low complex chronic conditions (asthma, mood/anxiety disorder including depression, diabetes, epilepsy, hypertension, osteoarthritis or osteoporosis), as defined by the Chronic Disease Registries.
PS06 Medium Chronic Conditions	Medium Chronic Conditions B.C. residents with one or more medium chronic conditions (angina, COPD, multiple sclerosis, Parkinson's, pre-dialysis chronic kidney disease, or rheumatoid arthritis), or have had a major cardiac event or intervention (CABG, AMI, PTCA), or have a specific combination of chronic conditions (diabetes & mood/anxiety disorder, osteoarthritis & hypertension, osteoporosis & hypertension, osteoporosis & osteoarthritis), as defined by the Chronic Disease Registries.
PS07 Severe Mental Health & SU	Severe Mental Health & Substance Use B.C. residents who were hospitalized with a specific range of conditions recorded as the Most Responsible Diagnosis in the hospital abstract for mental health conditions such as schizophrenia, mood disorders, drug addiction, etc. in the last five fiscal years; or received methadone treatment in the fiscal year; or used PharmaNet Plan G in the fiscal year.

PS08 Maternity & Healthy Newborns	Maternity & Healthy Newborns B.C. residents who received maternity or obstetric services from a physician or a midwife (MSP fee-for-service billings) or a hospital (DAD) in the fiscal year.
PS10 High Chronic Conditions	High Chronic Conditions B.C. residents who have one or more high chronic conditions (Alzheimer's, dementia, cystic fibrosis, heart failure or organ transplant), had stroke or are on dialysis, or have a specific combination of chronic conditions (AMI & pre-dialysis chronic kidney disease, angina & COPD, diabetes & hypertension & osteoarthritis), as defined by the Chronic Disease Registries.
PS12 Cancer	Cancer B.C. residents with cancer identified via administrative data using a similar approach as the Ministry's chronic disease registries. Specifically, the Matrix assigns people to this population segment if during the current or previous fiscal year they had specific malignant diagnoses recorded on at least two physicians' MSP fee-for-service billings within 365 days or at least one hospitalization. It is important to note that the people undergoing active treatment for cancer would be more comprehensively identified using the cancer registry maintained by the B.C. Cancer Agency. However, the Ministry does not have access to this cancer registry.
PS13 Frail in Residential Care	Frail in Residential Care B.C. residents in residential care facilities that provide 24-hour nursing care and assistance with activities of daily living. These residents are identified as follows: <ol style="list-style-type: none"> 1. Registered with PharmaCare's Plan B (which covers prescription drugs for Permanent Residents of Licensed Residential Care Facilities) or 2. Long-term residential care clients (as reported by Health Authorities to Continuing Care Data Warehouse and the Home and Community Care Minimum Reporting Requirements Data Warehouse).
PS14 End of Life	End Of Life B.C. residents who received palliative care services from physicians (based on physicians' MSP fee-for-service billings for palliative care), were hospitalized specifically for palliative care, received palliative services from health authority's home and community care programs, or were registered in PharmaNet's B.C. Palliative Care Benefits Program (Plan P).

** Note: PS09 (frail in the community) and PS11 (high chronic conditions with frailty) are currently not available in HSM v10.1 because home and community data were not available.*

Appendix 6

Recommendations from *In Plain Sight*

Orientation

Addressing Indigenous-specific racism in B.C.'s health care system as identified in this report requires attacking the roots of the problem.

Despite progress and efforts made, the current health care system continues to reflect the legacy of colonialism. This legacy enables and permits systems, behaviours, and beliefs in which racism and discrimination against Indigenous peoples remain. The Recommendations of this Review are designed to confront that legacy, and establish a renewed foundation for Indigenous peoples' access to, interaction with, and treatment by, the health care system.

A Renewed Foundation

There are three foundational elements to addressing the legacy of colonialism in the health care system:

1. Racism in the health care system is a reflection of a lack of respect and implementation of the basic human rights of Indigenous peoples.
2. Racism within the health care system is integrated with, and in many aspects indivisible from, broader patterns and conditions throughout society.
3. While those who experience the problem of racism in the health care system must be intimately involved in developing solutions, we know that the responsibility and burdens of this work lie with non-Indigenous individuals, communities, organizations and governments.

First, as discussed and analyzed in this Review, racism in the health care system is a reflection of a lack of respect and implementation of the basic human rights of Indigenous peoples as described in the *UN Declaration on the Rights of Indigenous Peoples*. Adopting the *Declaration on the Rights of Indigenous Peoples Act (DRIPA)* obligates the B.C. government to have an action plan, developed co-operatively with Indigenous peoples, to achieve the "objectives of the Declaration".¹ The objectives of the *UN Declaration* include ensuring that racism, discrimination and prejudice against Indigenous peoples are addressed, and creating patterns throughout society that uphold the minimum standards for the survival, dignity and well-being of Indigenous peoples. By necessity, the action plan must address the full

¹ Section 4

range of topics, from Indigenous self-determination and sovereignty, to Indigenous self-government and legal orders, to land and resource decision-making including free, prior and informed consent, to the health, well-being and safety of Indigenous children, women, families and communities.

At the time of completing this Review, co-operative work on developing this action plan was on-going. Recognizing that the action plan must include tangible and significant actions in the health sector, these Recommendations have been developed to inform, and even shape, the health system components of an action plan to achieve the objectives of the *UN Declaration*. These Recommendations were developed based on months of dialogue and study, hearing thousands of Indigenous voices, inclusive of interviews and information from all major health care actors, with the goal of addressing racism and ensuring the basic human rights of Indigenous peoples are upheld in the health care system. As such, government is encouraged to accept and implement all of these Recommendations, and also to work co-operatively with Indigenous leaders to ensure the implementation of these Recommendations is co-ordinated with the work of achieving the objectives of the *UN Declaration* through the action plan required in *DRIPA*.

Second, racism within the health care system is integrated with, and in many aspects indivisible from, broader patterns and conditions throughout society. The legacy of colonialism and reality of racism is a challenge that all jurisdictions throughout Canada must continue to address, and these challenges within the health care system cannot be fully addressed without complementary progress in other social sectors. Health care is accessed at many points in an individual's life – including the beginning and the end – and for a wide range of reasons. Often the health care system is called upon because of inadequacies or failures of other social sectors. Poverty, inadequate housing, limited access to proper education resources and reduced availability of social supports are just some examples of challenges which are unfairly experienced by Indigenous peoples as a result of the legacy of colonialism and racism, and drive different health needs, utilization patterns and outcomes. Improving the health and wellness of Indigenous peoples, including addressing racism, requires recognition that coherent efforts must be made across all social sectors. While the Recommendations are all specific to the health care system, they have been developed in consideration of necessary linkages to work that is occurring and still must occur in other sectors.

Third, while the work of addressing racism in the health care system must be done together, we know that the responsibility and burdens of this

work lie with non-Indigenous individuals, communities, organizations and governments. It is amongst those populations, contexts and structures where change needs to occur. At the same time, those that experience the problem of racism in the health care system must be intimately involved in developing solutions. The experience and knowledge of Indigenous peoples must guide this work, including illustrating when racism is being successfully confronted. History has taught us that, with respect to Indigenous health and wellness, government does not know best and unilateral changes do not work. All of the Recommendations must be understood as requiring a joint approach with Indigenous peoples in their implementation, consistent with the *UN Declaration* which calls for consultation and co-operation between governments and Indigenous peoples in upholding Indigenous human rights. This also acknowledges that colonialism and racism has not been, and is not, experienced the same way by all Indigenous peoples – Indigenous women, children, LGBTQ+ and others all have experienced distinct expressions and impacts. Working jointly with Indigenous peoples means understanding these distinctions, and ensuring all experiences, knowledge and voices are a vital part of moving forward.

It is important to emphasize that the Recommendations build on exceptional work and well-intentioned efforts that have been taken in the past and are already underway – this is particularly the case with many of the excellent efforts regarding cultural safety and humility made in recent years. These Recommendations do not reinvent the wheel – they are designed to build upon what has been done, and move us forward in a coherent way in supporting Indigenous health and wellness, and improving the experience of Indigenous peoples in the health care system.

At the same time, however, this Review reveals the need for, and provides the opportunity to accelerate, a comprehensive approach to the long-standing challenges of racism and the legacy of colonialism, including near-term and longer-term actions, rooted in a principled human rights foundation and a commitment to anti-racism, that will increase success of all efforts. This includes change at all levels of the health care system, from front line care delivery, to leadership, to organizational culture, to strategic planning. It is with this vision in mind that these Recommendations chart a path forward.

Structure

A coherent and transformative approach to addressing racism in B.C.'s health care system requires co-ordinated actions that effect shifts in multiple, distinct ways. In order to create a system where Indigenous rights are upheld, and

an anti-racist mindset and skillset are the norm, there must be changes in *systems, behaviours* and *beliefs*.

Systems refers to the structures, processes and contexts we operate through and within, and ensuring those systems uphold the minimum standards of the *UN Declaration*, and Indigenous health and wellness. *Behaviours* refers to the norms and actions that are taken, and how they reflect an anti-racist skillset and are respectful of Indigenous human rights, health, and well-being. *Beliefs* refers to attitudes and understandings that individuals or groups hold, which reflect, enable or reinforce anti-Indigenous racism.

The Recommendations aim to advance an integrated and comprehensive change approach where actions in relation to *systems, behaviours* and *beliefs* are purposefully designed in relation to one another, and reflect the fact that to fully achieve the benefits of progress in any one area requires advancements in the others. One cannot 'pick and choose' from amongst the Recommendations. They are not an interchangeable 'laundry list' – they rely and depend on each other and must be read as part of one action plan for moving forward. They need to be implemented through strategies and efforts that pursue all of them in a co-ordinated and systematic way. Given that a primary observation of the Review is the lack of a systemic approach, the majority of Recommendations fall into this category.

Recommendations: Systems

Recommendation 1

That the B.C. government apologize for Indigenous-specific racism in the health care system, setting the tone for similar apologies throughout the health system, and affirm its responsibility to direct and implement a comprehensive system-wide approach to addressing the problem, including standardized language and definitions, and clear roles and responsibilities for health authorities, regulatory bodies, associations and unions, and educational institutions.

Key Details

The B.C. government to:

- Consistent with the *Power of an Apology Report*, the Minister of Health to issue an apology and set the tone that will support similar apologies at the point of care in the health system.² Such apologies could also be accompanied by efforts toward meaningful public atonement and events involving health authorities, facilities, and other sites and organizations that have inflicted harm and racism on Indigenous peoples. Whenever possible, such events and actions should reflect cultural protocols and practices that are respectful, meaningful and appropriate to the specific Indigenous peoples on the territories where health services are provided.
- Confirm that it is the government's responsibility to lead the work of implementing a system-wide response to address Indigenous-specific racism, prejudice and discrimination, and achieve substantive health equality for Indigenous peoples.
- Commit to dedicating the resources and capacity to fulfilling this responsibility, including the full implementation of all of these Recommendations.
- "Hard-wire" expectations of health authorities, regulatory colleges and professional associations and unions, health education institutions, health care workers and others to play an active role within their areas of responsibility for health services so that racism is rooted out. This could include new mandate letters, service plans, medical staff bylaws and other compliance and accountability mechanisms.
- Work together with First Nations governing bodies and representative organizations and MNBC.

² <https://bcombudsperson.ca/assets/media/Special-Report-No-27-The-Power-of-an-Apology-Removing-Legal-Barriers.pdf>

Recommendation 2

That the B.C. government, in collaboration and cooperation with Indigenous peoples in B.C., develop appropriate policy foundations and implement legislative changes to require anti-racism and “hard-wire” cultural safety, including an Anti-Racism Act and other critical changes in existing laws, policies, regulations and practices, ensuring that this effort aligns with the UN Declaration as required by DRIPA.

Key Details

The B.C. government to:

- Enact an *Anti-Racism Act* that specifically includes references to the health care system and requires anti-racism policies, training and reporting in the health care system.
- Enact legislation to mandate the collection, use and disclosure of disaggregated demographic data for social change, with Indigenous institutions and governments in support of self-determination and sovereignty as recommended in the Office of the Human Rights Commissioner report, *Disaggregated demographic data collection in British Columbia: The grandmother perspective*.
- Implement changes to the *Health Professions Act*, *Hospitals Act*, *Health Authorities Act* and others to set standards, definitions and expectations for anti-racism and Indigenous cultural safety and humility and to ensure that all definitions and standards of quality require health services to be free from all forms of racism and discrimination against Indigenous peoples.
- Introduce amendments to the *Patient Care Quality Review Board Act* to:
 - Make discriminatory behaviour as defined in the *BC Human Rights Code* grounds for a care quality complaint, concurrent with any other remedy, including an application to the Human Rights Tribunal
 - Require that the Patient Care Quality Office advise an individual, at the earliest opportunity, of the services of the Indigenous Health Representative and Advocate, and provide the contact information for doing so
 - Require the Patient Care Quality Review Board to advise an individual that if they are unsatisfied with the outcome of their complaint they may complain to the Ombudsperson, and provide the contact information for doing so.
- Articulate anti-racism and Indigenous cultural safety and humility expectations in the standards of all health regulatory bodies.

- Amend ss. 7 - 14 of the *BC Human Rights Code* to include Indigenous identity as a protected ground from discrimination as recommended in *Expanding Our Vision: Cultural Equality & Indigenous Peoples' Human Rights*, Ardith Walpetko We'dalx Walkem, QC.
- Amend section 51 of the *Evidence Act*, including, but not limited to, subsections (2), (5) and (6), to ensure that in cases involving Indigenous complainants, as well as for the purposes of reviews and investigations regarding the treatment of Indigenous peoples in the health care system, proper and appropriate information can be disclosed, that the existence and incidents of Indigenous-specific racism are documented and made public, and that the current environment of secrecy and distrust that exists – which also reinforces power imbalances faced by Indigenous peoples – is ended.

Recommendation 3

That the B.C. government, First Nations governing bodies and representative organizations, and MNBC jointly establish the position of B.C. Indigenous Health Officer with legislative recognition and authority in the Public Health Act, and a structured relationship with the Provincial Health Officer.

Key Details

The creation of a B.C. Indigenous Health Officer position should involve the following:

- The development of legislative amendments in collaboration and cooperation with Indigenous peoples in B.C., to establish the role of Indigenous Health Officer.
- A principled, rights-based and distinctions-based approach to addressing the specific health and jurisdictional contexts and realities of First Nations, Métis and Inuit.
- The co-development with First Nations of necessary agreements, using s. 7 of *DRIPA*, for how the Indigenous Health Officer will, where appropriate, jointly make decisions with the Provincial Health Officer or other health care system actors.
- Engagement with Indigenous leadership and the federal government to determine if the Indigenous Health Officer role may benefit from mandate or empowerment through federal mechanisms.

The B.C. Indigenous Health Officer to:

- Create the mechanism and focus to produce timely and relevant population health reports while upholding Indigenous data governance principles and processes.

- Provide for an independent function, expertise and authority for Indigenous health protection, disease prevention and health promotion.
- Focus the system on the specific health needs and perspectives of Indigenous peoples in B.C.
- Provide targeted response to the impacts of public health emergencies on Indigenous individuals.
- Work with the B.C. Provincial Health Officer to establish clear roles and responsibilities to ensure seamless health and safety policy, regulation and compliance to protect Indigenous peoples.

Recommendation 4

That the B.C. government, First Nations governing bodies and representative organizations, and MNBC jointly establish the Office of the Indigenous Health Representative and Advocate with legislative recognition and authority to provide a single, accessible, supportive, adequately funded resource for early intervention and dispute resolution for Indigenous people who require assistance to navigate, fully benefit from, and resolve problems within, B.C.'s health care system, including all health authorities, regulatory colleges and other health providers. The position should be reviewed in five years after establishment to determine if it has been effective in rooting out racism in the B.C. health care system.

Key Details

The B.C. Indigenous Health Representative and Advocate position to:

- Support Indigenous people encountering racist behaviour, policies and practices within the health care system.
- Provide support to Indigenous complainants with regard to their concerns about the health care system, including representation before the patient care quality boards, Human Rights Tribunal and the Ombudsperson.
- Report publicly on issues related issues of racism relating to Indigenous peoples' interactions with any part of B.C.'s health care system and gaps existing within the delivery of health services to Indigenous populations.
- Have a physical presence in all regions and be connected to Indigenous governments, where possible, for accountability and effectiveness.
- Develop and utilize cultural and restorative justice approaches and demonstrate respect for a diversity of Indigenous cultural norms and practices in all stages and elements of the dispute resolution process and

provide associated support for participants to engage meaningfully in these processes.

- Demonstrate consistency with the minimum standards identified in the *UN Declaration*, including Article 15, Article 22 and Article 40.
- Support more robust public reporting on progress in implementation of these Recommendations and the development of anti-racist mindsets and skill sets within health care organizations and throughout B.C.'s health care system.
- Issue special reports, including in collaboration with the Indigenous Health Officer, on matters such as the unique needs of particular Indigenous groups (e.g., Indigenous women, Elders or youth), health sectors (e.g., emergency transport, mental health and substance use).

Recommendation 5

That the B.C. government, First Nations governing bodies and representative organizations, and MNBC jointly develop a strategy to improve the patient complaint processes to address individual and systemic Indigenous-specific racism.

Key Details

The jointly developed strategy to:

- Be informed by engagement with Indigenous patients, First Nations governing bodies and representative organizations, MNBC, and Indigenous service organizations.
- Include immediate, medium-term and longer-term changes to patient complaint processes including options for a separate process for Indigenous complaints, as well as immediate changes to the current processes for complaints within health authorities and regulatory colleges such as embedding Indigenous support roles, training and staffing within complaints processes and offices.
- Involve amendments to legislation governing complaints to confirm cultural safety as integral to quality care in B.C., and that discriminatory behaviour on the basis of race or Indigenous identity is a ground for a care quality complaint.
- Provide that “professionalism” standards include delivering services free from all forms of prejudice or discrimination against Indigenous peoples and that breaches of these standards will invite accountability processes and potential sanction.

- Require that complaints processes advise Indigenous complainants, at the earliest opportunity, of the services of the Indigenous Health Representative and Advocate, and the roles that can be played by the Ombudsperson.

Recommendation 6

That the parties to the bilateral and tripartite First Nations health plans and agreements work in co-operation with B.C. First Nations to establish expectations for addressing commitments in those agreements that have not been honoured, and for how those expectations will be met through renewed structures and agreements that are consistent with the implementation of DRIPA.

Key Details

Engagement to consider:

- The commitments and priorities in health plans and agreements from 2006 to present, including actions to address racism and discrimination, the degree to which those have and have not been achieved, and the factors that have contributed to and constrained progress, including the degree of government appetite to effect change.
- The standards of the *UN Declaration* and existence of *DRIPA* must be considered in relation to previous agreements, particularly how these agreements can now be enhanced by new tools and recognition of the authority of Indigenous governing bodies.
- A strengthened mandate and structure for the FNHA that is appropriate and functions with some form of comparable “authority” to other health authorities, and in effective structured relationship with the Indigenous Health Officer, Indigenous Health Representative and Advocate, and Associate Deputy Minister-Indigenous Health.
- A legislated basis for an FNHA to ensure the work evolves from charitable status to operating under proper direction and authorization from B.C. First Nations, with structured relations with other health care organizations.
- Dr. Mary Ellen Turpel-Lafond has been invited to provide a “management letter” to the parties to the *Tripartite Framework Agreement on First Nation Health Governance* based on observations and information gleaned during the Review, to detail concerns with non-compliance with the *Framework Agreement*.

Recommendation 7

That the Ministry of Health establish a structured senior-level health relationship table with MNBC, and direct health authorities to enter into Letters of Understanding with MNBC and Métis Chartered Communities that establish a collaborative relationship with clear and measurable outcomes.

Key Details

These steps with MNBC should include:

- B.C. Ministry of Health mandate letters to the health authorities to emphasize commitments under the *Letters of Understanding*.
- *Letters of Understanding* to state clear expectations of the health authorities regarding their relationship with MNBC, the role of MNBC in the health care system and shared principles and priorities.
- Partnership tables to be established between MNBC, Métis Chartered Communities and each health authority.
- Jointly-developed workplans to cascade from the *Letters of Understanding*.
- Appropriate funding for Métis participation in these partnership processes and for the commitments described in jointly approved workplans.

Recommendation 8

That all health policy-makers, health authorities, health regulatory bodies, health organizations, health facilities, patient care quality review boards and health education programs in B.C. adopt an accreditation standard for achieving Indigenous cultural safety through cultural humility and eliminating Indigenous-specific racism that has been developed in collaboration and cooperation with Indigenous peoples.

Key Details

The accreditation standard to:

- Finalize the promising work that is underway in B.C. on Health Standards Organization 75000:2020, commencing a public review process as soon as possible that includes proactive engagement with Indigenous peoples.
- Clarify common definitions and concepts, including the distinction between the problem of racism, the mindsets and tools needed to shift beliefs and behaviours, and the outcome of cultural safety at the point of care.
- Advance integration of Indigenous practices and culture across systems and organizations and ensure that cultural safety standard permits appropriate

respect for Indigenous protocols, practices and requirements at the regional and local level where health services are delivered.

- Ensure adoption of Indigenous-specific racism policies that reflect the standard.
- Ensure appropriate and adequate training for surveyors to monitor and support the implementation of the standard.
- Ensure alignment between the standard and the new measurement framework recommended in this report.

Recommendation 9

That the B.C. government establish a system-wide measurement framework on Indigenous cultural safety, Indigenous rights to health and Indigenous-specific racism, and work with First Nations governing bodies and representative organizations, MNBC, the Indigenous Health Officer, and the Indigenous Health Representative and Advocate to ensure appropriate processes of Indigenous data governance are followed throughout required data acquisition, access, analysis and reporting.

Key Details

The establishment of a measurement framework to:

- Enable a high-level, comparable view of the B.C. health system while also providing for regional and local meaning and variability.
- Provide indicators to be regularly reported upon, and integrated within established processes of health system reporting and accountability, addressing at minimum patient experience, access to services, appropriateness of care, and health and wellness outcomes.
- Build upon the indicators and measures utilized in this Review, including routine surveying of health care workers, students and Indigenous peoples about Indigenous-specific racism in health care and learning settings.
- Ensure standardized collection of information on race and ethnicity throughout the B.C. health care system.
- Ensure alignment between the measurement framework and the accreditation standard recommended in this report.
- Include the CIHI to support alignment with national work.

Indigenous data governance processes to:

- Be developed with Indigenous institutions and governments in support of self-determination and sovereignty.
- Create clear protocols for access to information, including for Indigenous communities, the Indigenous Health Representative and Advocate, and Indigenous Health Officer.
- Accelerate the movement towards a vision of a Nation-governed and mandated regional data centre and alignment with the National Data Governance Strategy.
- Result in renewal of the *Tripartite Data Quality and Sharing Agreement (TDQSA)* to reflect the *UN Declaration*, align with the vision of a regional data centre, and to address recommendations provided in the *TDQSA Rapid Review (February 2019)*.

Recommendation 10

That design of hospital facilities in B.C. include partnership with local Indigenous peoples and the Nations on whose territories these facilities are located, so that health authorities create culturally-appropriate, dedicated physical spaces in health facilities for ceremony and cultural protocol, and visibly include Indigenous artwork, signage and territorial acknowledgement throughout these facilities.

Key Details

The partnerships to address the following:

- Co-development and implementation of facility guidelines with local First Nations and Métis.
- Creation of at least one dedicated space within all hospitals in B.C. to provide safe spaces for ceremony, protocol and family gathering.
- Changes to policies to ensure support for ceremony, cultural practices, learning and family gathering.
- Measures to ensure respect for the physical spaces, artwork and signage.
- Measures to ensure Indigenous individuals have knowledge of, and access to, the dedicated spaces.
- Requirements that new capital facilities demonstrate innovation and transformative approaches to enhance cultural safety through facility design.
- Design of the new St. Paul's Hospital and health campus, including an Indigenous Wellness Centre, as a demonstration of the clear commitment to Indigenous cultural safety in B.C.'s health care system.

Recommendations: Behaviours

Recommendation 11

That the B.C. government continue efforts to strengthen employee “speak-up” culture throughout the entire health care system so employees can identify and disclose information relating to Indigenous-specific racism or any other matter, by applying the Public Interest Disclosure Act (PIDA) to employees throughout the health care sector without further delay.

Key Details

A speak-up culture will:

- Apply to all aspects of the health care system
- Make regulatory changes as soon as possible to ensure that health employees are included in the class of persons protected under *PIDA* (SBC 2018, Chapter 22).
- Strengthen codes of ethics and anti-Indigenous racism workplace standards.
- Designate ethics and standards of conduct advisors in all health authorities and health care professions.

Recommendation 12

That the Ombudsperson consider including a focus on Indigenous-specific racism in the health care system as a key priority and seek input from appropriate partners on current plans to strengthen this priority through engagement, special activities to promote greater fairness in public services to Indigenous peoples, and reporting to the public on progress.

Key Details

Addressing Indigenous-specific racism in health care through the Ombudsperson to:

- Engage on best approach to transition the current telephone line, email and website established for this Review to the Ombudsperson.
- Consider including Indigenous-specific racism in the health care system as a core priority in the Indigenous Communities Services Plan currently being developed by the Ombudsperson, in collaboration and cooperation with Indigenous peoples, by mid-fiscal 2021/22.
- Provide advice and support to the creation of the Indigenous Health Representative and Advocate and consider the appropriate structured collaborative relationship to address Indigenous-specific racism and related matters.

Recommendation 13

That the B.C. government establish the new position of Associate Deputy Minister for Indigenous Health within the Ministry of Health, with clear authorities including supporting the Deputy Minister of Health in leading the Ministry's role in implementing these Recommendations.

Key Details

The new Associate Deputy Minister position to:

- Markedly increase dedicated leadership, capacity and effort within the Ministry on matters of Indigenous health and wellness.
- Be held by an Indigenous individual with strong knowledge about the B.C. context, systemic change abilities, demonstrated expertise in Indigenous health and wellness, the Indigenous right to health, the *UN Declaration* and addressing Indigenous-specific racism.
- Coordinate system-wide responsibility and accountability in eliminating Indigenous-specific racism and achieving Indigenous cultural safety.
- Ensure consistent visibility of Indigenous health in Ministry policy, strategy, detailed operating plans and mandate letters.
- Work with appropriate organizations in the health system to develop a renewed approach to, and placement of, functions for knowledge development and exchange in Indigenous-specific racism and Indigenous cultural safety and humility.
- Lead the Ministry's responsibility to implement these Recommendations.

Recommendation 14

That the B.C. government, PHSA, the five regional health authorities, B.C. colleges and universities with health programs, health regulators, and all health service organizations, providers and facilities recruit Indigenous individuals to senior positions to oversee and promote needed system change.

Key Details

Action taken to:

- Ensure responsibilities for anti-racism and advancing cultural safety are embedded in job descriptions of all senior executive and Board member roles.
- Clearly articulate the purpose and associated standards and criteria for the selection of Indigenous individuals to serve in health authority board

positions. This should include a systemic understanding of Indigenous cultural safety and Indigenous health priorities, and context of Indigenous Nations, governments and peoples in B.C.

- Develop senior executive leadership positions within these organizations with responsibility for Indigenous health. A focus on recruiting individuals from the territories within that region, where applicable, can contribute to building stronger relationships with local Indigenous communities.
- Establish measures to support Indigenous senior leaders to meet and network collectively to play an effective role on Indigenous-specific racism. This includes regular meetings of Indigenous Board members, and a network amongst Indigenous senior executives coordinated by the Associate Deputy Minister.
- Implement a program to build the supply and networking of qualified Indigenous senior executive and Board leadership.

Recommendation 15

That the B.C. government, First Nations governing bodies and representative organizations, MNBC, the Provincial Health Officer and the Indigenous Health Officer develop a robust Indigenous pandemic response planning structure that addresses jurisdictional issues that have arisen in the context of COVID-19, and which upholds the standards of the UN Declaration.

Key Details

The plan to address the following:

- The specific needs of Indigenous Elders, including immediately creating allowances for Elders to be accompanied by an escort for all hospital and medical visits during the COVID-19 pandemic.
- Include Indigenous peoples amongst the vulnerable populations that may be given priority when approved vaccines are issued.
- Distinctions-based approaches, including the unique jurisdictional contexts of First Nations in relation to community protection.
- Ensure rural, northern and remote Indigenous peoples and communities are served.
- Measures to address the increased stress and mental health issues faced by Indigenous peoples as a result of the pandemic.

Recommendation 16

That the B.C. government implement immediate measures to respond to the MMIWG Calls for Justice and the specific experiences and needs of Indigenous women as outlined in this Review.

Key Details

The measures to address the following:

- Finish the Indigenous Women Health Report, including refreshing the data where necessary.
- Establish specialty services for Indigenous women that provide for safe and welcoming experiences, including considering the development of a province-wide specialized service for peri-menopausal, menopausal and post-menopausal health accessible to Indigenous women.
- Enhanced access to maternal, child and reproductive health care, including in-community and similarly safe screening opportunities.
- Performance measures and associated monitoring and accountability.

Recommendation 17

That the B.C. government and FNHA demonstrate progress on commitments to increase access to culturally safe mental health and wellness and substance use services.

Key Details

Progress would include:

- Addressing lagging commitments to stand-up projects, and ensure these are informed by broader engagement with First Nations, and available data including that outlined in this report.
- A specific focus on Indigenous youth.
- Increased harm reduction availability, including on-reserve.
- Integration of traditional and cultural activities, knowledge and practices.
- Vigilant performance measurement, evaluation, and associated monitoring and accountability.

Recommendation 18

That the B.C. government require all university and college degree and diploma programs for health professionals in B.C. to implement mandatory strategies and targets to identify, recruit and encourage Indigenous enrolment and graduation, including increasing the safety of the learning environment for Indigenous students.

Key Details

The requirements to:

- Include standardized targets and expectations established by the B.C. government including the Ministry of Advanced Education and Ministry of Health.
- Include specific targets for B.C. First Nations learners.
- Include immediate-, medium-, and long-term approaches to accommodate and uphold the human rights of Indigenous students, and to increase identification, recruitment and encouragement of potential Indigenous applicants.
- Update targets for Indigenous enrolment and graduation that represent a significant increase from current rates and issue annual reports to appropriate Indigenous representative organizations.
- Be designed to ensure recognition of distinctiveness between First Nations, Métis and Inuit.
- Involve screening for racism and prejudice amongst all applicants to health professional programs.
- Include support and protection for Indigenous students, including mentorship and networking, and clear and safe pathways for reporting of any experiences of racism.
- Be supported with information and education programs for faculty, staff and students about the importance of increasing the numbers of Indigenous health practitioners as part of addressing Indigenous-specific racism, achieving cultural safety, implementing the Indigenous right to health including as identified in the *UN Declaration*, and advancing the work of reconciliation.
- Be developed and implemented in collaboration with First Nations governing bodies and representative organizations and MNBC.

Recommendation 19

That a Centre for anti-racism, cultural safety and trauma-informed standards, policy, tools and leading practices be established and provide open access to health care organizations, practitioners, educational institutions and others to evidence-based instruments and expertise and to expand the capacity in the system to work collaboratively in this regard.

Key Details

This Centre to:

- Consolidate available evidence-based tools, resources, and instruments and develop virtual mechanisms to make these available.
- Develop tools, resources, webinars and other mechanisms to advance standardized definitions, terminology, and leading practice in anti-racism, cultural humility and cultural safety.
- Work with health system organizations to design, prototype and evaluate initiatives and interventions in anti-racism, cultural humility and cultural safety.
- Hold and share expertise in change leadership and change management, anti-racism, cultural humility and cultural safety.
- Be delivered through clear governance structure that can independently and equitably deliver these functions throughout the health care system.

Recommendations: Beliefs

Recommendation 20

That a refreshed approach to anti-racism, cultural humility and trauma-informed training for health workers be developed and implemented, including standardized learning expectations for health workers at all levels, and mandatory, low-barrier components. This approach, co-developed with First Nations governing bodies and representative organizations, MNBC, health authorities and appropriate educational institutions, to absorb existing San'yas Indigenous Cultural Safety training.

Key Details

This new approach to:

- Mandate completion of identified components as a component for onboarding, qualification for service and health professional licensure.

- Ensure specific clinical and point-of-care training is available in addition to entry-level and awareness-raising training.
- Include elements that foster a mindset and skills for confronting Indigenous-specific racism in all aspects of the health care system.
- Ensure integration with training by health authorities, which should include content appropriate to the distinct Indigenous communities in those regions.
- Be delivered through an independent, clear governance structure that has authority for delivering the program consistently throughout the health care system.
- Be supplemented with mandated data gathering, reporting and analysis to track how the program is contributing to meeting goals. Weaknesses and gaps must be addressed, but with clear protocols on the gathering and use of data that are solely for the purpose of identifying successes, challenges and improvements in the program, ensuring that harms are not escalated or reproduced through the use of data, and that the data are not for purposes of publishing research.
- Include clear mechanisms to evaluate comparable out-of-province training that medical practitioners may have received in order to determine what mandatory training they must take as part of working in B.C.

Recommendation 21

That all B.C. university and college degree and diploma programs for health practitioners include mandatory components to ensure all students receive accurate and detailed knowledge of Indigenous-specific racism, colonialism, trauma-informed practice, Indigenous health and wellness, and the requirement of providing service to meet the minimum standards in the UN Declaration.

Key Details

The mandatory components to:

- Include the integration of content throughout the curriculum regarding traditional understandings and practices of Indigenous health and wellness, the Indigenous right to health and the minimum standards of the *UN Declaration*.
- Include focus on fostering a mindset and skills for confronting Indigenous-specific racism in all aspects of the health care system.
- Include multiple required learning opportunities which all students must successfully complete.

- Be part of, and integrated into, meeting the regulatory requirements for licensing to practise as a health care professional in B.C.
- Where appropriate, include jointly developed opportunities for intensive and immersive learning within First Nations communities and in settings serving a high proportion of Indigenous patients.

Recommendation 22

That the B.C. government, in consultation and co-operation with Indigenous peoples, consider further truth-telling and public education opportunities that build understanding and support for action to address Indigenous-specific racism in the health care system; supplemented by a series of educational resources, including for use in classrooms of all ages and for the public, on the history of Indigenous health and wellness prior to the arrival of Europeans, and since that time.

Key Details

The educational resources to:

- Be developed with guidance and partnership of key experts, such as the Centre for Excellence in Indigenous Health at the University of British Columbia, and with education experts.
- Renew the #itstartswithme campaign and be tied to relevant major initiatives such as an *Anti-Racism Act*.
- Integrate, as appropriate, stories and findings from this Review.
- Include materials for K-12 classrooms, as well as online educational resources that can be accessed and utilized by the public.
- Include a public exhibition that can be visited in museums, public buildings and halls in communities across B.C.
- Address the history of Indigenous health, including the diversity and extent of pre-contact Indigenous health and wellness systems, the disruptions caused by colonialism including the role of the *Indian Act*, the residential school system, Indian hospitals and medical testing on Indigenous peoples.
- Explain the importance of the Indigenous right to health, including as identified in the *UN Declaration*.
- Discuss the challenges of Indigenous-specific racism still faced today and the roles everyone can play to address this racism.

Recommendation 23

That the B.C. government, in partnership with First Nations governing bodies and representative organizations, MNBC, Indigenous physicians, experts, and the University of British Columbia or other institutions as appropriate, establish a Joint Degree in Medicine and Indigenous Medicine. That the B.C. government, in partnership with First Nations governing bodies and representative organizations, MNBC, Indigenous nurses, experts, and appropriate educational institutions, establish a similar joint degree program for nursing professions.

Key Details

The joint degree programs to:

- Be informed by the model of the University of Victoria Indigenous Law Joint Degree Program and offer an additional qualification in addition to the current training and education programs.
- Consider related steps such as an interdisciplinary course to advance appropriate integration of Indigenous medicine. Such a course could be cross-posted across all medical disciplines and be mandatory.
- Include development of educational and training content in traditional Indigenous health and wellness knowledge and practices, developed in collaboration with Indigenous peoples.
- Involve education opportunities within Indigenous communities and health service organizations.

Recommendation: Implementation of Recommendations

Recommendation 24

That the B.C. government establish a task team to be in place for at least 24 months after the date of this report to propel and ensure the implementation of all Recommendations, reporting to the Minister of Health and working with the Deputy Minister and the Associate Deputy Minister for Indigenous Health, and at all times ensuring the standards of consultation and co-operation with Indigenous peoples are upheld consistent with the UN Declaration.

Key Details

The task team to:

- Be comprised of individuals with specific expertise in the B.C. health care system, cultural safety and humility and addressing Indigenous-specific racism.
- Be clearly mandated to drive forward the implementation of the Recommendations across the health care system, with the full support of the Ministry of Health.
- Have clear protocols for how they will work with Indigenous peoples and organizations in the implementation of the Recommendations, including to ensure the standards of the *UN Declaration* are being met.
- Work to ensure that the action plan required under s. 4 of *DRIPA* addresses these Recommendations.
- Establish clear mechanisms for evaluating and reporting publicly on progress in implementation of these Recommendations, including to First Nations governing bodies and representative organizations, and MNBC.
- Establish a proper table inclusive of senior leadership of all health authorities, regulatory colleges, associations and unions, the Indigenous Health Representative and Advocate, and the Indigenous Health Officer to ensure steps are being taken to meet their roles and responsibilities in the Recommendations.
- Report to the public on progress in implementing these Recommendations at the conclusion of its 24-month term.

Federal Government Role and Responsibility for Indigenous Peoples' Health

Many of the Observations, Findings and Recommendations have implications for the federal government as responsibility for health is an area of shared and overlapping jurisdiction and authority, especially in relation to Indigenous peoples. As the scope of this review was specific to B.C., Recommendations have not been directed to the federal government. However, tangible and urgent action is needed by the federal government, as well as national health organizations, to address Indigenous-specific racism in the health care system.

The Review has identified a number of areas where federal actions could be helpful to eliminate all forms of discrimination against Indigenous peoples. Examples of such necessary action include:

- Federal legislation to specifically implement the *UN Declaration* to bring the federal laws, policies and practices in conformity with the Indigenous human rights, principles and standards in the *UN Declaration*.
- Federal Indigenous-specific health legislation and other legislative amendments which explicitly make cultural safety a desired outcome or requirement of quality within Canada's health care system, affirming Indigenous peoples' individual and collective rights to health, facilitate Indigenous authority over their health services, and assure consistency with the minimum standards in the *UN Declaration*.
- Federal health regulatory standards that address anti-racism, cultural humility and trauma-informed practices.
- Active co-operation by the federal government consistent with the standards of the *UN Declaration* to make necessary changes to the First Nations health governance structure in B.C.
- Direct support by national health organizations to identify measures and tools to address anti-racism, encourage cultural humility, and promote trauma-informed practices throughout all spheres of authority and work.

Appendix 7

Finding 11 Extract from *In Plain Sight*

11. There is no accountability for eliminating Indigenous-specific racism in the B.C. health care system, including system-wide data and monitoring of progress.

The problem of Indigenous-specific racism has been evident and very publicly acknowledged through *Declarations of Commitment* signed by health care leaders across B.C. and nationally. Despite the widespread knowledge of the serious harms experienced by Indigenous peoples in the health care system, there has been little taking of true responsibility and no appropriate structure put into place to ensure progress.

To combat Indigenous-specific racism and create widespread cultural safety in the health care system, measurement and monitoring of progress are critical. Quality data reveals whether change processes are working, supports compliance with expected accountabilities and enables the sharing and spread of knowledge. The Review found that, despite a recognition of the importance of clear accountabilities and data collection regarding Indigenous-specific racism, the necessary protocols, systems and structures are not in place. There has been some public reporting and evaluation, but these examples are insufficient and unconnected to any validated measurement approach.¹ There is very little evidence of systemic, timely, replicable and actionable measurement specific to the issue of Indigenous-specific racism and cultural safety. This must urgently change.

Further, the Review notes a number of systemic challenges that are impeding progress and that, taken together, contribute to masking the problem of Indigenous-specific racism:

- Data and measurement have been historically used as an instrument of colonialism against Indigenous peoples, aided by government controlling the collection and analysis of data. From an Indigenous perspective, it has not been safe or helpful to be counted as Indigenous. There is work to do to ensure appropriate data governance processes are recognized in

¹ The BC Health Regulators have issued two public reports which summarize their collective activities. The *Tripartite Evaluation* included a detailed case study again describing various activities underway across the health system. The *Population Health and Wellness Agenda (PHWA)* between FNHA and the PHO includes a cultural safety measure which will be reported on through a process reflective of First Nations data governance.

all data collection initiatives and to build trust in those processes amongst Indigenous peoples.

- Data measurement tools have been developed by the dominant non-Indigenous population and focus on pathological measures that reinforce stereotyping of Indigenous peoples.
- There has been a lack of political will and resourcing to address the collection of Indigenous identification information, either through self-identification or other systematic measures.
- Existing Indigenous data governance processes have not produced sufficiently timely data to support health systems transformation, nor have they evolved to reflect the current realities and understanding of Indigenous data sovereignty, including standards regarding Indigenous knowledge and information in the *UN Declaration*.
- There is a lack of evidence-based standard assessment criteria and indicators, particularly as related to outcomes of anti-racism efforts. This may be due to the newness of the field, the lack of integration of cultural safety into legislated standards, and the inherent complexity of translating an individual-based practice underpinned by personal reflection and learning into quantitative or statistical measures.
- The provincial government, to date, has been unwilling to cede or share control of unaggregated Indigenous data to Indigenous governments, and relies on privacy legislation that ignores the roles and responsibilities of Indigenous governments, laws and jurisdictions, or the standards of the *UN Declaration*.
- The mixed public-private delivery of health care has meant that there are multiple independent providers of care which increases the complexity of data in sectors that rely heavily on both types of delivery, such as mental health and addictions.

Collecting the data to inform transformative action to address Indigenous-specific racism is a necessary foundation for clear structures and processes of accountability. As the Review reveals, the challenge of Indigenous-specific racism is system-wide, which means that all actors at all levels hold some form of accountability for collecting this data and acting upon it. Coordination is required across the system to ensure standardized data collection, and leadership is required to assess where progress is, or is not, being made and direct change efforts accordingly. For these reasons, the Review also stresses that the Ministry of Health must assume ultimate accountability to monitor

change on the health system's problem of Indigenous-specific racism. This must be done in ways that uphold Indigenous data governance and in partnership with Indigenous peoples. The shared objective of relevant information being provided in a timely, actionable and ethical way must guide this partnership.

Reflections

Indigenous identity information is not sufficiently collected in health care

One expression of Canada's historical focus on assimilation of Indigenous peoples has been through practices that aim to erase distinct and diverse Indigenous identities. A result is a lack of comprehensive and factual understandings within the B.C. health care system about the number of First Nations, Inuit and Métis peoples, or the diversity amongst them. There is no coherent system for recognizing Indigenous identity, and no Indigenous identifiers – such as status under the *Indian Act* or being registered as a Métis citizen – embedded in B.C. identification processes (such as B.C. Care Card).

Due to this complexity, there is a significant reliance on self-identification processes for data collection related to Indigenous peoples. Self-identification is the means by which Indigenous people voluntarily identify as First Nations, Inuit and/or Métis at the point of care and/or via various survey processes. In B.C., there has been an effort to standardize the collection of self-identification information through the Government Standard for Aboriginal Administrative Data supported by the First Nations Leadership Council (FNLC) and MNBC, which supports consistency in the technical aspects of the data points to be collected by the provincial government and government agencies.² This allows for comparability and quality of data across all government and other agencies in the province.

There are complexities associated with collecting this data. Due to historical processes in which the state used Indigenous identity to discriminate against and control the lives of Indigenous peoples, there continues to be significant fear and mistrust on the part of some Indigenous clients to be identified as Indigenous. Further, the continued existence of systemic and interpersonal racism makes many Indigenous peoples reluctant to self-identify, due to fear of discriminatory treatment. The potential for culturally unsafe encounters is compounded by the fact that information about self-identification is being gathered by thousands of different people at thousands of different sites. From

² https://www2.gov.bc.ca/assets/gov/government/services-for-government-and-broader-public-sector/information-technology-services/standards-files/aboriginal_administrative_data_standards.pdf

a data perspective, there is a risk of inconsistent counting, undercounting or biased counting.

The Ministry of Health is a 'mandatory adopter' of the Standard and endorsed it in principle, but has never made it a priority for funding or implementation, given the high cost and complexities attendant in this process as described above. As a result, the health sector has been slow to adopt the self-identification data standard. However, where the self-identification data standard has been implemented,³ these efforts suggest that, despite the issues and complexities, collection of this information spurs action, often in the form of target-setting and development of strategies for improvement. There is a notable absence of the collection of this information at the point of care, except through intermittent patient surveys, or in primary health care. A comprehensive approach has been lacking.

³ The College of Physicians and Surgeons has embedded an Aboriginal identifier in its mandatory annual license renewal form since 2019. This contributes to the measurement of an indicator included in the 2006 *Transformative Change Accord: First Nations Health Plan* which has heretofore been unmeasurable. Interior Health collects self-identification information for all of its staff and has instituted the Aboriginal administrative data standard in its hospital admissions process. The PREMS is a tool to understand patient experience in sectors of the provincial health system.

Indigenous data governance rights must be implemented in a manner that facilitates timely access to necessary data to address Indigenous-specific racism

As a response to the continuing misuse of First Nations data, and expropriation of their intellectual property, First Nations collectively developed the *Ownership, Control, Access, and Possession (OCAP®)* principles to assert their rights to data sovereignty. There are nuances and intricacies specific to MNBC that are not addressed by *OCAP®*. In response to this, the Manitoba Métis Federation developed the *OCAS* principles (*Ownership, Control, Access, and Stewardship*), however this work has not been sufficiently explored for MNBC to adopt them. Instead, MNBC has temporarily adopted the *OCAP®* principles for its own data governance in order to ensure its partners and their organizations are held accountable with the data of the Métis citizens.

In 2010, a *Tripartite Data Quality & Sharing Agreement (TDQSA)* was signed between the Government of Canada, Province of B.C., and the First Nations Health Council (FNHC). At the time, the *TDQSA* was a ground-breaking agreement that reinforced First Nations decision-making related to First Nations data and established a principled and pragmatic framework and a First Nations Client File (FNCF)⁴ that enabled the parties to generate First Nations-specific data to monitor the health of First Nations and the success of programs and services provided to First Nations communities.

Similarly, MNBC, the Office of the PHO, and the Ministry of Health have an ongoing collaborative surveillance and reporting relationship to monitor the health and wellness of Métis citizens in B.C. as articulated in the 10-year program charter of the Métis Public Health Surveillance Program and operationalized through an information-sharing agreement between MNBC and the Ministry. This has allowed for the creation of the Métis cohort, which now includes more than 20,000 individuals.

These agreements have contributed to the visibility of how well the health system is performing with respect to Indigenous peoples, and the resulting impacts on their health and wellness.⁵ However, the value of these agreements has not been maximized. A *Rapid Review* of the *TDQSA* conducted in 2019 indicated that the current decision-making structures under the *TDQSA* are not effective in advancing the health data work – they are too slow, cumbersome

⁴ The FNCF creates a registry that links the personal health number and Indian status number of individuals resident in B.C.; this registry can then be matched with other data sets to generate evidence related to health system utilization and health outcomes for status Indians resident in B.C.

⁵ A summary of progress pursuant to the *TDQSA* is summarized in the *Data and Information Governance Case Study* completed as part of the tripartite evaluation of the Framework Agreement.

and do not fully reflect good governance practices. In addition to these practical lessons learned, the context surrounding the *TDQSA* and the *MNBC Agreement* has significantly shifted in the past 10 years. There has been an increasing recognition of Indigenous data rights and strategies developed to enable Nations to empower their own governing bodies and institutions to carry out data-related work on their behalf.⁶ These contextual shifts have not been reflected in these data governance agreements and processes.

Disaggregated data are necessary to highlight health system performance for Indigenous peoples

In addition to the implementation of *OCAP*[®] and *OCAS* principles, there has been an increasing movement toward accessing disaggregated data. This is a response by Indigenous organizations and governments to being prevented, often based on privacy rationale, from accessing detailed “row-level” data which would allow them to conduct their own analyses and draw culturally informed interpretations on the wellness of their populations. Rather, data provided are in aggregated format, which limits what understanding and use the data can have for identifying Indigenous-specific realities and concerns.

Disaggregated data assist with this challenge by revealing inequalities and enabling comparison across categories, such as ethnicity and geography. Historically, disaggregated data have been used to the detriment of Indigenous peoples in the health care system, often to reinforce perceptions of Indigenous persons as inferior, vulnerable, sick and dying. Today, disaggregation of data is being pursued by Indigenous governments and organizations as a tool to be used to fight Indigenous-specific racism.

A recent report by the Office of the BC Human Rights Commissioner recognizes and supports this focus on disaggregated data. The report identifies that a framework is needed which positions disaggregated data as a tool that must be accompanied by a process grounded in community governance that supports the purpose of reducing systemic racism and oppression and achieving equity. This report recommends an *Anti-Discrimination Data Act*, which would set out a framework for the collection, use and disclosure of disaggregated demographic data and should include provisions that outline, among other things, the development of a data governance model with Indigenous institutions and governments in support of self-determination and sovereignty.⁷

⁶ This includes a recent national data governance strategy released by the national First Nations Information Governance Centre. This has received funding to commence early implementation of Nation-empowered regional data and information governance centres.

⁷ https://bchumanrights.ca/wp-content/uploads/BCOHRC_Sept2020_Disaggregated-Data-Report_FINAL.pdf

As well, the federal government's Throne Speech on Oct. 2, 2020 pledged to redouble efforts on anti-racism, including building a whole-of-federal-government approach around better collection of disaggregated data.⁸

In conducting this Review, a conscious effort was made to remove barriers to accessing disaggregated Indigenous-specific level data, and ensure that the findings and Recommendations are grounded in the best possible evidence. This report demonstrates the value of disaggregated data, when used to shine a light on systemic failure of, and harm to, Indigenous peoples.

There is insufficient measurement and reporting on Indigenous-specific racism and cultural safety in health care

There are some processes through which various organizations have chosen to measure and report on cultural safety and humility and anti-racism. This includes general reporting on activities in annual reports, embedding of questions in some existing survey instruments and evaluation of initiatives.

These efforts are unconnected and uncoordinated. There are major data and information gaps related to the experiences of Indigenous peoples in health care – particularly Métis peoples; and the system is not availing itself of opportunities to systemically examine the issue of Indigenous-specific racism using existing tools and data sets.

A good illustration of the current deficits and challenges in measurement and reporting regarding cultural safety and humility is the work that had to be done during the Review process to fill information gaps. For the purposes of producing this report, the Review sought to fill information gaps through designing and launching surveys of Indigenous peoples and health workers, initiating data matches that had not previously been requested and critically mining existing data sets from the perspective of Indigenous-specific racism. Such work, and more, must be integrated and standardized throughout the health care system to assess progress and support accountability in creating cultural safety and eliminating racism.⁹

⁸ <https://www.canada.ca/en/privy-council/campaigns/speech-throne/2020/speech-from-the-throne.html>

⁹ This pressing need was also recognized in the *2018 Cultural Safety and Humility Change Leadership Strategy*, which included an early action for the Standing Committee on Performance Measurement, Analytics, and Evaluation to develop a measurement framework for Indigenous cultural safety and humility. Although a working group was formed by this Standing Committee to examine this issue, no meetings were held and no draft framework has been developed.

Conclusions

The Review concludes the following related to the accountability for, and measurement of, Indigenous-specific racism:

- The Ministry of Health must assume ultimate accountability to monitor change on the health system's problem of Indigenous-specific racism, including articulating expectations of various health system organizations. This must be done in ways that maintain partnerships with, and accountability to, the Indigenous peoples who experience this widespread problem.
- The problem of Indigenous-specific racism across the entire B.C. health system is acknowledged and yet invisible. There is no systemic measurement or reporting, which is critically required to ensure improved health system performance for Indigenous peoples, including the elimination of Indigenous-specific racism. This Review has clearly demonstrated that this work can be done quickly, comprehensively and ethically when appropriately resourced, empowered and done in partnership between Indigenous peoples and the health system.
- Enhanced implementation of collection of self-identification across the health system is required. This will necessitate training in gathering self-identification information, explaining the value of self-identification amongst Indigenous peoples, undertaking validity testing over time with regard to rates of self-identification and exploring more systemic and permanent solutions, such as the opportunity to embed an Indigenous identifier in provincial identification cards.
- Application of data governance principles supported and adopted by First Nations and Métis peoples is a critical aspect of supporting the implementation of the *UN Declaration*. Current Indigenous data governance processes need to evolve to align with the latest principles in Indigenous data governance, and to produce required data in a more nimble and timely manner.



About the Artist

Eliot White-Hill (Kwulasultun) is a Coast Salish artist and storyteller from the White family of the Snuneymuxw First Nation. His traditional name – Kwulasultun (Many Stars) – comes from his late great-grandmother, Dr. Ellen White (Kwulasulwut). He has roots with the Rice family of Penelakut and in the Nuuchah Nulth world through the Hamilton family of Hupacasath, from whom he carries the name Kwaayas. He practises traditional Coast Salish art and works to preserve and pass down the teachings he has received. Through all practices, he hopes to share his appreciation for Coast Salish worldview and ways of knowing with others.

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