

In Plain Sight

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



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Addressing Racism Review
Full Report, November 2020

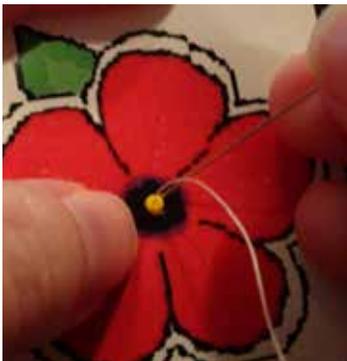




“Métis Nation British Columbia was pleased to work with the Review Team on this report addressing racism in B.C.’s health care system. The Métis Nation needs to be recognized as a distinct people making up one-third of the Indigenous population in B.C.



The mental health and wellness for Métis people is enhanced when they see the word Métis intentionally and authentically used. By working with MNBC, our Citizens see themselves included in provincial and regional policy, planning and strategies.



We are seeing some early progress in starting to have Leadership meetings with health authorities but have very little human resource capacity to respond at the level we need to for our people. We will need to ensure the Métis Nation is engaged and resourced to participate at the appropriate tables to address the health disparities and gaps we face moving forward.”

~ MNBC President Clara Morin Dal Col
Métis National Council, National Minister of Health



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

Knowledge Keeper's Message

Te'ta-in (Sound of Thunder) Shane Pointe is a Musqueam Knowledge Keeper, whose motto is "Nutsamaht!" (We are one). Te'ta-in is a proud member of the entire Salish Nation, the Pointe Family and Musqueam Indian Band. In addition to being a grandfather and great grandfather, he is a facilitator, advisor, traditional speaker and artist. Shane has worked for five different school boards, Corrections Canada, Simon Fraser University, the University of British Columbia and the First Nations Health Authority. He provides advice and guidance on ceremonial protocols for local, national and international cultural events.

While addressing racism, whether individual incidents or broader systemic issues, we often find the root cause is willful ignorance. The ignorance of distinct cultures and histories as well as the knowledge of bodies, both physical and spiritual – the knowledge of a shared history that, while common to us all, has been experienced very differently by the Indigenous branch of our collective B.C. family.

When the other branches of our collective family think of us, there is a common perception of Indigenous peoples as being less than. Less able to care for ourselves. Less able to achieve. Less able to advocate for the services we need. This report is not about less; it is about unity and the fundamental rights of all peoples. It is about confronting and acknowledging the negative, while making room for the positive.

The Truth is, to be happy and balanced, we must know both the positive and negative aspects of our lives and the systems within which we coexist. When pain and suffering has been inflicted on us, it is necessary to take the time to heal, assess and recover our strength. Positive healing energy will move us forward hand in hand with those who have hurt us. It is this collective energy that will bring true healing to the perpetrator and victim alike.

This Truth is what we build this report on, in structure, it is not to 'name and shame'. Our goal is to build the collective strength necessary to advance as a whole and healthy society. The truths we have collected will help us – all of us – learn from our failures and successes to confront the uncomfortable histories and negative systemic practices that surround us so we can all begin to heal.

Before you absorb this report and begin excellent work that will follow:

I would like to welcome you to this moment, which is the sum total of the positive and negative truths and histories written and unwritten. The truth of those who freely gave their voices, and of those wonderful human beings who couldn't. I ask you good people to please enjoy this humble moment, learn from it and, with all your integrity, bring dignity to those who have not been afforded it.

I invite you to help redistribute the wealth of cultural safety, dignity and integrity to all my First Nations relatives and others who have suffered the indignity of systemic racism.

Nutsamaht (we are one)

Nutsamaht xwalmox (we are one as human beings from this Earth)

Te'ta-in

“Racism against Indigenous peoples is a malignant disease that has been in the health care system in British Columbia since inception. Every person who works in the health care system, in fact every British Columbian, must acknowledge this reality and work together to ensure health care for Indigenous people is equitable and culturally safe and focusses on the needs of the individual, not the attitudes of the system. It is a glaring fact that Indigenous peoples encounter racism on a regular basis in the health care system and we need an effective mechanism or complaint process to bring the issue to light and have it addressed. First Nations in British Columbia must be protected from all forms of racial discrimination in seeking health care. Racism is not just hurtful words or ideas – in health care, it leaves Indigenous peoples suffering without proper care. In the moment when you need health care, it is too much of a burden to put on the backs of First Nations peoples, having to deal with this racism. That is not compassionate, it is cruel and painful.”

~ Grand Chief Stewart Phillip
President, Union of BC Indian Chiefs

About the Artwork



The works presented throughout this report are focused on drawing from traditional Coast Salish art to express themes and concepts through an Indigenous lens. Throughout Coast Salish stories and art, Snuw'uyulh (teachings) can be found regarding profound philosophical statements upon the nature of being and morality. A major component of the education behind these teachings is that a critical lens is always applied: How could this be done better? How are specific actions right or wrong?

These works find their basis in teachings that the artist has been given and their relationship to the broader themes contained within the report. It is important to see what is happening – the people, the ancestors, and the land are witnesses. What will those who witness do to act upon what they have seen?

It is imperative to come together to stave off injustice and not allow it to settle within our communities and it is a responsibility of the institutions and bodies that lead and govern to ensure access in a safe and good way. Through this difficult but critical work, it is possible to create new understandings from which space can exist to allow future generations to flourish. In making these works the artist sought guidance from family and teachings, looking to ancestors and the ancient pieces that have been handed down in the Coast Salish tradition.

There is significance in the four spindlewhorl designs and the use of colour. Four is sacred, and teachings from the artist's family have discussed how xu'athun (four) is derived from xe'xe (sacred). In the Coast Salish world things are done in fours: the four directions and their winds, the four posts of the house, the four limbs of the body. The spindlewhorl, one of the strongest instances of Coast Salish art, is a thing of movement and creation. It contextualizes and assists the work to spin the fibers and create what is new.

The color palette is focused on the use tumulh (red ochre) which is both sacred and offers protection. Visually, it serves to help read this report and participate in the energies it carries and acknowledges. The artist has drawn upon these colors to tell and retell stories that are both old and new in his own way with the hope that it can contribute to a greater understanding of the work that lays ahead.

The Investigator wishes to thank Kwulasultun for the creative work, insight and inspiration his work provided to our team and for bringing life to the stories and teachings that are foundational to this report.

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Executive Summary

In June 2020, claims surfaced about a “*Price is Right*” game allegedly being played in some B.C. hospital Emergency Departments, in which health care workers were guessing blood alcohol levels of Indigenous patients. The Minister of Health commissioned an independent Review to investigate the “*Price is Right*” allegations and whether this game or other forms of Indigenous-specific racism are being experienced by Indigenous people using the provincial health care system, make findings of fact, and “*to make any recommendations it considers necessary and advisable.*” (See Appendix A for Terms of Reference) The Addressing Racism Review was formally launched on July 9, 2020.

Specific to the allegation of a “*Price is Right*” game, the Review did not find evidence of an organized game with this name occurring in B.C. hospitals as originally depicted. The Review has produced anecdotal and episodic evidence of multiple activities in the health care system that resemble these allegations in some fashion, but none of them could be described as coordinated, organized, widespread or targeting only Indigenous patients.

While the “*Price is Right*” allegations were unsubstantiated, the Review, consistent with its mandate, examined the experience of Indigenous peoples in B.C. health care system. The results are disturbing. Through listening to thousands of voices – through survey results, direct submissions, health care data, and interviews – a picture is presented, as illustrated by Findings 1-5, of a B.C. health care system with widespread systemic racism against Indigenous people. This stereotyping, discrimination, and prejudice results in a range of negative impacts, harm, and even death. Indigenous women are particularly impacted. Public health emergencies are magnifying these issues.

The Review also found, as illustrated by Findings 6-11, that this problem is widely acknowledged by many within the health care system, including those in positions of authority. There have been some well-intentioned and positive efforts to address this problem. However, these efforts are sporadic, disconnected, at times personality-dependent, and not underpinned by strong and systemic foundations.

Addressing systemic racism requires coherent, systematic action. Uprooting Indigenous-specific racism in health care requires shifts in governance, leadership, legislation and policy, education, and practice. The 24 Recommendations provide a coherent and comprehensive approach to achieving these changes. They will shape shifts in behaviour and beliefs at

individual and societal levels. We know that achieving these shifts requires humility, anti-racist mindsets and tools, and human rights approaches.

This Review has been conducted in a moment of increasing understanding about the colonial history of Canada and its enduring legacy, and the requirement for change. B.C. remains in the midst of a transition from this colonial legacy of segregation, disempowerment and dehumanization of Indigenous peoples, to an equitable system that upholds the basic human rights of Indigenous peoples. In November 2019, the B.C. government laid an important foundation for such approaches through the passage of the *Declaration on the Rights of Indigenous Peoples Act (DRIPA)* that affirms the application of the *United Nations Declaration on the Rights of Indigenous Peoples (UN Declaration)* to the laws of B.C., and requires an action plan to meet the objectives of the *UN Declaration*. Among the many standards and principles in the Declaration relevant to this Review, is the critical recognition in Article 24 of the Declaration that “Indigenous individuals also have the right to access, without any discrimination, to all social and health services.”

The Review Recommendations target immediate, principled and comprehensive efforts to eliminate all forms of prejudice and discrimination against Indigenous peoples in the BC health care system. This is essential if we aspire to an accessible and effective health care system. It is also needed to reach a state of substantive equality in health care and outcomes for Indigenous peoples, that adequately address the legacy of colonialism in health care, and enables the expression and enjoyment of Indigenous human rights and improved quality of life.

We all have vital roles to play in confronting this historic legacy, and in creating positive change. This Review has been conducted in such a way as to help advance the momentum of positive change. In reading this Report, we invite you to examine your own beliefs, build your understanding of the past and present reality of health care for Indigenous peoples, and consider the role each of us can play in building a strong B.C. health care system for all British Columbians.

PART 1
Background



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In June 2020, claims surfaced regarding a “*Price is Right*” game allegedly being played in B.C. hospital Emergency Departments (EDs), in which health care workers guess blood alcohol levels of Indigenous patients. B.C. Health Minister Adrian Dix appointed Mary Ellen Turpel-Lafond to lead an independent review into these allegations on June 19, 2020. This Addressing Racism Review (Review) was formally launched on July 9, 2020.

The Review team was asked to investigate the “*Price is Right*” allegation, situated and examined within a broader context of Indigenous-specific systemic racism in the health care system in B.C., to make findings of fact, and describe recommendations (see Appendix A: Terms of Reference). Delegation was provided under the *Ministry of Health Act* regarding access to data and information needed for the Review (see Appendix B: Delegation letter).

Expectations and Scope

The scope of the Review was to investigate the “*Price is Right*” allegation, and to examine Indigenous-specific racism – and in particular, systemic racism – in the B.C. health care system. There was a tremendous response to the establishment of the Review. We listened to the people who came forward, developed key themes, anonymized some of the accounts to include in this report, and combined these with other data sources to produce a systematic examination of the issue.

More than 600 people submitted accounts of their experiences to the Review. Many were highly disturbing, and expressed deep frustration and the pent-up need to be heard. Many of the people who made submissions to the Review expected the team to investigate, address and impose remedies with respect to their individual experiences. Although in some cases, the Review Team helped navigate service and made the system confront the racism in real time, we acknowledge that many of those who made submissions will be disappointed by the fact that the Review cannot impose remedies, and lacks the statutory authority to impose appropriate consequences in cases. Assurances that case histories shared with the Review would be kept strictly confidential, and sealed following its conclusion, will be honoured, meaning that the Review itself cannot provide an avenue for further investigation of these specific incidents.

Some Review submissions included incidents of racism in sectors other than health, including education, the justice and child welfare systems, which were outside the Review's scope. Individual submissions also included incidents brought forward by people of other racialized groups, particularly from Black and South Asian populations. Those, as well, fell outside the Review's mandate. As a result, racism in other sectors and as experienced by other racialized groups is yet to be fully revealed, much less addressed. Particularly concerning were numerous complaints about Indigenous children and families not receiving proper respect or access to health-related services in the K-12 education system, such as psycho-educational testing, speech language therapy or occupational therapy. Government should consider commissioning similar reviews into Indigenous-specific racism in its other public service systems that intersect with health care, and it might be advisable to place a priority on the special needs stream of health supports in the education system.

Definitions and Context

It was important for the Review to work from a clear definition of racism and related concepts, and an understanding of the historical and contemporary context of Indigenous-peoples in Canada.

Racism is the belief that a group of people are inferior based on the color of their skin or cultural background. This belief drives discriminatory behaviours and practices, such as negative racial profiling, and policies that oppress, ignore, or treat racialized groups as 'less than' non-racialized groups. The result is substantive inequity – where members of racialized and culturally distinct peoples, such as Indigenous peoples, do not receive the services they require or enjoy equitable opportunities or outcome with other citizens from non-racialized groups. This is systemic racism – wherein acceptance of these discriminatory and prejudicial practices are normalized across our society, in public services and institutions.

In Canadian society, there is a direct line between the history and experience of colonialism and the challenges of Indigenous-specific racism within the health care system today. The cultivation of racist beliefs that Indigenous peoples were weak, dying off, incapable and primitive enabled the state to enact policies to segregate, assimilate and govern all aspects of the lives of

the Indigenous peoples and expropriate their lands. These beliefs, embedded in laws and policies for more than a century, have shaped and continue to permeate public services such as health, education, justice and child welfare. A lack of readily available accurate factual information, knowledge, and understanding about this history contributes to ongoing negative attitudes and social inequities. In fact, this broad-based ignorance about racism and the history of Indigenous peoples in Canada is one of the ways that racism is held in place, as there is very little in our educational systems and in the media to contradict these beliefs. As a result, racist assumptions endure about the true reasons for substantive inequity for Indigenous peoples. The system enjoys “privilege” because those in it have no compelling reason to examine or reflect on the assumptions they carry, as those assumptions are considered inherent characteristics of those profiled based on racial and other forms of discrimination.

During the course of the review, events happened which illustrated the enduring reality of racism in health care in other parts of the country. The racist taunting and subsequent death of Joyce Echaquan took place in Quebec, demonstrating that the problem is likely not unique to B.C. This report, aimed at addressing this problem in B.C., may be instructional to other jurisdictions and at a national level, as some of the presenting issues may indeed be national in scope and experienced more widely.

Achieving this shift requires cultural humility, anti-racist mindsets and tools, and human rights approaches (see Appendix C for a glossary of terms).

Anti-racism is the practice of identifying, challenging, preventing, eliminating and changing the values, structures, policies, programs, practices, profiles and behaviours that perpetuate racism. As Ibram X. Kendi, a leading scholar of anti-racism, states it's not enough to be 'not racist'. It is not enough to claim to be "colour blind." *"The opposite of 'racist' isn't 'not racist,'" he writes. "It is 'antiracist'".* To be antiracist involves eliminating racism from our policies and institutions, understanding how the present exists upon colonial and racist foundations, and committing to educate oneself and take action to create conditions of greater inclusion, equality and justice.

Key Terms

- **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.
- **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.
- **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.
- **Indigenous-specific racism** refers to 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 that perpetuates power imbalances, systemic discrimination and inequitable outcomes stemming from the colonial policies and practices.
- **Colonialism** occurs when groups of people come to a place or country, 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 their governance, legal, social, and cultural structures, and force them to conform with the colonial state.
- **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 present notion, often causing them to receive different and discriminatory treatment.
- **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.
- **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.
- **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 center 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.
- A **culturally safe** environment is the desired outcome and can only be defined by the Indigenous person receiving care in a manner that is safe and does not profile or discriminate against the person but is experienced as respectful, safe and allows meaningful communication and service. It is a physically, socially, emotionally and spiritually safe environment, without challenge, ignorance or denial of an individual's identity. To be culturally safe requires positive anti-racism stances, tools and approaches and the continuous practice of cultural humility.

In B.C., the adoption of the *UN Declaration on the Rights of Indigenous People* and passage of the *Declaration on the Rights of Indigenous Peoples Act* now provide a framework for addressing Indigenous-specific racism, and facilitate taking the further steps required to recognize Indigenous rights to health, self-determination and achieve cultural safety. Working in partnership, based on recognition and respect of Indigenous rights, including the right of self-determination, with a clear grounding in Indigenous understandings of health and wellness, and a commitment to tangibly implementing anti-racism measures and tools, is the foundation for moving forward.

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. The *Declaration on the Rights of Indigenous Peoples Act* defines Indigenous with the same definition as Aboriginal in the Constitution Act, 1982.

From a data perspective, the term of choice within many government databases is “Aboriginal”, the term used in the *Constitution Act, 1982*. “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.

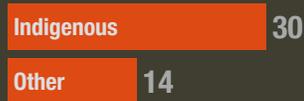
The federal government also continues to use terminology “Registered or Treaty Indian,” “Indian reserves”, and “Indian Status” in its documentation – a by-product of the *Indian Act*. However, in this report, these terms are only used to accurately identify a data’s original descriptors. First Nations,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

DEMOGRAPHICS OF INDIGENOUS PEOPLES IN BC

Percentage of BC population



More likely to live in rural areas than non-Indigenous population



More youthful than non-Indigenous population



Lower median income than non-Indigenous population



Less likely to hold university certificate, diploma or degree at bachelors level and above



More likely to worry during pandemic that food would run out before they had money to buy more



Data sources: 2016 Canadian Census; COVID-19 Speak survey

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 team also completed extensive qualitative and quantitative analysis of existing data, a document and literature review, in-depth review of a number of case histories, and a close examination of the original allegations that gave rise to the Review. The Review engaged both Indigenous and non-Indigenous methodologies, included a multitude of quantitative and qualitative data sources, and followed established Indigenous data governance principles and processes.

The Review team was headed by two Indigenous women – the Independent Investigator 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.

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.

The sources of information considered in this Review included:

- The launch of two surveys
- Creation of a website and a toll-free phone number and email address
- A detailed examination of the allegations that gave rise to this Review
- Interviews with leaders across the health care sector
- Analysis of health sector data relating to usage, outcomes, complaints and experiences
- A literature review to provide context and additional background information
- Review of documents related to relevant initiatives, investments, and barriers

- Dialogue with experts in Indigenous rights, Indigenous health and wellness, and the *UN Declaration on the Rights of Indigenous Peoples (UN Declaration)*.

Given the Review had the opportunity to examine a such a wide array of data related to health system performance, Indigenous peoples’ experiences and health and wellness outcomes, not all data could be stated within the Report. A portion of this data is drawn upon and summarized within the body of this report. Recognizing the value of the data, and honouring the experiences of Indigenous peoples reflected within it, was important to Indigenous leadership in B.C. Therefore, a separate data report will be released.

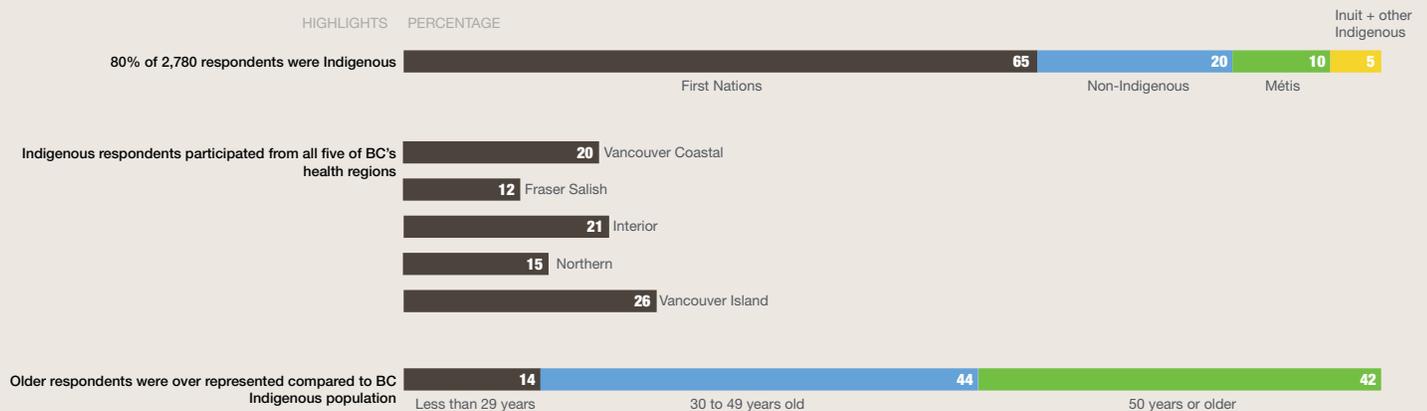
Indigenous Peoples’ Survey

The Indigenous Peoples’ Survey (IPS) 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 approach and methodology, Appendix E)

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.

INDIGENOUS PEOPLES’ SURVEY

Demographic Snapshot



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 Care Workers' Survey

The Health Care Workers' Experiences of Discrimination in Health Care Services Survey (HWS) was launched online on July 30, 2020, and remained open until Aug. 27, 2020. (Survey approach and methodology, Appendix E)

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.

HEALTH CARE WORKERS' SURVEY

Demographic snapshot



The HWS solicited the following from respondents:

- Prevalence 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
- How to improve cultural safety in health care for both users and health workers.

The final number of 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; 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, which is similar 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 submissions from both Indigenous and non-Indigenous respondents, including patients, family members and caregivers, health care workers, third-party witnesses and others.

Callers utilizing the toll-free line were prompted to record a submission of up to 20 minutes in length, or leaving contact information for a member of the Review team to return their call and take their submission by telephone. Due to COVID-19 precautions, in-person interviews were not commonly conducted, although the Review team did conduct a limited number of these in special circumstances, such as when an Elder expressed being uncomfortable providing their history over the phone.

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. All submissions were qualitatively analyzed by the Review team. Summaries written for these calls were closely coded for key concepts. Themes were

developed from these codes through an iterative approach looking for similarities, differences and relationships between and within codes. These themes were then grouped into six broad categories. The frequency with which each category appeared was determined across the different groups of Indigenous and non-Indigenous respondents, health receiver respondents and health provider respondents, and the health authorities identified in the respondent’s case history.

Review team members determined whether any specific cases should be reviewed in greater depth and/or possibly used in an anonymized fashion in the report.

In some cases where respondents indicated they needed urgent assistance – and when their permission was obtained – Review team members referred their cases on to applicable health organizations for help. Mental health and wellness supports were also made available to respondents.

DIRECT EMAIL AND 1-800-NUMBER SUBMISSIONS

Demographic snapshot



In-depth Review of Select Cases

In addition to locating and interviewing individuals connected to the initial allegations of the “Price is Right” game, members of the Review team also conducted on-going monitoring of submissions being received via the website and toll-free number. Follow-up interviews were conducted by telephone or social media platforms regarding allegations that were similar in nature or that conveyed other particularly egregious experiences of racism.

These interviews were conducted to elicit additional information about the incidents that had been described and to ensure that the information received could be managed in a way that would protect personal privacy. In some cases, the interviews revealed active or ongoing issues with patient care that were referred to the appropriate body for immediate action.

Key Informant Interviews

The Review also conducted interviews with leaders in the health care sector, including the Minister and Deputy Minister of Health, and the CEOs of the five regional health authorities, the Provincial Health Services Authority (PHSA), Providence Health Care and the First Nations Health Authority (FNHA), as well as leadership from the Métis Nation BC (MNBC), First Nations Health Council (FNHC), health regulatory college leaders, Indigenous health team leaders from all health authorities, and other relevant stakeholders.

The primary purpose of these interviews was to:

- Better understand the extent of Indigenous-specific racism in health authorities
- Identify if and how the issue of Indigenous-specific racism is being addressed, and the effectiveness of these approaches
- Identify insights, barriers and recommendations to inform a way(s) forward.

Transcripts or notes were prepared for each interview. These interviews provided required context and understanding, as well as key themes, for the content of this report.

Additional Data Sources

Aside from the data generated by the work of the Review, a broad range of additional data was accessed and analyzed. This included:

- Complaints submitted by or on behalf of Indigenous people to selected regulatory colleges and health authorities
- Discussion boards and course module participation rates in the San'yas Indigenous Cultural Safety Training
- Surveys regarding patient experience and outcomes, including the First Nations Regional Health Survey, Patient Reported Experiences Measurement Surveys, and the BC COVID-19 Speak survey

- Health system utilization data, including related to primary care, emergency departments, hospitals and cancer screening
- Health condition prevalence, including for acute and chronic disease, opioid overdoses and COVID-19
- Health outcomes, including socioeconomic measures

Literature and Document Review

More than 500 health authority core planning documents, policies and related documents were submitted, analyzed and summarized by the Review. In addition, regulatory colleges provided nearly 200 documents for the Review's consideration.

The Review also maintained an evolving list of resources provided by experts, academic institutions and researchers amounting to more than 200 total articles, reports and research studies. Some of these were recent literature reviews that included search strategies involving the same matters of focus as the Review.

Limitations of the Review

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 a report only five months.

Undoubtedly, a longer time frame would have resulted in a larger sample size from the surveys and 1-800/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 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 small 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 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.

Analytical Approach

The Review's analytical methodology, data source descriptions and statistical tools are appended to this report.

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.

PART 2

The “Price Is Right” Game Allegation



The initial media reports that a disturbing “*Price is Right*” game was being played in B.C. hospital Emergency Rooms involving the guessing of Indigenous patients’ blood alcohol levels originated from an April 27, 2020 post on an online discussion forum as part of Indigenous cultural safety training for B.C. health care workers.

That post ultimately resulted in B.C. Health Minister Adrian Dix initiating the Addressing Racism Review on June 19, 2020. Part of the mandate provided to the Independent Reviewer and her team was to explore that allegation, its veracity and how the matter was subsequently dealt with.

The Review team conducted a significant number of interviews and examined all existing documentation, emails and notes on the subject. This process was rendered more difficult due to the absence of expected documentation as well as the contradictory recollections of some of those interviewed.

The Original Post

The April 27 forum post was made by a participant (“Participant X”¹) in the San’yas 2020 Core Indigenous Cultural Safety (ICS) training program. This cohort included 25 participants and was held over a period of eight weeks. As part of the training, a San’yas facilitator ran a discussion board that focused on the stereotyping of Indigenous people. The following post was made by Participant X:

“I am not proud of my example but am willing to share as this may be helpful for others to read what happens behind closed door [sic] in the hospital as it is for me to become aware of how harmful these actions have been for myself and others. When I worked at a rural hospital surround [sic] by multiple reservations we would play a guessing game typically on the weekends. In the emergency department we would routinely receive Indigenous people that were intoxicated by the police/ RCMP or the paramedics.² We would provide adequate care but we would guess at their alcohol levels when we ran the blood work. I used to think this was normal as the cultural [sic] of the department seemed to support the game and even the doctors would occasionally get in on the game.”

All participants in the forum were assigned screen names in order to safeguard their anonymity, but the facilitators were aware of their actual identities. Although the original forum post was deleted in the wake of the publicity

¹ Participant X was not the actual pseudonym used by the participant who made this post.

² Participant X did not mean to suggest through this wording that the RCMP or paramedics had any role in these people becoming intoxicated.

that eventually followed, a copy was retained by San’yas and subsequently obtained by the Review.

The San’yas Program

San’yas Indigenous Cultural Safety Training (ICS) is an online cultural safety training program developed and delivered by the PHSA’s Indigenous Health Program. The program was developed in 2009 in response to the Transformative Change Accord: First Nations Health Plan that stipulated First Nations and the Province would develop a curriculum for cultural competency. Although this curriculum was originally envisioned as being mandatory for both Ministry of Health and health authority staff, participation remains voluntary for most organizations.

San’yas ICS Training brings together a virtual cohort of anonymous participants with a facilitator. Individuals work through the training modules via individual and group forums. These forums are run by facilitators who lead discussions and provide feedback. Course content is broad and includes culture, stereotyping and the impacts of colonialism. Specific topics include diversity, history (i.e., residential schools and Indian hospitals) and terminology. Participants are encouraged to discuss their lived practice and personal experience of interacting with Indigenous populations, provide examples of these interactions and discuss their views.

PHSA leaders and staff told the Review that the San’yas program’s longstanding informal protocol is to follow up with the authors of forum posts who have identified serious harms, including actual or potential bodily harm to an Indigenous person, family dislocation, criminal behaviour or systemic racism. This informal protocol was formalized in June 2020 into a one-page flowchart entitled, *Serious Harms Identification and Follow-Up Process* approved within the PHSA Indigenous health team.

In this instance, the facilitator of Participant X’s forum consulted with her supervisor regarding the posting and, together, they concluded there were grounds for follow up. On June 10, 2020, the forum facilitator sent the following message to Participant X, via the San’yas platform, inviting him to participate in a follow-up call:

“Hello, [Participant X]. I hope you are well and thank you for your important contribution in the discussion board. Given the gravity of what you’ve shared on the second discussion board, we would really like to have a quick phone call regarding the details of this experience. In addition to the work that San’yas does to facilitate an individual learning experience in the training, we also work towards larger systems change. This call would involve exploring the circumstances of examples like you have shared and ensuring participants feel supported in doing this important work. Thank you for your ongoing engagement with this work, [Participant X], and looking forward to connecting with you more. A facilitator will be in touch by phone.”

The facilitator and her immediate supervisor consulted with the San'yas program leader prior to engaging in telephone calls with Participant X. The San'yas program leader felt that the timeframe of the events described was unclear and directed the forum facilitator to make the call to Participant X, based on their prior engagement on the discussion board, and to determine, among other details, when these events had occurred.

The facilitator subsequently had two telephone calls with Participant X on June 11 and 12, 2020, with the second call being made to identify the hospitals where “*the game*” was occurring. The facilitator made notes of the phone calls that included the following observations about what she described in those notes as the “*racist game example*”:

“When? – 10 yrs ago in Emergency dept but not unique to ER – other hospitals too [Hospital location deleted]
 Has anyone reported it? – No, inability to see change so ppl didn’t report, normalized practice/culture
 How were you introduced to game? Others playing it regularly.
 Accountability? – no higher level action, embedded practice
 Practices – hold them overnight 8 hrs, discharge without follow services/ supports/care.
 Game used “*Price is Right*” rules
 –knew about 4 or 5 hospitals playing game, physicians knew + no complaints
 Authority had no practice of following through on complaints no action from above so game + other discriminatory practices continued.”

These notes written by the facilitator represent the first documented use of the term “The Price is Right” with regard to the allegation. In an interview with the Review, Participant X denied ever using this term himself. The San'yas facilitator told Review investigators she didn't specifically recall Participant X using the term but did recall that he confirmed the rules of “*the game*” were the same as the television game show.

The facilitator reported the results of her phone calls with Participant X to her colleagues in the following email:

“Participant shared experience of “game” with “*Price is Right*” rules where nurses, doctors and other staff would guess the blood alcohol levels of Indigenous patients coming to the ER. The participant shared they were introduced to the game as a new nurse 10-years ago at [hospital name deleted]. They indicated that versions of this game are widespread across hospitals and that they had directly seen it played

in Emergency Departments at [hospital names deleted] but had heard about it being played in other hospitals as well... ”

During her interview with the Review, the facilitator reiterated that Participant X confirmed “*the game*” had occurred at all three of the hospitals where he had worked, and that nursing staff and physicians guessed the blood alcohol levels of Indigenous patients, a practice she recalled him describing as embedded and widespread.

The facilitator also recalled Participant X stating that “*the game*” was only played with Indigenous patients, although she admitted that they talked about it solely in the context of anti-Indigenous racism. She told investigators she had never heard of any prior reference to “*the game*” during her work with San’yas and was aware of the fact that these allegations had originated earlier in Participant X’s career.

Participant X also received a follow-up phone call from another lead San’yas facilitator on June 19, 2020, in the wake of a media release earlier that day announcing that the Minister of Health was initiating an independent Review into allegations of “*the game*” and systemic discrimination in health care against Indigenous people. She recalled Participant X being surprised to see the media reports and later described to the Review the call with him that day as being a “check in” to offer support and recognition for what was occurring as a result of his allegations. She followed up with an email assuring him that his posts had been removed from the discussion board to protect his anonymity.

The Participant X Interview with the Review

Participant X has had a long career in healthcare, including working in a hospital emergency department where he first encountered blood alcohol level estimation. In his efforts to improve his own skill level, Participant X had lobbied his superiors to approve him for the San’yas training.

In his interview with the Review, Participant X immediately expressed that he was finding “*some of the things that are coming out [in the media] are hard to understand.*” In particular, he was concerned that the estimation of blood alcohol levels by hospital staff was being portrayed as something exclusive to Indigenous patients. “*I struggle with the racism piece, because it wasn’t targeted at people as much as it was at someone who had enough alcohol or drugs onboard to be hospitalized... It was never about targeting and so it’s morphed into something it wasn’t.*” He was also struggling with the descriptive term “*Price is Right*” and, as previously mentioned, denied using that in his portrayal of the alcohol estimation game.

Participant X described encountering “guesstimation” of alcohol levels for the first time early in his career. In his recollection, it was the nursing staff and possibly a lab tech who were involved. Physician involvement was rare, he said, as the single doctor on staff in the ER was usually too busy to engage. He never saw money change hands, and never witnessed any other benefit resulting from a successful guess: “*There’s nothing to win, it’s something to pass the time.*” He also took issue with the frequency with which such estimation occurred, stating “*I feel from the news that this was [portrayed as] happening every day and all the time, and this wasn’t happening every day and [wasn’t] something people would line up for.*”

When Participant X left the hospital where he had begun his nursing career, he took a few casual shifts in the ER at his new hospital. He said he did not observe blood alcohol estimation occurring there, although his exposure was very limited. He has had no direct ER involvement for the last nine years, nor has he heard of events resembling “*the game*” during that time.

The Response to the Allegation

Following the call with Participant X on June 11, 2020, the facilitator debriefed with her supervisor and the San’yas program lead who had previously been alerted to the issue. The decision was made then for the facilitator to call Participant X again in order to confirm the locations of the events described.

On June 12, the San’yas program lead informed her supervisor, the Indigenous lead for PHSA, about what they had learned. The San’yas program lead told the Review that she believed that “*the game*” was a current practice and that it was ongoing in multiple locations, and this belief informed her discussions with the Indigenous lead. When asked if she was aware of the fact that the original allegations were almost a decade old, the PHSA Indigenous lead told the Review that she hadn’t been, but added that she was not surprised as it was her experience that San’yas training often surfaced issues that had occurred in the past rather than focusing on contemporary events. While San’yas has received hundreds of reports of alcohol and drug-use stereotypes directed at Indigenous people, neither the San’yas program lead nor the Indigenous lead had previously heard of this particular “*game*.”

The Indigenous lead expressed deep concern and asked for a summary of the incident, including the significance of the behaviour, to be shared with PHSA senior leadership and Risk and Quality Assurance staff.

After further discussion within PHSA, the decision was made to call a meeting of the Adverse Events Committee (AEC). The AEC meets to provide rapid

response to issues across health authorities and includes representatives from each of the regional health authorities as well as the Ministry of Health. The Indigenous lead from PHSA requested that the Indigenous health leads from each regional health authority be invited, and engaged them in a series of conference calls on June 16 to provide context for the meeting.

Also on June 16, the Indigenous lead met with her supervisor, another senior executive member, and the PHSA CEO for a “Get to know the new CEO” meeting. During this meeting, the allegation of *“the game”* was mentioned. PHSA’s CEO expressed concern and asked that the Indigenous lead take appropriate steps.

According to the meeting notes of the AEC meeting, held on June 17, two participants shared that they had each made inquiries to several colleagues in different Emergency Departments about this allegation. They reported to the group that these individuals all confirmed this game is played and it is *“across the board”* and an *“overall game played with all patients”*. During a follow-up interview with the Review, one of these individuals stated that the two colleagues she contacted indicated that blood alcohol levels were being estimated as part of an overall initial patient assessment, *“just like hemoglobin levels.”* There was no indication from either of her sources that this was racially motivated or done in some kind of competitive fashion.

At the conclusion of its meeting on June 17, the AEC decided to develop an action group that would go forward to address the issue of *“the game”*. The PHSA Indigenous lead felt Indigenous leaders must be briefed and involved in developing strategies. As a result, she conducted two external briefings the following day.

The External Briefings

Representatives from the First Nations Health Authority (FNHA), Métis Nation BC (MNBC) and the B.C. Association of Aboriginal Friendship Centres (BCAAFC) were briefed by phone on June 18.

When interviewed by the Review, the representative from the BCAAFC stated that she had drafted the media release that was issued the following day. This was done in collaboration with both FNHA and MNBC representatives although the FNHA ultimately felt it could not participate in the media release without further internal engagement and the release was amended to say merely that the FNHA had been *“informed”* of the situation. Participants of the Indigenous organizations represented in the meetings confirmed to Review investigators that they were unaware that the San’yas participant’s post was an historical allegation.

The Ministry Briefing

A June 18, 2020 briefing note prepared for the Ministry of Health by the PHSA described that *“the issue is a ‘game’ referred to as ‘price is right’ being played with incoming intoxicated patients in Emergency Departments guessing the blood alcohol level (BAL test) and betting on it... Allegation referred to Indigenous people being targeted.”*

The briefing note further stated that *“the game”* takes place *“in Emergency Departments in 3 hospitals and 2 Health Authorities in B.C.”* The briefing note named those three hospitals and noted that three witnesses had confirmed that the game is widespread in hospitals in B.C. The Ministry was also informed about the impending media release by the BCAAFC and MNBC. It was on the basis of this information that the Review was launched.

Additional Evidence Considered

During the course of this Review, which included dozens of interviews with patients and health care providers, a number of other allegations bearing some similarities to *“the game”* were examined. These other allegations came through interviews as well as subsequent San’yas discussion board posts examined by the Review. However, none of this evidence confirmed or suggested the presence of an organized activity targeting Indigenous patients.

Although one witness provided evidence that a staff member who correctly guessed a patient’s blood alcohol levels was rewarded with a free coffee at one hospital, the episode described had occurred a decade ago and was not apparently racially motivated. Other witnesses, including doctors, nurses and paramedics described how the estimation of blood alcohol levels was a legitimate part of patient assessment, although it was also clear that patients whose blood alcohol content was found to be extraordinarily high could sometimes be subject to negative and judgmental comments, regardless of race.

Conclusion

The information presented to decision-makers that led to the establishment of this Review does not square with evidence gathered during this process. It is at odds with Participant X’s interview with Review investigators, in which he denied using the term *“Price is Right”* to describe the activity, said that there were no prizes for *“the game”* and that Indigenous people were not specifically targeted. The claim that *“the game”* is played in three hospitals and two health authorities could not be confirmed by the Review. As the issue was escalated through San’yas, up the PHSA ranks, to other health authorities and Indigenous

partner organizations, and to the Ministry of Health, this information was framed as ‘facts’, and the fact that Participant X’s observations were nearly a decade old was not conveyed.

It is the Independent Reviewer’s conclusion that the eventual public and media accounts of *“the game”* that spurred this Review were inaccurate. The Review found no evidence to substantiate the allegation that the *“Price is Right”* game was being played in B.C. hospital emergency departments, and if such games did occur in the past, they are not occurring today. The Review has produced evidence of multiple activities in the B.C. health care system that resemble these allegations in some fashion, but none of them could be described as coordinated, prevalent, widespread or targeting only Indigenous patients. It is also evident that the guessing by medical professionals of various patient levels – not limited to blood alcohol – is routine and in many cases may be clinically appropriate, although the Review does find extensive profiling of Indigenous patients based on stereotypes about addictions.

Most significantly, it has become clear during the Review that the functions of delivering a training program must be distinctly separated from functions of complaints, incident management, and quality assurance. The San’yas program prepared regular “serious harms reports” and other reports that referenced “thousands of examples of harm” that did not provide any actionable information for those responsible for addressing incidents and adverse events. The conflation of these functions and associated responsibilities within the San’yas training program did not help bring issues forward in an accurate light, and ultimately did not serve the purpose of addressing Indigenous-specific racism.

PHSA senior leadership has acknowledged that the briefing process undertaken in this allegation did not follow established protocols for investigating allegations and incidents of a serious and harmful nature in health care. These leaders have also confirmed that changes have and are being made to ensure that the focus of the San’yas program is on training, with appropriate protocols for following up on harmful disclosures, and assuring confidentiality of program participants.

PART 3

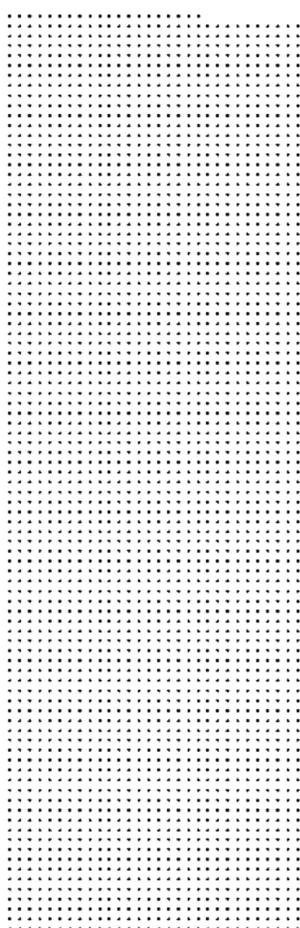
Experience of Indigenous Peoples In B.C. Health Care



WE HEARD FROM ALMOST 9,000 PEOPLE

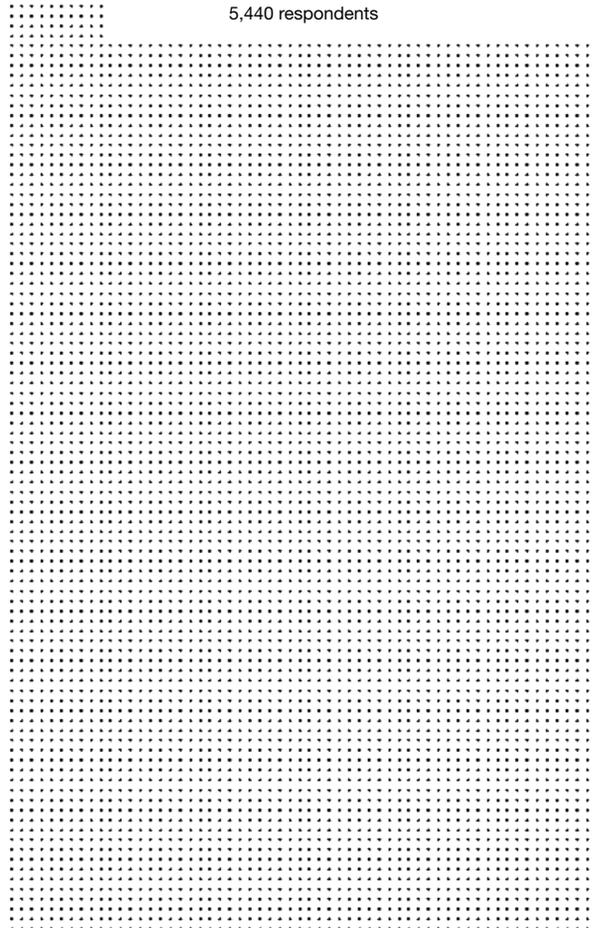
INDIGENOUS PEOPLES' SURVEY

2,780 respondents



HEALTH WORKERS' SURVEY

5,440 respondents



DIRECT EMAIL AND 1-800-NUMBER

600 respondents



KEY INFORMANT INTERVIEWS

150



WE ANALYZED HEALTH SECTOR DATA

185,000

Health utilization and health outcomes of First Nations and Métis individuals.

12,335

Indigenous respondents to the COVID-19 Speak survey.

3,026

Adults in the First Nations Regional Health Survey data.

1,246

Indigenous respondents to a Patient Reported Experiences Measurement Survey of emergency departments.

430

Complaints from Patient Care Quality Offices, Colleges and the First Nations Health Authority.

LITERATURE REVIEW

Submissions from health sector and Indigenous organizations
Detailed investigation of specific ER allegations
Investigation of other select cases
Extensive literature review of previous investigations, inquiries, and academic or historic findings
Dialogue with experts in Indigenous rights, Indigenous health/wellness, UNDRIP
Review of existing anti-racism/cultural safety initiatives already underway

While the *“Price is Right”* allegations were unsubstantiated, the Review, consistent with its mandate, examined multiple other examples of racism and discrimination experienced by Indigenous peoples in B.C. health care system. This broader examination based on what we heard directly, and reviewed in the system itself, reveals abundant evidence that significant Indigenous-specific racism is widespread and has been for some time.

What We Heard

Who did we hear from?

Using surveys, phone and email, the Review heard from approximately 9,000 people. These voices of patients, health workers, family, caregivers and concerned observers were heard and their opinions had a place in the Review.

A broad interview strategy amongst those administering the health system resulted in contributions from Indigenous leaders, health service executive leaders, health professional regulators, and Indigenous health care professionals and administrators.

Through data linkages with provincial administrative databases, the Review has reported on health utilization and health outcomes of approximately 185,000 First Nations and Métis individuals. Additional Review sources include the B.C. First Nations Regional Health Survey, which collected data from 3,026 adults through 2015-17. Other survey data which inform this review, and where Indigenous data is identifiable, include the COVID Speak Survey, and the Patient Reported Experiences Measurement Survey of emergency departments.

What did Indigenous patients, families and communities tell us?

Indigenous people told us that they encounter racism and discrimination in the B.C. health care system, including stereotyping, unacceptable personal interactions and poorer quality of care.

Many Indigenous people said they do not feel safe when accessing health care services and interacting with health providers – some noting that they “never” feel safe, and many sharing that they “always” have negative experiences. Indigenous women spoke up more than any other Indigenous people, and shared their particular feelings of unsafety.

Indigenous people want to see change. They want to be treated with professionalism, compassion, and respect. They want to be believed when they report health care concerns and symptoms. Participants want to see policies and actions in the health system that meaningfully address racism and discrimination, including an accessible, meaningful and safe feedback process regarding health care experiences. Indigenous people see the need for training among health care workers to counteract stereotypes.

What did Indigenous health care workers tell us?

Indigenous health care workers believe that racism is a problem in their workplaces and organizations, and over half of Indigenous respondents to the HWS have experienced workplace discrimination themselves. This racism most often came from a colleague or fellow student, or from an individual in a position of authority over them. There is a fear of reprisal in speaking up against racism in the workplace. Prejudice results in emotional, mental, spiritual and physical harm. Some key informants emphasized that being Indigenous in the health care profession is career-limiting.

Indigenous health workers stressed that the problem of Indigenous-specific racism does not get enough time, attention or resourcing in their organizations. Although everyone knows about the problem, it is not treated the same as other problems. Indigenous health care workers need to continuously push for leadership attention, resourcing, and system change.

“This investigation has ignited change within our health care system. This could not have been possible without the overwhelming participation from patients, family members, communities and health care providers. I hold my hands up to every single person that came forward and spoke out. It is a result of their bravery and courage that for the first time there is a sense of hope for the future. Miigwetch, Marsi, and thank you.”

**~ Dr. Kate Elliott, BSN, MPH, MD,
Minister of Mental Health and Addictions,
Minister of Women and Gender Equity, Provincial Women’s Chair, MNBC**

INDIGENOUS PEOPLES' SURVEY

What we heard

PERCENTAGE

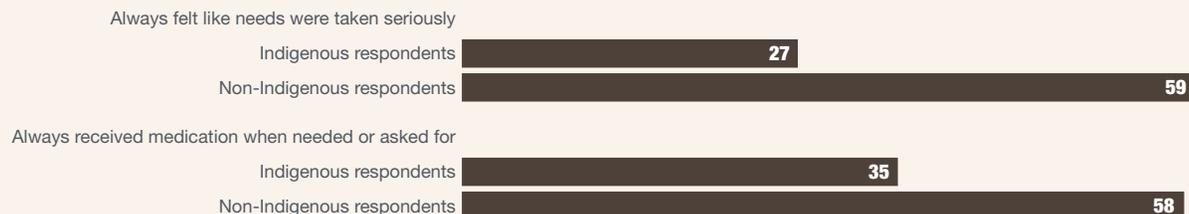
Widespread and ongoing stereotyping and racism leads to discrimination at point of care



Discrimination at point of care negatively affects access to health care



Less access to health care leads to poor outcomes



What did non-Indigenous health care workers tell us?

Over one-third of all non-Indigenous respondents to the HWS reported that they had personally witnessed interpersonal racism or discrimination directed to Indigenous patients, and almost half of non-Indigenous respondents acknowledged its existence in their organizations.

The majority would like to see inclusion of Indigenous practices in patient care plans, including death and dying protocols, birth protocols and smudging or cleansing ceremonies. There is strong support for cultural and institutional changes in health care facilities. There is a need for better quality training for health care workers – training that transfers the learnings to the workplace.

Approximately 13 per cent of – or 531 – non-racialized health care workers made at least one racially antagonistic comment in the survey. Some of these respondents denied that racism exists in the health care system, others believed that Indigenous people need to adapt to the health care system as it currently exists, or expressed other racist sentiments.

What did health care leaders tell us?

Without exception, every health care leader – within government, health authorities, regulators and other health care organizations – acknowledged that racism exists in their organizations and the health care system. They expressed concern about the well-being of Indigenous people and their families. Leaders questioned whether current training and education programs are making any change at the front line, and sought new support and approaches to achieve this result. They welcomed the Review's process and committed to implement recommendations to deal with the problem in their own organizations and professions.

Many leaders noted that the change within their organizations and at the front line must be enabled outside of their organizations, through major structural shifts in processes – such as complaints processes – policies and standards that create the conditions for the eradication of Indigenous-specific racism.

Leaders spoke to their own learning they have garnered from the relationships and partnership processes in place with Indigenous people, communities and organizations, and the need for similar continuing learning journeys to be supported for health care professionals and all British Columbians.

HEALTH CARE WORKERS' SURVEY

What we heard

PERCENTAGE



Findings

Findings 1 to 5 describe the problem of Indigenous-specific racism in the B.C. health care system. This problem has significant impacts for Indigenous patients, women and health care workers. It contributes to inequitable health outcomes, including in the context of the public health emergencies of COVID-19 and the overdose crisis.

Findings 6 to 11 examine the range of efforts underway across the health care system to address the problem of Indigenous-specific racism and support Indigenous human rights. These findings consider the effectiveness of education, training, and complaints processes, and the degree to which major change levers such as “hard-wiring” and accountability mechanisms have been utilized.

Each Finding includes reflections of what the Review heard and observed, as well as conclusions.

1. Widespread Indigenous-specific stereotyping, racism and discrimination exist in the B.C. health care system.

Evidence overwhelmingly indicates that stereotyping and the racist treatment that often accompanies it are common experiences for Indigenous people in B.C. health care.³ In fact, only 16 per cent of Indigenous IPS respondents reported not being discriminated in any of eight factors related to stereotyping, when receiving health care.⁴ More than one-third (35%) of health care worker respondents have personally witnessed interpersonal racism or discrimination inflicted upon Indigenous patients or their families and friends.^{5,6}

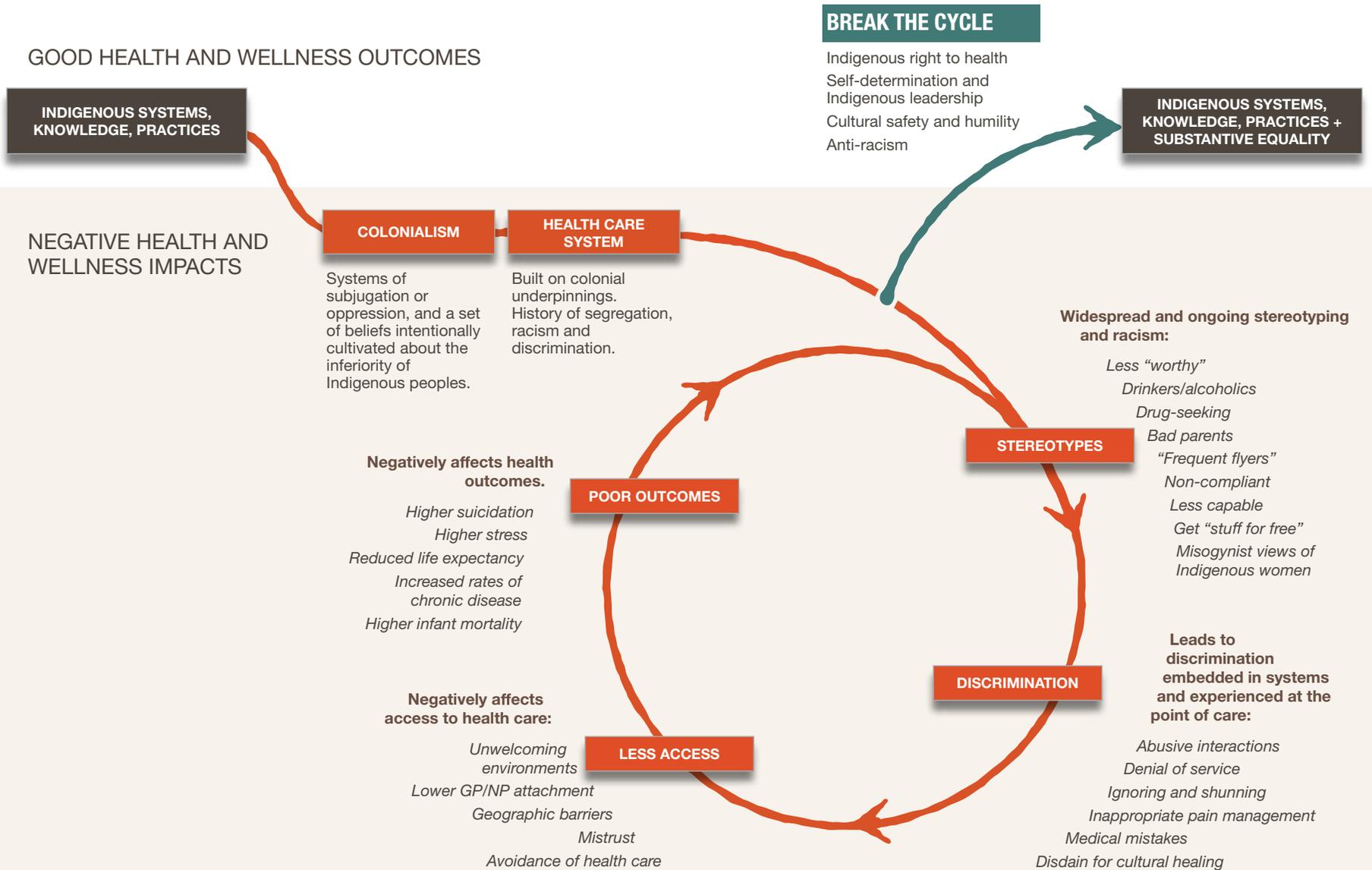
Almost half (48%) of the health care workers and students who made direct submissions to the Review talked about the breadth or systemic nature of

³ The evidence demonstrating the existence of racism and discrimination was consistent across the more than 600 submissions to this Review, the data collected from surveys of health care workers and Indigenous patients, a review of posts made by health care workers participating in San'yas Indigenous Cultural Safety training discussion boards over a 10-year period, and analysis of complaints made to health care organizations and regulators.

⁴ Respondents could choose the top three of the following factors: ancestry or origins, income level, education, sexual orientation, substance use, skin colour, appearance and residence.

⁵ An additional 8% of HWS respondents were unsure whether they had witnessed interpersonal racism or discrimination.

⁶ These findings are not limited to Review-gathered evidence. In the *B.C. First Nations Regional Health Survey* completed in 2017, 31% of respondents said they had personally experienced racism in the B.C. health care system during the previous 12 months. Of complaints submitted by Indigenous people to the Ministry of Health's Patient Safety and Learning System between 2016 and 2020, 43% cited incidents of racism.



the problem, which exists consistently across all regions.⁷ While hospital emergency departments were cited as the most problematic location, racism is reported at all points in the system.⁸ Many informants spoke about the layers of the problem – that it manifests in the direct interactions between health professionals and those seeking their help, as well as in organizational and system-wide functions such as complaints, education, resource allocation and accountability processes.

Reflections

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. Stereotypes lead to “profiles” or fixed assumptions about the character or behaviour of racialized people.

Negative stereotypes about Indigenous people are pervasive in the health care system

One-quarter of non-Indigenous health care workers surveyed reported that incorrect assumptions were “regularly” made about Indigenous patients. A much larger share (43%) of Indigenous health care workers reported that to be the case.⁹ These incorrect assumptions are made on the basis of rampant negative stereotypes about Indigenous people.¹⁰ This kind of stereotyping is consistent with profiling or generating an assumption about the motives and condition of the Indigenous patient.

Common Stereotypes of Indigenous Patients

- **Less “worthy” of care** – Indigenous patients seen as inherently less valuable than non-Indigenous (and particularly white) patients due to a number of generalized, negative perceptions of Indigenous people
- **Drinkers/alcoholics** – Patients presumed by staff to be intoxicated or have a drinking problem
- **Drug-seeking** – Patients requiring pain medication presumed to have ulterior motives (e.g., to obtain prescription drugs to use for non-medical purposes or to sell)
- **Bad parents** – Negative judgments made about the capacity of patients to care for their children
- **“Frequent flyers”** – Patients presumed to be mis-using or over-using the health system, particularly the ED
- **Irresponsible/non-compliers** – Patients seen as unwilling to take responsibility for their health care or to follow through on aftercare instructions
- **Less capable** – Patients seen as lacking the capability to take responsibility for their health care
- **Unfairly advantaged** – Patients seen as “always getting stuff for free”.

⁷ Health care workers from three health authorities reported witnessing racism or discrimination against Indigenous patients at a higher rate than the overall percentage – Northern (52%), Vancouver Coastal (45%) and Vancouver Island (38%).

⁸ 38% of incidents reported in submissions to the Review occurred in EDs, with 17% occurring elsewhere in hospitals. 25% of submissions cited “multiple” health care settings.

⁹ Higher proportions of Indigenous respondents – compared to non-Indigenous, non-racialized respondents – reported that they had “occasionally” or “regularly” witnessed each of nine forms of racism or discrimination examined.

¹⁰ Stereotyping was cited in 45% of analyzed individual submissions to the Review. Two-thirds of San’yas training participants’ postings analyzed described instances of stereotyping. Of 35 complaints to the BC College of Physicians and Surgeons from Indigenous patients between 2014 and 2020, more than 70% could be broadly categorized as involving stereotyping.

Less Worthy” of Care

The most frequently mentioned stereotype among submissions to the Review (27% of the total) was of Indigenous people being considered “less worthy” of health care.¹¹ This stereotype was reflected in a range of prejudicial attitudes and acts that devalued Indigenous personhood, culture, history and experiences.

Racist Treatment After Surgeries Leaves Woman Fearing Hospitals

Within the last two years, an Indigenous woman from a remote community has twice travelled to a Lower Mainland hospital to undergo surgery for brain aneurysms. On both occasions, she has experienced racist treatment from the recovery room nurses.

The woman describes waking up from the first surgery in 2018 feeling very unwell, needing to vomit but with dry heaves. She recalls one of the nurses yelling at her across the recovery room: “You’re going through withdrawal; it’s from all alcohol you people drink; you’ll have to wait for your booze.” She says she was subsequently moved for three days to a different room, where she got no nursing assistance.

The same thing happened in the recovery room in 2019, where she came to feeling very sick and dry heaving. Once again, a nurse made reference to alcohol, suggesting she was going through withdrawal with the comment: “You people drink too much.”

The woman hadn’t been drinking before either surgery and wonders if she was having a reaction to the drugs used to sedate her. The woman inquired about getting help from an Aboriginal Health worker but was told none were available and no one advised her about the patient complaint process. Complaints to her surgeon went unanswered.

These experiences have left the woman so fearful that she plans to refuse any future surgeries. She feels the risk to her safety is higher attending this hospital than it would be living with an aneurysm. She says she was treated in a way no human being should be treated and is frightened that the lack of treatment could result in her dying.

Submissions by patients, family members, health care workers and third-party witnesses recounted patients being treated poorly simply because they are Indigenous. Comments and actions attributed to health care providers suggested Indigenous patients were perceived as a homogenous group that was less entitled to care and respect, including describing or treating Indigenous peoples as living in poverty, being dirty, sexually promiscuous and inclined to criminal behaviour. 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. Other data sources also revealed that Indigenous patients living in Indigenous communities was viewed as inherently problematic.¹²

¹¹ Being considered “less worthy” was mentioned in 59% of the submissions to the Review that specifically discussed stereotyping. 41% of San’yas ICS discussion board postings mentioned this stereotype.

¹² 9% of Indigenous respondents to the IPS reported that they faced discrimination based on where they live. San’yas participants also cited this as a common stereotype.

Drinkers/Alcoholics or Drug-seekers

Negative assumptions about Indigenous patients often centre on drug or alcohol use.¹³ More than one-quarter (26%) of Indigenous IPS respondents reported “always” being treated as if they are drunk or being asked about substance use when accessing health care, compared to only five per cent of non-Indigenous respondents.

Submissions to the Review described situations in which Indigenous patients were assumed to be drunk when their presentation was due to other medical causes, something they said often led to their needs going unassessed or untreated. They reported that the first, sometimes repeated, and often unwarranted, question from health care workers was: “How much have you had to drink?” This treatment sometimes persisted despite the patient in question insisting on having never drunk alcohol or having not had a drink in many years.

Inappropriate Questions Lead to “Horrible” Experience for Young Girl

An Indigenous mother recently called 9-1-1 after her 11-year-old daughter experienced a seizure. The daughter has epilepsy and her mother didn't realize that she had stopped taking her medication.

Once at the hospital, a nurse asked if the pre-teen had been consuming alcohol or drugs, to which the mother replied no. This question was asked again by at least three additional nurses and a doctor. She felt that this questioning was highly inappropriate given her daughter's age and the fact she is epileptic and was clearly having a seizure.

The mother was advised by a nurse that these questions were “protocol.” She waited for nearly five hours before a doctor arrived to examine her daughter. Eventually, with no further communication from the staff, they left the hospital. The mother describes the experience for her daughter as “horrible”.

Suspected illicit drug use and unwarranted seeking of prescription drugs for non-medical reasons were other reported stereotypical behaviours assigned to Indigenous patients, some of whom also reported receiving inappropriate and repeated questions about their drug use.¹⁴

“I'm sad to say that I experienced racial stereotyping... I was made to feel ashamed and they did not believe that I had food poisoning but in fact [that I] was just wasted. I was so sick I could barely keep my head up but understood the stigma I was experiencing. I felt judged and mistreated. I left feeling shame...”

~ First Nations woman who attended hospital with severe case of food poisoning

¹³ Indigenous respondents to the IPS were five times more likely than non-Indigenous respondents to report that health staff “always” make assumptions about their drug or alcohol use. 22% of all submissions to the Review talked about patients being stereotyped as alcoholics or drug users/seekers.

¹⁴ 11% of individual submissions to the Review mentioned the stereotype of “drug-seeker”, the third most-mentioned stereotype among submissions.

“Frequent flyers”

“Frequent flyer” is a derogatory stereotype of people believed to be mis-using or over-using the system by, for example, attending the ED rather than using primary care, attending the ED when the injury or illness doesn’t warrant it, or using the hospital as a ‘place to stay’.¹⁵

Multiple IPS respondents mentioned they had overheard themselves being referred to as “frequent flyers” among health care workers, a common phrase utilized by participants in the San’yas program. Other similar terms were also used such as “regular”, “drunk Indians”, “St. Paul’s Special”, and “drug-seeking”. Problematizing people who use hospital services on a regular basis frequently recurred in data examined by the Review, with phrases being used such as “oh no, not again”, “they do that to themselves” and “that’s just what they are like – they won’t change”.

“I have [an Indigenous] client who went to an Emergency Department every day for almost two weeks feeling like they were having seizures or passing out. The client was turned away every day for two weeks. Once they were finally admitted to the hospital, it was found that their ICD [Implantable Cardioverter-defibrillator] was actually completely malfunctioning and was defibrillating them every day, sometimes multiple times in one day. This client was turned away so many times and I have heard people refer to them as a ‘frequent flyer’... This person should have never been turned away from the hospital, even once, let alone multiple times.”

~ Registered nurse who made a submission to the Review

Irresponsible/Incapable

Stereotypes of Indigenous patients being irresponsible, lazy or incapable, and thus non-compliant with treatment or medical advice and unable or unwilling to attend appointments on time, were also common. Indigenous people were often seen by health care workers as “non-compliant” or “difficult”.¹⁶ In a number of examples provided, these stereotypes informed decisions by health workers not to “waste time” by referring Indigenous patients on for further treatment or specialist services.

¹⁵ Submissions to the Review, IPS survey respondents and San’yas participants all included some version of the “frequent flyer” stereotype.

¹⁶ 14% of the San’yas data analyzed referenced this category of stereotype, including characterizations of Indigenous patients as lazy, incapable of being on time, not caring about or taking poor care of their health; having no self-control or accountability, being non-compliant and wasting resources.

“Bad” Parents

Another common stereotype is that Indigenous people are inadequate, neglectful or undeserving parents. Fourteen per cent of Indigenous IPS respondents reported “*always*” being treated as though they are bad parents with another 45 per cent saying that this happens to them “*rarely or sometimes*”.¹⁷

The “bad parent” stereotype was the fourth-most commonly cited in individual submissions to the Review, mentioned in 12 per cent of those that discussed stereotypes. Submissions by both patients and health care workers were explicit that social workers and child welfare authorities often became involved in cases for no reason other than that the patient was Indigenous.

Unfairly Advantaged

Review data sources revealed a common belief that Indigenous people “*get things for free*”, including education, taxation and medication. This is connected to the idea that Indigenous people are believed to be somehow less deserving of further support from health care workers.

“It was disheartening to read so many stories of mistreatment that Métis and other Indigenous people experienced in the health care system. Emergency Rooms and hospitals are places people go as a last resort. Hearing that Métis people were reluctant or afraid to seek out care when they needed it most shows deep-rooted problems in the system. This report is an important first step in recognizing that change needs to happen so that Métis people in B.C. can have equity in treatment within our health care system and receive the same level of care other British Columbians are afforded. I am hopeful the B.C. government will work quickly to implement the recommendations and work with the Métis Nation in addressing these profound concerns.”

~ Paulette Flamond,
MNBC Minister of Health, Northeast Regional Director

Indigenous people experience harm and poorer quality of care as a result of stereotyping

Negative stereotyping and profiling leads to discriminatory behaviour by health workers and poorer quality of care for Indigenous peoples. Indigenous respondents to the IPS were 2 to 2 ½ times more likely than non-Indigenous respondents to report “*always*” having adverse experiences across nine subjective care experience categories. In the Patient Reported Experience

¹⁷ Indigenous IPS respondents were seven times more likely than non-Indigenous respondents to report staff “*always*” treating them as if they are bad parents.

Instead of Cultural Safety, Family got Reported to MCFD

In 2017, a six-year-old Indigenous child was attending therapy sessions as part of the pediatric social work program at a B.C. hospital. The therapy was to support the child to deal with a range of matters, including suicidal thoughts, as well as tantrums, including those that have physical behaviours. These behaviours were intensifying as a result of the child's sibling dealing with a life-threatening illness.

At the commencement of the therapy sessions, the child's mother informed the counsellor about the child's Indigenous heritage, culture and identity, and the importance of these factors to the child's health and well-being. The family emphasized a need for culturally informed and culturally safe practice. The mother remembers being struck at the time by the fact the counsellor did not seem responsive to – or inquiring about – these factors and did not outwardly appear to take them seriously.

Based on the account of the child at the time, during a therapy session the child recounted to the counsellor about some of the tantrums, and how he would have to sometimes be physically restrained to stop hurting himself or others. As part of explaining this to the counsellor, he stated that his father had to “choke him” – which the parents explain was a reference to the father having to grab him around his shirt to stop the child from being physically violent.

After a session, the therapist called the parents and indicated that she was reporting them to the Ministry of Children and Family Development and also that she was going on holiday. According to the parents, no other explanation or information was provided, and what the child had said that precipitated this action was not recounted. The only information they received was from their child.

During the subsequent investigation, the parents never felt the observations, concerns or accusations of the counsellor were ever made clear to them, and that they were presumed guilty throughout the process. While the investigation was ended and the file was ultimately closed, including through the intervention of lawyers and advocates, the end result was that the family, even to this day, has sought less help for their child than they feel he may need. As well, because of lack of trust and the trauma that no care for their other child's life-threatening illness could occur at the same hospital, they have had to arrange and travel a considerable distance on a regular basis since then. This has been a major strain and burden for a critically ill child, as well as the entire family.

The parents did file a complaint to the Patient Care Quality Office. In its review of the matter, the PCQO stated: *“We are actively pursuing improvements related to the concerns you have raised. In particular, we will be working to support our teams in being better equipped to embed culturally safe practices in all that we do, and to reach out to families to better understand their needs and desires related to culturally appropriate care.”*

Measures Survey (PREMS), across all regions and measures, self-identified Aboriginal patients tended to rate “patient experience” measures – receiving timely care, communication with providers, culturally responsive and compassionate care, and how well continuity across transitions in care is managed – lower than non-Aboriginal patients.¹⁸

¹⁸ The recent PREMS survey analysis by the FNHA showed significant differences between Indigenous and non-Indigenous patients accessing the ED and acute care. Four areas of “patient experience” were found to drive overall experience ratings in EDs – receiving timely care, communications with providers, culturally responsive and compassionate care, and how well continuity across transitions in care is managed. (Comparable across regions with some exceptions such as timely care and continuity across transitions in VCHA, culturally responsive care in FHA). [First Nations Health Authority, 2019a. Evaluation of the British Columbia Tripartite Framework Agreement on First Nation Health Governance].

Forms of Discriminatory Treatment and Poorer Quality Care

- Unacceptable personal interactions
- Long wait times/ denial of service
- Lack of communication / shunning
- Not believing / minimizing concerns
- Inappropriate/no pain management
- Rough treatment
- Medical mistakes
- Lack of recognition/ respect regarding cultural protocols

Unacceptable Personal Interactions

Only 28 per cent of Indigenous IPS respondents reported that they are “always” treated with courtesy and respect when accessing health care, and 24 per cent said that health care workers “always” treat them as dishonest. “Cold” or “harsh” treatment of Indigenous patients by health care workers was reported in 10 per cent of submissions to the Review, describing interactions lacking in compassion, caring or humanity.

Nearly half of the non-Indigenous health care workers surveyed said that health care workers made disrespectful, disparaging or joking remarks about Indigenous patients’ cultures or racial identities.¹⁹ Indigenous health care workers described these behaviours as being much more common, with 26 per cent reporting that such racist comments were made “regularly” and 46 per cent saying they were made “occasionally”.

Thirty-eight per cent of submissions to the Review described examples of these very types of interactions. These included health care workers making rude or racist comments directly to Indigenous patients or such comments being overheard by family members, other patients or other health care workers.

Twenty-two per cent of submissions described health workers being verbally abusive – including directing rude or racist comments at patients; mocking, laughing or yelling at them; and sharing their information loudly.

A review of formal complaints made about doctors, nurses and midwives²⁰ shows that roughly half such complaints involved problematic interactions with these professionals. Such interactions with physicians also included Indigenous patients being subject to rude or racist comments, being yelled or laughed at, and having personal information shared inappropriately. Complaints about nurses and midwives included registrants treating patients with a disrespectful attitude, yelling, lying or making inappropriate or racist comments. San’yas participants described health care staff as sometimes laughing at Indigenous patients, with their comments accompanied by disrespectful gestures such as eye-rolling.

¹⁹ Indigenous respondents cited this happening “occasionally” (40%) or “regularly” (9%).

²⁰ 46% of complaints by Indigenous patients to the BC College of Physicians and Surgeons referenced problematic interactions with professionals while 49% of Indigenous complaints to the BC College of Nurses & Midwives referenced problematic interactions with members of that College.

Non-Indigenous Witness Recalls Terrible Treatment of Patient

A non-Indigenous woman remains troubled by something she witnessed while a patient in a hospital ED. She recalls that an Indigenous man in his 40s arrived in the ER via ambulance. He was calm and quiet as he lay on the gurney that the accompanying paramedic had placed in front of the nursing station.

The paramedic turned her back on the man and proceeded to chat with two nurses. At one point during the conversation, the paramedic walked over to the Indigenous man and lifted up his shirt, remarking to the nurses that the man had a large scar – the result of a stabbing incident that had occurred in Vancouver.

The witness says both the paramedic and the nurses then ignored the man while they continued their conversation. Within the course of 15 minutes, the Indigenous man asked twice very politely if someone could help him get to the bathroom. The nurses and paramedic continued to ignore him. The man urinated while lying on the gurney and, when the paramedic turned around and noticed, she yelled at him for “*pissing his pants*” before taking him away.

Long Wait Times/Denial of Service

Lengthy wait times and accounts of Indigenous patients being made to wait while non-Indigenous patients were seen ahead of them was another common theme in surveys and submissions. Of non-Indigenous health care workers surveyed, 43 per cent reported that Indigenous patients were ignored or made to wait longer than necessary either “*regularly*” (12%) or “*occasionally*” (32%). More than three-quarters of Indigenous health care workers (77%) reported that Indigenous patients received this treatment either “*regularly*” (30%) or “*occasionally*” (47%). Similarly, Indigenous patients reported to the Review that they had been deliberately responded to slowly or “*put to the bottom of the wait list*” and been made to wait while non-Indigenous patients were seen first. Others described being left to wait alone, in empty rooms or away from others.²¹

Nearly one-quarter (23%) of Indigenous IPS participants reported “*always*” receiving poorer service than others. In submissions to the Review, Indigenous patients reported a failure to meet their basic needs, including incidents in which health care workers did not provide them with adequate food or liquids, ignored their bathroom and hygiene requirements, and left them without clothing or blankets.

²¹ 16% of individual submissions to the Review included mention of being made to wait and 9% of these respondents described receiving demonstrably different treatment than non-Indigenous patients. However, in a review of 30 EDs where the average time to physician assessment was monitored by size of the hospital, age group of the patient and level of acuity, the results were mixed. The First Nations average time to assessment in some hospital groups and age groups was higher than that of Other Residents (e.g., adults in medium-sized hospitals seeking non-urgent care) and in other age group/hospital type/triage level groupings, the First Nations average time was lower. No overall trend could be established.

“I have seen the symptoms of an Indigenous patient go untreated for days despite the concerns voiced by our unit physiotherapist, resulting in this patient having a stroke.”

~ Hospital social worker who contacted the Review

One important component of a good care experience is a patient understanding the issue that brought them to seek care. In the IPS, 66 per cent of Indigenous respondents felt they received a proper diagnosis in the health system only “rarely” or “sometimes,” and five per cent said they “never” did. A similar pattern of responses was received when respondents were asked if they had received a proper referral.²² This is confirmed in a review of health system data, which demonstrates that Indigenous patients presenting to EDs received a diagnosis of “general signs and symptoms” at an 80 per cent higher rate than other patients in 2017/18.²³

Lack of Communication/Shunning

Only 28 per cent of Indigenous respondents to the IPS said they felt included in their care decisions, compared to 54 per cent of non-Indigenous respondents. San’yas participants said that health care workers may “*subtly disengage*” with Indigenous patients in a number of ways, including talking to the person accompanying the Indigenous patient rather than the patient themselves, and trying less hard to engage Indigenous patients in care discussions.

Several San’yas participants reflected on the ways in which stereotypes of Indigenous patients being reluctant, mistrustful or non-compliant made them reduce their efforts to reach out. Others discussed situations in which health care providers failed to give appropriate information to Indigenous patients, such as not properly explaining health care procedures or proceeding without informed consent. A number of submissions to the Review described being unable to contact Indigenous health liaisons and health care staff failing to advise them of complaint options and procedures.

In Review submissions, patients spoke of various other ways in which they had been “*shut out*” of care – from being physically locked out of buildings, to being sent home without assessment, treatment or planning, leaving them to make repeated attempts to access care. Additionally, 22 per cent of Indigenous IPS respondents said they “*never*” have received a thorough discharge process.²⁴ This finding was validated in the HWS, where 42 per cent of Indigenous

²² 8% of Indigenous IPS respondents reported they “*never*” receive a proper referral, while 56% said they “*rarely or sometimes*” did.

²³ FNHA (Health System Matrix) 2020. 14.1% First Nations; 7.9% Other Residents.

²⁴ Premature discharge was “regularly” experienced or witnessed by 30% of Indigenous IPS respondents.

health care workers and 20 per cent of non-Indigenous workers reported that Indigenous patients were “regularly” discharged without proper support. A significant number of health care workers also reported that Indigenous patients were discharged without consideration for the living condition that they were returning to.²⁵

Not Believing Patients/Minimizing Concerns

Seventy-four per cent of Indigenous respondents to the IPS reported that their concerns have been minimized in the health care environment.²⁶ Submissions to the Review on this same theme described this at times as a passive act – a failure to listen to them or take them seriously – while others described it as a more aggressive one, such as being accused of “faking” or being manipulative. Formal complaints about interactions with physicians included accounts of not being listened to or believed, and of being met with dismissive or uncaring attitudes.²⁷

Rough Treatment/Physical Harm

Indigenous patients also reported that some health care workers showed “disrespect” for their bodies. Seven per cent of submissions to the Review describe patients being physically manhandled or treated roughly, particularly when it came to procedures such as drawing blood or inserting an IV needle. Eight per cent of Review submissions included accounts of patients who were physically harmed as a result of the care they received. These interactions were described as inducing chronic pain and broken bones, brain injuries and excessive scarring.

Formal complaints examined by the Review included patients being physically or sexually assaulted, treated roughly and having their hair cut without consent.²⁸

One Elder vividly described feeling the “angry hands” of health care workers over her lifetime.

~ Indigenous woman’s submission to the Review

²⁵ 40% of Indigenous HWS respondents and 23% of non-Indigenous respondents believed this to “regularly” be the case.

²⁶ 12% of Indigenous respondents to the IPS felt like their needs were “never” taken seriously while another 62% said their needs were taken seriously only “rarely or sometimes.” Further, 9% of individual submissions to the Review mentioned health care providers not believing them or their family members and of minimizing their concerns, opinions or choices regarding health care.

²⁷ BC College of Physicians and Surgeons complaint data.

²⁸ BC College of Nurses & Midwives complaint data.

“They Just Thought I Was a Drunk”

One evening in February 2019, a 57-year-old Indigenous man fell while walking to the bathroom in his home. It was nearly midnight and he realized that he was badly hurt, so he called an ambulance to take him to the nearest hospital, where he was x-rayed. Nurses subsequently informed the man that there was “*nothing wrong*” with him and that he had to go home. He protested, insisting he was certain that he was injured and couldn’t walk, particularly since he had left the cane he used – due to a pre-existing spinal condition – at home.

He says two nurses – a male and a female – treated him poorly and made fun of him. “*They just thought I was a drunk.*” Eventually, as the argument with nurses continued, security was called, followed by the police. The man was ultimately arrested and taken to jail for the night.

The next morning, he was released from jail but he was still in pain and couldn’t walk. The man was taken by ambulance back to the same hospital where, this time, he was diagnosed with two cracks in his pelvis. He recalls one of the same nurses commenting sarcastically: “*Well, you were able to walk out of here last night.*”

Medical Mistakes

Medical mistakes and misdiagnoses of patients were cited in 16 per cent of the submissions to the Review and commonly discussed amongst San’yas participants. This was mentioned most often in relation to falls – in examples of failure to diagnose concussions, tumors 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 reported to be missed in the medical treatment of a number of patients or misattributed to alcohol use. Stereotyping was identified as the cause of symptoms of stroke and diabetes being misinterpreted, and seizure-inducing conditions, such as brain haemorrhage and Parkinson’s disease, being missed. In several accounts, patients who were conscious or semi-conscious were mistakenly assumed to be drunk or high and their medical needs left unattended.

Inappropriate Pain Management

Patients described various ways in which their pain had been ignored or minimized.²⁹ At times, pain was acknowledged but treatment was withheld, sometimes with an explicit reference to the stereotype that Indigenous people were drug-seeking or somehow felt pain differently. At other times, the pain management offered was simply ineffective.

Nearly one-fifth (19%) of non-Indigenous health care workers surveyed said they had witnessed Indigenous patients being denied needed medication either “*occasionally*” or “*regularly*”. Indigenous workers reported this to be much more common, with nearly half (49%) reporting that such denial of medication occurred “*regularly*” (19%) or “*occasionally*” (30%).

²⁹ 14% of individual submissions to the Review cited incidents of pain of Indigenous patients being ignored or minimized.

More than 10 per cent of Indigenous IPS respondents reported experiencing or witnessing poor or insufficient care 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 pain medication. This appeared as an issue that affects women in particular, with only 31 per cent of female IPS respondents reporting that they “*always*” receive medication, including pain medication, when needed or requested.

“I Do Not Want to be Treated Like Pieces of Garbage When I go to Get Help”

A First Nations woman in her 50s, living in Vancouver’s Downtown Eastside, told the Review about her recent experience when, after going to the hospital for a COVID-19 assessment, she was mistakenly assessed as suicidal and temporarily detained under the Mental Health Act. She said she was held involuntarily, and police were called to watch over her, simply because she was frightened of the virus and given her previous adverse experiences with racism.

The woman, who has recently been working as an advocate for Indigenous women in her neighbourhood, has become deeply afraid of going to the Emergency Department to seek care because of past traumatic experiences in more than one hospital. She told the Review that the only time she has been able to get respectful treatment, and not be assumed to be drunk or high or subject to racism, was when she had a non-Indigenous friend accompany her as an advocate and support person. This was the only time she felt safe, with health care staff focusing on her medical conditions and not on stereotypes of addictions and judgments about her past.

The woman is dealing with a range of health care issues including a seizure disorder, making it necessary for her to seek emergency care on a regular basis. She believes there is something in her file that flags her as a ‘problem’ and that health care workers pre-judge her as an addict or somehow at fault for her medical conditions. *“I do not want to be treated like pieces of garbage when I go to get help,”* she said. *“We don’t deserve this. On the street, these hospitals are called the Death Hospitals because of the bad service and because they throw you back out on the street without any help.”*

Since the pandemic began, some of her health conditions have worsened as services are not open or easy to access for somebody without transportation. She is concerned about being discharged in the middle of the night in a cab into a dangerous neighbourhood – something that has happened to her on previous visits to the ED.

Lack of Recognition and Respect for Cultural Values, Protocols or Traditional Medicines

The second biggest health care issue cited by Indigenous IPS respondents was a lack of respect for their cultural and traditional healing practices, with 33 per cent reporting that health care workers are “*never*” open to hearing about traditional medicine, and 30 per cent reporting that their cultural

traditions were “never” appreciated by health care workers.³⁰ This is consistent with the outcomes of the HWS, through which more than half of Indigenous respondents said that Indigenous patients’ requests for cultural protocols, such as surrounding birth and death, were “regularly” or “occasionally” denied.

Twenty-six per cent of non-Indigenous respondents also reported that such requests were denied.³¹

Seven per cent of patients and family members who made submissions to the Review cited examples of health care workers failing to recognize or value the importance of family or cultural ceremony and protocols such as smudging, drumming, song, history, languages, names and hair care for Indigenous patients. Similarly, complainants made by Indigenous patients and families described health providers specifically denying that culture had any role in their care, and of being prevented from, or demeaned for, participating in ceremony, dance and other cultural practices, as well as being prevented from visiting and being shut out of information-sharing and planning.

“The overall tone of what I can only describe as ‘disdain’ that was shown to my family day in and day out for taking up space in the hospital. The glances, the glares, the apathy was heavily noted by many of us, as it seemed they would prefer that we not be there... Throughout watching the head of our family die, we maintained our dignity, decorum and ensured that we were respectful of all rules and policies, and with all of this ‘on our side’ we were still met with indifference, intolerance and discrimination.”

~ First Nations woman, describing her family's experience in ICU before her father's death

³⁰ This is supported by self-identified Aboriginal participants in the PREMS. Across all regions and in both hospital and ED settings, self-identified Aboriginal patients less often reported that their care providers were respectful of their culture and traditions than non-self-identified Aboriginal patients. Data used from two PREMS survey cycles: ED – randomly selected individuals who utilized one of 108 EDs across B.C. between January and March 2018. More than 14,000 or 35.9% of all eligible respondents participated. The survey included 1,246 self-identified as Aboriginal. Acute care – randomly selected individuals who were discharged from one of 78 acute care hospitals and two freestanding rehab facilities in B.C. between September 2016 and March 2017. The survey included 24,000 respondents or 46.9% of eligible respondents participated, of which 865 self-identified as Aboriginal. [FNHA 2019a]

³¹ Fifty-nine per cent of Indigenous health care workers said such requests were either “regularly” (27%) or “occasionally” (32%) denied. Non-Indigenous respondents said cultural requests were either “regularly” (6%) or “occasionally” (20%) denied.

Stereotyping and discrimination lead to mistrust and avoidance of the health care system by Indigenous people, and anticipatory behaviours and strategies to avoid discriminatory treatment

The experience of receiving discriminatory treatment instills mistrust of health care, and anticipatory behaviours and strategies to avoid discriminatory treatment.

Fear/Lack of Trust in Health Care Workers and the Medical System

Among Indigenous IPS respondents, lack of trust in doctors and the medical system was the third biggest issue in health care. Indigenous IPS respondents were significantly more likely to report feeling unsafe when accessing health care than non-Indigenous people. They were most likely to report feeling “not at all safe” in institution-like settings such as hospitals, specifically emergency departments, and assisted living facilities. More than one in five Indigenous respondents were likely to feel “not at all safe” when interacting with hospital social workers and security staff, and when using mental health or substance use services and discharge planning services. Indigenous respondents were significantly more likely to report that providers never want to work with or provide quality, safe care for them.

Responses to Discriminatory Treatment

- Fear/Lack of trust in doctors and the medical system
- Prove ‘worth’ as a patient
- Hide Indigeneity or bring along a non-Indigenous person or any ‘witness’ as an advocate
- Leaving a health facility against medical advice
- Avoidance of health care

Need to Prove Being ‘Worthy’ of Care or to Hide Indigeneity

Some patients talked about their experiences leaving them with a feeling that they needed to prove themselves to health care workers as being ‘worthy’ of care.³² This included feeling the need to ensure they are well-dressed before they attend an emergency department, or feeling like they have to bring a non-Indigenous person with them in order to be treated properly by medical staff. Some patients described scenarios in which they were able to access appropriate care only after a non-Indigenous person intervened on their behalf.

“I am afraid to go to any hospital. When I do have to, I dress up like I’m going to church [in order to receive proper treatment] It’s ridiculous.”

~ Young Indigenous woman who reported being treated with contempt and not receiving the care she needed in the ER after being violently assaulted

³² Individual submissions to the Review.

Leaving Against Medical Advice/Avoidance of Health Care

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.³³

“After the third time, we gave up and I just started taking the kids to every appointment because I am a white male and got better service. Sad, but reality.”

~ Non-Indigenous man whose family gets better treatment when he accompanies them to health care instead of his wife, who is First Nations

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 was 3.7 per cent; compared to a 1.4 per cent rate for other patients.^{34,35}

Another byproduct of racism in the health care system is the potential for Indigenous people to avoid seeking health care in the future after having a negative experience. This was mentioned in eight per cent of the direct submissions to the Review.

“I avoid the hospital at all costs because as an indigenous person I feel unsafe and feel like they won’t bother treating me.”

~ First Nations man who presented in hospital with a head injury but was presumed to be drunk and discharged to walk home alone

³³ 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

³⁴ FNHA (opioid). 2020. Analysis on a large provincial cohort of First Nations (65% random sample) and Other Residents (20% random sample) between 2015 and 2018.

³⁵ Opioid related admissions are a small subset of total admissions. LAMA findings were similar for opioid related admissions; however, the difference between First Nations and Other Residents was not as large.

“Because of how he was treated in both hospitals, he refused to go back”

A young Indigenous man who was living with HIV, became very ill and went to the ED at the hospital near his home community in 2016. He was slurring his speech, seeing flashing lights and exhibiting stroke-like symptoms. Staff at this first hospital asked how much he'd had to drink, what drugs he was on, and if he was looking for opioids, but his aunt said the young man was offered no help. As he was extremely ill, he attended another nearby hospital, where she said he was also refused treatment and asked similar questions.

“He was very afraid and was very frustrated and scared,” she said. “Because of how he was treated in both hospitals, he refused to go back to the hospital.”

The nephew's father lives with HIV, and took his son along with him to one of his regular appointments at another hospital. The doctor there advised the young man to go straight to a hospital in Vancouver. But it was too late. He died six weeks later.

Conclusions

The Review presents the following conclusions about Indigenous-specific stereotyping, racism, profiling and discrimination in the B.C. health care system. These are intentionally broad, as these matters are discussed in greater detail in subsequent Findings.

- Racist stereotypes of Indigenous people spring from the existing roots of colonial attitudes and beliefs that underpin the health care system, and cause harm and suffering to Indigenous peoples. All forms of racism experienced by Indigenous peoples leads to avoidance of care in large part because Indigenous people seek to avoid being stereotyped, profiled, belittled and exposed to prejudice.
- This pervasive mindset of misinformed and prejudiced beliefs about the inferiority of Indigenous peoples exists across all regions and health care settings, meaning that this is a systemic problem that requires systemic and multi-layered solutions.
- Racist commentary and behaviour towards Indigenous patients is tolerated in health care environments. Neither Indigenous patients nor health care workers have safe pathways for disclosure and resolution.
- There is limited public education and awareness of the history of colonialism in health care and its present-day impacts.
- There is limited public education and awareness of racism, and a lack of accessible anti-racism tools for health care workers, particularly in relation to tools to expose and eradicate anti-Indigenous racism.

Family Searching for Answers After Lengthy Mental Health Detention

In late-June 2020, 23-year-old Canadian Armed Forces member Connor Sutton³⁶ was on leave to attend a funeral on Vancouver Island. The member of the T'Sou-ke Nation was temporarily staying in Maple Bay, near Duncan.

Mr. Sutton began to experience chest pains, as well as nausea, vomiting, speech difficulties, shortness of breath and disorientation, which led him to drive to the Cowichan District Hospital ER. He was admitted to the hospital for the night. Staff eventually determined that a hole in his esophagus was causing the chest pains and related symptoms. He was treated and discharged with antibiotics.

The following day, Mr. Sutton was experiencing the same symptoms, along with significant mental distress. That evening, he again visited the Cowichan hospital and begged to be admitted. He recalls that hospital staff refused to admit him and instead told him to find a homeless shelter, at which point he left. Mr. Sutton returned later that evening in a second attempt to be admitted, however a dispute ensued, a security guard was called and restrained Mr. Sutton against a wall. Mr. Sutton says he hit the security guard in self-defence and exited to the parking lot. Following this, he says he was tackled by multiple security guards, resulting in the RCMP becoming involved and briefly detaining him in cells prior to releasing him to his father's custody without charges.

The following evening, Mr. Sutton's father drove him to the ER at the Royal Jubilee Hospital in Victoria, where he was admitted. It is unclear why, but Mr. Sutton was moved from his admission unit to the Psychiatric ICU five days after he was initially admitted. Ten days later, Mr. Sutton was transferred once again to 2NW (schizophrenia services) in Adult Mental Health. The Sutton family recalls that nurses in the hospital relayed that the psychiatrist had labelled him as a *"highly trained military weapon"* and indicated that he may be dangerous.

Once Mr. Sutton was transferred permanently to 2NW, his family members found it almost impossible to speak with him. They say they were not given a diagnosis, provided updates on his condition, his medications, nor the reasoning for his move from the Cardiac Unit to the Psychiatric Unit and subsequent move to 2NW. The family believes he was heavily drugged during this period.

In an effort to understand why Mr. Sutton had been detained and after he had been alone in hospital for nearly a month, the family pushed for a psychiatric hearing. It is their recollection that, by this point, he was not certified/committed by the Authority, and they feel the doctors were intentionally misleading about his status. Three days prior to the hearing date, the hearing was cancelled and, according to correspondence from the Mental Health Review Board, Mr. Sutton had been decertified. The family says they were told it could be three months before a second hearing could be booked.

In addition to media coverage and a rally for Mr. Sutton, the Canadian Forces became involved and provided a full-time member to be with him until the situation resolved itself. Mr. Sutton was eventually released into the care of the Canadian Forces out of CFB Esquimalt, with the Forces assuming responsibility for his care.

Mr. Sutton and his family are worried that if he has similar physical symptoms in the future, he will not seek treatment due to his negative experiences. The family has retained legal council and is trying to understand which medical decisions were made and when.

While the family has spoken with VIHA leadership, they are still struggling to access the case notes, charts and physicians' orders that led to Mr. Sutton being shuffled out of Cardiac ICU and into Psychiatric ICU. The family notes that the Indigenous liaison they worked with was great, but they felt the liaison had no real power to help them find answers. They feel they were treated as second-class citizens by facility medical staff.

³⁶ Unlike other submissions featured in this report, the Review is using Mr. Sutton's name as his case has already been widely reported on in the media.

2. Racism limits access to medical treatment and negatively affects the health and wellness of Indigenous peoples in B.C.

Finding 1 demonstrates a profound level of concern voiced by Indigenous peoples about racism, prejudice and the absence of their cultural safety in health care settings. While these concerns exist in varying degrees in all populations, they are magnified for Indigenous peoples due to the history of colonialism and the increased experiences of trauma and violence. Racism and stereotypes specifically target Indigenous peoples. The Interpersonal racism contributes to less accessible and responsive health care. This is compounded by structural racism, including continued socio-economic inequities and the geographic reality of many Indigenous communities which were forced onto small *Indian Act* reserves. The result of these compounding factors is continued gaps in services and inequitable health outcomes. Additionally, the very experience of racism is associated with lower health and well-being, particularly in relation to trauma and mental stress.

One goal of the Review was to collect data that explores connections between racism, reduced access to health care, ill health, and health outcomes. What was learned from the data analysis is that while explicit colonial policies that undermined quality care for Indigenous peoples may no longer be on the books, the extent of Indigenous-specific racism today in the health care system continues similar, enduring, harmful beliefs and has negative impacts on Indigenous peoples' health and well-being.

Reflections

An extensive First Nations survey has described the profound effects of racism on health and well-being

The connection between racism and lower health and well-being was well-documented before this Review. Racism tends to precede ill-health rather than vice-versa, and does so in both mental ill-health and physical disease.^{37,38} This relationship has been explored in the first, and only, national First Nations health survey of its kind, the *BC First Nations Regional Health Survey*³⁹ (RHS), which periodically collects wide-ranging information about First Nations on reserve and Northern communities based on western and Traditional understandings

³⁷ Paradies YC and J Cunningham (2012). The DRUID study: racism and self-assessed health status in an Indigenous population. *BMC Public Health* 2012, 12:131.

³⁸ 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>

³⁹ FNHA. 2019b. *BC First Nations Regional Health Survey, 2015-17*.

of health and well-being. Examination of the *RHS* has demonstrated this same connection between the experiences of racism and many other determinants of health.^{40,41}

In the most recent round of the *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. This section provides a summary of the associations highlighted in the *RHS* analysis linking the question on racism to a variety of health and social measures.⁴²

Distress and stress were associated with experiences of racism

In the *RHS* data, stress⁴³ showed a strong association with a previous racist experience. Respondents were asked about the level of stress they experienced on most days. Individuals who answered yes to experiencing racism were more likely to respond that they were stressed than the persons who said they had not experienced racism. The largest gap between the 'yes' and 'no' respondents was seen in those who were extremely stressed – in this group, over two times as many people who answered yes to having had a racist experience compared to those who answered no. Conversely, persons who replied that they were not stressed at all were less likely to have had a racist experience.

Suicidal ideation was higher among those who experienced racism

The *RHS* probed for both contemplation of suicide and actual attempts. The percentage of individuals who answered that they had considered suicide or attempted it was higher among those who had experienced racism in the last 12 months compared to individuals who had not experienced racism.

⁴⁰ 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 strongly support the extensive body of existing research.

⁴¹ 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>.

⁴² A more detailed review of the analysis is presented in the Review's Data Report. Throughout this Finding 2, all rates reported are age standardized (a/s) unless otherwise noted or represent an age group. Differences between populations are noted in the text only 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.

⁴³ 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 racism.

Racism is associated with increased use of mood-altering substances

Persons who had experienced racism were more likely to have used mood-altering substances, such as cannabis and/or illicit substances. With the latter, the disparity was 1.7 times higher – 10 per cent of persons who experienced racism also used illicit substances, compared to six per cent of persons who had not experienced racism.

Health outcomes were poorer among those who experienced racism

Persons who had experienced racism tended to have higher rates for allergies, high blood pressure, asthma, dermatitis, and injury. On average, the rates for persons who had experienced racism were about 20 per cent to 40 per cent higher than those without these experiences. With anxiety disorders and mood disorders, the disparity was about 75 per cent higher between the rates reported for those with a racist experience and those not having one. The connection between racism and health outcomes can be multifactorial and complex. For example, increasing levels of morbidity are associated with increased health care access, which then provides for a greater opportunity to be exposed to racism.

Health services may provide situations where racist experiences can occur

Significant differences were obtained between respondents who did and did not experience racism across a variety of health access 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 and also not culturally appropriate compared to those who did not report a racist experience. In addition, respondents who experienced racism were more likely to have accessed prostate and colorectal screening services, and they were more likely to have sought treatment for substance/alcohol use and addictions.⁴⁴

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.

⁴⁴ Variability was high in the responses to treatment for substance use/alcohol use and addictions. Interpret with caution.

Indigenous peoples experience inequitable access to primary preventative 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 service utilization data illustrate a reduced access to primary health services. In 2017/18, Other Residents in the province had higher rates of using physician services and receiving laboratory and diagnostic testing as an outpatient, compared to First Nations people.^{45,46} This finding is seen across all regions of the province, from remote to rural to urban. For a population with demonstrated greater health needs, physician, laboratory and diagnostic testing rates for accessing basic primary care would be expected to be comparatively higher, not lower, and counters the notion that First Nations people use the health system more frequently and inappropriately.

This pervasive reduced access by First Nations people is reinforced by lower rates of continuity of care, or the recommended spectrum of services to ensure treatment and return to healthy living with supports as recommended. 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.⁴⁷ 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.⁴⁸ 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 for First Nations peoples in all age groups, sexes and across all health authorities.

⁴⁵ This pattern of lesser use of physician services was seen across all age groups and both sexes, except for females ages 30 to 64 years where there was no difference. A lower access to physician care spills over to lesser laboratory and diagnostic testing which requires a physician's order. First Nations males of all ages, particularly younger than 17, had lower access to labs and diagnostics 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.

⁴⁶ FNHA (HSM) 2020. Note: In Finding #2, FNHA data sources are identified in footnotes: Health System Matrix (HSM); Perinatal Services BC (PSBC); Population Grouper (PG), opioid and COVID.

⁴⁷ 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

⁴⁸ 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. If less than five visits are found in a fiscal year, then up to 10 previous years are included to find at least five visits.

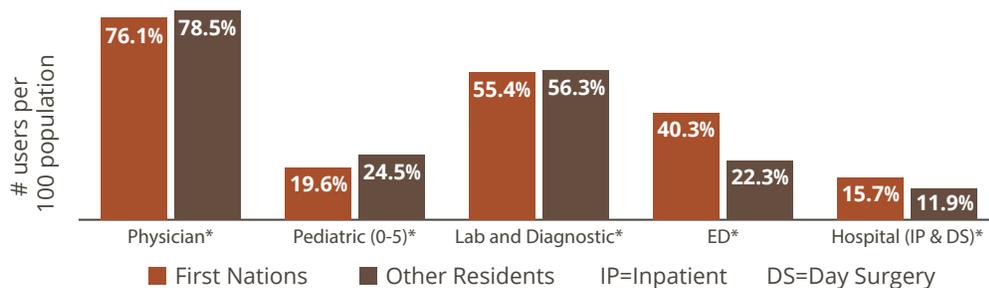
Screening for early detection of cancers and pre-cancerous conditions is a key disease prevention strategy in primary care. In all age groups in 2017/18, First Nations women had lower rates of accessing Pap testing for cervical cancer detection – 68 per cent of the rate in the Other Resident population. With respect to FIT testing which screens for colon cancer, the First Nations rate was also only 70 per cent of the Other Resident populations’ rate in this year.^{49,50}

Lack of equity in primary care services results in a disproportionately high requirement for emergency services

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 reliance on EDs by First Nations people 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.⁵¹

Based on physician records, 40 per cent of First Nations people visited the ED at least once in 2017/18, a rate which was 1.8 times higher than the comparable rate for Other Residents.⁵²

Compared to Other Residents, First Nations were less likely to use primary care services and more likely to visit EDs/be admitted to hospital in 2017/18



*First Nations rate significantly higher than Other Resident rate

**First Nations rate significantly lower than Other Resident rate

Data is from 2017/18, except for pediatric physician (2016/17)

⁴⁹ There was no difference between the Métis and Other Residents a/s rates for Pap and FIT testing.

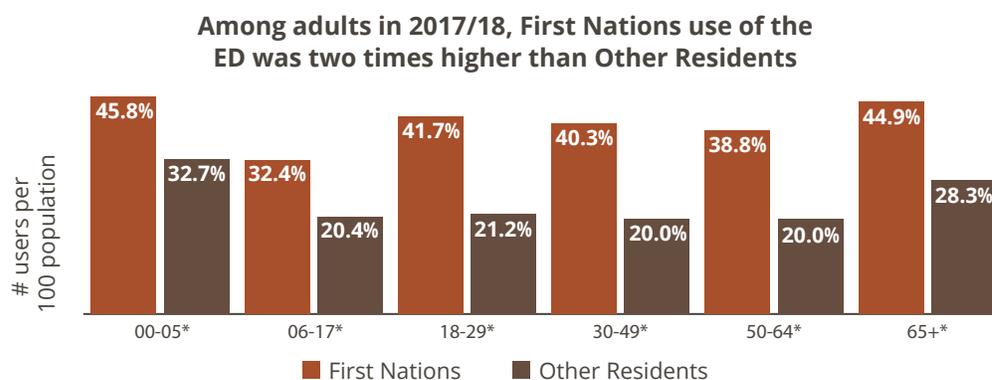
⁵⁰ Review. 2020.

⁵¹ In a survey of the Surrey Memorial Hospital, the reason for having more than one visit in the past six months was analyzed, and pointed to additional factors driving ED use. Having more than one visit was significantly associated, not just with being Indigenous, but also 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. Source: Surrey Memorial Hospital (SMH): EQUIP Baseline Data Highlights. May 2020. Data collection undertaken in 2018 on 664 patients at SMH ED.

⁵² FNHA (HSM) 2020.

Both First Nations men and women had higher rates of ED utilization compared to Other Residents; however, First Nations female rates were higher and the disparity greater, suggesting that First Nations women bear a disproportionate burden related to reduced access to primary care and the attendant health consequences. This higher First Nations utilization of ED services was seen in all age groups, with the greatest difference between First Nations people and Other Resident ED utilization for those ages 18 through 64, where the First Nations rate was approximately two times greater.⁵³

On average, First Nations people who used the ED in 2017/18 visited between two and three times. By age group and health authority, the average number of ED visits overall per First Nations user ranged from 1.71 among six- to 17-year-olds, up to 3.14 visits among those 65 and over.^{54,55}



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

The 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 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, 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.⁵⁶ 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

⁵³ FNHA (HSM) 2020.

⁵⁴ Across regions in B.C., the average number of ED visits per First Nations user increased between 2008/09 and 2017/18 when looking at all ED visits in totality, and also most notably in the mental disorders subspecialty.

⁵⁶ FNHA (HSM) 2020.

⁵⁶ FNHA. 2019.

44.1%) using CTAS scoring.⁵⁷ CTAS 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. Irrespectively, First Nations persons ages 30 to 64 had lengthier stays in the ED, for all CTAS levels, from resuscitation/emergent needs to non-urgent care.⁵⁸

The premise of higher need for ED care as a reflection of inadequate access to primary care is bolstered by 2018/19 data, which shows First Nations people in all age groups except 65 plus years and older having higher hospital admissions from the ED across all the CTAS levels including non-urgent.⁵⁹ These higher admission rates run counter to the PREMS finding that First Nations people 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.^{60,61}

The higher utilization of ED care among First Nations was also evident across across ED reasons for visits, and further supports the premise First Nations people do not appear to be receiving adequate primary care, which could prevent these higher admissions. In all 14 diagnostic categories which describe reasons for visiting the ED, First Nations 2017/18 rates were higher than Other Residents, with ratio differences averaging two-fold.^{62,63}

Among all health care users in B.C., those who are non-attached have a higher need for services from the ED; however, disparities in access to physicians serve to magnify the issue in the First Nations population. The difference in 2017/18’s ED user rates between non-attached and attached First Nations people was up to eight to 18 percentage points depending on the age group, and was the largest for the elderly. As an example, 63.6 per cent of non-

⁵⁷ The urgency of an individual’s condition during an ED visit is based on the Canadian Triage & Acuity Scale (CTAS) distribution. The CTAS is a rapid assessment upon presentation to the ED. A 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. CTAS 1: resuscitation; CTAS 2: emergent; CTAS 3: urgent; CTAS 4: less urgent; CTAS 5: non urgent.

⁵⁸ Review. 2020.

⁵⁹ Assessed by CTAS 1/2, CTAS 3 and CTAS 4/5. There was variability in this finding when looking at admissions by category of hospitals (teaching and community small, medium and large).

⁶⁰ Review. 2020.

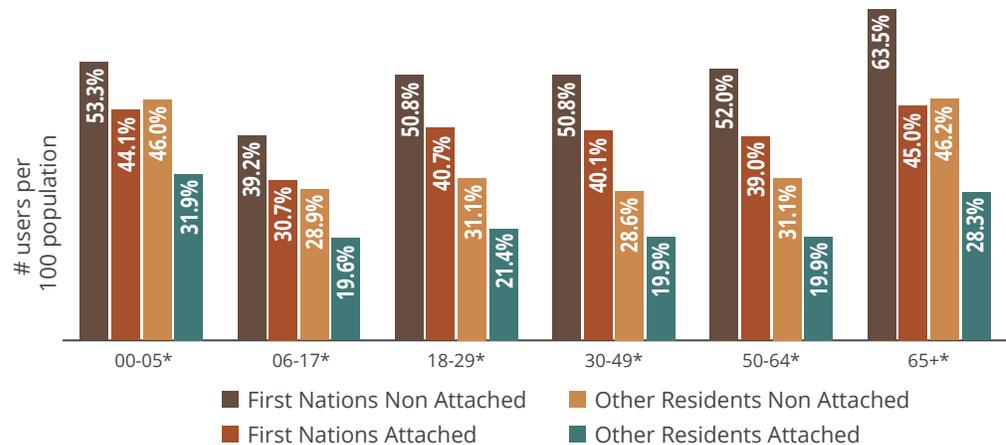
⁶¹ Review. 2020.

⁶² When looked at by individual health authorities, 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 health authority level, which were suppressed and prevent an assessment of rate change, or were insufficient for a statistical comparison.

⁶³ The most common reason for First Nations to visit the ED was general signs and symptoms (GS&S), meaning that the underlying cause of a person’s health condition could not be determined by the ED visit. The second most common reason was for treatment of trauma, followed by respiratory, digestive, musculoskeletal and mental disorder issues. Between 2008/09 and 2017/18, the greatest average annual increase in First Nations utilization of the ED by diagnostic speciality were oncology (4.9%), mental disorders (6.2%), endocrine disorders (3.7%) and kidney/reproductive conditions (3.4%).

attached First Nations people 65 and older visited the ED in 2017/18, whereas First Nations people of the same age and with continuity of physician care had an ED rate of 45.1 per cent. The difference is most stark when looked at from the perspective of the general population who benefit from continuity of physician/nurse practitioner services. The ED rate for Other Residents' attached 65-plus group was 28.3 per cent.⁶⁴

Persons who were not attached to a primary care practitioner had a higher utilization of the ED in 2017/18



First Nations attached rate significantly higher than First Nations non attached rate; First Nations attached rate significantly higher than Other Resident attached rate; and First Nations non-attached rate is significantly higher than Other Resident non-attached rate.

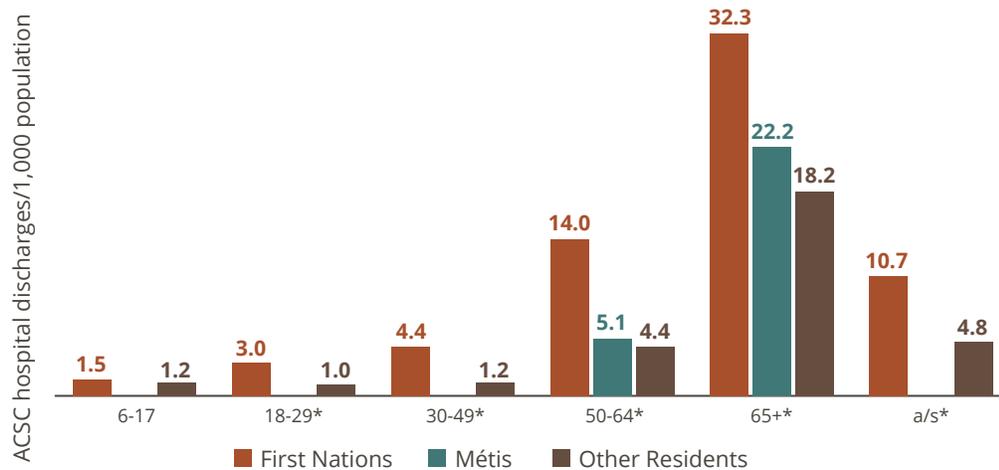
Inadequate primary care can result in hospitalization, including admissions for avoidable reasons

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. Hospitalizations related to ACSCs are commonly considered preventable. The hospitalization rate for ACSCs among First Nations people in 2017/18 was elevated in all age groups compared to the Other Resident rate, and for those aged 30-49, it was 3.6 times higher.⁶⁵

⁶⁴ FNHA (HSM) 2020.

⁶⁵ FNHA (HSM) 2020.

In 2017/18, First Nations adults had higher rates of hospitalization for conditions which are commonly treated in primary care



*First Nations rate significantly higher than the Other Resident rate

“There is clearly an over-representation of Indigenous people in the mental health system. One only needs to look at the stats and look on our streets. Our colonized history, and our existing health care systems have driven Indigenous peoples to these dark places. We have placed them on a highway fraught with barriers and challenges. Many Indigenous people find it difficult to access mental health resources, because services are either non-existent, inaccessible, will result in further stigmatization, and are culturally not safe. Navigation of services becomes even more difficult when clients experience a lack of clear understanding of the service delivery map, fear of being further discriminated against, and will experience ongoing systemic racism. The current mental health highway for Indigenous peoples needs to become one that is: safe, inclusive, and meets the needs and the rights of the people it serves. This needs to occur from a place of respect, honoring clients’ rights and ensuring adequate resources are in place. Then collectively we will be on the right path.”

~ Lise Haddock, Executive Director
Canadian Mental Health Association Cowichan Valley Branch

Inequitable health care access compounded by racism contributes to inequitable health outcomes

The Review gathered new data, and analyzed existing data, which demonstrates that inequitable health care access, which is contributed to by racism, is implicated in inequitable health outcomes. This is seen in issues of birth and death, as well as dealing with the challenges of chronic illness and multi-morbidities.

Indigenous peoples have reduced life expectancy

In B.C., the life expectancy at birth for the First Nations population decreased from 75.9 years in 2011 to 73.4 years in 2017, with the decline in part attributable to the opioid health emergency.⁶⁶ This life expectancy is almost nine years less than that of the B.C. population (82.2 years in 2016-2018).⁶⁷

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. PYLL is driven by mortality in younger ages, such as from injuries, suicide and overdose fatalities. The all-cause age-standardized mortality rate (ASMR) among First Nations 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.⁶⁸ For B.C. as a whole, the ASMR was just over half of the First Nations rate, at 65.4 per 10,000 population in 2015.⁶⁹

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.⁷⁰ Over the past two decades, the unacceptable high rates of suicide in Indigenous populations have only marginally changed. There has been 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 the aggregate time period 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.⁷¹

Indigenous peoples have increased rates of significant early-life health challenges, including mortality

Over the 2015/16 to 2017/18 time period, First Nations birth rates exceeded those of Other Residents by about 45 per cent. First Nations were twice as likely to have very-preterm (gestational age <32 weeks) and preterm (<37

⁶⁶ FNHA and OPHO. 2020.

⁶⁷ 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>

⁶⁸ FNHA and OPHO. 2020.

⁶⁹ BC 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>

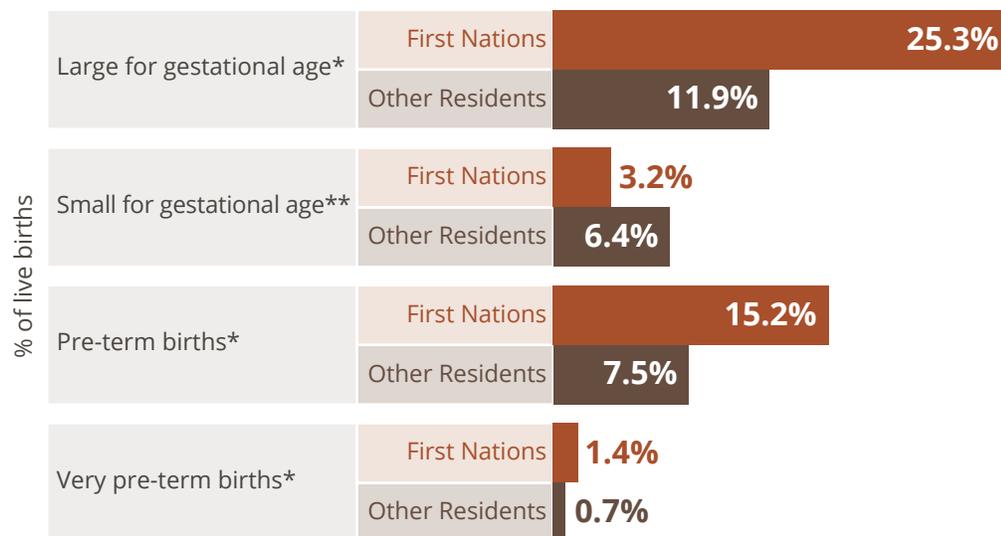
⁷⁰ Review. 2020.

⁷¹ FNHA and OPHO.2020.

weeks gestational age) births compared to Other Residents in 2017/18, with no appreciable change to these rates since 2011/12.^{72,73,74}

The First Nations population 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 during the 2011/12 to 2017/18 time period examined, however the First Nations rate remained elevated.⁷⁵ Infant mortality (in the first year of life) has also historically affected First Nations to a larger extent than the general population, both within B.C. and nationally. B.C. First Nations infant mortality for the five-year aggregated 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 2013-2017 data was almost twofold.⁷⁶

First Nations infants were more likely to be not a healthy birthweight when born and be delivered prematurely in 2017/18



*First Nations rate significantly higher than Other Resident rate

** First Nations rate significantly lower than Other Resident rate

⁷² FNHA (PSBC) 2020.

⁷³ 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. These include 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.

⁷⁴ 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. The Long-Lasting Effects of Preterm Birth. (accessed Sept 21, 2020) <https://www.nichd.nih.gov/newsroom/resources/spotlight/012612-effects-preterm-birth>

⁷⁵ FNHA (PSBC) 2020.

⁷⁶ FNHA and OPHO. 2020.

First Nations infants were more likely to be large for gestational age compared to Other Residents, at a greater than two-fold higher rate (25.2%), and less likely to be small for gestational age.^{77,78,79}

Indigenous peoples have increased rates of chronic disease

Of the 16 chronic conditions with prevalence rates of greater than one per cent in the First Nations population, all but cancer (year of diagnosis) and hypertension rates were higher in the First Nations population compared to the Other Resident population.^{80,81,82}

⁷⁷ 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.

⁷⁸ FNHA and OPHO.2020.

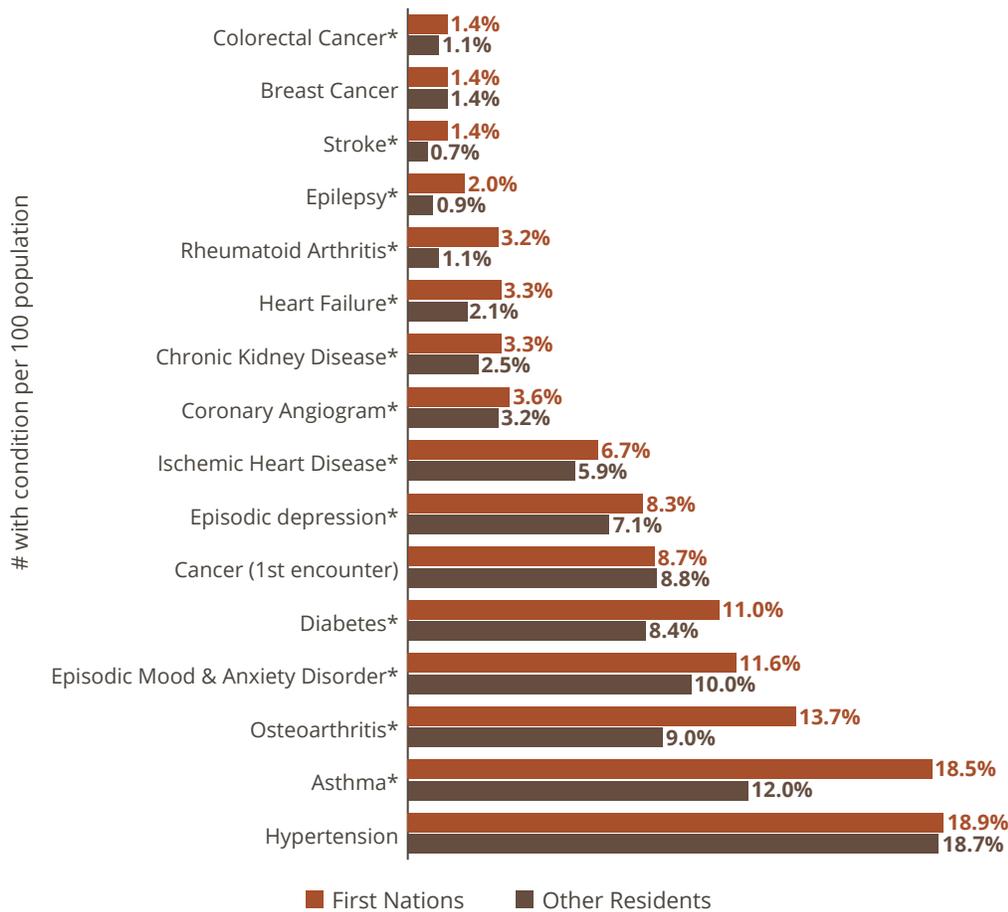
⁷⁹ Possible outcomes for these infants include respiratory problems associated with breathing, imbalances in blood sugar and increased growth due to over production of insulin (as a result of maternal diabetes), over-burdening of organs such as the liver, and the possibility of traumatic injury during the birthing process. University of Rochester Medical Center. Large for gestational age [Internet]. Rochester, NY: University of Rochester Medical Center; [cited 2020 Sept 21]. Available from: <https://www.urmc.rochester.edu/encyclopedia/content.aspx?ContentTypeID=90&ContentID=P02383>

⁸⁰ FNHA (HSM). 2020.

⁸¹ Chronic conditions in B.C. are monitored through the Chronic Condition 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.

⁸² 2017/18 data on overall service use in the health system shows that, except for asthma, mood and anxiety disorder, depression and epilepsy, the First Nations age group most requiring care for a chronic condition includes those 65 and older. 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, 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). [FNHA (HSM) 2020]

In 2017/18, First Nations prevalence rates were greater than Other Residents in 14 of 16 Conditions (First Nations rates >1%)

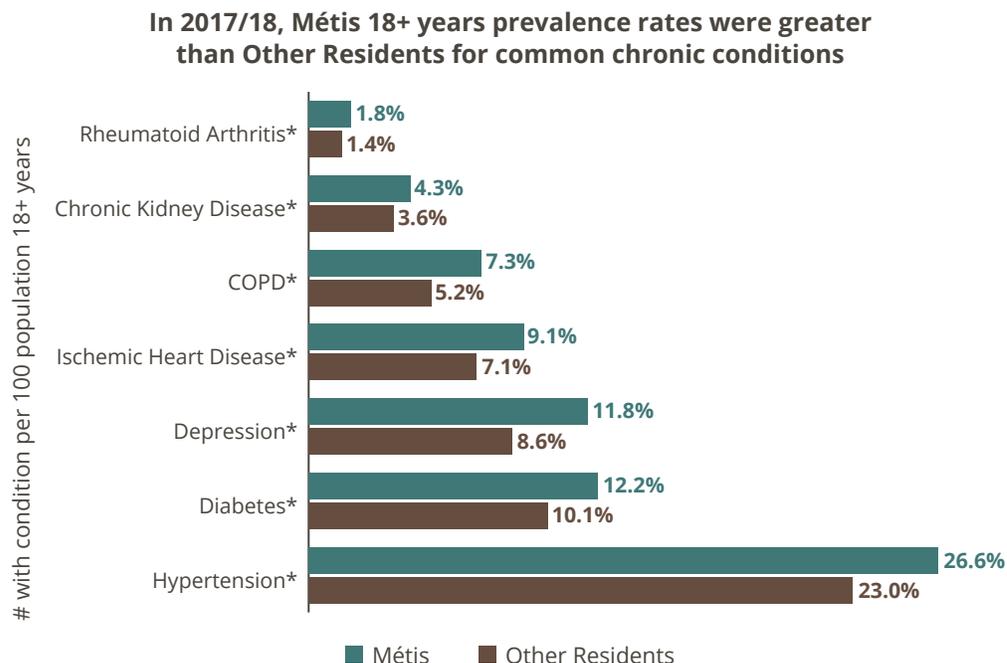


*First Nation rate significantly higher than the Other Resident rate.

In four of the above 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).⁸³

⁸³ FNHA (HSM). 2020.

Métis prevalence rates (based on the 18-plus 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).⁸⁴



*Métis rate significantly higher than the Other Resident rate

In B.C., chronic conditions are typically grouped into three levels (population segments) which are analogous to increasing complexity of conditions from low to medium to high.⁸⁵

Between 2008/09 and 2017/18, proportionately more First Nations people were diagnosed with a low complexity chronic condition (LCC) or a high complexity chronic condition (HCC).⁸⁶ 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

⁸⁴ MNBC. 2020.

⁸⁵ Overall, in B.C during 2017/18, 27.1% of First Nations were diagnosed with one or more of chronic conditions of a low complexity, with 10.0% assigned to a medium complexity and 7.1% assigned to a high complexity. In each of these three chronic condition groupings, First Nations rates were significantly higher than Other Residents; a pattern which was replicated in all five health authorities.

⁸⁶ 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. Note: not age standardized; represents the true percentage in the population.

were diagnosed with asthma, mood/anxiety disorder (including depression), diabetes, epilepsy, hypertension, osteoarthritis and/or osteoporosis.⁸⁷

Chronic conditions affect Indigenous peoples earlier in life

In 2017/18, most First Nations newly diagnosed with either a low or medium complexity chronic condition (MCC) were in the 18 to 29 and 30 to 49 age groups. Differences are apparent when compared against Other Residents, as First Nations residents were more likely to be entered into LCC when they were younger compared to Other Residents, demonstrating that chronic conditions impact First Nations earlier in life than they do for the rest of the population.

This pattern is repeated in the MCC group. This acceleration of chronic conditions is ultimately expressed in the HCC entrants, as 58 per cent of First Nations residents 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 the First Nations population experiences 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.⁸⁸

Indigenous peoples are more likely to have multiple diverse health conditions

The increased health burden extends past chronic disease to include diverse health conditions. In an analysis of 227 health conditions extending across all aspects of disease which are treated in the health system, both First Nations and Métis populations were examined.

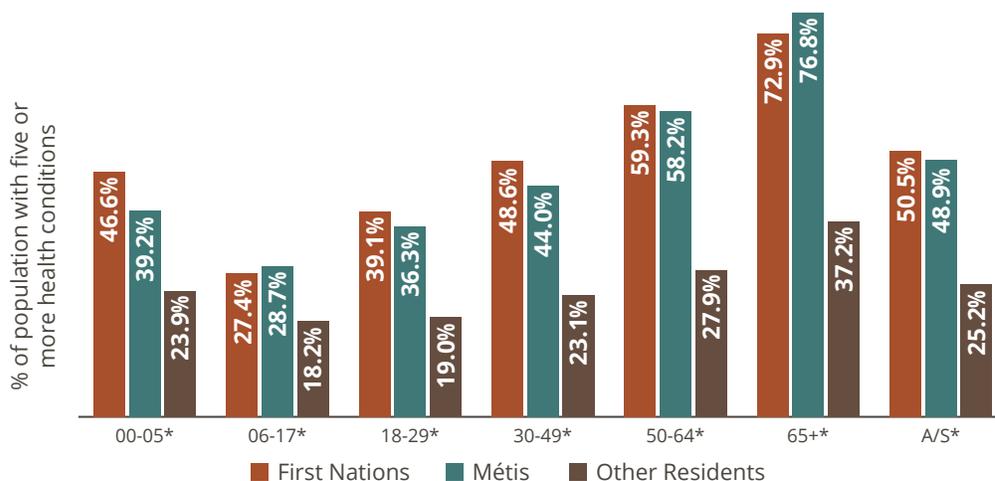
Multi morbidities are present in all age groups, including the very young. In all age groups, First Nations and Métis were more likely to have five or more health conditions, typically at over two times higher rates for adults.⁸⁹

⁸⁷ FNHA (HSM) 2020.

⁸⁸ FNHA (HSM). 2020.

⁸⁹ Review 2020 & FNHA (PG) 2020. These conditions are part of the Population Grouper database 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.

In all age groups, First Nations and Métis were more likely to have five or more health conditions, typically over two times higher for adults, 2017/18



First Nations rate significantly higher than Other Residents rate, and Métis rate significantly higher than Other Residents rate

Conclusions

The Review concludes the following about health system gaps and challenges in meeting the needs of Indigenous peoples:

- There are pressing needs for – and persistent gaps in access to – necessary health services for Indigenous peoples. Both structural and interpersonal racism contributes to this challenge. These gaps have been identified for some time with nominal progress.
- The very experience of racism is in and of itself is associated with lower health and well-being and this is compounded by poorer access to health services, in particularly preventative primary care.
- There are some efforts underway to address these inequities through establishing new and culturally safe primary care and mental health and wellness services specifically for Indigenous peoples and to ensure that major system initiatives in primary care involve Indigenous peoples.⁹⁰ These efforts are not, however, intentionally and systematically designed to uproot the colonial legacy; they are not systemic, coordinated or explicitly framed within a broader logic model which positions racism and the legacy of colonialism as

⁹⁰ Amongst these are the Joint Project Board Projects (see the Tripartite Evaluation), mental health treatment centres and land-based healing projects, as well as additional projects and service teams established by health authorities (e.g., Aboriginal Mental Wellness Team at Interior Health, Indigenous Primary Care Network at Fraser Health). The Province has focused extensively in recent years on the establishment of Primary Care Networks (PCNs) across B.C., designed to increase attachment of British Columbians to primary care physicians and nurse practitioners. The funding and policy parameters for these PCNs require engagement with local First Nations and Métis Chartered Communities in service planning and design.

key drivers of poor system performance for Indigenous peoples. Furthermore, new agreements and frameworks for mental health and addictions strategies are years behind in planning and progress and conditions to build these out effectively are not promising at this time without significant focus and attention.

- Expanded work is needed to create substantive equity in health care access and outcomes, with specific efforts to eradicate racism which is an active contributor to poor health system performance and negative health outcomes for Indigenous people.
- This report draws upon 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. Some of these indicators include:
 - Attachment to primary care practitioners is a primary strategy to improve the quality of health services and it shows greater disparity in the First Nations population than simply the ability to access a physician.
 - Encounter rates 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 its 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.
 - 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 to 75 per cent of

all readmissions are preventable by patient education, pre-discharge assessment and aftercare.⁹¹

- Access to screening: equitable access to screening programs for cancer 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.

Re-Framing Indigenous Health Outcomes

The work of this Review was to examine health system performance for Indigenous peoples in B.C. This requires a significant focus on inequities experienced by Indigenous peoples – recognizing these inequities result from colonialism and continuing racism, and are not inherent to Indigenous peoples.

It is critically important to also represent these inequities in context, and to broaden reporting to include issues of importance to Indigenous peoples, and which reflect their strength and resilience. Work by the FNHA and OPHO is reframing Indigenous health outcomes from a typical deficit focus to one that uses a strength-based approach to examine wellness and resilience. Their message is that achieving a healthy, self-determining and vibrant B.C. First Nations population means that the roots of wellness, such as self-determination and connection to land, must be well nourished, and supported at the system level. These roots of wellness and system-level contributions will be manifested in improving health outcomes by First Nations in B.C. The first report of this collaboration has established baselines in three themes from which progress will be evaluated: healthy, self-determining Nations and communities, supportive systems, and healthy, vibrant children and families.

In the inaugural Public Health and Wellness Agenda (PHWA) report, which looked at 22 indicators of First Nations health experience and health outcomes, the results were mixed, indicating that there are diverse areas where improvements are needed which would improve wellness.

3. Indigenous women and girls are disproportionately impacted by Indigenous-specific racism in the health care system.

During the course of this Review, a horrific racist incident took place in Quebec's health care system. Joyce Echaquan, an Atikamekw woman and mother of seven, sought medical care for stomach pains. While undergoing care, she informed hospital staff of her concerns about experiencing an adverse reaction to the level of morphine she had been administered. Ms. Echaquan started a Facebook live-stream of her treatment by hospital staff – treatment that exemplified the continuing toxic colonial stereotyping of Indigenous women; that they make “*bad choices*”, are “*stupid as hell*”, are only “*good for sex*” and that non-Indigenous Canadians are “*paying for*” Indigenous peoples' medical care. Joyce Echaquan died shortly after the live-stream was stopped by hospital staff.

⁹¹ Benbassat J, Taragin M. Hospital Readmissions as a Measure of Quality of Health Care: Advantages and Limitations. Arch Intern Med. 2000;160(8):1074–1081. doi:10.1001/archinte.160.8.1074

This tragic incident sparked national outrage and condemnation, and advanced the urgent and needed dialogue nationally about Indigenous-specific racism. It was also representative of what has long been known, and was re-affirmed by this Review – that there is an intersection of Indigenous-specific racism with misogyny and gender discrimination that has resulted in Indigenous women and girls being distinctly and disproportionately subject to risks and harm.

The Review revealed a particularly challenging reality:

- a higher need for Indigenous women – when compared to Indigenous men and non-Indigenous people – to receive health care services
- unique forms of racism experienced by Indigenous women within the health care system, including virulent misogynistic stereotypes specific to Indigenous women
- unique traumas have been experienced by Indigenous women, including forced sterilization and the impacts of child welfare policies that separate and disrupt Indigenous families
- a high feeling of unsafety amongst Indigenous women in interacting with the health care system
- the need for extensive interface with the health system by Indigenous women due to their role as primary caregivers
- the need for women to interface with the health system in more regularly intimate ways than men, primarily related to reproductive health and maternal care.

Witness Shares Account of Racism in the Delivery Room

An obstetrician told this Review about the terrible treatment received by an Indigenous woman who has a history of trauma and sexual assault. The woman attended a B.C. hospital to have a child by C-section.

Prior to the procedure, the obstetrician witnessed an anesthesiologist manhandling and yelling at the patient. The same anesthesiologist later made the statement that *“People like her should be sterilized.”*

Essentially, Indigenous women have a demonstrated greater need, but 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. There are insufficient measures in place to address the unique oppression, violence, risk and racism experienced by Indigenous women in health care in B.C.

Reflections

Indigenous women experience misogynistic stereotyping

The Review heard many examples of misogynistic stereotyping of Indigenous women by health care professionals. Older women were described as “squaws”. Younger women were characterized as sexually promiscuous. This led to girls being falsely assumed to be sexually active, to mistaken diagnoses of sexually transmitted diseases and to patients being treated in ways that left them feeling dirty and ashamed. The devaluing of Indigenous women’s bodies was evidenced by accounts of assaults, rough treatment (particularly in relation to gynaecological issues), and non-consensual sterilization and hair-cutting.

Health care workers disclosed that mothers were referred to child protection services for no reason other than that they were Indigenous. They talked of normal childhood injuries, parental concerns and parenting experiences being pathologized for Indigenous families in ways that were not extended to non-Indigenous families. Examples were given of health care workers stating that Indigenous women should not be allowed to have children, that they had too many children and that their children would grow up to be unhappy.

Indigenous women feel less safe than males in accessing health services

The IPS responses were predominantly (70%) provided by Indigenous women sharing their experiences. When asked about feelings of safety in different health care settings or with various health providers, a lower proportion of Indigenous women reported feeling “*completely safe*” compared to men. Indigenous men were 83 per cent more likely to feel “*completely safe*” when visiting the emergency department, with high differences also received for hospital admissions (75% more likely), specialist, nurse and nurse practitioner visits (40% more likely), and services from paramedics (34% more likely) and social workers (31% more likely).

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.⁹²

This perceived lack of safety is also evidenced by the disproportionate rate at which Indigenous women leave hospitals against medical advice. In the one specialty women’s hospital in the province, First Nations women in 2017/18

⁹² Review (IPS) 2020.

left the hospital against medical advice at a rate which was 11 times greater than that seen with Other Residents.⁹³

Indigenous women are disproportionately affected by poor health compared to their male counterparts

When compared to First Nations men, First Nations women carry a higher burden of disease. First Nations women have higher prevalence rates of most chronic conditions than First Nations males (with notable exceptions being cardiovascular conditions).⁹⁴ The same observation applies to a variety of other diseases not captured in the chronic condition registry,⁹⁵ as First Nations females have a higher utilization of hospital care, and sometimes physician care, than First Nations males for these same conditions. The available data also shows that Métis females have higher utilization of hospitals and physician services than Métis males in a lesser number of conditions.⁹⁶

The health gap between Indigenous and non-Indigenous women is greater than that seen with males

While the foregoing observation demonstrates disparities between Indigenous women and Indigenous men, comparing Indigenous women and Indigenous men to non-Indigenous residents reveals that Indigenous women face more extreme health status disparities. In the vast majority of health conditions that the Review examined, 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.⁹⁷ In the Métis population, numbers were often insufficient for analysis; even so, this higher female disparity was observed in a minority of health conditions.⁹⁸ Both female and male First Nations had higher rates of emergency department utilization compared to Other Residents in 2017/18; however, First Nations female rates were higher and the disparity greater.⁹⁹

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

⁹³ FNHA. 2020.

⁹⁴ FNHA (HSM). 2020.

⁹⁵ FNHA (PG). 2020. Such as eye disorders, infectious and non-infectious upper respiratory conditions, gastrointestinal disorders (with a breakout for liver and pancreatic conditions), endocrine conditions, mental disorders and malnutrition.

⁹⁶ Review (PG). 2020.

⁹⁷ FNHA (PG) 2020. These conditions include acute and chronic respiratory illness, cardiovascular disease, gastrointestinal conditions, acute and chronic kidney disease, sepsis, mental disorders, amputations and diabetes.

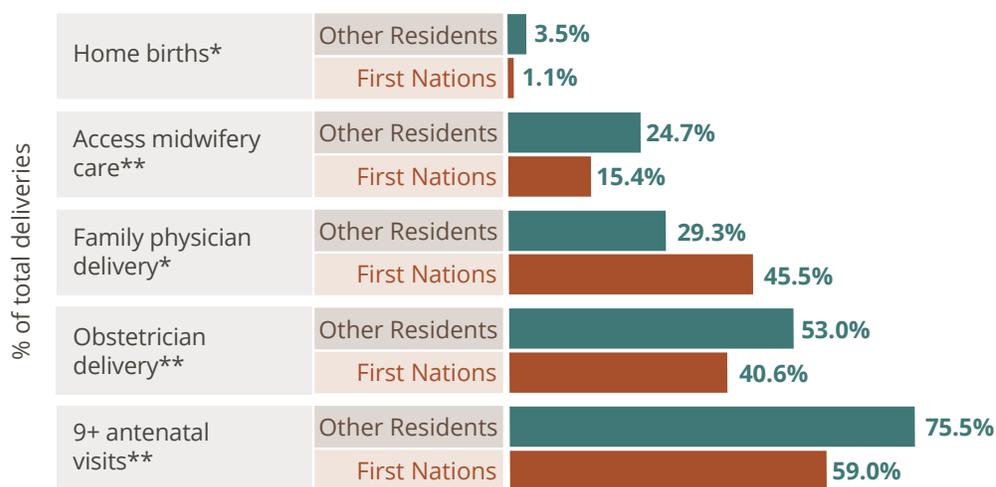
⁹⁸ Review. 2020. Including respiratory, cardiovascular, gastrointestinal and mental health disorders.

⁹⁹ FNHA (HSM) 2020.

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.¹⁰⁰

A service gap between Indigenous and non-Indigenous women is also evident when examining maternal and child health. 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.¹⁰¹

First Nations had lower access to antenatal care, as well as obstetricians, midwives and home births, 2017/18



*First Nations rate significantly higher than the Other Residents rate

**First Nations rate significantly lower than Other Residents rate

Indigenous women are disproportionately 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. Between Jan. 1, 2020 and Oct. 31, 2020, 32 per cent of First Nations deaths were female compared to 17 per cent female deaths among Other Residents. The overdose mortality rate among First Nations females in this time period was 10.1 times higher than the comparable rate for Other Resident females.¹⁰² In the COVID-19 pandemic, First Nations females are over-

¹⁰⁰ Review (PG). 2020.

¹⁰¹ FNHA. (PSBC). 2020. On the positive side, First Nations were less likely to have a Caesarian section than Other Residents in 2017/18, with a rate close to international recommendations for this practice.

¹⁰² FNHA (Opioid). 2020.

represented in the number of confirmed First Nations cases.¹⁰³ In the Statistics Canada survey, *Perceptions of safety of Indigenous people during the COVID-19 pandemic*, 41% of Indigenous participants reported that they were “very” or “extremely” concerned about the impact of confinement on family stress, compared to 28% among non-Indigenous participants. Indigenous women participants (47%) were more likely to report this concern than Indigenous men (33%).¹⁰⁴

Initiatives to support Indigenous women’s reproductive and maternal health are not coordinated or sufficient as a response

The unique and pressing needs of Indigenous women – particularly in Indigenous maternal, child and family health – has led to some largely disconnected efforts amongst federal and provincial governments, and Indigenous and non-Indigenous agencies and organizations.¹⁰⁵

A maternal, child and family health case study completed as part of the *Tripartite Framework Agreement* evaluation (December 2019) reveals the continuing challenges. Despite the work being done, Indigenous infants, children and youth continue to experience inequitable health outcomes. Women and families from rural or remote communities often have to travel long distances when it is time to deliver their babies (including when ground and/or air ambulances are not available); and recruitment and retention of community-based health personnel remains a barrier to access. As noted above, First Nations women, compared to Other Residents have a much lower rate for cervical cancer screening,¹⁰⁶ despite having a 1.6 times higher prevalence rate of this cancer.¹⁰⁷ This is all suggestive of a strong need for a coordinated systemic response; yet concerns were expressed that provincial-level focus between ministries and the FNHA on this issue has declined, and key informants suggested that, given the data and increasing national focus on women’s health, increased system-wide collaboration and coordination is needed.

¹⁰³ FNHA (COVID). 2020.

¹⁰⁴ Arriagada P, T Hahmann and V O'Donnell. 2020. *Perceptions of safety of Indigenous people during the COVID-19 pandemic*. August 14. <https://www150.statcan.gc.ca/n1/pub/45-28-0001/2020001/article/00071>. While most Indigenous and non-Indigenous participants expressed that they were “not at all” concerned about the impact of the pandemic on violence in the home, 11% of Indigenous participants reported some level of concern (somewhat/very/extremely), more than twice the corresponding percentage among non-Indigenous participants (5%). The level of concern among participants surrounding violence in the home was higher among Indigenous women (13%) than among Indigenous men (9%).

¹⁰⁵ Examples include: development of a number of culturally-relevant information resources for Indigenous families; doula training materials and the Doulas for Aboriginal Families grant program; a joint Ministry of Health/FNHA-funded project to support births closer to home for women in the northern region of Vancouver Island; BC College of Nurses & Midwives (BCCNM) Indigenous Midwifery panel to advance establishment of new class of midwifery.

¹⁰⁶ Review. 2020

¹⁰⁷ FNHA (HSM). 2020.

Planning, reporting and accountability related to Indigenous women's health is deficient

Despite the unique harms, outcomes, needs and experiences of Indigenous women in health care in B.C., the Review found no established strategy or plan that would assure continued focus, progress and accountability. This remains the situation despite major studies and commitments – such as the National Inquiry into Missing and Murdered Indigenous Women and Girls – that call for specific actions. Sixteen of the Inquiry's 231 Calls for Justice specifically relate to health and wellness, and are directed at government and health service providers. The urgency to address these Calls for Justice was affirmed through this Review, particularly those that focused on:

- The need for trauma-informed sustainable, permanent, no-barrier, preventative, accessible, wholistic, wraparound services that meet the health and wellness needs of Indigenous women and girls
- Ensuring that health and wellness services are designed and, wherever practicable and feasible, delivered by the Indigenous peoples they are supposed to serve, grounded in their practices and world views
- Revitalization of Indigenous health, wellness, medicinal and child and Elder care practices
- Ensuring that all persons involved in the provision of health services to Indigenous peoples receive ongoing training, education and awareness in areas including, but not limited to, the history of colonialism, anti-bias and anti-racism, and local language, culture and health practices
- Supporting Indigenous people to train and work in the area of health and wellness.¹⁰⁸

One year following the release of the Calls for Justice, the B.C. government issued *Reflection on Ending Violence Against Indigenous Women and Girls: A Statement on the Anniversary of the Release of the Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*.¹⁰⁹ This document summarized a range of efforts underway to address the systemic causes of violence experienced by Indigenous women and girls; however, it did not articulate any clear plan or commitment to implement the Calls for Justice. Many women's organizations continue to press for a clear and resourced plan to be developed in collaboration with Indigenous women, girls, 2SLGBTQQA+ people and family members.¹¹⁰

¹⁰⁸ https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Calls_for_Justice.pdf

¹⁰⁹ <https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/about-bc-justice-system/inquiries/mmiwg/mmiwg-overview-report.pdf>

¹¹⁰ https://www.ubcic.bc.ca/open_letter_call_for_a_bc_action_plan_on_mmiwg2s

“I Was so Scared They Would Send That Lady Again in the Ambulance”

A Métis woman in her 60s fell asleep after taking her medication one evening at her home. When she awoke, she was itchy over her entire body and extremely weak. Realizing something was wrong, she called 9-1-1. She managed to get to her front doorstep and collapsed as she waited for the ambulance.

After it arrived, she says the ambulance attendant sternly ordered her to “get up” from where she was lying on the step. She was unable to rise and a fireman who had also attended helped her into the ambulance. The woman recalls that, once she got in, the female paramedic was very rough with her, not allowing her to use a pillow to balance herself in the seat, snatching it away and yelling “That is not for you!” When she fell against a ledge in the ambulance, she recalls the attendant saying: “Get off of there. That’s expensive equipment, sit up, sit up in the seat!” She could feel diarrhea coming on and told the paramedic that she had to urgently go to the bathroom but was ignored.

After they arrived at the hospital, the woman repeated her urgent request to use a bathroom and was again ignored. She was placed on a bed, where she blacked out. She awoke to the sense of having to go to the bathroom very urgently. She recalls sliding off the bed, and slowly making her way to the washroom where she again passed out. She was essentially trapped in the bathroom. When she was found much later by a staff member, she remembers medical personnel calling out “Code Blue.” She says she had gone septic and was having an anaphylactic episode. She was hospitalized for five days. The woman has gone into anaphylaxis twice since this experience and it appears that she has an aspirin allergy.

“I am a professional driver, I do not drink or use recreational drugs ever ... my income and clients depend on me to keep them safe, my license is how I make a living ... So what the heck went wrong? Did the ambulance driver decide I was just drunk or high on drugs and influence the nurses that was what was happening to me? Why if I was a cardio, as I heard mention, was I just rolled onto a gurney and left there? Would they not have to monitor my heart rate and blood pressure?”

She made formal complaints to the BC Ambulance Service and to the hospital’s Patient Care Quality Office. She said the reply she received from the hospital was riddled with errors and that the Ambulance Service responded by saying “they would be sure to have the attendant receive more empathy training.”

“The next two episodes that I had, I drove myself to the hospital holding my epi pen ready to jab myself if I felt I needed to, I was so scared they would send that lady again in the ambulance.”

The 2019/20 FNHA Summary Service Plan included a commitment to publish a report on women’s health in collaboration with the Office of the BC Provincial Health Officer. This report has not yet been released and is overdue. A comprehensive women’s health report such as this may establish a critical baseline for key indicators, and spur much-needed action planning.

Conclusions

The Review concludes the following with respect to racism’s unique impacts on Indigenous women:

- Women’s health is not just a women’s issue. Women are caregivers, leaders, heads of families and keepers of knowledge. Women’s health is family health, community health, nation health and cultural health.

- Indigenous women are carrying too much of the burden of Indigenous-specific racism in B.C.
- The MMIWG report and other studies have surfaced the problem and pointed to solutions. The PHO/FNHA Indigenous Women’s Health Report is overdue. Other strategies and reports regarding women’s health have been shelved or are limping along with little focused attention. The lack of response reflects gender racism.
- Cohesive, strategic, and measurable actions are required to address the disproportionate risk faced by Indigenous women in B.C. society and the provincial health care system, and to support their wholistic health and well-being.
- Limited data and response to the IPS from LGBTQ+ Indigenous persons makes it difficult to fully understand their experiences of health services and closer analysis of the needs of gender diverse Indigenous peoples should be an ongoing focus.

4. Current public health emergencies magnify racism and vulnerabilities and disproportionately impact Indigenous peoples.

B.C. is currently grappling with dual intersecting public health emergencies. On April 14, 2016, the Provincial Health Officer (PHO) declared a public health emergency under the *Public Health Act* related to the unprecedented rates of overdose and death due to a toxic and unpredictable drug supply. On March 17, 2020, the PHO declared another public health emergency related to the transmission of COVID-19.

It has long been understood that public health 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. For Indigenous peoples, the interlocking systems of dependency and neglect created by settler governments have further magnified disproportionate impacts throughout multiple waves of pandemics experienced since contact.

The Review received data and many reports surfacing concerns about the disproportionate impacts of the two current public health emergencies on Indigenous peoples. The fear and stigma associated with these public health emergencies magnify racist beliefs, prejudices and barriers. Indigenous peoples' access to necessary care is lower, and avoidance of care is higher, during these emergencies – a significant concern as we know that Indigenous health needs are elevated in many areas, and gaps in outcomes should be accompanied by a larger pull for services, not a withdrawal from services. The disproportionate impacts of the twin public health emergencies on the health and wellness of Indigenous peoples – including physical disease, mental health and death – are evident. Yet, Indigenous governments are not recognized as full partners in the response, and proper data sharing, information systems and system governance does not promote routine collaborative work with Indigenous peoples' governments and representatives. While it is evident that Indigenous health leaders and political leaders can provide for the unique and pressing needs of their citizens, whether the system does more than hear them out, is a major concern. Urgent action is required given that these public health emergencies are currently worsening, and are part of our reality for the foreseeable future.

Reflections

Indigenous peoples are disproportionately impacted by public health emergencies

The gap in overdose-related health outcomes for First Nations people compared to other B.C. residents is wide and continues to grow. From Jan. 1, 2020 to Oct. 31, 2020, the rate of overdose deaths among First Nations was 5.5 times higher than the Other Resident rate.¹¹¹

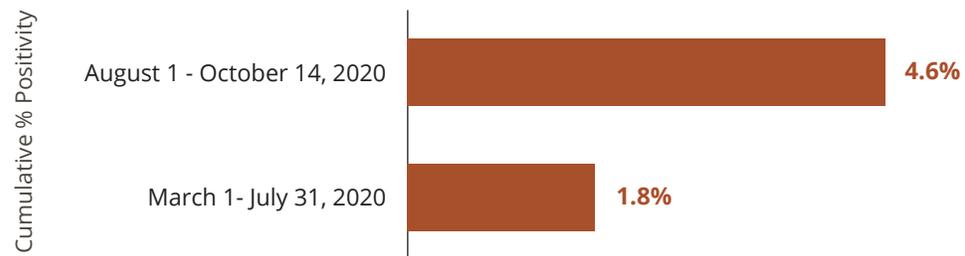
With respect to COVID-19, First Nations in B.C. in the first 7 ½ months of the pandemic are experiencing a larger rate of infections than what has been seen in the general population of the province. The cumulative incidence of COVID-19 among First Nations as of Oct. 14, 2020 was 80 per cent higher than the rate of Other Residents.¹¹² The cumulative per cent positivity amongst First Nations has increased in the 'second wave' of the pandemic to 4.6 per cent in the August to Oct. 14 time period, up from 1.8 per cent in the initial five months of the pandemic.¹¹³

¹¹¹ Women's data is in Finding 3. FNHA (opioid) 2020.

¹¹² 383.1 cases per 100,000 amongst First Nations, compared to 210.2 per 100,000 amongst Other Residents.

¹¹³ FNHA (opioid) 2020

The proportion of positive COVID cases has increased in the First Nations population



Métis to date have a lower incidence of COVID-19 than the Other Resident population. Statistics to Oct. 20, 2020 show the Métis case rate of those 18 and older was 14.2 per 10,000 population, whereas the comparable rate for B.C. was 23.2.

Indigenous people are experiencing disproportionate effects on their mental well-being during the pandemic¹¹⁴

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-19 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%).¹¹⁵ 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%).

¹¹⁴ BC 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. The survey included an opportunity for Indigenous respondents to self-identify as First Nations, Métis or Inuit (which cumulatively accounted for 6% of total responses).

¹¹⁵ Unless otherwise noted, all First Nations/B.C. and Métis/B.C. comparisons are statistically significant.

COVID-19 Protocols Leave Elderly First Nations Woman in Traumatic Situation

An elderly Indigenous woman who has multiple medical issues – including one that complicates the ability to communicate – and is hard of hearing, made two visits to the local hospital in September 2020. She was experiencing severe abdominal pain, cramping and constipation; she was cold, clammy and could barely walk. Despite her communication challenges, she was not permitted to have a family member attend hospital with her due to COVID-19 policies.

On her first visit, the woman was discharged with laxatives and no further information. After the second visit two days later – when she was also experiencing shortness of breath – a doctor advised the family that their mother was critically ill with kidney and heart failure and that she needed to be medevaced to another city immediately. The woman's first language is a First Nations language, and a translator was provided to help her to understand the seriousness of her condition. But the request for a family member to escort their elderly mother to the larger hospital was denied.

The woman was medevaced by herself while various family members separately made their way to the larger city to support her. When one daughter arrived at 9 p.m. that night, she was permitted by hospital staff to check on her mother for “one minute”. Despite the time limitation, the daughter was able to carry her mother to use the washroom and to interpret for her what was happening. She assured her mother that she was safe and that the medical staff were going to do all that was possible to find out what was causing her severe symptoms. The daughter then reluctantly left the hospital but, prior to leaving, she conducted a spiritual ceremony to help calm her mother, who is a residential school survivor and who was clearly traumatized by being alone in hospital in a strange city.

Another daughter arrived at the hospital the next day but was denied access to visit her mother despite having been reassured by hospital staff that she would be able to do so. The daughter attempted to explain her mother's trauma, her language barrier and her hearing problems, all to no avail. She recalls being abrasively disregarded and dismissed by the nurse after multiple attempts to set eyes on her mother. The sister left a toiletry bag, a spiritual pouch, paper and a pen for her mother to communicate with hospital staff.

Two days later, the family was advised by a nurse that their mother was much better and would likely be discharged soon. The family was unhappy that promised diagnostic testing, including a colonoscopy, had not been completed and that she was being discharged without a proper medical diagnosis. They were informed that their mother, who resides more than two hours away from this hospital, would be required to return for the colonoscopy as an outpatient sometime in the future.

Upset about this plan, one of the daughters reached out to various individuals to raise the alarm about what was happening. As a result, the mother was kept in hospital until the colonoscopy could be completed two days later. She was discharged the same day as the procedure with no plan of care or medical diagnosis for the family.

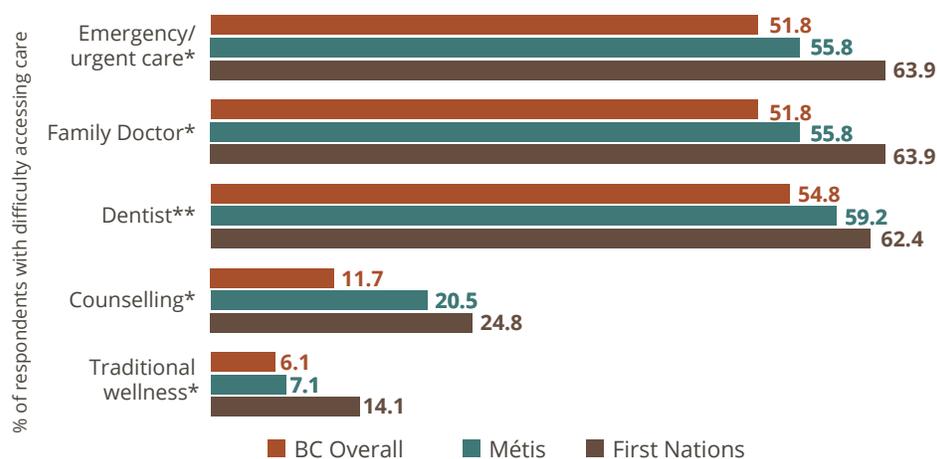
One of the daughters told the Review that her mother has still not received a diagnosis or the results of the colonoscopy. She says that COVID-19 policies need to be revisited, to ensure those facing significant multiple barriers in understanding their medical needs are not denied that understanding before being treated.

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. Relatedly, 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, and also higher than the Métis response (22.6%).¹¹⁶

Comparatively more First Nations and Métis have difficulty accessing health care during the pandemic

For the Indigenous population, which 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, their family doctor and dentist. The greatest difference was with counselling services and traditional wellness, as First Nations were over two times more likely to experience difficulty accessing these services than the overall B.C. population.

Comparatively more First Nations and Métis had difficulty accessing care



* Both First Nations and Métis rates significantly higher than the overall BC rate

** First Nations rate significantly higher than the overall BC rate

Source: BCCDC. 2020. BC COVID-19 Speak Survey

¹¹⁶ BCCDC. 2020.

A Health Director's Perspective

As First Nations people, we have a vivid memory of pandemics, and this collective fear sets us apart from others. When we experienced a COVID-19 outbreak, it brought out a lot of fear, with a reaction to lock down to protect ourselves and also to know 'who' had tested positive. I was trying to have a wholistic view of protecting our people – ensuring confidentiality, protecting the community from COVID-19, and thinking about the unintended consequences of lockdown, especially for our people's mental health and access to health care. These were, and are, very difficult discussions.

The outbreak and lockdown brought out a lot of racism in other residents including on social media and in monitoring the movement of our people and who was getting tested. Now, our people are avoiding going to the Emergency Room because they are afraid of racism. And because of COVID, they can't bring anyone with them to speak on their behalf.

Our team has had to talk passionately about our fears and fight for ourselves every step of the way to get what was needed. Including for supplies, testing, human resources support, and to be included in decision-making. We have experienced a lot of personal impacts – stress, anxiety, lack of sleep. Much of this came from having to manoeuvre so many issues and barriers. Non-First Nations communities do not have to put up with the same stuff as we have. You can't tell us that this isn't systemic racism. This 'us and them' needs to stop.

All of this exposed the lack of a system for health emergency response. We weren't set up for this – we had no staffing relief options, there was a lack of working protocols, we had six weeks of meetings talking about the same thing and going nowhere. There was lots of passing the buck, *"not our responsibility, you guys get money from FNHA (First Nations Health Authority)."* FNHA was not ready for this, they did provide support in some areas but weren't able to come through on many of our other needs. This was so insecure. No one was taking care of us. We are still working on many of these same issues.

In the middle of the pandemic, we had to come up with agreements to outline how to work together. Those agreements used to exist a long time ago. As a Health Director, I felt safe because I would sign off an agreement developed at the provincial level every year that outlined responsibilities. These said that B.C. would take care of us in an outbreak, as they do with all British Columbians. We need to redevelop those agreements and clarify the role of Health Directors, the FNHA and B.C. There need to be proper policies, mandates, infrastructure and agreements, so that as Health Directors we have clear partnerships to support the health and safety of our communities.

One result of systemic racism in the context of public health emergencies is the avoidance of care

A significant stigma remains associated with the use of opioids – a stigma that results from many factors including criminalization, social norms and lack of understanding of the nature of addiction and how it intersects with other factors. For Indigenous peoples, the opioid overdose public health emergency has reinforced and magnified stereotypes that already exist regarding addiction and drugs. This reinforcement further results in higher rates of Indigenous peoples not seeking medical care. At the same time, it is more likely that poor quality health care will be received by Indigenous peoples as care assumptions may be made based on stereotypes.

A similar dynamic can be seen in the COVID-19 pandemic. In a recent report compiled by the Union of BC Indian Chiefs (UBCIC), First Nations expressed a priority concern about Indigenous individuals avoiding hospital and/or institutional care as a result of experiences of unethical, racist and discriminatory treatment by health care professionals, as well as broader racist incidents in society linked to the pandemic. This was borne out in the data on care avoidance collected through the *COVID-19 Speak Survey*.¹¹⁷ This 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 also twice as likely as the B.C. population to avoid using counselling services (22% versus 11%). FNHA offered comment to the Review that it has established virtual physician and mental health services to ameliorate this concern.

Jurisdictional complexity is amplified during emergency response, and creates systemic barriers to Indigenous governments in protecting the health and safety of their citizens

In both public health emergencies, resourcing for Indigenous peoples has been provided as part of an effort to support a tailored response to their specific needs.¹¹⁸ However, legislative and policy frameworks do not yet properly recognize the roles and authorities of Indigenous governments, and rest upon colonial instruments such as the *Indian Act*. As a result, there is significant jurisdictional confusion between federal, provincial and Indigenous governments.¹¹⁹ In health emergencies, where coordinated decisions must be made quickly, such jurisdictional complexity is amplified and creates systemic barriers to Indigenous governments in protecting the health and safety of their citizens. As reported by key informants to the Review, these include:

- Lack of timely and complete sharing of data related to positive or presumptive cases of COVID in or near First Nations communities with that Nation's government. There is a mix of both dissatisfaction and lack of clarity about the process by which critical information is disseminated (or not) to impacted communities. There is frustration that information is primarily held and acted upon by the regional health authority and FNHA, rather than with the Indigenous government that holds the right of self-government. This

¹¹⁷ BCCDC. 2020.

¹¹⁸ Examples include funding from B.C. to FNHA for implementation of a Framework for Action for opioid overdose response, funding from B.C. to MNBC for a number of opioid overdose initiatives, and federal and provincial funding to MNBC, FNHA and BCAAFC for COVID-19 response strategies.

¹¹⁹ See the following paper for more detailed discussion https://irshdc.ubc.ca/files/2020/05/UNDRIP_Article6_Jurisdiction_and_emergency.pdf. For broader discussion of Indigenous rights and emergencies see: https://irshdc.ubc.ca/files/2020/03/UNDRIP_Article5_Emergencies.pdf

is a matter of continuing discussion and problem-solving, but no systemic solution has been implemented

- Inability of MNBC to receive opioid data on its population, four years into the overdose emergency, as the necessary paperwork to enable this sharing is still being worked on
- Lack of emergency resourcing for prevention and security measures, such as checkpoints, deemed necessary by Indigenous governments. Instead, these decisions on the part of Indigenous Nations must be ordered by the PHO or a Medical Health Officer (MHO) under EMBC Policy 5.13¹²⁰ for reimbursement of costs, unless ordered by the MHO. In the UBCIC report summarizing the views of its members, First Nations reported significant financial expenditures towards the enforcement of community isolation protocols signage, employment of security/guardians, lack of respect for Indigenous jurisdiction and lack of funding for these services. The FNHA notes that it has received more than \$60 million in federal and provincial funding to assist First Nations communities in dealing with COVID-19.
- Lack of effective integration of First Nations in the supply chain for personal protective equipment and other necessary supplies, even when those Nations are located in close proximity to urban centres. FNHA reports that significant resourcing has been provided to address these challenges and that many of these barriers have been resolved or are being resolved.

“Indigenous peoples have faced racism since settlers arrived in our territories and brought with them the colonial doctrine of discovery and terra nullius. Our people, lands, ways of life, and the fact that we have governed ourselves since time immemorial and exercise self-determination, were not recognized. We were described as inferior and not considered citizens of this country. This deep racism has resulted in marginalization of our people and Nations from the economy, social acceptance of substandard infrastructure in our communities and inequitable health outcomes, and the ignoring of our Title and Rights.

This is why our Chiefs are rightfully concerned about COVID-19. We are not on an equal footing – our jurisdiction continues to be ignored, and we face inequitable social conditions. This exposes our communities to greater risk, without the jurisdictional and economic tools to protect our citizens. The only thing many of our Chiefs could do is close down their communities.

¹²⁰ https://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/emergency-preparedness-response-recovery/embc/policies/eligibility_assessment_supplement_policy_513.pdf

When COVID impacted my community, the lack of recognition of our jurisdiction was at the root of many issues and challenges. We were not able to access adequate supplies in a timely manner, the small pots of funding we received in a piecemeal fashion were inadequate for our scope of responsibilities, we did not receive formal data or information, and contact tracing and quarantine measures simply did not reflect how things work in our communities. Our existing staff were burdened with an even greater amount of work and it was a struggle to provide them support and meet the needs of the communities.

Our communities have been governing ourselves since time immemorial, including providing leadership in times of epidemics. We have survived and thrived. Eliminating racism means respecting our jurisdiction and capability, and the value our governance brings to the health and well-being of our communities and all British Columbians. This is all the more critical as we face future waves of COVID-19. The Premier has the tools to fix this now, and ensure alignment of COVID response with the UN Declaration on the Rights of Indigenous People, including providing adequate funding to First Nations and to First Nation organizations to carry out their jurisdictional obligations to provide for the safety and well-being of their citizens and communities. ”

~ Kukpi7 Judy Wilson
Neskonlith Indian Band and Secretary-Treasurer,
Union of BC Indian Chiefs

Conclusions

The Review concludes the following with respect to the intersection of Indigenous-specific racism and public health emergencies:

- Public health emergencies and pandemics have been met by resilience of Indigenous people over many generations, despite their devastating losses. The compounding impacts of dual public health emergencies and of racism are disproportionate for First Nations and Métis people and the response has not been adequate to date.
- The intersection of this Review and these public health emergencies creates an impetus to achieve the necessary clinical, legal, policy and practice shifts to address racism and uphold Indigenous human rights, particularly as both of these public health emergencies are with us for the foreseeable future.
- The adoption of the *UN Declaration* and passage of the *Declaration Act* in B.C. provide a framework for addressing jurisdictional complexity, and recognizing the self-determination and self-government of Indigenous peoples. Proper recognition of roles and responsibility of Indigenous governments, including in times of emergencies, will help facilitate public health generally.

A focus on mental health and substance use

Threaded across this report and the separate data report is information related to Indigenous peoples' mental health and needs for mental health and substance use services. These needs are disproportionately high, are intertwined with trauma and feelings of unsafety, and are exacerbated by the experience of racism.

Mental health needs

- The First Nations prevalence rate for depression in 2017/18 was 8.3 per cent compared to 7.2 per cent for Other Residents, and for mood and anxiety disorders, was 11.5 per cent and 9.2 per cent, respectively.¹²¹
- With mental health services, First Nations user rates were 1.1 times (physician) and 1.9 times (hospital) greater than Other Residents.¹²²

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.¹²³
- Compared to Other Residents, First Nations user rates for addictions services in 2017/18 were 3.4 times (physician services) and 5.6 times (hospitalizations) higher.¹²⁴

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.¹²⁵
- The BC Adolescent Health Survey of Grades 7-12 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.¹²⁶
- Eleven percent of First Nations aged 6 to 17 had a mood and anxiety disorder in 2017/18, which was 1.3X higher than that seen with Other Residents. In terms of utilization of health services, 9% of First Nations of the same age visited a physician for severe mental health issues in 2018/19. The rates for

¹²¹ FNHA (HSM) 2020.

¹²² FNHA (HSM) 2020.

¹²³ FNHA and OPHO. 2020.

¹²⁴ FNHA (HSM) 2020.

¹²⁵ FNHA and OPHO.2020.

¹²⁶ McCreary Centre Society 2016. Raven's Children IV. Aboriginal Youth Health in BC. https://www.mcs.bc.ca/pdf/ravens_children_iv.pdf

both mood and anxiety disorder prevalence and physician mental illness services showed steady growth from 2008/09, with the latter increasing at 4.5% annually on average.¹²⁷

Relationship with racism

- In the First Nations Regional Health Survey 2015-2017, adults who had experienced racism were more likely to have used illicit substances. The disparity was almost double – 10 per cent of persons who experienced racism also used illicit substances, compared to six per cent of persons who used but had not experienced racism. They were also more likely to report feelings of stress and extreme distress.¹²⁸

Lack of safety

- More than one in five Indigenous respondents were likely to feel “not at all safe” when using mental health or substance use services (23%).¹²⁹

Overdose

- Between Jan. 1, 2020 and Oct. 31, 2020, 32 per cent of First Nations deaths due to overdoses were female compared to 17 per cent in the Other Resident population.
- The gap in overdose-related health outcomes for First Nations people compared to other B.C. residents is wide and continues to grow. From Jan. 1, 2020 to Oct. 31, 2020, the rate of overdose deaths among First Nations was 5.5 times higher than the Other Resident rate. The data also illustrate that these impacts are primarily in urban settings, and are particularly disproportionate amongst Indigenous women.¹³⁰

COVID-19

- 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%).¹³¹

Taken together, this information points to complex and increasing needs for mental health and substance use supports for Indigenous peoples. Various provincial and FNHA strategies, policy statements, and funding announcements recognize this need, yet spending and operationalizing of this funding is lagging, and concerns were expressed to the Review that planning may not be focused in geographic areas and populations where need is most acute.

¹²⁷ FNHA (HSM) 2020.

¹²⁸ FNHA (RHS). 2020.

¹²⁹ Review. 2020.

¹³⁰ FNHA (opioid). 2020.

¹³¹ BCCDC 2020.

“ Racism and stigma cannot continue in our health care system, especially as it relates to mental health and substance use. These combine to make people less likely to seek or receive the services and support they need. We have to work together with Indigenous partners to end racism and stigma while we build out a mental health and addictions system that is integrated and culturally safe and that values and embraces Indigenous models of healing. There is a lot of work to do, but we are eager to do it right. ”

~ Christine Massey

Deputy Minister, Ministry of Mental Health & Addictions

5. Indigenous health care workers face significant racism and discrimination in their work and study environments

Indigenous respondents to the IPS indicated that the most important strategy to improve health care for Indigenous people is more Indigenous representation in health care positions (82% of respondents). However, Indigenous peoples face significant barriers and racism in entering and serving within the health care system. Indigenous students overcome much greater systemic racism, including socio-economic disparities, to reach admission to health professional education, only to be faced with learning and collegial environments reported to be chilling and racked with fear of reprisal for raising issues of racism and discrimination. The racism experienced by Indigenous health care students and workers has a negative impact on their health and well-being. It is career-limiting to voice concern about racism and can bring negative professional impacts, and can lead to decisions to leave their profession. Those who do raise concerns are often traumatized by the experience.

The fact that Indigenous-specific racism is not only experienced by patients, but also by Indigenous health care professionals and staff, reinforces that Indigenous-specific racism in health care is a systemic reality that, in various ways, is seemingly taken for granted and tolerated. A focus cannot be placed on improving the patient experience alone, although clearly that must be a core focus. Rather, a comprehensive approach to change is needed that gets at the roots of racism that exist throughout the health care system, and there must be a positive collegial environment for Indigenous health professionals and staff.

This change must create the safe learning and practice environments necessary to set, strive towards and achieve necessary targets for the training and

education of Indigenous health care workers. There are obvious gaps in the recruitment, training and retention of Indigenous health care professionals and staff, particularly from BC First Nations. While the post-secondary institutions in BC serve a national and international population, it is clear that they do not have adequate focus on the needs of BC First Nations communities and population, as they have no specific targets in that regard and the data does not provide effective visibility into this critical issue.

A Doctor's Experiences With Racism

An Indigenous physician offered the Review some personal observations about the racism they have experienced on the job:

- I have been asked to look after my *"drunk relatives"* in the ER or have had Indigenous patients reassigned to me on the wards [who were considered difficult patients] when I was a resident.
- As a resident, I was often required to advocate for Indigenous patients who were scared and frightened due to mistreatment while they were in hospital.
- Within my first six months at one hospital, I had to report two nurses for unethical behaviour: One for continuously going through patients' personal items looking for drugs and/or equipment used for drugs; the other for lying to the patient about how much medication they were giving them.
- I work in a number of remote First Nations communities now and one phrase that has followed me uttered by Indigenous patients/people since I was a resident is a refusal to seek higher levels of care by going to the ED/hospital because *"that is where our people go to die."*
- As someone who supervises many Indigenous and non-Indigenous residents who are allies in health equity, I have heard many accounts from them of racism they have experienced or have witnessed. The accounts are worse for those who look more *"visibly"* Indigenous.
- I have heard Indigenous residents talk about nurses pulling on their braids in the hospital, which is disrespectful; hearing allied health professionals make derogatory comments about their *"Indigenous sounding"* names or appearances; and being told repeatedly or in many different ways that they get a free ride in society/into medicine and that less is expected of them than others.
- My own family members have left without receiving care because they were told they were just *"drug-seeking."*
- I have refused to go to hospital when I've had life-threatening infections because I am scared of the treatment I'd receive and I'm a DOCTOR. It is also so triggering for me due to my own personal trauma in the health care system.

Reflections

Indigenous health care workers experience prejudice and racism at work

Over half of the Indigenous respondents (52%) who took part in the HWS stated that they had personally experienced racism at work because of their Indigenous identity. These experiences were reported in each of the health authorities.

The majority (59%) of respondents reported hurtful or discriminatory comments from their colleagues. Over one-third (35%) of respondents described feeling like a token Indigenous person when invited to teams or committees. They also reported feeling that colleagues resented them because they thought their education was free (32%), or feeling excluded or isolated from their coworkers (25%). Smaller proportions of respondents said that the prejudice or discrimination they experienced interfered with their function in providing health services, as information needed to do their job was withheld (11%), and that discrimination prevented access to educational opportunities needed for career enhancement (8%).

Racist behaviours directed towards Indigenous staff most often came from other colleagues or people in positions of authority

Indigenous respondents who had experienced racial prejudice or discrimination at work were most likely to report that this behaviour was from a colleague or fellow student (74%), or individual in a position of authority over them (58%). They also reported that prejudice or discrimination came from individuals in another department (33%), a patient or resident (30%) or, to a lesser extent, from family members or visitors of patients or residents (22%).

“At my very first meeting of a group of physician leaders, within less than five minutes of my arrival, one of the physicians came over and very aggressively started a monologue about how First Nations funding was extreme. She honestly said, ‘First Nations people get everything. You should give your budget over to immigrants.’ I do not take kindly to being schooled by anyone – especially non-Indigenous people – on what Indigenous people must do. It has been my life’s work. I pushed back hard, had lots to say to her, but very quickly several physicians came and stood between us, as if we were having a physical fight. It was quite a welcome, and quite an introduction to physician leadership.

It is a strong memory for me. I am often in places where First Nations people have seldom tread [even though this particular meeting was in

my ancestral territory], but this felt like – and still does – a push, a head butt – out of your hallowed halls.

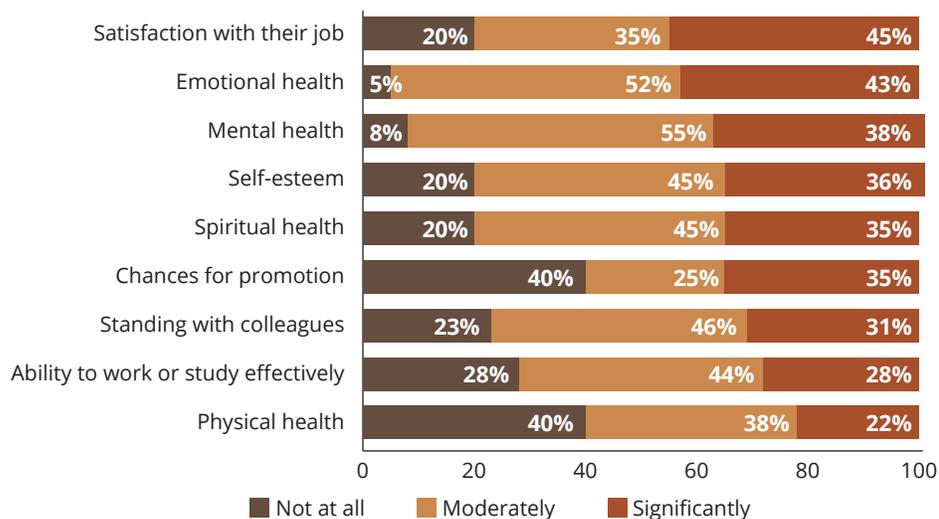
What really stung wasn't her ignorance – most Canadians have what I consider only a basic knowledge about the history and perspectives of the original peoples of Canada – it was her audacity. Clearly, she felt entitled to her opinion. Her thoughts and conviction were more important to her than what or who stood in front of her. In fact, I would say that her opinion about First Nations people prevailed over mine. I've left that group of physicians; I am sure she is still there. ”

~ Dr. Evan Tesla II Adams, M.D., MPH, Tla'amin Nation
Deputy Chief Medical Officer of Public Health, Indigenous Services Canada

Indigenous staff who were the targets of racist behaviour reported that they experienced negative personal outcomes

Over one-half of respondents said they experienced negative effects from racist behaviour. These negative effects included everything from physical health to self-esteem and chances for promotion. Close to 100 per cent of respondents reported moderate or significant negative effects on their mental and emotional health.

Reported effects of racial discrimination at work by Indigenous respondents



Source: Health Workers' Survey

Many Indigenous health care workers did not feel safe reporting the racism they were experiencing or believe that making such a report would create change

Almost half (45%) of Indigenous people who responded to the HWS thought that reporting the experience of racism through established workplace processes would have a negative impact on their relationship with their colleagues in the workplace. Almost as many (42%) believed that making a report would not change the problematic behaviour. Just over one-third (35%) had seen reports previously submitted without it making any difference in the workplace.

Similar dynamics were reported in terms of specifically filing a complaint to a B.C. regulated health profession college about racism they had experienced in the workplace. Over half (56%) were concerned that nothing would come of the complaint. Just less than half (46%) thought that the professional college would not have the sensitivity or awareness to understand the racist behaviour underlying the complaint. A slightly smaller number (41%) of people expressed concerns that their identity would be made known to the person the complaint was made against.

During the interviews conducted with Indigenous health students, residents and professionals across B.C., many expressed fear that they not be directly identified in the course of this Review as they felt it necessary they be protected from recrimination, stating repeatedly that conditions were already “difficult enough” for them.

The Experience of Indigenous Medical Students

With the support of our peers across Canada, we – two Indigenous students at the University of British Columbia (UBC) – designed received ethics approval, and distributed a survey to Indigenous medical students across the country. The purpose of this survey was to give Indigenous medical students an opportunity to provide feedback on how their schools have been implementing the TRC's Calls to Action 23 and 24.

23. We call upon all levels of government to:

- i. Increase the number of Aboriginal professionals working in the health-care field.
- ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.
- iii. Provide cultural competency training for all health-care professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

The survey demonstrated that medical schools across the country, including UBC, have been advancing positive change. However, many Indigenous medical students still feel like they are working and studying within racist environments.

What we heard time and time again from Indigenous medical students is that they are not only having to educate their peers about the colonizing history of Canada – past and present – but they are also having to educate their preceptors and their teachers. What's more is that not only are our preceptors ignorant of this history, they often directly disagree with it. This subjects us to quite traumatizing situations that force us to take time off of school.

As a result, many of us get very involved in advocacy work for our people. And while this is an important honour, some of us burn out because we are constantly fighting against a system that doesn't want to listen, on top of trying to manage all the rest of medical school.

Additionally, there are limited opportunities for students to meaningfully draw upon cultural supports. While schools are saying they want more Indigenous medical students, they actually don't make space for our lives. We often don't get protected time to attend ceremony and don't get protected time to attend funerals in our communities.

We found that the culture of medicine is still racist. True implementation of 23/24 will not occur until the culture of medicine has changed. In order to achieve this change, we have to do more than simply increase the number of Indigenous students in medical school. We also need to increase supports for Indigenous students and make sure they are aware of those supports. We need to increase the number of Indigenous people in faculty and leadership roles. Critically important is mandatory training for all medical students, faculty and preceptors, to increase the number of Indigenous allies in leadership roles and in medicine.

~ Emily Green, mixed European and Algonquin, from Timiskaming First Nation, MD Candidate
~ Celine Hounjet, Red River Métis and mixed European, MD Candidate

There is insufficient supply and training of Indigenous health care professionals

The IPS asked respondents to rate a range of health improvement strategies to make health care settings safer and more welcoming for Indigenous peoples. One of the strategies ranked consistently as “*very important*” was more Indigenous representation in health care positions (82% of respondents).

This is a long-standing priority that was embedded in the *Transformative Change Accord: First Nations Health Plan* in 2006. This Plan committed to measure and publicly report on the “*number of certified, practicing, First Nations health professionals in BC.*” However, in the past 14 years, this indicator has only been recently reported, and only with respect to physicians.¹³²

One of the key ways to increase the supply of Indigenous health care professionals is by increasing enrolment of Indigenous students in health care programs, and implementing proactive strategies to address the barriers that Indigenous students face – including, but not limited to, racism in the learning environment.

In 2018/19, there were a total of 1,186 self-identified Aboriginal students enrolled in health professional programs in B.C., close to 40% of which were enrolled in Registered Nursing programs, and 25% in Health Care Assistant programs.^{133,134} The program groupings with the highest annual growth of Aboriginal students since 2014/15 were Health Care Assistant (12.3%) and Nurse Practitioner (10.7%).

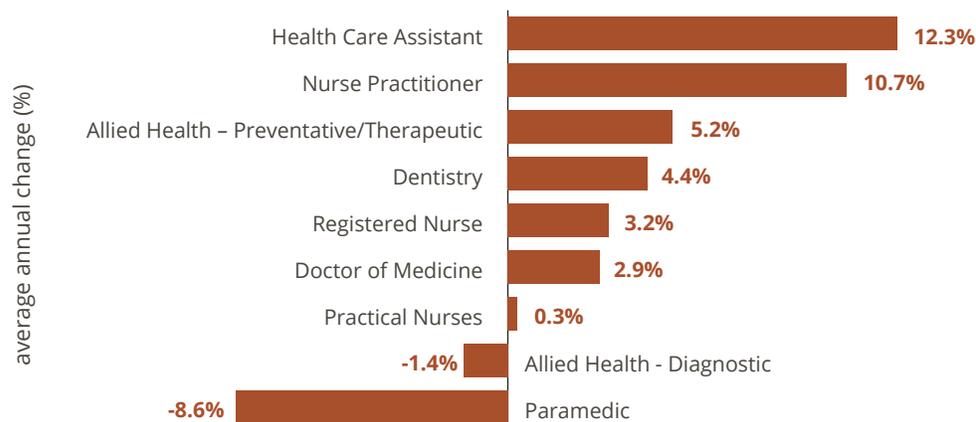
In the entire complement of health professional programs offered through 23 institutions in 2017/18, Aboriginal students represented 7.9% of the student body aged 18-39 years, which was slightly higher than the Aboriginal proportion of the BC population reported in the 2016 Canadian census for those aged 15 to 34 (7.2%).

¹³² FNHA and OPHO. 2020.

¹³³ The self-identification data is limited; after identifying as “Aboriginal”, many students do not go on to subsequent questions identifying whether they are First Nations, Métis, or Inuit, if they have Indian status (where applicable), and what their Nation affiliation is (where applicable).

¹³⁴ This analysis focuses on ten health program groupings representing 23 different health programs.

Most Aboriginal growth between 2014/15 and 2018/19 was in Health Care Assistant and Nurse Practitioner programs



Note: insufficient data to report on midwifery enrolment

The data illustrate a significant interest and growth in health care assistant programs, which in part likely relates to extensive promotion and support of these programs amongst Indigenous people, and in at least one institution, their availability online even before the pandemic. The data also show that there continue to be low numbers and/or limited growth in enrollment of First Nations, Inuit, and Métis students in many health professional programs, including those that are more specialized. A wider time frame shows an encouraging picture of Indigenous growth in the UBC Doctor of Medicine program. Indigenous enrolment in this program increased 36 per cent between 2010-2014 and 2015-2019.

Targets and reserved seats for Indigenous peoples are one way to focus on increased admissions and enrollments in certain professional programs. Yet very few maintain or successfully meet these targets. Reviewing UBC medical programs for Indigenous admissions targets reveals two programs with established targets:

- The Faculty of Medicine Indigenous Medical Doctor Admissions Program since 2002 has set aside five per cent of all available seats each year for qualified self-identified Canadian Indigenous applicants. This target has not been consistently met on an annual basis. In 2018/19, the Doctor of Medicine program had 47 or 4.1% Indigenous students. The Faculty of Medicine has based their 5% target on the 2016 Canadian census which reported that the BC population included 5.9% Aboriginal persons. Not only is their target 80% of what the census has suggested, it is even lower when assessed against

the actual percentage of Aboriginal persons in the age group most likely to be attending medical school. Using the 7.2% proportion obtained from census data for this age group, a cohort of 80 Aboriginal students in the Doctor of Medicine program would demonstrate a population-based parity.

- The Midwifery Program holds two seats for Indigenous applicants (10 per cent). Even though this target has not been consistently achieved, the 2018/19 student enrolment has met this target.
- Other UBC health professional schools do not have reserved seats for Aboriginal students, nor have they met the 7.2% population-based parity noted above, with the 2018/19 occupational therapy Aboriginal student population at 4.2%, physiotherapy at 4.4% and audiology and speech therapy at 6.5%.¹³⁵

“I am a First Nations Registered Nurse with an MSc in Nursing, former President of the Association of Registered Nurses of BC, and former Board member of the Canadian Nursing Association.

My 17 year career-long experiences demonstrates that Indigenous-specific racism and discrimination is found at every level of the health care system, and throughout educational and professional environments. This has been both personally damaging, and career limiting for me.

As an undergrad student I was told by a faculty member to “leave your Indianness at the door”, as a graduate student I was told that my offer to mentor Indigenous students new to nursing was “not possible”. I was labeled as “one dimensional” and “too Indian” for advancing issues of importance to Indigenous people while in nursing leadership positions. Continuous roadblocks and excuses were the norm in response to any ideas related to integration of Indigenous perspectives in both my practice and my nursing leadership roles.

Indigenous patients experience racism as well. In my work as a nurse, I have seen time and again the relief expressed by Indigenous patients when they see that I am working on the day they come to the ER. There have been experiences in my own family where we have been discriminated against and received care that does not meet the standards of care that we have committed to provide as health professionals.

A commitment to care is what draws us all to the health care profession. We are united in our belief in a “culture of caring”. Nurses do the heavy lifting across the health system, and can lead the work to drive positive change at the front line, where it is most needed. I believe that the

¹³⁵ Submission from the University of British Columbia to the Review. 2020.

nurses of BC and nurses across this country can have a critical role in eliminating Indigenous-specific racism and discrimination from our health care system. ”

~ Tania Dick, Dzawada’enuxw First Nations
First Nations Health Council member, Vancouver Island region

Conclusions

The Review concludes the following with respect to Indigenous health care workers and students:

- Increasing the number of Indigenous health care workers is a critical strategy to enhance cultural safety within the health care system. It is also a key strategy to support the socio-economic development of Indigenous communities and populations.
- There is increasing but insufficient enrolment in, and very few and insufficient targets established for Indigenous student admission to, health care education programs. To be successful, such targets must be accompanied by strategies to eliminate barriers to admission and support retention of Indigenous students.

“The Faculty of Medicine will actively collaborate in the work needed to transform our health care system to make it accessible, safe, and a positive contributor to the health and wellness of Indigenous people and populations. We are fully committed to supporting the recommendations put forward to the University. There is much work to be done and we will stand up. ”

~ Dr. Dermot Kelleher,
Dean, UBC Faculty of Medicine and Vice-President, Health

- Changes are needed in the learning environment to address the racism experienced and witnessed by students. This includes assessment and training of faculty members in anti-racism and Indigenous cultural safety, and improved mechanisms for students to report incidents of racism that occur in both university and health authority learning environments. The development of Indigenous faculty could also assist with Indigenous student safety, the development and delivery of Indigenous curricula, admissions support, and play a role in remediation of racism in medical education.
- Indigenous staff and health care professionals experience racism in their collegial and workplace environment and often experience barriers to retention, promotion, particularly if they speak up and seek to have the racism and discrimination addressed within that setting.

- Changes are needed in the work environment to address the racism experienced and witnessed by Indigenous health care workers. This includes improved mechanisms for health care workers to report incidents of racism that occur in the workplace, and integration of racism and bias assessment in hiring processes. This should also consider formalized networks or associations for Indigenous health care professionals within regulatory bodies and associations or as stand-alone entities to provide support, mentorship, and assistance to support the retention and well-being of Indigenous health care professionals.

Keegan's Tragic Death Shines Light on Importance of Cultural Safety

Keegan, a 29-year-old First Nations man, died in hospital in 2015 following delayed diagnosis and treatment for an accidental poisoning. He was a high school graduate, a grade 10 pianist, and a chess champion enrolled in a trades college at the time of his death. Keegan also lived with disabilities and was mostly non-verbal by choice. He is remembered, missed and loved by his family, caregiver and those who knew him.

On the afternoon of Sept. 15, 2015, Keegan's caregiver called 9-1-1 after finding him at home slumped, incoherent and covered with vomit. Keegan was admitted to an urban hospital, where he spent the night without receiving a diagnosis or treatment, despite lab results indicating the cause and severe health consequences of his condition being available within three hours of his arrival at the ER.

Those lab results indicated that Keegan had ingested toxic levels of methanol and was experiencing a medical emergency (metabolic acidosis). However, it took more than 12 hours from the time the lab results and the cause of Keegan's condition came in, to the time that he was diagnosed. Missing these results prevented Keegan from getting timely access to treatment. By the time it was determined that Keegan had accidentally ingested methanol – which is highly toxic but treatable if caught in time – his condition had deteriorated while in the care of the health system to the point where he required intubation and was admitted to the ICU. He died on Sept. 26, 2015.

Keegan's caregiver, who is also Indigenous, identified a series of culturally unsafe experiences with the health system that contributed to his preventable and unnecessary death. These included a sense that health care workers had a preconceived bias – “*we know Keegan*” – that affected the way he was cared for, including an initial reluctance on the part of paramedics to even take him to hospital. Once at the hospital, the caregiver felt that her worries about the severity of Keegan's condition were not taken seriously or acted upon.

Six hours into Keegan's hospital stay, with lethal toxicity levels in his system, he was showing increasing signs of illness and was still undiagnosed. No further lab testing was sought, no internal medicine consult had been ordered, and he had still not seen the physician in charge. At one point during this first night in hospital, a resident wanted to discharge Keegan, leaving the caregiver to have to advocate to keep him in hospital. Later that night, the same resident recommended to the caregiver that a DNR order be placed on his file while in the same room with Keegan. His caregiver felt the request for a DNR order reflected that the resident did not feel Keegan's life was worth saving, and only saw him for his disabilities – not his many abilities.

When Keegan's caregiver left the hospital in the evening for a rest, she put trust in the health providers that they would monitor and respond to any issues that arose. However, that night he was restrained, neglected and his condition worsened to the point of critical. Medical directives and protocols were not followed.

Following Keegan's death, the caregiver was disappointed with both the initial Coroner's Report and the patient safety review conducted by the health authority. She says neither process adequately included her or the family, or recognized the lack of cultural safety for Keegan at the hospital and the significant role systemic racism played in how he was treated. She believes Keegan received inferior care due to the fact that he was Indigenous and lived with disabilities.

Keegan's supporters believe the lack of urgency and neglect that he experienced at the hospital suggested that he was being left to 'sleep it off' and echoes common experiences of racist stereotypes regarding Indigenous people that are shown to lead to discriminatory behaviour in emergency health care settings. Layered on top of this was a failure to effectively navigate Keegan's disabilities. They stress that patients with complex needs, including those related to living with disabilities, substance use, or other challenges that may lead to frequent engagement with the health system, deserve to receive quality health care like anyone else.

In the years since Keegan's death, his caregiver has worked persistently to advocate for changes at the hospital and within the health care system that would prevent discrimination and harm to other First Nations patients, including those with disabilities.

Her advocacy efforts led to a meeting that involved First Nations leadership, First Nations health leaders, and health system leaders that responded with shared commitments to make things right, and work to make things better. A ceremony took place at the hospital where a plaque and artwork were installed in Keegan's honour. Leadership statements were made by the regional health authority acknowledging that systemic racism exists, and their commitment to work with First Nations.

6. Current education and training programs are inadequate to address Indigenous-specific racism in health care.

There is no mandatory training for health care staff on Indigenous cultural safety and Indigenous-specific racism despite this commitment being made by the province 14 years ago, in the *Transformative Change Accord: First Nations Health Plan*. Similarly, there is no mandatory content threaded across professional programs, which have very few Indigenous-specific health courses and where relevant content, if offered at all, is within general social determinants of health, and race and culture courses.

“Patient care starts with caring for patients. I know that emergency care providers are caring individuals but we are not perfect. We all have unconscious racial biases. This Review provides us with an opportunity to reflect on our behavior from the eyes of others. We pride ourselves in our professionalism, and believe that we treat all others equitably and without bias – always in a caring and compassionate manner. This Review shows us that, unfortunately, this is not always the case. Each of us needs to reflect on our own behaviours and thoughts. Each of us

must make a conscious commitment to ensure that our actions are always appropriate, that we recognize our unconscious biases, and that we are all responsible for pointing out to each other any inappropriate behaviours that we witness. We can all make a difference as individuals and as a community. I invite all of my colleagues to join me in playing their part in ensuring that inappropriate and prejudicial behaviours are not tolerated in our learning and working environments. ”

~ Jim Christenson, MD FRCPC
Professor and Head, Department of Emergency Medicine, UBC
Executive Lead, BC Emergency Medicine Network

The Review also found that current training is operating in isolated and independent pockets without an overall conceptual framework, and with no standardization or overarching theory.

Access is limited, not timely, and not universal. It is largely unfunded and therefore only covered by larger organizations with available resources. The training is of mixed quality. There is no systematic, long-term evaluation to determine if existing programs are creating the change they seek. Informants do not believe that online and awareness-raising training in and of itself results in practice change.

Both Indigenous patients and health care workers called for increased educational opportunities, an improvement in the quality of the training, and emphasized the need for mandatory training in foundational topics dealing with colonialism, Indigenous experiences and the impact of historic and current racism on the health of Indigenous peoples. The current level of training falls far short of being able to meet this demand, and create systemic change within the health care system.

“Racism I have witnessed”

A non-Indigenous registered nurse in a senior leadership position offered the Review *“a few examples of the racism I have witnessed”*:

- A patient in acute pain in the ER being told they were drug-seeking and to “go back to the Rez”
- An Indigenous female patient being referred to as a “Squaw”
- An Elder who complained about her nurse, being left without hygiene support while the three other patients in her room were assisted to wash and bathe
- A nurse mocking an Indigenous senior female about her weight
- A nurse touching and holding an Elder’s ceremonial bundle without asking for permission
- An Indigenous renal patient being considered to be taken off dialysis because “he can’t comply”
- Indigenous staff being asked to drum and sing at organizational announcements and events; then told “You only have five minutes”.

Reflections

The San'yas Indigenous Cultural Safety training program requires a reset

The San'yas Indigenous Cultural Safety (ICS) training is offered through PHSA's Indigenous Health Program.¹³⁶ It was developed in 2009 in response to the *Transformative Change Accord: First Nations Plan* commitment that stipulated that First Nations and the Province would develop and provide mandatory training for cultural competency. The Core ICS Health module offered by San'yas is broadly considered the primary foundational training for health care practitioners in B.C. and is promoted or supported by many health regulators, health authorities and other health organizations.

Although originally envisioned as being mandatory for Ministry of Health and health authority staff, participation remains largely voluntary and completion rates reflect the lack of commitment and resources for training related to these issues. In the 10-year period from 2009/10 to August of 2020, the Core ICS health module has been completed by an average of approximately 2,660 people a year, for a total of 30,489 people. This is a miniscule percentage of the approximately 200,000 people who currently work in health care in B.C., particularly when one considers the turnover in staff that has occurred during this time period.

Long-term evaluation data regarding whether this training has improved the practice of professionals or has contributed to a decrease in racism within the B.C. health system has not been collected; this, as well as the inability to accurately track who has taken the course, was expressed as an issue in gauging effectiveness and supporting system-wide change. The assessment provided by informants to the Review was generally consistent in acknowledging the value of gateway and awareness-raising programs such as San'yas, when purposefully identified as an early awareness-raising step in a longer and more intentional learning journey, supplemented with further training opportunities, such as those that reflect local and regional Indigenous contexts, and which drill down to the work and practice environment.

¹³⁶ San'yas ICS training brings together a cohort of anonymous participants with a facilitator. Individuals work through training modules via individual and group forums that are shaped by the facilitators. The content includes information on culture, stereotyping and the impacts of colonialism; specific topics include diversity, history (i.e., residential schools and Indian hospitals) and terminology. Participants are encouraged to discuss their lived practice and personal experience of interacting with Indigenous populations, provide examples of these interactions, and discuss their views with the goal of promoting shared learning and developing positive partnerships between service providers and Indigenous peoples.

Accessibility was frequently expressed as a concern by health system organizations, with barriers including the costs associated with tuition, time off for staff and long wait lists. The lack of core funding for San'yas has created an incentive for the program to make seats in the program available in other regions and to develop modules for areas other than health.¹³⁷ This is contributing to a proliferation of approaches, as organizations of various sizes within B.C. attempt to provide their staff, registrants and leadership with some form of low-barrier education and training on cultural safety and humility, Indigenous history and Indigenous-specific racism.

San'yas at a Glance

Since its inception in 2010, San'yas has trained approximately 125,000 participants, primarily in B.C., Ontario and Manitoba. Just over one-third of participants (44,297) were located in B.C. There are 12 different training modules which have been developed for various audiences, including health, child welfare and justice. Looking at B.C. only:

- With respect to all training modules, one-half of participants were in direct service/clinical positions (51.8%), with administrative support/human resources/information technology positions accounting for 17.0%, leadership for 8.4% and the academic sector at 6.6%.
- 69% of the 44,297 B.C. San'yas participants have completed the Core Indigenous Cultural Safety (ICS) Health Training.
- After Core ICS, the highest utilization of modules has been the Core ICS mental health (11.6% of participants) and Core Foundations for non-health professionals working in organizations such as justice, education, business, and government (7.4% of participants).
- The Core ICS current annual enrolment is approximately 3,500.
- If based on the number of health care workers in the province's five collective agreements and the physician workforce, the reach of the Core ICS is about 2.5% annually. This coverage drops to 1.4% annually if considering the entire health and social workforce in the province.¹³⁸ These are gross estimates that do not include turnover/attrition of the workforce.

¹³⁸ The government estimates that there are 250,000 health and social workers who are eligible for COVID-19 pandemic pay. <https://globalnews.ca/news/6960819/pandemic-pay-b-c/>

¹³⁷ San'yas is offered in B.C., Ontario and Manitoba. Currently, San'yas offers the following online courses: Core ICS Health; Mental Health; Child Welfare; Justice; Cross-Sectional Foundations; and Bystander to Ally. 125,000 participants in these regions have taken one of these courses. The 29,000 participants from B.C. who have taken the Core ICS Health course represent 23% of this total number of participants.

In addition to the proliferation of training, another frequently expressed concern from key informants is the lack of integration of training. It was noted that there is no collective ownership or influence by the health system – particularly regional health authorities – over the San’yas program. Paired with the accessibility issues noted above, this is leading to very limited integration of San’yas with the training that each health authority currently offers. The early model for the program, the development of which was initially co-funded and governed amongst the regional health authorities and PHSA, has drifted through time.

“The San’yas training program is one tool, and should be part of a larger toolkit that needs to be further developed. For many years, this has been our only tool available in B.C. and beyond, and is used by other jurisdictions across the country to do basic training on Indigenous peoples history and experiences. It has the advantage of being well-known and recognized. I believe there is a solid foundation for San’yas to be recalibrated and integrated with additional necessary training at the clinical level for B.C. health care workers. This Review has unquestionably demonstrated the problem of individual and systemic racism against Indigenous peoples and our accountability to fix it. I look forward to actively contributing to the implementation of this Report’s recommendations, which aim at meaningful cultural safety transformation in B.C. I trust we can collectively achieve world class results in this context.”

~ Benoit Morin
CEO, Provincial Health Services Authority

Health authorities and regulators are independently developing Indigenous-specific racism and cultural safety and humility education and training

Each regional health authority has largely independently developed education and training specific to their organization, some of which include San’yas and others which do not. For example:

- Island Health has developed a number of initiatives conceptualized within an Indigenous Cultural Safety Learning Journey.
- Interior Health has developed four online modules that, as of Oct. 6, 2020, had been completed by more than 20,000 Interior Health employees (93% of all staff). These are supplemented by instructor-led training targeted to specified high-priority staff.

- Fraser Health offers a mix of nine virtual and in-person courses that include foundational Indigenous health and cultural safety concepts as well as more specific courses in subjects such as two-eyed seeing and mental wellness.
- Vancouver Coastal has developed and evaluated an Indigenous Cultural Safety pilot project at Vancouver General Hospital which included a foundations course and subsequent learning circles.
- Northern Health has developed and offers a number of training modules available internally as well as externally with nursing students at the College of New Caledonia and UNBC.

“One of the things that we have done in our organization is to create communities of practice where people can come together. We’ve been doing this for about three years now. These forums provide space for employees to come together to talk about cultural safety and humility. Participants are encouraged to bring ‘wicked problems’ that they’re facing in their work. It’s a safe place... It’s a safe space for people to bring forward difficult questions and challenges that they may not bring forward in a large group or day-to-day work. We’ve created this safe space as a complement to training... Just because you take some training, that doesn’t mean the learning stops. It took us a lifetime to learn our various individual values and the ways that each of us is now, as individuals. Discussions in spaces such as these allow us to reflect upon these sorts of personal attributes and the work that lies ahead.”

~ Health care lead

Providence Health Care and regulatory colleges are also designing or providing some form of training or educational materials to their leadership and staff that are supplemental to, or in place of, San’yas. These are taking the form primarily of reading lists, webinars and workshops on implicit bias, race and Indigenous cultural safety. Many of the regulatory colleges emphasized the variable capacity across their organizations, the need for more collaboration and sharing of tools and resources, and the pressing need for low-barrier and no-cost options.

It is accepted by key informants that a coordinated and coherent approach to building understanding and skills for creating cultural safety and addressing Indigenous-specific racism should be a mandatory part of advanced training throughout the work life of all health professionals. This is opposite from what is currently taking place. Current efforts to address this need are disconnected and not part of an overarching strategy intended to achieve any accepted standard. Further, inequities and inefficiencies exist as a result of a lack of

proactive and resourced coordination and knowledge exchange across the health sector.

There is inconsistent training about Indigenous-specific racism and health needs in post-secondary health care education and training programs

The Review examined course outlines within 22 regulated health professions at public college and university institutions in the province.¹³⁹ While most, although not all, programs offer specific race and culture courses, there are few that offer Indigenous-specific courses. There were 35 Indigenous-specific courses identified, only 13 of which were specific to Indigenous health (the remainder were generally about Indigenous people and issues and not specifically health-related). It is unknown how many of the Indigenous-specific or Indigenous-specific health courses were developed in conjunction with Indigenous people and communities. A number of programs offer some Indigenous content within their equivalents of race and culture or vulnerable population courses.

“We really do have to get at where people are being trained and what kinds of courses are included. Or, examine the experiences people have in their training within the health care system. I think that if they don't learn anything in these programs about who they may be serving, then what are they really learning? What are people being taught in their residencies or practicum? If there's already racism in the system, it could be perpetuated even further.”

~ Health care lead

This exercise revealed wide variability and inconsistency in education about Indigenous-specific racism, health and cultural safety amongst health profession education and training programs at the post-secondary level in B.C. Many key informants emphasized the need to move upstream in providing mandatory education on cultural safety, Indigenous human rights and Indigenous-specific racism, so that the health system can focus on continuing education in the practice setting, and foundational training for those health workers who do not receive health professional education in B.C.

“We are going to have a larger impact by getting in front of up-and-coming health professionals.”

~ Health care lead

¹³⁹ This relied on program websites to collect the outlines. Not all course outlines were available online nor were all up to date.

Conclusions

The Review concludes the following with respect to education and training of health care workers and students:

- Cultural safety and anti-Indigenous racism training for health care workers is not universal to all health care workers in BC. It has not reached enough workers and is inadequate to address Indigenous-specific racism in health care. There is little or no evidence that current forms of training are having an impact at the practice level in the clinical settings where health services are delivered.
- The current voluntary model with limited uptake is not sufficient. Building understanding and skills for creating cultural safety and addressing Indigenous-specific racism, including how to confront racism both in the classroom and once one is in practice, should be a mandatory part of training throughout the work life of all health professionals and staff.
- A cohesive and coherent training pathway is needed for health student and workers, including clear mandatory requirements as well as multiple opportunities for advanced and deepening training. This should include a standardization of the foundational introductory material to ensure the acquisition of a common knowledge base across professions, as well as the development of more Indigenous health-specific modules grounded in the specific profession and/or workplace and respectful of local Nations.
- There is a need for a standardized and low-barrier starting point for health worker education related to colonialism, Indigenous-specific racism and Indigenous health and wellness that is specific to B.C. This “onboarding” type of training must be designed with further opportunities in mind for education and training that demonstrably result in practice changes and which relate directly to the Nations and territories in which health workers practice. Training at the clinical level must reflect direct and meaningful engagement with First Nations peoples on whose traditional territories such services are delivered to be respectful, meaningful and culturally safe.
- Greater coordination and knowledge exchange are needed to support continuous learning and enhanced access to available education resources for health workers and students. This includes enhanced data and longitudinal evaluation. We need to know how our education programs targeting Indigenous-specific racism do, or do not, effect positive change, so that we can continually refine and target our efforts.

- Development and evaluation of system-wide work on education and training should be led by an organization seen as somewhat independent of the health authorities so that accountability mechanisms can bring issues forward rather than cause splintering of the approaches throughout the system, as is now the case.

“In order to better integrate cultural safety into their practices, doctors need additional training opportunities that are accessible to both facility-based and community-based doctors. The voice of doctors should join the Indigenous voice in the development and delivery of any new training programs to ensure that training meets doctors’ need, which will enable doctors to meet the cultural safety needs of their Indigenous patients and colleagues.”

~ Allan Seckel
CEO, Doctors of BC

7. Complaints processes in the health care system do not work for Indigenous peoples.

Patients have a variety of options to lodge a formal complaint before, during or after a service has been provided. Complaints may be filed directly with a care provider, health authority Patient Care Quality Office (PCQO), a health care provider’s regulatory college, or all three. Where complaints are not resolved to a patient’s satisfaction, review boards exist for both the health authority and regulatory college complaints processes. Both of these processes are required by legislation.

Additionally, the FNHA has established a quality office and associated complaints process for FNHA-funded and FNHA-delivered services, which also serves as an avenue for Indigenous clients to navigate health authority and regulatory college complaints processes. This is not a legislated process.

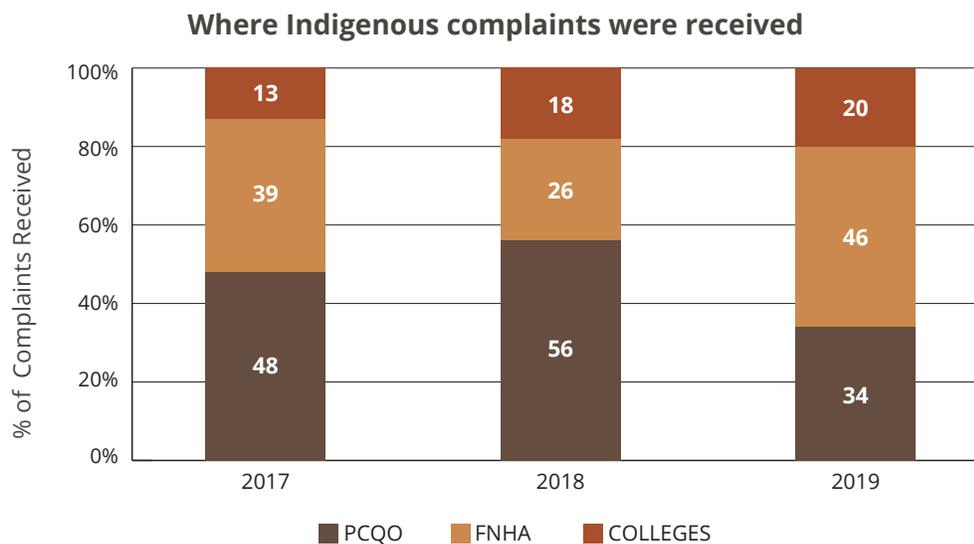
The Review gathered and analyzed data regarding the use of these complaints processes by Indigenous peoples. The evidence demonstrates that these processes are not easily accessible to Indigenous people, do not include space for Indigenous processes and methods, and can reinforce experiences of racism 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. To rectify this, an integrated, accessible and culturally appropriate Indigenous complaints process is needed.

Reflections

Indigenous people find the complaints process inaccessible, and this is reflected in a low number of complaints filed by Indigenous people

The number of complaints made by, for or about Indigenous people is small when compared to the many negative health care experiences that have been shared with the Review, and the existing data regarding Indigenous interactions with the health care system. 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. This three-year total amounts to an annual average of roughly 118 complaints.



This is consistent with findings of both the HWS and IPS, which inquired about the willingness of Indigenous peoples to make complaints. When asked about making complaints regarding poor treatment in the health care system, Indigenous respondents to the IPS were significantly less likely to report being willing to make complaints, and significantly more likely to cite a number of reasons for filing a complaint if they had grounds to do so than non-Indigenous respondents.

Though there were some significant differences by gender and age¹⁴⁰ in willingness to make a complaint when treated poorly, Indigenous respondents encountered similar barriers and emphasized the same priorities for improvement in the B.C. health care system.

The top three reasons as cited by Indigenous respondents for not making a complaint include:

- That their complaint would not be taken seriously (31%)
- That they would be treated poorly or unfairly through the complaint process (27%)
- That they would receive worse treatment from health staff for any future medical condition (25%).

The top three reasons as cited by non-Indigenous respondents for not making a complaint include:

- That it would take too much effort or energy (19%)
- That their complaint would not be taken seriously (17%)
- That they would receive worse treatment from health staff in future (13%).

These findings show that, although there are some similarities between Indigenous and non-Indigenous respondents regarding reasons for not submitting a complaint, the groups differ regarding their top reasons, with Indigenous respondents significantly less likely than non-Indigenous respondents to indicate that effort or energy required would be a barrier to making a complaint and significantly more likely to indicate that their complaint would not be taken seriously. Although Indigenous and non-Indigenous respondents interact with the same system, their perceptions and experiences within that system can be quite different.

Nearly one-half of health workers who responded to the HWS 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 respondents, compared to non-Indigenous respondents, reported that they would place a complaint if they thought it was necessary.

¹⁴⁰ Women were less likely than other gender groups; respondents ages 50 and older were more likely than other age groups.

All health worker respondents were similar in the top three barriers that would stop them from placing a complaint with their supervisor about racism or discrimination they experienced. The most commonly reported reasons were:

- potential that it could adversely affect a relationship with colleagues in the future (45% of Indigenous respondents)
- the respondent did not think making a complaint would change behaviour (42%)
- the respondent had seen complaints submitted in the past and felt it did not make a difference in their workplace (35%).

Another series of questions asked about health worker views on placing a complaint with a B.C. regulatory college. Smaller proportions of Indigenous respondents compared to non-Indigenous respondents responded that they would place such a complaint if necessary. Higher proportions of Indigenous respondents reported barriers to utilizing college or registrar complaints processes.

“We welcome the findings from Ms. Turpel-Lafond’s report. It is deeply disturbing to contemplate the extent to which Indigenous-specific racism has been embedded in our health care system, and the devastating impact this has had on health outcomes for Indigenous people. But we must confront it head on if we want to break this destructive cycle. BCCNM is committed to acting on the recommendations outlined in the report, in consultation with Indigenous communities, patients and clients, registrants, and our other partners. Together, we can create a health care system where everyone can receive culturally safe, person-centred care.”

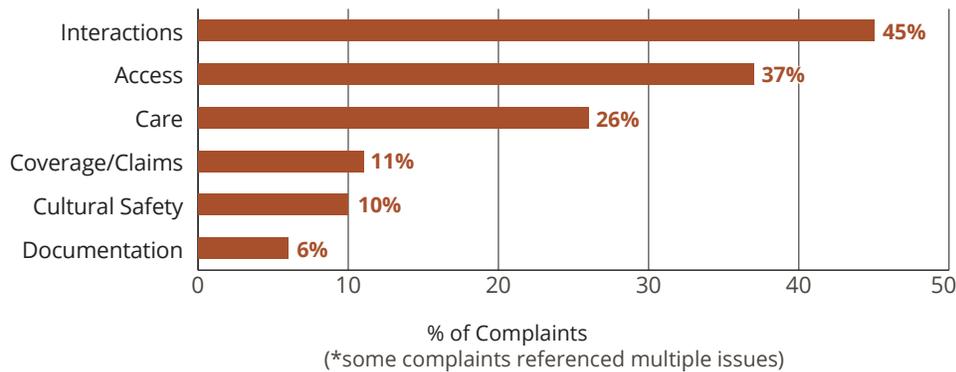
**~ Cynthia Johansen, Registrar & CEO,
BC College of Nurses and Midwives & Chair, BC Health Regulators**

The types of complaints Indigenous peoples have filed are most commonly connected to matters related to racism, including negative interactions, stereotypes, denial of treatment and cultural unsafety

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. 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.

The most common issues included in complaints were interactions with providers and access to care



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.

Most complaints of racism and discrimination by Indigenous individuals are not meaningfully addressed

There was little evidence that complaints officers were routinely identifying the cultural identity of complainants or patients. 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, reports of disrespectful, racist or discriminatory behaviour were justified with reference to the provider's 'true' intentions, met with broad statements of the responding body's commitment to cultural safety, or 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 focussed 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.

“The system has an enormous opportunity and obligation to improve, particularly in how we handle complaints. A complaints process is not just about being heard and addressing the issue raised, it is also about re-building rapport and trust. When people experience harm, they want three things: to know what happened, to receive an appropriate apology and most importantly to know, and be a part of, what will be done to improve and ensure something similar won't happen to others. People are often able to forgive the event itself when these three things are in place. What they won't forgive, or be able to move on from, is how they were treated after the event happened. Modelling after the restorative justice approach that has been used in the legal system will support re-building trusting relationships so that Indigenous people feel safe to seek and receive care. Establishing an approach based on reciprocal accountability will provide a foundation to honour and build upon existing efforts of Indigenous communities as well as the health care system to help eliminate the systemic Indigenous-specific racism that currently exists.”

~ Christina Krause
CEO, BC Patient Safety & Quality Council

Current improvement efforts are uncoordinated and lack a systemic focus

There is some evidence from across complaints processes of individual complaints officers striving to manage complaints involving Indigenous people respectfully and, at times, their work clearly has a direct impact on improving the quality of service delivery.

There is also some evidence of local and regional improvements being made at the health authority level, including pilot projects to integrate Indigenous cultural safety into PCQOs, and to address the lack of an Indigenous identifier

in the complaints data system. Some health authority Indigenous patient navigators and liaisons help patients navigate the complaints process but the function of these roles varies across the province, and this support is much less likely to be found in rural and remote areas or centres with limited health infrastructure.

At a regulatory level, it has been recognized that the complaints investigation and discipline processes – as currently existing in the *Health Professions Act* – “needs significant revision to make it more efficient and effective, transparent and fair” and that this revision process must be done, “... in a manner that acknowledges deeply rooted, historic health inequities and combats systemic racism...”¹⁴¹ This work has only just begun.

These efforts and complaints processes are independent and isolated from one another, with any improvement efforts being undertaken primarily within a specific organization or a specific complaints process, and not in a system-wide manner that considers the unique needs and experiences of Indigenous peoples.

“Many of our citizens in Fraser Region have called on me to assist in bringing attention and resolution to unacceptable and egregious incidents of racism they have experienced. This shows a lack of trust in the complaints processes, and a lack of faith that anything will change without political pressure. Bringing some form of closure to these incidents has involved working in partnership between Fraser Salish Health Caucus and the Fraser Health Authority. Together, with the Fraser Health Chair, Directors, CEO and senior executives, we draw upon our cultural teachings and practices for guidance, and honouring those who have experienced harm. We seek to demonstrate learning from their experience and ensuring it does not happen again. We need to design and implement a systemic complaints process that reflects these approaches, and that our people can trust.”

~ Grand Chief Doug Kelly, President, Stó:lō Tribal Council & former Chair,
First Nations Health Council

¹⁴¹ In response to concerns regarding governance and operations of the College of Dental Surgeons of British Columbia (CDSBC), the Minister of Health launched a two-part review into the administrative and operational practices of the College in 2018; these reviews are collectively referred to as the *Cayton Report*. A provincial response to this report, *Recommendations to Modernize the Provincial Health Profession Regulatory Framework: Steering Committee on Modernization of Health Professional Regulation*, was released in August 2020.

Conclusions

The Review concludes the following related to complaints processes:

- Current complaint processes are not responsive to the circumstances of Indigenous peoples or designed to address the individual and systemic racism widely experienced by Indigenous peoples. This feeds the perception that the health system has set up a complaints process intended to protect itself and its providers from the public, rather than to protect the public.
- Current complaint processes do not have the capability and skills to appropriately identify, investigate, verify and support resolution of issues related to racism and discrimination, often do not validate the Indigenous person's experiences, and do not have a grounding in Indigenous human rights as described in the *UN Declaration*.
- Indigenous populations do not see current complaints processes as a viable option owing to perceptions of systemic discrimination, fear of reprisal and a lack of trust.
- Improvement efforts to the current complaints processes remain ad hoc, independent and isolated from one another, and do not centre the unique needs, methodologies and experiences of Indigenous peoples at the core of system design and transformation.
- Complaint processes do not have Indigenous staff to build cultural safety in the process and are not incorporating Indigenous practices and protocols for conflict resolution.

8. Indigenous health practices and knowledge are not integrated into the health care system in a meaningful and consistent way.

Although specific practices and systems differ across cultural, language and family groups, Indigenous health and well-being is often characterized by a wholistic model that balances emotional, spiritual, physical and mental health. Prior to colonialism, First Nations communities had their own systems of care and individuals with community roles and responsibilities who supported their health and well-being, such as healers, traditional medicine experts and midwives. With the arrival of Europeans, First Nation health systems and roles were disrupted, traditional knowledge about health and wellness dismissed and suppressed, and a different set of values, norms and practices imposed.

Today, Indigenous peoples consistently report that traditional practices and ancestral knowledge remain important components of culture, health and well-being. They also report that the care environment as it currently exists does not reflect their beliefs and needs, nor is it supportive of their treatment

One Family's Struggle to Find Supports for Their Son

An Indigenous woman told the Review about her family's long and often frustrating experience with the health care system over the past 11 years, following her son suffering a brain injury and mental health challenges.

The son, who is First Nations, was injured in his late-20s, resulting in complex mental health impairments. His family, in particular his mother, have advocated strongly to obtain assessments, services, funding – and at times even the simple courtesy of a return phone call – from medical professionals regarding their son, who suffers from severe anxiety disorder, PTSD and a brain injury as well as a continuing substance abuse disorder. He has been deemed not 'damaged enough' to be fully funded for supportive housing and that has resulted in the family's ongoing struggles to find appropriate, culturally suitable and affordable supports for their son to live life to his full potential.

These efforts have left his family feeling frustrated and exhausted, particularly with having to share their family story over and over again. Without a Representation Agreement, which they feel is culturally biased, many doors have closed, and so the family finally had one put in place. Indigenous families have historically supported each other and been present at family and community events without question or the need for an 'agreement'. The requirement to have a legal agreement to receive information that is vital to support her son has left this Indigenous mother appalled at the systemic racism within this process. She says there is no seamless system that can help an Indigenous family navigate through all that is required to obtain services for their loved one and themselves and that this type of continual interface with a colonial health system is trauma inflicting. *"I am an educated person and I know how to advocate for my son," she says. "However, I can only imagine what Indigenous families who don't have these resources are up against in facing such a confusing health system."*

The long road for this family has included their son being inappropriately discharged from hospital without a discharge plan or support services. It has included being dismissed by some mental health and medical professionals and treated with some disdain and judgement regarding his alcohol use when it was colonialism that brought alcohol to Indigenous communities. The woman says their son's holistic health needs and artistic talents and cultural values, such as family centeredness, have been disregarded or ignored as potential healing avenues. Their journey has also included inappropriate and damaging living arrangements. One service provider actively resisted their son's harm-reduction approach and showed a troubling lack of understanding about cultural safety and need for family and community involvement that is not 'managed' or 'controlled'.

The young man has recently moved into a much better living situation with an Indigenous caregiver who understands him and provides a safe and loving home. He is also well supported by a strong Indigenous team who approach harm reduction through an Indigenous lens. *"I feel I can finally get a bit of rest because my son is in a caring, supportive Indigenous home of which we need many. I am convinced that this model of Indigenous community and family care is the key. We hope there is some funding to open the doors to others needing this type of supportive environment and community of caring. I hope your report can help with that."*

modalities. This is consistent with the minimum standards in the *UN Declaration* regarding the use and inclusion of Indigenous health practices and knowledge.

The Review found that current efforts to enhance access to traditional and ancestral medicine and healing are inconsistent and sporadic across regions, facilities and providers, often driven by a few individuals or experts, and not rooted in an understanding of the necessity for Indigenous approaches to health and wellness as part of creating more effective and less discriminatory approaches to Indigenous health.

For example, Indigenous ethnobotany might be given limited examination today in schools of anthropology or environmental studies but is not effectively tied into health professional or post-secondary research contexts. The limited current approaches are consistent with a colonial “collections” approach rather than with working together with Indigenous peoples on their living health practices approach with the use of plants, medicines and practices to promote health and wellness. Cultural humility and respect for Indigenous medicine, and wellness has been identified as requiring a land-based approach to learning and respect for Indigenous knowledge and practices. While there are some leading researchers and scholars in this regard (Professor N.J. Turner, *Ancient Pathways, Ancestral Knowledge* (MQUP, 2014), efforts to seriously expand and invite Indigenous knowledge have been limited. Indigenous midwifery may be one exception, although fairly recent, yet positive.

Reflections

Integration of Indigenous knowledge, cultural healing practices and traditional medicines is important to Indigenous peoples and is supported by health workers

The IPS validated the importance of integrating traditional practices and knowledge into service delivery. Indigenous respondents rated the following strategies as “*very important*” in improving health care for Indigenous people:

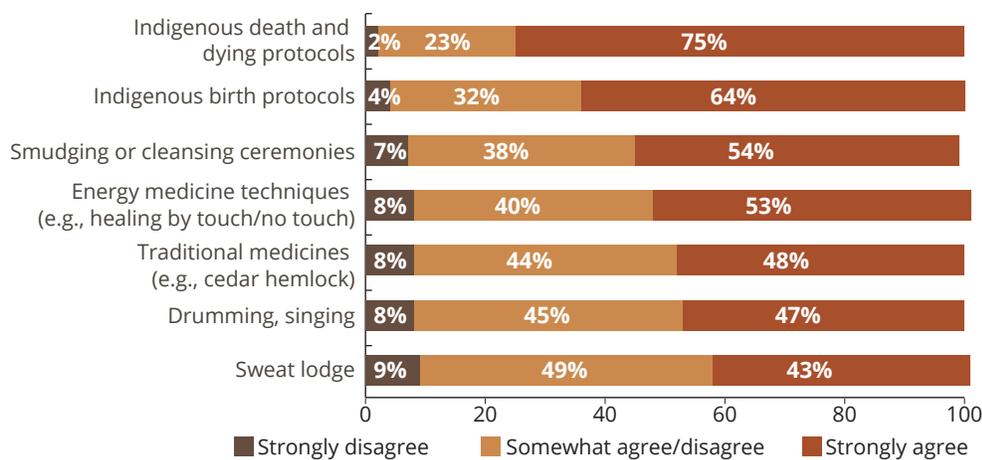
- Access to traditional medicine, healers and elders (67% of respondents)
- Indigenous cultural spaces in health care settings (64% of respondents)
- Increased visibility of Indigenous Nations’ culture in health care settings (62% of respondents).

Indigenous respondents also reported that access to Indigenous navigators or liaisons (70% of respondents) was more important than providing Indigenous-only services (40% of respondents), suggesting that integration of Indigenous healing within western-based healthcare is more desired than a parallel or separate system.

When IPS respondents were asked to comment on “*what needs to change for Indigenous people to feel safe when using health services,*” a similar proportion of both Indigenous and non-Indigenous respondents suggested the integration of Indigenous practices into health care settings would increase safety. The highest feeling of safety was expressed by Indigenous respondents to receiving care from a traditional healer, with 71.2 per cent reporting that they “*always*” felt safe.

Respondents to the HWS similarly agreed that there is a need for more presence of Indigenous practices in health care settings to improve cultural safety for Indigenous patients. A large majority of HWS respondents “strongly agreed” or “somewhat agreed” with the inclusion of traditional Indigenous practices in patient care plans, specifically death and dying protocols (98%), followed closely by birth protocols (96%). A slightly lower percentage of Indigenous health workers also supported the use of traditional medicines, drumming and singing, and sweat lodges. These high levels of support were seen across both Indigenous and other respondents, although Indigenous respondents were more likely to provide “high priority” ratings.

A high level of support was obtained across HWS respondents to the inclusion of Indigenous practices in care plans



The HWS survey also revealed differences in views across different health care professions, with nurses and midwives being most supportive of a variety of efforts to improve cultural safety and include traditional practices in patient care plans. In contrast, those who identified themselves as working in dental health, or as physicians or surgeons, were significantly less likely to support any interventions to promote cultural safety compared to other groups. Further, these groups were significantly less likely than most other groups to support the inclusion of nearly all traditional Indigenous practices in patient care plans. These findings highlight inconsistency across the system in acceptance of the role of Indigenous knowledge and practices.

There are barriers to the use of traditional medicine and cultural healing practice

The IPS queried patient experiences when attempting to utilize cultural practice and medicine in the B.C. health care system. Compared to non-Indigenous respondents:

- Indigenous respondents were significantly less likely to “*always*” receive permission to practice traditional medicine
- Significantly more likely to experience that providers are “*never*” open to hearing about traditional medicine.

These themes are also supported by a series of journey maps published by the BC Patient Safety & Quality Council (BCPSQC).¹⁴² The existence and recognition of cultural protocols and reconnection to them, the inclusion of Elders in the healing journey, and the role of traditional medicines are all prominent themes across patient and provider maps, as are barriers to accessing diagnosis, treatment and support.

Some largely independent projects have been undertaken to incorporate traditional healing and wellness into various models of care and care systems.¹⁴³ A review of these activities generally reveals that the recognition of Indigenous medicine and its integration into health care systems and settings is increasing. As integration increases, barriers are emerging, including: determining regulatory, quality assurance and safety approaches; providing training and support for team-based care involving health care experts from Indigenous and non-Indigenous fields of medicine; and, that the demand for traditional medicine may soon outstrip the pace of knowledge transmission amongst Indigenous practitioners.

¹⁴² 1) Substance Use Treatment Journey Map: What do Indigenous peers experience? 2) Journey Mapping in Cancer Care: Patient and Provider Experiences in Receiving and Delivering Cancer Care in British Columbia. 3) Accessing Treatment: What do providers experience?

¹⁴³ Funding has been provided in support of projects focused on restoring traditional ways of knowing, healing and maintaining wellness for Indigenous populations (e.g., wellness camps, land-based healing, building cultural and spiritual rooms into hospitals, and establishing navigators and Elders in Residence programs.

Conclusions

The Review concludes the following related to the hardwiring of cultural safety into the health care system:

- The basic standards of the *UN Declaration* include rights to Indigenous health practices, including Article 24: *“Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.”* The *Declaration Act* makes this a requirement in B.C.
- Greater acceptance and understanding of Indigenous knowledge, traditional practices, medicines and healing modalities as fields of practice to be respected and learned about is needed, in both medical education and health care worker settings.
- There is not enough integration of Indigenous culture and practices into facility design, which contributes to conditions of cultural unsafety.
- Integration of Indigenous cultures, medicine and healing practices is currently not consistent across facilities, institutions, regions or programs. There are limited options for Indigenous patients who wish to pursue cultural and traditional healing approaches.
- No organization appears to be leading efforts to address perceived barriers to integration of traditional medicine into the B.C. health care system, including analysis and development of quality, safety and regulatory options.
- No strategies are in place to anticipate and address the demand for traditional medicine, including for training and education of Indigenous practitioners.

“I was so grateful to be invited by the First Nations Health Authority to join their educational visit to the Nuka System of Care in Alaska. I was truly inspired by their model of dedicated space for Indigenous health and wellness, and culturally safe accommodation for Indigenous patients and families who come from a distance for care. I believe that we can learn from their approaches to create a First Nations Health and Wellbeing Centre at the New St. Paul’s Hospital and Health Campus, which would be a visible demonstration of B.C.’s commitment to reconciliation.**”**

~ Fiona Dalton
President and CEO, Providence Health Care

Indigenous Art in Medical Spaces

In recent years, there have been shifts in medical spaces in Canada and around the world. These shifts have been fuelled by research into the health outcome benefits of the social environments we inhabit. This research ranges from studies of how colours can add to the comfort levels of patients, to significant evidence of better health outcomes in spaces that make substantial use of artwork.

Over the last decade, I have been honoured to have had the opportunity to be a part of this movement toward developing new medical spaces using Coast Salish artwork.

I am from the shishálh First Nation. For my people and family, much of our experience since colonization has been of drab, depressing, foreign medical spaces. Such environments have reinforced dynamics of racism and oppression that have been part of the experience of Indigenous peoples in the health care system. Such environments also contribute to the increased ways in which Indigenous peoples avoid necessary medical treatment altogether.

So how does our Indigenous artwork alleviate these feelings?

Many are unaware, but our Coast Salish artwork was and is a written language. Our history, culture, worldview, and even our laws, are codified in our art. When we bring our Indigenous artworks into a space, it does several things.

First, the presence of this art conveys that there is respect for our cultures and an acknowledgement of the people whose land the medical environment exists upon. For our people, this can help develop a level of comfort for those having to enter these institutions.

Second, the artwork can be used to convey meanings and messaging that create comfort and support in the healing process – such as around security, equality, spirituality, resilience, hope and so much more.

Third, using our Nations' respective stories and symbolism, Indigenous artwork can convey a sense of agreement, of there being a trust, through which medical care will be offered and received.

These understandings were the basis for a large art piece we created in the Sechelt Hospital adjacent to my Indigenous community of shishálh. In collaboration with members of my Nation and a committee selected by the hospital, we developed a piece designed to enshrine our relationship today and into the future. Incorporated into the artwork was symbolism around mutual respect, partnership, healing and reciprocity. All of us understood these commitments and we endeavoured to produce a piece that encouraged positive change.

This art piece has been revisited numerous times when issues of poor care have arisen. The art is referred to as part of building understanding about what went wrong, and how we can do better. I personally met several times



with hospital staff and recently with the head of the hospital to discuss patient care, using the artwork as a point of reference. The art has helped to resolve challenges.

It is my firm belief that Indigenous art can be a part of helping advance the systemic changes needed in our health care system. Let us embrace it.

~ Shain Niniwum Selapem Jackson
(Coast Salish, shishálh First Nation)

President, Spirit Works Limited
Executive Director, Golden Eagle Rising Society

9. There is insufficient integration, or “hard-wiring” of Indigenous cultural safety throughout the health care system.

“Hard-wiring” refers to making a function, belief or behaviour a standard, instinctive and permanent feature of a system. Legislation and policy are the strongest tools that governments and organizations deploy to achieve intended results across sectors and systems. Other supporting instruments to achieve systemic results include mandating, and strategic and service planning.

With respect to cultural safety and humility, and anti-racism tools to address discrimination in clinical settings, hard-wiring¹⁴⁴ describes the intention to meaningfully embed Indigenous cultural safety and the practice of cultural humility into the core quality, accountability and planning functions of the B.C. health care system. This Review received documentation that demonstrates efforts to integrate Indigenous cultural safety and humility in different ways across the health system and within health care organizations. However, hard-wiring has not been comprehensively achieved, and the most critical necessary legislative and policy foundations for such hard-wiring are not yet in place. A comprehensive, coherent, systematic approach that lends itself to tracking, monitoring and accountability does not exist, and is critically required.

“Over the past decade, we have worked closely with Indigenous partners and organizations, especially the First Nations Health Authority and First Nations Health Council, to plan for and better serve Indigenous peoples in the health care system in B.C. Many specific activities and collaborative efforts have been underway within the province, and in conjunction with Canada. These efforts have been positive and urgently required. However, I recognize that despite these actions, a system approach remains elusive. The many instances of Indigenous-specific racism that have been surfaced in the independent Review and Report tell us that direct, indirect and systemic discrimination and prejudice against Indigenous peoples is in our system. We must put in place a fully responsive system to end all forms of discrimination against Indigenous peoples. I recognize this is not just a moral imperative and sound health policy, but is now a legal requirement with the adoption of the United Nations Declaration on the Rights of Indigenous Peoples Act. Everyone in the system needs to reflect on this, change our practices and pull together to root out all forms of racism.”

~ Stephen Brown
Deputy Minister, Ministry of Health

¹⁴⁴ Two aspects related to “hard-wiring” – data and measurement and Indigenous participation in governance and decision-making – are discussed in more detail in separate findings in this report. This finding focuses more specifically on the scope and comprehensiveness of approaches to embedding cultural safety and humility throughout the system.

Reflections

Legislation has not been utilized as a lever to address Indigenous-specific racism and enhance Indigenous cultural safety

The B.C. health care system is structured through a series of federal and provincial laws, some of which are health-specific and others which more broadly apply.

Health specific legislation – including the *Canada Health Act*, *BC Health Act*, *Health Authorities Act*, *Public Health Act*, *Hospital Act* and *Health Professions Act* – does not directly address Indigenous rights, Indigenous-specific racism or discrimination, or Indigenous traditions of health and wellness. While some of these statutes have powers that could be used to address the health needs of a specific group, such as Indigenous peoples, these powers have not been broadly used.

In the development of the B.C. First Nations health governance structure, the concept of legislation was contemplated, and provisions within the *Framework Agreement* commit to a tripartite collaborative process to assess whether there is a need to enshrine any authorities and powers for the FNHA in provincial legislation or regulation; and for the federal government to explore ways to acknowledge and express support for implementation of the *Framework Agreement* through federal legislation. No specific legislative proposals have been developed in this regard.

Of course, there are legislative provisions that deal with racism and discrimination broadly, such as the *BC Human Rights Code*. However, as noted in a recent report prepared for the BC Human Rights Tribunal, *Expanding Our Vision: Cultural Equality & Indigenous Peoples' Human Rights*, the current grounds of discrimination under the Code do not adequately address the discrimination experienced by Indigenous peoples, and the report recommends that Indigenous identity be added as a protected ground to the Code.

Reporting on issues such as racism and discrimination can also be achieved through the *Public Interest Disclosure Act*, which came into force on Dec. 1, 2019. This legislation provides an avenue for government employees to report wrongdoing without fear of reprisal. In its first phase of implementation within the health sector, this act currently applies to the Ministry of Health, Provincial Health Officer's office, and the Office of the Senior's Advocate. It does not currently apply to health authority employees.

Unique to B.C. is the *Declaration Act*. This legislation creates an obligation for the Province to take all measures necessary to ensure the laws of B.C. are consistent with the *UN Declaration*. It also creates an obligation to develop an action plan in consultation and cooperation with Indigenous peoples, to achieve the objectives of the *UN Declaration*. The federal government has also indicated its intention to table national legislation in support of the *UN Declaration*. Currently an action plan does not exist.

Taken together, this demonstrates that opportunities exist and have not been utilized to address Indigenous-specific racism.

“We have a tremendous amount of work to do and our whole team is committed to do it. I am fully accountable to act and push things forward within my role as CEO and a leader in the health care system. We believe that by working with our First Nation and Métis partners to provide tools, support and education through direct community engagement powerful change is possible. We want to further build our relationships with First Nations and Métis partners, to truly develop patient-centred care and integrate traditional medicine with the health care system.”

~ Susan Brown
CEO Interior Health

Requirements for cultural safety and humility and addressing Indigenous-specific racism are not adequately embedded throughout policy and standards

The Review examined examples of both system-wide policy, such as that issued by the Ministry of Health, as well as organizational policies that establish expectations and parameters for behaviour and decision-making. The Review also examined the standards that describe the professional basis of health professional practice by guiding the attitudes, skills and knowledge needed to practice in a safe manner.

The Ministry, health authorities and some regulatory colleges and other organizations have adopted policies to advance Indigenous cultural safety. These include policies and protocols that: require cultural safety and humility as an attribute of care; enable cultural and traditional healing practices; support land acknowledgements; and support Indigenous cultural safety and seek to eliminate systemic racism. Some organizations have, or are producing, systemic assessment tools that support staff to build cultural safety and humility into any policy, initiative or guideline in development. However,

there is no overarching policy guidance or expectation on this subject matter grounded in upholding Indigenous human rights. Further, some of what exists is buried within broader efforts on equity, diversity and inclusion. Eliminating Indigenous-specific racism and upholding Indigenous human rights must be an explicit policy objective mandated by the Ministry of Health and expected of all health care organizations.

“We must listen to the voices of patients, families and communities. It is time for change, for creating cultural safety, and for embedding it into every level of the system. We want the systems and the resources, to improve care now. We want standardized processes and measurable outcomes. I’m seeing the drive for action and solution in our people. It’s our work to do now and we’re ready. It’s my responsibility to ensure we take action in partnership with First Nations, Métis and Indigenous peoples.”

**~ Kathy MacNeil
CEO, Island Health**

In their submissions to the Review, many regulatory colleges emphasized the need for all national bodies to embed cultural safety competencies, which then apply to and guide professional practice in B.C. Some, but not all, national professional regulatory bodies have embedded cultural safety, cultural competence, cultural sensitivity and trauma-informed care into national competencies. Within B.C., some of the regulatory bodies have developed provincial professional standards, guidelines and principles, as well as practical tools. The smaller regulatory bodies are challenged in this regard, and emphasized the need to consolidate and make these practical tools available to all organizations in the B.C. health system.

“Cultural change in the medical system requires mindful and purposeful action. We must find ways to create safe and supportive environments for Indigenous physicians to provide leadership within Doctors of BC. We want to understand and serve the needs of Indigenous and Métis communities in a culturally sensitive manner. Many of our members are working to do so, in particular through implementing cultural safety and humility as a required attribute of primary care networks. Doctors of BC is committed to working with First Nations and Métis people to build effective, strategic partnerships moving forward.”

**~ Dr. Kathleen Ross
President, Doctors of BC**

Mandate letters and service plans have insufficient accountability requirements related to cultural safety and humility and Indigenous-specific racism

Each year, the Premier issues mandate letters to each minister, and the Minister of Health issues mandate letters to the health authorities that fall under the *Health Authorities Act*.

Until very recently, B.C. Minister mandate letters did not explicitly reference racism, a matter rectified in the mandate letters issued on Nov. 26, 2020. Since 2016/17, the mandate letters issued to health authorities have made mention of cultural safety and humility, and Indigenous decision-making and health and wellness.¹⁴⁵ These mandate letters show, through time, broadening expectations for health authorities regarding Indigenous health. However, the letters are high level and are not effectively cascaded into service planning and measurement and accountability requirements. It is not possible to determine whether the expectations outlined in these mandate letters have been fulfilled.

Service plans prepared by both Ministries and the health authorities are intended to demonstrate how the expectations described in these mandate letters will be achieved. The *2020/21-2022/23 Ministry of Health Service Plan*¹⁴⁶ and the Ministry of Mental Health and Addictions' service plan for this same period¹⁴⁷ include commitments to cultural safety and humility, and specific objectives and strategies on matters such as increased access to Indigenous-specific services, and full adoption of the *UN Declaration* and *TRC Calls to Action*. Health authority service plans for 2019/20 to 2021/22¹⁴⁸ vary in terms of specific objectives and strategies, but reflect partnership structures with Indigenous peoples; priority areas such as primary care and mental health and wellness; and, embedding cultural safety and humility across health services. Many additional strategies were examined during the course of this Review, which included clear actions designed to address Indigenous-specific racism and more broadly improve the quality of services accessed by Indigenous

¹⁴⁵ Some of the relevant aspects of current mandate letters include: implementing the *UN Declaration*, TRC Calls to Action and the Province's Draft Principles that Guide the Province of British Columbia's Relationship with Indigenous Peoples; achieving greater diversity and inclusion on health authority boards; the health governance partnership with B.C. First Nations and the First Nations Perspective of Health and Wellness; expectations that health authorities maintain effective working relationships with FNHA, directly with First Nations where appropriate, and with MNBC; and requirements regarding cultural safety and humility and Indigenous health services.

¹⁴⁶ <https://www.bcbudget.gov.bc.ca/2020/sp/pdf/ministry/hlth.pdf>

¹⁴⁷ https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/ministries/mental-health-addictions/mmha_sp_2020.pdf

¹⁴⁸ Health authority service plans 2019/20-2021/22 are all available on health authority websites.

peoples.¹⁴⁹ While these plans reflect commitments to address some of the core problems highlighted in this Review, the impact that these plans actually have on addressing racism and upholding Indigenous human rights is impossible to discern. Many of the strategies have not been implemented due to a lack of resourcing. There is limited accountability, reporting and measurement of results.¹⁵⁰

“We are working on developing tools to effectively and immediately bring change into the health setting and proactively respond to issues. Fraser Health is working with our partners to continue to build trust in a trauma-informed health system. We want to empower all stakeholders in the provincial system, share resources, remain accountable and make change for the better together.”

**~ Dr. Victoria Lee
President and CEO, Fraser Health Authority**

Change Leadership Strategy on Cultural Safety and Humility has not been effectively and comprehensively implemented

An effort took place in 2018 to develop a *Change Leadership Strategy on Cultural Safety and Humility* amongst the Ministry of Health, health authorities, FNHA, BCAAFC, MNBC and the BC Patient Safety & Quality Council (BCPSQC). The purpose of the strategy was to outline approaches across the system to provide support and coordination to work underway, identify additional strategies needed, and permanently embed cultural safety within the system. The overarching goal of the strategy was to identify and reduce the harms (including systemic barriers and disproportionately adverse health and wellness outcomes) that Indigenous peoples experience due to anti-Indigenous racism and discriminatory behaviour within the B.C. health system, and to advance cultural safety through cultural humility.

Of the early actions approved in this strategy, one has been fully completed – the redesign of the *BC Quality Matrix*.¹⁵¹ The strategy also mandated the development of both a standard and measurement framework for cultural

¹⁴⁹ Examples include: the Ministry of Mental Health and Addictions *Pathway to Hope*; joint First Nations-health authority regional health and wellness plans; the *Urban Aboriginal Health Strategy* in Vancouver Coastal region; the *Indigenous Cancer Strategy*; Fraser Health's cultural safety and humility framework to action; Northern Health's framework and detailed operational plans for Indigenous health; Interior Health's cultural safety assessment instrument.

¹⁵⁰ See Finding 11 for more on this issue.

¹⁵¹ The matrix is a guiding framework that defines quality care in B.C., and therefore is central to the development of provincial policy, measurement, and patient care protocols and procedures. BCPSQC collaborated with the FNHA, knowledge keepers, MNBC and FNHDA as part of the development and update of the matrix. The redeveloped document references cultural safety and humility throughout, has added a quality dimension of 'respect', and has broadened the definitions of terms such as safety and evidence to reflect Indigenous knowledge.

safety and humility, with the goal of providing clear, comprehensive and practical tools that support system-wide implementation and accountability. These tools have not been concluded as of the writing of this report.

The strategy also supported the establishment of a ‘backbone team’ – essentially a centralized cultural safety and humility and anti-racism team responsible to maintain a system-wide view, proactively drive forward mandated cross-system strategic priorities, and undertake knowledge development and exchange to support rapid uptake of leading practice. In 2019, the decision was made by the Ministry of Health and the FNHA to house this team on an interim basis at the FNHA. This five-member team has recently been fully staffed. In the fall of 2020, the Ministry of Health indicated that this team should move to the Ministry on an interim basis, recognizing the Ministry’s accountability to drive change in the provincial health care system. Key informant interviews and submissions to the Review emphasized two key themes related to this team: 1) the pressing need for proactive knowledge exchange and sharing; and 2) a lack of awareness that this centralized team exists.

The purpose of this strategy aligns with one of the key observations of this Review – that efforts are disconnected and independent, and that systemic approaches are needed. The strategy has not been effectively led, resourced or positioned to achieve the necessary results.

“During my time with the FNHA, I was looking to establish a system wide approach to addressing the issue of racism and discrimination that would strive to bring out the best in people to tackle the hard issues at both a systemic and interpersonal level.

While it’s necessary to swiftly deal with incidents of racism, this is not a problem that gets solved one person at a time, or one complaint at a time. It needs systemic solutions that starts with committed leadership from all parts of the health system to create the required change. This is why we sought to have every single major health system organization sign on to Declarations of Commitment to Cultural Safety and Humility – a constructive approach so they would all acknowledge the problem and their responsibility to resolve it.

We used the concept of reciprocal accountability to shape the work – with each organization responsible to the other, and to Indigenous peoples, to play their appropriate role to eliminate Indigenous-specific racism and achieve cultural safety through cultural humility. This was also a way to eliminate siloes as barriers to progress and honor the BC First Nations health governance partnership with BC and Canada.

I firmly believe that it is the system's responsibility to solve this issue, and that Indigenous peoples must be part of the solution given that we are the ones that experience the problem every day in health care and other sectors. We also need to move beyond these partnership approaches to have Indigenous, and specifically B.C. First Nations, people embedded in senior roles across the provincial health system to help these organizations better uphold Indigenous human rights. We need to build upon our current structures, such as the Tripartite Committee on First Nations Health, to involve all health sector decision-makers, and ensure these meetings and other processes ensure full health system accountability and responsibility to Indigenous people and First Nations governments. ”

~ Joe Gallagher, k'wunəməŋ, Tla'amin Nation
Founding & Former CEO, First Nations Health Authority

Conclusions

The Review concludes the following related to the hard-wiring of cultural safety and humility and Indigenous-specific racism into the health care system:

- Legislation has been underutilized as the foundational mechanism to systemically address issues of Indigenous-specific racism in health care. Existing legislative commitments, such as the federal government's commitment to distinctions-based Indigenous health legislation, and alignment of federal and provincial legislation with the *UN Declaration*, can clearly describe that the core responsibility for addressing Indigenous-specific racism is system-wide, and that this work must be accountable to Indigenous peoples. Such clarification will both properly focus the work of Indigenous-specific racism on comprehensive and coherent system-wide approaches, and create necessary standard expectations.
- Health jurisdiction is shared between federal and provincial governments, and First Nations governments have been recognized as having a partnering role, but not as having inherent rights and responsibility to support the health and wellness of their citizens.
- Policies, practice standards and assessment tools related to Indigenous-specific racism and Indigenous cultural safety are unnecessarily and widely variable across the system. In some areas they simply do not exist. This is in part because there is no guiding Indigenous cultural safety and anti-racism policy established by the Ministry(ies) that then cascades into policy and practice expectations within all health care institutions. It also suggests that anti-racism policies and assessment tools are not being proactively shared and are not cascading from a specific evidence-based standard.

- Indigenous cultural safety and humility policies, strategies and plans should also include clear anti-racism tools, approaches and language, clearly positioning anti-racism as one key way in which cultural safety is created.
- Indigenous cultural safety strategies and frameworks include important commitments yet most, if not all, have no protected and identified resourcing.
- There is a gap between policy and strategy expectations and the front-line health care worker. There is a need to create strong standard(s) that bridge this gap from strategy to practice. These must create standardized expectations while providing flexibility for local implementation.
- The majority of efforts are taking place through the accountability relationship and processes between the Ministry of Health and the health authorities. Efforts are needed to exercise other available accountability processes to drive the change into all parts and amongst all actors of the health system, including regulatory colleges and associations. For example, collective agreements and funding instruments are other key accountability instruments in which cultural safety and humility expectations can be embedded.
- The *Change Leadership Strategy* remains relevant. Key informants reported to the Review that progress has lagged over the past year. Awareness and integration of the backbone team and its work is low amongst the health authorities and regulatory bodies; yet all express the pressing need for this type of support. The necessary change of eradicating racism, and responsibility for it, rests with the health system and its leadership. So, too, should the change leadership capacity designed to support the system to lead that change.

Racism's Reach Extends Beyond the Clinical Setting

A non-Indigenous woman employed in food services at a B.C. hospital told the Review about her experiences with racism in the health care workplace. She says a fellow employee went on a “rant” about Indigenous people, “and when I informed them that my partner was Native, they doubled down and declared that Native people and their partners (i.e., me) should be ‘sterilized so they don’t have eight kids on welfare.’”

The woman emailed her supervisor about the incident and recalls being told: “We can’t control peoples’ opinions, sweetie.” She says the employee who made the comments to her received no correction or reprimand.

The woman knows she is not the only employee who has complained about racism in her workplace. An anonymous complaint about it resulted in her supervisor sending out a “scathing” response that criticized the person who had complained. She is now fearful to bring complaints forward herself, knowing she may face similar treatment.

10. Indigenous structures and roles in health decision-making need to be strengthened.

This finding reflects a broader reality that exists throughout all sectors, as part of the legacy of colonialism. Indigenous peoples have been structurally and systematically disempowered from governing and making decisions throughout Canada's history. Fighting through the courts – resulting in hundreds of victorious cases for Indigenous peoples – has taken place over decades to re-establish that Indigenous peoples must be involved in all decisions that impact them.

The jurisprudence on section 35(1) of the Constitution Act, 1982, has been largely determined through the efforts of B.C. First Nations, who have not accepted colonial imposition of laws and policies, nor have they acquiesced to the imposition of systems of care on them premised on stereotypes and racial prejudice. The passage of the *UN Declaration* a decade ago and now the implementation of the Declaration into B.C. law and policy can serve to provide a stronger framework to uphold the vital roles for Indigenous governments. What is required, across all sectors, is the establishment of proper Nation-to-Nation and government-to-government relationships and clear structures and mechanisms between them for how decisions will be made. The vision of proper Nation-to-Nation or government-to-government relationships is not one of separation and distance. It is a vision of how to work together, recognizing that the realities of all peoples in Canada are interconnected and interdependent, and our collective well-being is grounded in the principles of recognition, equity and justice.

“This investigation reminds us of the daily, lived experience for First Nations in B.C. as they access health care. Our made-in-B.C. health governance structure comes from the wisdom and leadership of our Chiefs and leaders and is grounded in a community-based, Nation-driven approach. Our shared goal of equal access to health care requires each health partner to be accountable to the other for their actions moving forward. This will help ensure that First Nations peoples' lived experiences with the B.C. health system are free from racism. We will ensure that through our engagement pathways, that our citizens and leaders will be heard and represented in this critical work going forward.”

~ Charlene Belleau
Chair, First Nations Health Council

In addition to clarifying the roles of Indigenous governments, laws and jurisdictions, this also means having Indigenous peoples increasingly in positions of authority and decision-making throughout the health care system. This is vital to ensure that the system as a whole is ever more inclusive, culturally appropriate, and contains necessary forms of Indigenous knowledge and expertise. It can also provide a leadership stream which can collaborate more effectively with Indigenous government representatives and service agencies to ensure anti-racism efforts are coordinated and visible.

In some respects, the health sector has made more progress in this regard than other sectors. Due to the strong advocacy from B.C. First Nations leaders, B.C. First Nations health governance structure has developed in a positive direction in comparison to what existed a decade ago. It is now recognized that First Nations must be involved in decision-making in the B.C. health care system, and a structure has been put into place to enable this to occur. MNBC is also creating partnership and collaborative agreements, tables and processes.

This Review has provided an important opportunity to take stock of such progress. The timing of this report coincides with a period of significant change in First Nations health governance in B.C., marked by major leadership turnover within the B.C. First Nations health governance structure. The disruptive nature of this change on progress in addressing Indigenous-specific racism was a recurring theme in key informant interviews and in the review of submitted materials. The Review found that there has been significant effort over the past 15 years to develop that First Nations health governance structure, and an overreliance on that structure to both represent Indigenous leadership and address Indigenous-specific racism. There has been comparatively less effort paid to establish Métis pathways to health system influence, and to build space in health system organizations for Indigenous leadership.

One of the main litmus tests of whether Indigenous roles in decision-making and governance in the health care system are appropriately extensive and effective is that this system is transformed in ways that make Indigenous-specific racism increasingly an aberration rather than a systemic reality. Based on this criteria, there is important work before us.

Reflections

Implementation of First Nations health plans, agreements and structures must be renewed and strengthened

In January 2020, two major evaluation reports were released: 1) a *Tripartite Evaluation Report*; and 2) an independent *Evaluation of the First Nations Health Authority*, supported by 11 technical case studies. These evaluation reports confirm the substantial increase in First Nations presence and influence into the health care system. Their conclusions and recommendations, paired with the outcomes of this Review, also confirm that much complex work is still required to dismantle the colonial legacy. While the formation of the FNHA has been an impetus for increased efforts, the work has been impeded by a number of critical factors, and some of the early health systems transformation commitments and actions have yet to be realized.

The initial *Transformative Change Accord: First Nations Health Plan* finalized in 2006 by the First Nations Leadership Council and the Province set out a transformation agenda with key areas of focus, including mandatory “cultural competency” training, increased access to maternity services, and dedicated post-secondary seats for Indigenous students in health professional programs. Fourteen years later, these remain pressing issues as described in this Review, suggesting that renewed attention is required.

It is important context to note that intergovernmental and First Nations health leadership discussion between 2009 and 2013 focussed heavily on negotiating and effecting the transfer of federal First Nations health programs, services and functions to a new First Nations health governance structure. This involved addressing informal federal-provincial agreements for funding First Nations health services that did not reflect proper partnering arrangements with First Nations, something widely acknowledged as poor policy. The subsequent seven years since the transfer of federal services to the FNHA has seen and focused primarily on enhancement and growth in First Nations health services. As noted, however, major system transformation priorities that characterized the early health plans and agreements remain to be meaningfully addressed.

Additionally, issues have surfaced in this review with respect to upholding the provisions of the *British Columbia Tripartite Framework Agreement on First Nation Health Governance*, including those related to the operations, standards, and compliance with good governance norms within the First Nations Health Council and FNHA Board of Directors. There is a need to move beyond divisions and return to fundamentals of governance and operational standards.

It is clear that the structure has outgrown the initial arrangements, which were based on political and contractual agreements rather than legislation. As a non-profit society, FNHA requires further mandating by Chiefs and leadership for some of the more ambitious plans it has disclosed during this Review, such as the exercise of provincial government health powers on reserve. With the pandemic, the FNHA points to a “moral authority” as the basis to exercise provincial government powers in relation to First Nations peoples and territories. On the other hand, First Nations representatives clearly told the Review that they are concerned about barriers to information-sharing and public health and safety, and note that FNHA cannot make arrangements for data, inspection, or other similar matters on their behalf without some form of structured authorization from the Nation. The public health emergencies have magnified the structural problems and the need to ground the work more solidly for the future. The absence of a clear mandate, structure and arrangements has been a point of friction at a time when clear steps are needed.

Without question, it is timely to consider the provisions of the *Framework Agreement* that contemplate providing a clearer legislative underpinning to the governance structure. The inclusion of these provisions suggest that the parties must have known that the time would come when it would be necessary, and that a charitable society would not be adequate to provide for the governance, structure and regulation of essential health services. The shifts in governance and reconciliation generally in B.C., such as the passage of *DRIPA* and other federal legislation recognizing jurisdiction and authority for First Nations governments (such as in relation to child and family services) means that the opportunity to address this is more feasible than it was seven years ago. Innovation could be encouraged through skillfully developed enabling legislation. As B.C. develops an action plan for *DRIPA*, in cooperation and collaboration with Indigenous peoples, some of the new tools and opportunities for First Nations to exercise self-determination in health, including through section 7 agreements, should be discussed.

This is a pivotal moment, informed by comprehensive evaluation reports and this Review, to renew a focus on founding priorities and commitments to systems transformation. While the health plans and agreements created important and valuable health improvements for First Nations over the past 14 years, the parties have not adequately addressed the systemic racism, individual racism, profiling and discrimination experienced by First Nations at the point of care. The increasing focus on this issue by governments and society more broadly means that the time is now to act upon this commitment. Additionally, there is a need to solidify the basis for First Nations health

service functions. This comprehensive work requires stronger structures throughout the health system which embody good governance, hold required competencies, and have a strong foundation to carry out their specific roles and functions. Underlying all aspects of this model is a principled foundation grounded in the standards of the *UN Declaration* and the Indigenous right to health free from any form of racism or discrimination.

“In the early days of the work, we had to advocate relentlessly for a place at the table, and the recognition of our rights to participate in health governance in British Columbia. This resulted in opportunity for us to create a new structure for First Nations health services, and establish regional partnership processes. However, what got us here will not get us to where we want to go. This review demonstrates that it is time for us to take stock of the structure, assess the shortcomings, and take action now to strengthen its foundations. We have to refocus and coordinate our work at a systems level, while not losing the importance of regional flexibility and implementation. We have to model compassionate leadership and focus on mentoring and nurturing new generations of Indigenous leadership to carry this work forward.”

**~ Grand Chief Doug Kelly, Stó:lō Tribal Council President and former Chair,
First Nations Health Council**

Today, as reported to the Review by FNHA Board members and many key informants, the FNHA Board of Directors is struggling to govern effectively, and organizational performance is suffering. There are divisions, even internal lawsuits and disputes that have to some measure slowed or stopped progress. Despite this problem existing in plain sight, there have been no clear and decisive efforts by any party – the organization’s governing members, First Nations leadership, or federal or provincial partners and funders – to work to address this situation. While a positive approach to the situation would view this as normal “growing pains” for a critically important organization and structure, the absence of a clear path to get through those pains and into a more durable and effective structure raises another concern.

Could the problems within this model of informal service partnering be a form of racism of low expectations for Indigenous institutions serving Indigenous peoples? The low expectations on the part of governments and health system partners does not speak highly of their capacity to identify a partner that is struggling and positively engage to support and address the difficulty. It reflects an approach of standing back and allowing things to be stuck without adequate support and engagement.

This is a pivotal moment, informed by comprehensive evaluation reports

and this Review, to consider reconfigured First Nations health governance structures that will best be able to meet the broad and unique needs of Indigenous people in B.C. and, importantly, are appropriately situated within the health system to achieve their specific functions. There is a need to ensure that each component of this reconfigured governance structure embodies good governance, holding the required competencies and strong foundation to carry out its specific roles and functions in pursuit of the common vision. Underlying all aspects of this model is a principled foundation grounded in the standards of the *UN Declaration* and the Indigenous right to health.

“The First Nations health governance structure was created by the hard work of many First Nations leaders in British Columbia. As Chair of the First Nations Health Council and later the First Nations Health Authority Board of Directors, it was clear to me that we were tasked to work together, but at times the options before us were limited. New frameworks and agreements to build change were developed as a result of our advocacy. We used agreements and other informal arrangements to guide the political and service relationships with governments, health service agencies and health providers. Bilateral and tripartite agreements were negotiated, always on the understanding that this would need to evolve over time.

From these agreements emerged the commitment to transfer First Nations health programs from Canada to a new First Nations Health Authority. There was no option to use for that entity other than a charitable organization. This important work hit a ceiling in terms of what can be mandated or the partnerships that can result, as a health ‘Authority’ requires a legislated mandate beyond the rules of the Societies Act which does not capture our rights and leadership as First Nations governments.

It was our strong advocacy and innovation that worked around obstacles in the way to get to the point we are at now. Our focus as Chiefs and leaders has been on ensuring the partnerships are in place supported by and directed by First Nations governments. Governance in First Nations health care must continue to evolve, grow and provide better accountability to address issues like racism and cultural safety for First Nations citizens. This was always the vision from the outset—it had to build over time and become embedded and mandated.

Our First Nations governments in B.C. are rebuilding, strengthening our Nations and are firmly grounded in the United Nations Declaration on the Rights of Indigenous Peoples as the framework for meaningful reconciliation. After the B.C. legislation to adopt the Declaration was

passed unanimously in 2019, we have to take another look at this work. How do we strengthen health governance and put in place the necessary lasting structures needed to do this work? While many innovative partnerships were accomplished over the past decade, we can solidify that work and make more permanent change with First Nations co-governance, accountability and protection from racism. The Declaration must guide this now as we are dealing with fundamental human rights.”

~ Lydia Hwitsum, JD
First Nations Summit Task Group Member & Founding Chair,
First Nations Health Authority Board of Directors

Expanded structures for Métis participation in health decision-making are required to be consistent with the Métis Nation Relationship Accord II

Although the Métis have a different history in B.C. than First Nations, and the section 35(1) rights of First Nations and Métis are in many aspects different, the Métis have a place in decision-making to ensure that health policy and services reflect the distinct history, circumstances, structures and demographics of Métis residents.

There is not a directly analogous Métis structure in relation to health as exists amongst First Nations. However, in recent years, some formalizing of steps and relations has taken place. Since 2006, the MNBC has had a Relationship Accord with the Province, which addresses health. MNBC has Letters of Understanding (LOU) in place with four of the six health authorities, with the other two in progress. However, these are not appropriately hard-wired or reflected across key accountability tools and processes of the health system, and MNBC does not have a sufficient senior table in place with key officials at the Ministry of Health. These matters must be addressed through clear processes, relationships and expectations at the Ministry-MNBC level that support inclusion of Métis citizens' perspectives related to the services they access and policies that affect them.

There currently remains a lack of capacity for MNBC or Métis Chartered Communities to participate in various health decision-making and service planning efforts. Expanded and formalized processes for Métis participation must consider the resourcing requirements for Métis organizations and communities to fulfill this important function.

Organizations across the health system must embed Indigenous people in senior roles

A major theme of key informant interviews, supported through document review, is that the health system has become highly reliant on First Nations and Métis organizations for leadership and perspectives on all matters Indigenous. However, these organizations also have their own work to do and often do not have the time or capacity to participate in all initiatives of all health sector organizations. Having Indigenous leadership embedded across the health care system – at board and senior executive levels – would support a deeper inclusion of Indigenous perspectives in the processes, cultures and conversations of those organizations, and enable a more strategic partnership with First Nations and Métis organizations.

While accountability for change rests with boards collectively, Indigenous participation in these dialogues supports consistent examination of work being done to address Indigenous-specific racism and the priorities of Indigenous peoples. Indigenous inclusion on board structures throughout the health care system is uneven. Currently, there are two Indigenous representatives on each health authority board, and regularly an Indigenous representative on the BC Patient Safety & Quality Council. However, despite a stated interest and intention to do so, Indigenous inclusion is inconsistent across regulatory boards; some have established Indigenous-led board committees, some have had between one and two Indigenous board members on a consistent basis; others have not been able to consistently maintain Indigenous representation; and others have never been able to secure an Indigenous participant. Despite all appointments being made through the Ministry of Health, there is unclear criteria for the selection of candidates and how they are supported to contribute to health care system transformation.

Even more challenging has been the lack of Indigenous individuals in senior leadership positions throughout the health care system. There are now two Indigenous individuals in senior executive positions across the regional health authorities, PHSA and Providence Health Care, and none at the Ministry of Health. Similar observations could be made about the senior positions at the Faculty of Medicine at UBC, health regulatory bodies, and professional associations. This absence results in a lack of important Indigenous perspectives being present to influence and shape dialogue and decisions inside organizations. If Indigenous people are not around the table, considerations that matter to them are rarely made visible.

“The appointment of a Vice President, Indigenous Health has had a profound impact on the senior leadership of Northern Health – she has challenged our thinking while enabling reflective thinking about our unconscious biases and changing how we lead individually and collectively.”

~ Cathy Ulrich
President and CEO Northern Health

Conclusions

The Review concludes the following related to the structures and roles through which Indigenous peoples participate in decision-making in the B.C. health care system:

- The role of Indigenous structures and peoples in health care governance and decision-making must continue to evolve and strengthen. Responsibility for this lies with Indigenous peoples as well as governments.
- A coherent collaboration structure at local, regional and provincial levels is needed between the MNBC and Métis Chartered Communities and the provincial health system, described in agreements, mandate letters, workplans and funding agreements.
- The regional engagement process established to create the current B.C. First Nations health governance structure should be used for Chiefs, health leaders and government partners to consider the findings of the two recent evaluation reports and this Review related to the First Nations health governance model.
- There is a need for more Indigenous participation in senior executive-level positions throughout the health care system. A specific focus on recruiting individuals from the territories within that region can contribute to building stronger relationships with local Indigenous communities.
- There is evidence of past positive collaboration between the First Nations health governance structure and MNBC. Consideration should be paid to increasing formalized relationships and collaborative processes.
- There is a need to clearly articulate the purpose and value of having Indigenous peoples on regulatory and health authority boards. This purpose needs to be reinforced through standards and criteria supporting the development and selection of individuals who bring a systemic understanding and connection to Indigenous communities and people in B.C. as well as measures to support these people individually and collectively to play an effective role

on Indigenous-specific racism and contribute to quality decision-making of those organizations.

- Proactive upstream work is needed to build the supply of Indigenous senior executive and board leadership.

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.¹⁵² 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

¹⁵² 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.

“Systems are made up of people; people are capable of applying prejudice when carrying out their work, and let's face it, some people can be outright racist. Systems must be held accountable and so must the people that make up the systems that provide care for British Columbians. Having data that measures peoples' performance as part of the systems of care is necessary to affect change at all levels and all points of care. This report is an example of the power of disaggregated data to prompt necessary systems change to better support the health and well-being of Indigenous peoples. B.C.'s sovereign Indigenous Nations need data about their citizens to improve care systems and to better support the health and well-being of their peoples, regardless of where they receive care. It is time – particularly with the UN Declaration now upheld as law in British Columbia – to educate people at all levels of the health care system and to build a better system of care. B.C. First Nations governments are intending to hold the provincial systems accountable for change and are proposing to jointly move beyond all of these work-around data arrangements and implement a new data governance model; a Nation-governed, ethical data approach that provides for timely access to quality data to plan, manage and account for outcomes. First Nations governments require meaningful information to support evidence-based decision-making at the Nation, regional and provincial levels; data to hold systems and people accountable.”

~ Gwen Phillips, Ktunaxa Nation
B.C. First Nations data champion

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 FNLC and MNBC, which supports consistency in the technical aspects of the data points to be collected by the provincial government and government agencies.¹⁵³ 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 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,¹⁵⁴ 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.

¹⁵³ 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

¹⁵⁴ 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 organization 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 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)¹⁵⁵ 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.¹⁵⁶ 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,

¹⁵⁵ 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.

¹⁵⁶ 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.

cumbersome 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.¹⁵⁷ 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 B.C. 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.¹⁵⁸

¹⁵⁷ 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.

¹⁵⁸ 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.¹⁵⁹

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.¹⁶⁰

¹⁵⁹ <https://www.canada.ca/en/privy-council/campaigns/speech-throne/2020/speech-from-the-throne.html>

¹⁶⁰ 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.

“This inquiry has clearly shown that racism towards Indigenous people in B.C. is a long-standing legacy of Canada’s colonial past. As a settler on First Nations unceded territory for almost 50 years, and as past Provincial Health Officer, I saw examples of such racism in personal life, in health care settings, and in the health outcomes data that informed my reports on the health status of Indigenous peoples in this province. It was a privilege to be asked to work on this report and to contribute in some small way to the acknowledgements that are necessary if we are to share this land.”

~ Dr. Perry Kendall
Former B.C. Provincial Health Officer

Health Indicator Dashboard

This dashboard provides a snapshot of a selection of indicators presented in this report which are representative of Indigenous health in B.C.

For each indicator, the dashboard shows:

- Indigenous data
- Comparator data (Other Residents of B.C.)
- Gaps in the data between Indigenous people and Other Residents
- Time trends in the Indigenous data
- If there are any disparities between the sexes in the Indigenous data
- Indigenous/Other Resident rate differences are provided only when statistically significant.

	Indigenous ¹	Other Residents (OR)	Indigenous/ OR Rate Difference	Indigenous Trend	Sex-Related Difference (Indigenous)
<p> ↑ Up  First Nations  Male ↔ Stable  Métis  Female ↓ Down - Data not available </p>					
Physician Care					
Pediatrician user rate, non-ED, O-5 years (%)	19.6% 	24.5%	0.80X 	~	 > 
MHSU physician rate, a/s, non-ED (%)	18.5% 	15.7%	1.2X 	~	 > 
ED user rate, a/s	40.3% 	23.3%	1.8X 	↑	 > 
Chronic and Acute Conditions					
Mood and anxiety disorder prevalence rate, a/s	11.6% 	10.0%	1.2X 	↑	 > 
Diabetes prevalence rate, a/s	11.0% 	8.4%	1.3X 	↑	 > 
Diabetes prevalence rate (18+), a/s	12.2% 	10.1%	1.2X 	-	 > 
Five+ health conditions prevalence rate, a/s	50.5%  48.4% 	25.2%	2.0X  1.9X 	-	 > 
Women's and Infant Health					
9 or more antenatal visits (rate per total deliveries)	59.0% 	75.5%	.78X 	~	N/A
Midwifery utilization rate (rate per total deliveries)	15.4% 	24.7%	.62X 	↑	N/A
Preterm birth rate (births per live singleton births)	15.2% 	7.5%	2.1X 	↑	-
Infant mortality (deaths per 1,000 live births)	5.8% 	3.4%	1.7X 	↓	-

Part 3: Experience of Indigenous Peoples In B.C. Health Care

	Indigenous ¹	Other Residents (OR)	Indigenous/OR Rate Difference	Indigenous Trend	Sex-Related Difference (Indigenous)
Screening					
Cervical cancer (PAP) screening rate (distinct clients), a/s	5.7%  8.4% 	8.0%	0.71X 	-	N/A
Colorectal cancer (FIT) screening rate, (distinct clients), a/s	5.5%  7.4% 	7.2%	0.76X 	-	-
Hospitalizations					
Hospitalization user rate, a/s	15.8% 	12.0%	1.3X 	-	♂ > ♀
Cardiovascular conditions* hospitalization user rate, a/s	11.7%  11.9% 	11.1%	1.2X 	-	♀ > ♂
Chronic respiratory conditions** hospitalization user rate, a/s	5.4%  4.4% 	3.7%	1.5X  1.2X 	-	♂ > ♀
Unintentional injury hospitalization rate (cases/10,000), a/s	15.5  11.7 	9.0	1.7X  1.3X 	~	♂ = ♀
Ambulatory care sensitive conditions hospitalization rate (discharges per 1,000 population), a/s	10.7 	4.8	2.2X 	~	♂ = ♀
Public Health Emergencies					
COVID-19 rate (cumulative % positive, tested)	3.2% 	1.8%	1.9X 	↑	♂ > ♀
COVID-19 rate, 18+ years (case rate per 10,000)	14.2% 	23.2%	0.61X 	↑	ISD
opioid overdose mortality rate (deaths/100,000), a/s Jan. 1 to Oct. 31, 2020	158.0 	28.6	5.5X 	↑	♀ > ♂
Other					
Life expectancy (years)	73.4 	82.7%	0.89X 	↓	♂ > ♀
Left against medical advice (% of total discharges)	3.7%	1.4%	2.6X	~	-
Experience of discrimination in health system based on ancestry (% respondents)	66.9%	4.7%	14.2X	-	♂ > ♀

¹ data are between 2015 and 2020 depending on the data source.

* heart failure, malformation of the cardiovascular system, cardiac valve disease, coronary artery disease, arrhythmia, other heart disease

** chronic obstructive pulmonary disease, pulmonary hypertension, other chronic lung disease, asthma, respiratory failure

a/s = age standardized; ISD = insufficient data; N/A = not applicable

PART 4

Recommendations



Contextualizing the Findings and Recommendations



Since Time Immemorial

First Nations lived in accordance with their own laws and governance structures. They enjoyed good health and active lifestyles informed by their own medical science, traditional diets and teachings passed down over time. Archeological evidence suggests complex social structures and roles, and trade and resource-based economies dating back nearly 14,000 years

1763 Royal Proclamation sets out guidelines for European settlement of Aboriginal territory, acknowledges Aboriginal title and that all lands are considered Aboriginal lands until ceded by treaty with the Crown

1774 Spanish explorers arrive in Yuquot in Nootka Sound and traded with the Mowachaht, marking the first known contact between B.C.'s Indigenous population and Europeans

1778 First recorded European "discovery" of B.C. led by James Cook

1839 *Crown Lands Protection Act* passes, making the government guardian of all Crown lands, including reserve lands

Over the last decade, public understanding of the history and realities of Indigenous peoples in Canada has deepened, in part due to the work of the Truth and Reconciliation Commission and the National Inquiry into Missing and Murdered Indigenous Women and Girls. A basic awareness has grown that the current inequities and injustices faced by Indigenous peoples in Canada – such as those examined in this Review – are deeply rooted in an enduring legacy of colonialism, and that confronting that legacy requires substantive, transformative change. An awareness has also grown of the fundamental human rights standards – such as those in the *UN Declaration* – that have to be implemented to effect that change.

It is necessary to do some truth-telling about the history of the health care system in B.C., and the *UN Declaration* standards we must now meet as “the framework for reconciliation”, if we are to understand the challenge of racism and how to address it.

This section of the report provides some of this truth-telling, as vital background information for understanding the Findings and Recommendations.

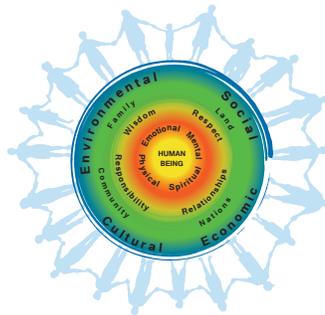
Indigenous Systems of Health and Wellness

Prior to the arrival of Europeans – and, in the case of the Métis, after their distinctive communities formed – Indigenous peoples throughout what is now called Canada had their own health and wellness systems. Like all human societies, these health and wellness systems are rooted in particular worldviews, knowledge, beliefs, and social roles, processes and structures.

Reflecting the diversity of Indigenous peoples, these health and wellness systems were also diverse, rooted in their particular cultures and laws and implemented through their own governance systems throughout their respective territories. At the same time, there are certain shared elements or characteristics to the Indigenous worldviews that animate and shape Indigenous health and wellness systems. Often noted is the wholistic and integrative character of Indigenous worldviews, which emphasize the connections, harmony and fundamental relationships

between all things. Such a wholistic vision means the well-being of each individual cannot be dissociated from the environments, lands and world around them, and from past and future generations. As has been described in the First Nations context, *“First Nations recognize that good health and wellness starts with every human being and extends outward to include broader social, economic, cultural and environmental determinants of health and wellness.”*¹⁶¹

Such a wholistic vision also speaks to the indivisibility of the inner and outer dimensions of health and well-being. Our physical, emotional, mental and spiritual well-being are all interdependent. One form of well-being cannot fully exist without the others, and all of them – as well as the relations between them – must be a subject of care. A patient, in such worldviews, is always the whole person in the full social and environmental contexts in which they live. A patient is never just a physical being, or a disease or a condition, or a body part, and is never an individual in isolation.



First Nations Perspective of Health and Wellness (FNHA)

Colonial Health Care in Canada's History

As the settlement of Europeans expanded, these Indigenous health and wellness systems were impacted and in various ways disrupted and displaced. As has been described, colonialism interrupted *“this [Indigenous] worldview and a Western European perspective of health became the dominant lens on which our current health care system is based.”*¹⁶²

Colonialism, however, is not only the imposition of a different worldview – it is a structured and comprehensive form of oppression intended to extinguish Indigenous peoples and gain access to their lands and resources. A full overview of the history of colonialism and First Nations, Métis and Inuit is beyond the

1857 the *Gradual Civilization Act* intended to assimilate First Nations people into Canadian society is passed. Allows for voluntary enfranchisement to First Nations males

1876 the *Indian Act* is created by parliament to define Indian status and outline the administration of Indigenous rights, but does not grant rights

1886 Compulsory school attendance for Indigenous children is decreed; residential and boarding schools are established

1936 The Department of Indian Affairs begins to offer health care services to Indigenous patients through a network of federally operated Indian hospitals

1946 Nanaimo Indian hospital opens on the site of a former military hospital

1981 all Indian hospitals either closed or converted to desegregated institutions

1986 Last residential school in B.C. closes

1987 Federal government introduces health transfer policy with the goal of providing First Nations and Inuit communities with an increased ability to control community health services

¹⁶¹ <https://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf>

¹⁶² <https://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf>

2005 *First Nations Leadership Accord* signed, creating the First Nations Leadership Council (FNLC) process; B.C. enters new relationship vision with FNLC; *Transformative Change Accord* signed by FNLC, B.C. and Canada

2006 MNBC Relationship Accord establishes objectives to address health, housing education, economic opportunities, and data.

2006 B.C. and FNLC release the *Transformative Change Accord: First Nations Health Plan*, identifying 29 action items to improve First Nations health and well-being

2007 Canada, B.C. and FNLC sign the *Tripartite First Nations Health Plan*, endorsing the *Transformative Change Accord: First Nations Health Plan* on a tripartite basis, and agreeing to develop and implement a new First Nations health governance structure

2007 United Nations General Assembly adopts the *United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)*

2008 Truth and Reconciliation Commission of Canada established as mandated through *Indian Residential Schools Settlement Agreement (IRSSA)*

2009/10 San'yas Indigenous Cultural Safety training program is developed by the PHSA, B.C., regional health authorities, MNBC, academics and Elders

scope of this report.¹⁶³ But it is important to sketch out some of this colonial history as it specifically relates to health care to contextualize the Findings and Recommendations in this report.

Colonialism was justified through the creation and perpetuation of racist beliefs about the inherent genetic, cultural and intellectual inferiority of Indigenous peoples. As related to the health and wellness of Indigenous peoples, these racist beliefs were entrenched through two pernicious propositions that gained structural, legal and policy form: first, that Indigenous peoples should be treated apart and separate, through a segregated health system; and second, that Indigenous peoples could be treated as objects of the health system – for the purposes of research and experimentation – and not as patients for whom the system existed to care. Both of these propositions demonstrate that health equity in access and outcomes for Indigenous peoples was never the goal of government policy.

Segregated facilities, underfunding, low standards of care, violations of individual integrity and autonomy – including of the physical bodies of Indigenous individuals, also injuring their mental, emotional, and spiritual domains in the process – and a failure to address needs expressed by communities and support Indigenous self-determination are all part of Canada's own story of health services for Indigenous peoples.

Mission and Community Hospitals

Historical segregation of Indigenous peoples in the health care system was intertwined with the broader policies of denial and assimilation that run through Canada's history.

In the early decades after the founding of Canada, health care for the settler population was a mix of private home care and publicly run hospitals. Over time, the reliance on public hospitals grew. These were some of the roots of today's system of public health care in Canada.

Health services for Indigenous peoples were treated differently than for the settler population. As Canada formed, the federal government assumed responsibility for "Indians" under section 91(24) of the

¹⁶³ There are excellent studies that provide critical insights into this history, including the work of the *Royal Commission on Aboriginal Peoples*, the Truth and Reconciliation Commission and the Missing and Murdered Indigenous Women and Girls National Inquiry.

Constitution. Through the imposition of legislation such as the *Indian Act*, a definition of “Indian status” was created, a reserve system was imposed, the residential school system expanded, and a model of provision of segregated services was entrenched. Multiple forms of denial – including Crown denial of the existence of a distinct Métis people – contributed to a lack of basic, culturally appropriate health services.

By the late 19th-century, medical services for Indigenous peoples were largely administered through a combination of mission-run hospitals and government services, with funding from the federal Department of Indian Affairs.¹⁶⁴ As public hospitals grew, there were also some segregated wards for Indigenous and other racialized populations.

In the 1920s, this began to change. The Department of Indian Affairs began to become more directly involved in the operation of health services for Indigenous peoples. There was a shift from segregated hospital wards within public community hospitals to more funding of separate Indian hospitals sometimes located on reserves in former mission schools.¹⁶⁵

Tuberculosis and Treatment

Amongst the drivers of this shift to separate Indian hospitals were racist attitudes about the ill-health of Indigenous peoples and fears they were contagious. Of course, colonialism brought with it waves of new disease for Indigenous peoples; First Nations in B.C. suffered high rates of infectious diseases, including influenza, whooping cough, bronchitis, measles and the 1918 Spanish Flu. The protection of white settlers – and not the well-being of Indigenous peoples – was a primary focus. In particular, the growth and centralizing of government health services for Indigenous peoples during this time was in response to fears associated with the communicability of disease to white communities and pressure from the public for the government to act.¹⁶⁶ In particular, tuberculosis (TB) emerged as the leading cause of

¹⁶⁴ Laurie Meijer Drees, *Healing Histories: Stories from Canada's Indian Hospitals* (Edmonton: University of Alberta Press, 2013), 12.

¹⁶⁵ Lux, 2016, 23-24

¹⁶⁶ Maureen K. Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s* (Toronto: University of Toronto Press, 2016), 19-20; Meijer Drees, 2013, 12.

2011 *Tripartite Framework Agreement on First Nation Health Governance* provides a legal path to transfer federal health programs, authorizing the FNHA to plan, design, manage and deliver First Nations health programs

2013 FNHA assumes the programs, services and overall responsibilities previously managed through Health Canada's First Nations & Inuit Health Branch

2015 *First Declaration of Commitment to Cultural Safety and Humility in Health Services for First Nations and Aboriginal People in BC*, signed by the Ministry of Health, PHSA, regional health authorities and the FNHA

2015 Truth and Reconciliation Commission of Canada releases summary report '94 *Calls to Action*' (June) and final report (December)

2015 Canada removes objector status and adopts *UNDRIP* without qualification

2016 National inquiry into missing and murdered Indigenous women and girls commenced

2016 Métis Nation Relationship Accord II reaffirms commitments in the Relationship Accord I and includes four additional priority areas – children and families, information-sharing, justice and wildlife stewardship

2017 Registrars of all colleges in BC Health Regulators (23 health regulatory bodies) sign a *Declaration of Commitment*

2019 *United Nations Declaration on the Rights of Indigenous Peoples Act (DRIPA)* is passed in B.C.

2019 *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* is released

2019 BC College of Family Physicians and BC Patient Safety and Quality Council each sign a *Declaration of Commitment*

2020 the *Evaluation of the BC Tripartite Framework Agreement on First Nation Health Governance, Cultural Safety and Humility Case Study Report and Evaluation of the First Nations Health Authority Final Report* are released

2020 Government of B.C. appoints an Independent Reviewer to examine allegations of Indigenous-specific racism in the health care system

death for Indigenous people across Canada,¹⁶⁷ with many Indigenous children contracting TB while at residential schools, and that rate of infection was exacerbated by poverty and poor health and living conditions in schools and on reserves.¹⁶⁸ This led to significant shifts in the health system for Indigenous peoples.

Starting in the mid-1930s, a Joint-Canadian Tuberculosis Association and Government Committee on Indian Tuberculosis distributed funds between the provinces to create TB preventoria adjacent to residential schools and recommended greater surveys in the schools.¹⁶⁹ In 1935, Coqualeetza residential school was the first to build a preventorium, staffed by one nurse, after the positive TB rates exceeded 75 per cent of the student population.¹⁷⁰ TB death rates for First Nations on reserve in the 1930s and 1940s were amongst the highest ever reported in a human population (700 deaths per 100,000 persons) with rates in residential schools reported at over 10 times higher (8,000 per 100,000 persons).

By the end of the 1930s, despite increased surveys and testing, preventoria were failing to address the rising rates of infection among students and within Indigenous communities.¹⁷¹ Over the following decade, regular x-rays, vaccination programs and tuberculin testing were carried out for First Nations and Inuit communities and the number of segregated sanatoria increased in the lead-up to the creation of a formal segregated hospital system in the post-war era.¹⁷² However, these measures failed to address important determinants of health, specifically access to adequate nutrition, water and shelter and, instead, emphasized the communicability of TB and therefore the need to prohibit any transmission outside of reserves.¹⁷³

¹⁶⁷ Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950* (Vancouver: UBC Press, 1998), 2; Truth and Reconciliation Commission of Canada (TRC), *The Final Report of the Truth and Reconciliation Commission of Canada's Residential Schools*, vol. 1 pt. 2, *The History, 1939-2000* (Montreal: McGill-Queens University Press, 2015), 192.

¹⁶⁸ Meijer Drees, 2013, 9.

¹⁶⁹ Lux, 2016, 33-34.

¹⁷⁰ Truth and Reconciliation Commission of Canada (TRC), *The Final Report of the Truth and Reconciliation Commission of Canada's Residential Schools*, vol.1 pt.1, *The History, Origins to 1939* (Montreal: McGill-Queens University Press, 2015), 434.

¹⁷¹ TRC, vol.1 pt.1, 436.

¹⁷² TRC, vol.1 pt.2, 194, 196.

¹⁷³ Lux, 2016, 33-35.

Experimentation, Health, and Residential Schools¹⁷⁴

While a segregated health system was being built with a driving focus to protect non-Indigenous Canadians from fears of the sickness of Indigenous peoples, at the same time Indigenous peoples were being used for medical research and experimentation. Reflecting prevalent social Darwinist attitudes, scientific research and the medical system was an arena in which racialized populations were sometimes treated as objects to be used on the path to finding treatments for the dominant white population.

Residential schools were central to creating negative health outcomes for Indigenous children. Residential schools were well known from early on to be severely dangerous to the health of the child. In 1907, Dr. Peter Bryce, in reporting on schools in Manitoba and the Northwest Territories, stated “*we have created a situation so dangerous to health that I was often surprised that the results were not even worse than they have been shown statistically to be*”. In the mid-1940s, a series of surveys were carried out in residential schools by the Red Cross, and later by the federal government. These surveys found nutritional deficiencies among students across the country and failures to meet *Canada’s Official Food Rules*. Such findings were evidenced by a lack of funding, insufficient training and cleanliness among staff, a reliance on cheaply processed foods, inconsistent access to fresh produce and inadequate preparation supplies and facilities.¹⁷⁵

Health practices in residential schools reflected the colonial stereotypes and perceptions of Indigenous peoples as inferior and subhuman, including specific stereotypes about women and girls. By law, residential school principals in B.C. were allowed to sterilize any children in their care.

Residential schools were also the sites of many scientific research experiments throughout the 20th century. For example, beginning in 1948, a five-year nutrition study was conducted at six residential schools, including Alberni School on Vancouver Island. A total of 1,000 students were part of this study. The goal of the project was to learn about the mental and physical health of students at residential schools and address the extent to which diets, including fortified foods, could address nutritional deficiencies, with the hope that the findings would guide federal initiatives for improvement and

¹⁷⁴ Historian Mary Jane Logan McCallum argues that the use of the term “experimentation” rather than “studies” or “research” is important in these contexts as it draws attention to the unethical practices surrounding consent, the extractive processes of many such projects, and their failure to benefit the communities involved. See Mary Jane Logan McCallum, “Starvation, Experimentation, Segregation, and Trauma: Words for Reading Indigenous Health History,” *The Canadian Historical Review* 98, no. 1 (March 2017): 103-105.

¹⁷⁵ TRC, vol.1 pt. 2, 243-245.

future spending.¹⁷⁶ Other health care that supported nutrition, such the use of fluoride, was denied to the students during the experiments for fear that it might compromise findings.¹⁷⁷ Despite the repeated surveys and studies carried out without parental consent, few of the findings and recommendations were implemented by the federal government to improve the diet and nutrition of students in residential schools.¹⁷⁸

Other studies carried out within residential schools between the 1940s and 1960s included extrasensory perception (ESP), vitamin D, treatments for dysentery, TB medication INH, hemoglobin and bedwetting.¹⁷⁹ A 1968 dematoglyphic survey led by University of British Columbia medical genetics faculty member R.B. Lowry aimed to collect fingerprints from children at residential schools. Lowry approached principals at five B.C. institutions: Alert Bay, Kamloops, Fraser Lake, Williams Lake and Kuper Island; and received agreement to participate from all but one. The principal at Kuper Island withheld his consent, arguing that parents would have to be contacted. As the Truth and Reconciliation Commission's findings note, the importance of parental consent was clearly apparent to this principal, further emphasizing the unethical – yet broadly accepted – actions of his colleagues at the other schools.¹⁸⁰



¹⁷⁶ TRC, vol.1 pt. 2, 252.

¹⁷⁷ Ian Mosby, "Administering Colonial Science: Nutrition Research and Human Biomedical Experimentation in Aboriginal Communities and Residential Schools, 1942-1952," *Histoire sociale/Social History* 46, no. 91 (May 2013): 162-164.

¹⁷⁸ TRC, vol. 1 pt. 2, 289.

¹⁷⁹ For more detailed discussion of consent to medical care and research experiments carried out in residential schools see: TRC vol.1, pt. 2, 220-231.

¹⁸⁰ TRC, vol.1, pt. 2, 231.

Racism Felt Across Generations and Communities

An Indigenous Elder spoke to the Review at length about her family's experiences with racism in the health care system over generations. Here are some of her recollections:

- Her father and all his siblings were sent to the Nanaimo Indian Hospital. Her mother was held there for nearly 18 years. She recalls that, as a child in residential school herself, the threat of being sent to the Nanaimo Indian Hospital was very real. She says children who were seen to be incorrigible or unteachable were sent there and that electric shock therapy, sterilization and multiple medical experimentations were used on Indigenous patients at the hospital.
- While at residential school, some of her teeth were pulled, causing her great pain, and she has had a fear of dentists ever since. She has experienced chronic tooth infections, complicated by Bell's palsy.
- She recalls in May 1993, when her elderly mother was in palliative care and she received a call at 11 a.m. with her mother crying: *"I need you."* She discovered that her mother had been waiting for a bedpan for four hours.
- Another morning, she received a call from her mother who was crying in pain. She discovered that, despite the doctor ordering pain medication every four hours and as needed, she had not had any for 24 hours. The nurses' response was that *"she didn't ask for it."*
- She recalls the premature death of her father at a care home. He required his food to be pureed as he did not know to chew. One day, staff left him with regular food, a piece of apple became lodged in his throat and, by the time they found him, he was in medical distress and subsequently died.
- When she was nearly 20, she was referred to a urologist for chronic interstitial cystitis in the bladder. The specialist was rough with the equipment and, when she cried out in pain, he said *"Come on, you know you native women like it rough."*
- She recalls the many times she has had to use the ER for treatment of the pain and chronic infections in her teeth. She's often heard *"What are you doing here? We don't give drugs."*
- Once, when calling 8-1-1, because of her Bell's palsy and the fact she has only one vocal cord, a nurse told her to *"hang-up and call back when you are sober."*



INDIAN MEDICAL CLINIC ESTABLISHED

Three-year-old Joan Wyse, daughter of Mr. and Mrs. George Rice Wyse, was the first patient to be treated yesterday at the first medical clinic on Nanaimo Reserve No. 1. Mrs. Wyse assisted Dr. Morris Wynrib, staff member of Nanaimo Indian

Hospital, which is the centre for Indian Health Services for this zone. Nanaimo Indian Health committee helped build the clinic which had been approved at the last Band meeting to be chaired by the late Chief Dan Brown. —(Free Press photo)

Indian Health Services and Indian Hospitals

Following the Second World War, the model of segregation became even more structurally entrenched. The Indian hospital system was launched as a network of federally-funded institutions for status Indian and Inuit patients administered under the newly created post-war Indian Health Services (IHS) branch of the Department of National Health and Welfare. Initially created to address high rates of TB infection, the Indian hospital system ultimately expanded to provide more general health services in many of its locations. At its peak, the IHS oversaw 29 hospitals in addition to nursing stations, clinics and other institutions run by provincial and charitable bodies.¹⁸¹ While some of the hospitals predated the IHS, most operated out of converted military facilities.¹⁸² Three hospitals were located in B.C.: Coqualeetza Indian Hospital in Sardis (1941-1969), Miller Bay Indian Hospital near Prince Rupert (1946-1970), and Nanaimo Indian Hospital (1946-1967).

Despite community desire for local care, the IHS design of the hospital system centralized sites in the southernmost areas of the country and many individuals were forced to travel far from their families to receive treatment.¹⁸³ Isolated from families, language and culture, extended periods of hospital admittance posed tremendous emotional toll on many individuals and their communities.¹⁸⁴

Indian hospitals were grounded in the same policies of denial and assimilation that were at the root of the creation of the *Indian Act* and the residential school system. The IHS was a race-based system of care rooted in perceptions of the inferiority and ill-health of Indigenous peoples:

*The economic status of the more remote peoples will always be on a lower level, but in the more populated areas, the Indian can assume, gradually, more and more of the responsibility of his neighbours. This economic evolution must be slow, because the native is psychologically distinctly a different race to the more western cultures of the new population of Canada. Provision for tomorrow is not, and likely never will be, a trait of the unadulterated Indian or Eskimo, but assimilation should be attended by education in economic independence, including provision against ill-health, to the degree current in their areas.*¹⁸⁵

¹⁸¹ Koskie Minsky LLP, *Statement of Claim*, Toronto, 2018, 12, https://kmlaw.ca/wp-content/uploads/2018/01/IHC_Statement-of-Claim_20180129.pdf; Meijer Drees, 43.

¹⁸² Meijer Drees, 2013, 18.

¹⁸³ Meijer Drees, 2013, 93-94; First Nations Health Council, *Implementing the Vision: BC First Nations Health Governance* (West Vancouver: First Nations Health Council, 2011), 16; https://www.fnha.ca/Documents/FNHC_Health_Governance_Book.pdf

¹⁸⁴ Meijer Drees, 2013, 17-18, 43.

¹⁸⁵ Canada, Department of National Health and Welfare, *Annual Report 1947-1948* (Ottawa, Government of Canada, 1948), 41, http://iportal.usask.ca/docs/Dept_National_Health_Welfare_Annual_Reports/1947-1948.pdf

A major rationale of the IHS system was also to help the federal government save money. Government found it could operate Indian hospitals at half the cost of care in community hospitals, with a result being a poor standard of care.

The lives of many Indigenous young people at this time were often characterized by a shuttling between segregated institutional systems – mandatory attendance at residential schools and legally compulsory treatment at hospitals.¹⁸⁶ Yet the history of experiences within the IHS has not been as well documented as that in the residential school system. The voices and stories of survivors need to be heard if we are to truly comprehend what must be confronted with respect to Indigenous-specific racism in today's health care system. Many former patients have reported traumatic experiences in Indian hospitals, including emotional, physical and sexual abuse; isolation; experimentation; forced sterilization; inadequate facilities; and negligent care, all compounded by consistently insufficient funding. A class-action lawsuit on behalf of former patients of the IHS is currently ongoing to address the allegations of abuse that occurred in the Indian hospital system.¹⁸⁷ A public, transparent and comprehensive process of bringing this history to light, in ways that do not further contribute to victimization and trauma, is needed.

“We have to understand the legacy of the Indian Hospital in this province. Still to this day, I have people in communities who tell me they do not want to go to the hospital for care because that is where their grandparents died under atrocious conditions. If hospital administrators don't understand that, how can we provide care? If they just say, 'Oh, they're non-compliant. They don't show up for appointments.' Well, yeah. Do you know why?”

~ Health care professional who spoke to the Review

¹⁸⁶ Lux, 2016, 116-117.

¹⁸⁷ David Carrigg, “Three former ‘Indian hospitals’ in B.C. part of recently certified class-action lawsuit,” Vancouver Sun, February 1 2020, <https://vancouversun.com/news/local-news/three-former-indian-hospitals-in-b-c-part-of-recently-certified-class-action-lawsuit>; Donna Carreiro, “‘Our people were experimented on’: Indigenous sanatorium survivors recall medical tests,” CBC News, September 22 2017, <https://www.cbc.ca/news/canada/manitoba/indigenous-sanatorium-suvivors-medical-experiments-1.4301131>

Medical Services Branch and Community Services

By the 1960s, the structure and operations of the IHS were amalgamated within the Medical Services Branch (MSB) of the federal government, which broadly oversaw all medical services that fell beyond the scope of the provincial governments.¹⁸⁸ During this time, there were discussions within Medical Services about closure of Indian hospitals, particularly given the falling rates of TB among First Nations.¹⁸⁹ The MSB was still plagued by funding challenges during this time, typically offering wages that could not compete with their counterparts in provincial services. By the late 1980s, only eight Indian hospitals remained in operation. Despite their poor condition, many surrounding communities were reluctant for the hospitals to close for fear that they would not be replaced with adequate services.¹⁹⁰

Indigenous activism, both prior to and following the 1969 White Paper¹⁹¹ also shaped the MSB and health services in the decades to come, advocating for self-determination in the delivery of health services. The 1960s brought a broader focus on community building through training services for Indigenous peoples to fill local positions that addressed areas of health and sanitation.¹⁹² By the late 1970s, the new “Indian Health Policy” and Canada’s commitment to the WHO’s Alma-Ata Declaration also signaled a larger shift towards health services that supported physical, mental and spiritual well-being developed and administered at a local level.



¹⁸⁸ D. Ann Herring, James B. Waldram and T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives*, 2nd ed. (Toronto: University of Toronto Press, 2006), 198.

¹⁸⁹ Lux, 2016, 130-131.

¹⁹⁰ Herring, Waldram and Young, 212-213.

¹⁹¹ https://indigenousfoundations.arts.ubc.ca/the_white_paper_1969/

¹⁹² Meijer Drees, 2013, 21-23.

Indigenous Man Dealing with Past Trauma, Alcoholism also had to Deal with Assumptions of First Responders

DD lived with his partner in both Metro Vancouver and various communities on Vancouver Island. He had five children, two of whom lived with the couple full-time. DD had worked various jobs for special interest groups both in B.C. and across Canada, as an activist, project manager and chair for a variety of Indigenous organizations including serving as both president and vice-president of the United Native Nations.

His partner describes him as charismatic, and among the most positive people she has ever met – an outlook she credits with helping to get her away from a traumatic and troubled family history. *“He was a very positive and optimistic person about everything in our lives right from the beginning. He was a happy person and wanted people around him to feel happy, especially me and the kids. He always had a smile on face when he greeted someone or met them for the first time.”*

Both of DD’s parents had been abused within the residential school system, resulting in less support during his childhood than he needed. DD experienced some PTSD and bouts of depression over the years, which led to the beginning stages of alcoholism. But he always maintained employment and sustained some periods of sobriety.

One night in 2016, while he was trying to intervene and help somebody involved in a domestic dispute, he was punched in the back of the head at the base of his skull. The resulting concussion changed the lives of he and his family forever. After the concussion, DD was in chronic, excruciating pain and he began to drink heavily to ease the pain. *“He would tell me ‘it hurts so much’ I could see the pain it caused him daily and regularly,”* said his partner. *“After that, I noticed he struggled to find words when he was talking to me about something and it frustrated him. Everything had come so easily to him and now he struggled to find simple words.”*

Around the same time, DD also dealt with the death of his father, worsening his post-concussion state. Following a referral to a concussion clinic, he was told that if, in six months to a year, his symptoms didn’t improve, then he was *“never going to be normal.”* From this point, he settled into an increasingly stronger depressed state with continued pain, feeling sad, scared, irritable and alone. He began to drink more frequently and, as his partner recalled: *“He couldn’t work ‘cause he couldn’t stop drinking and he couldn’t stop drinking ‘cause of the pain.”*

Six months later, DD reported feeling sick and began to vomit up blood. His partner recalls that paramedics and firefighters attended their home *“with their judgment and looks of disgust.”* She said that included their assumptions about the blood DD was throwing up, which one of the responders reacted to by saying: *“I assume he is drinking red wine.”*

“It was heartbreaking because, even when they treated him badly, he answered them politely and honestly and most times with a ‘yes sir’ or ‘no sir’ or ‘yes ma’am’ or ‘no ma’am’. David was never rude or belligerent towards any doctor, nurse or paramedics even when treated poorly... I often wonder how he felt as he sat on the floor in front of the toilet filled with blood he threw up, looking up at those faces of people who were supposed to be helping him...”

In April 2019, DD was hospitalized with a diagnosis of liver cirrhosis due to his struggles with alcohol. He was released, and readmitted in early June 2019 after being told that he had an approximately 45 per cent chance of surviving in the next year. He immediately ceased drinking, entered counselling and received medical assistance to help with cessation. While he was successful in his sobriety, his overall health began to deteriorate as complications from early stage liver failure began to arise.

During a family meeting with physicians, DD was told that, pursuant to a policy (‘Abstinence Policy’), he would not be eligible for a liver transplant until he had abstained from alcohol for six months. DD’s legal team wrote the Ministry of Health, BC Transplant and the PHSA to protest the policy as being discriminatory against Indigenous patients on account of higher rates of substance use arising from the impacts of racism, discrimination and colonialism and requested a policy review and confirmation for DD to be placed on the transplant list.

In September 2019, DD met with physicians and was considered for a liver transplant. However, his condition was by then just below the threshold required for a transplant. DD continued to feel ill, was depressed, discouraged and demoralized. His liver was unable to cope with the stress and, after a period in hospital under induced coma, he died in May 2020 at age 45.

Indigenous Health Care in B.C. Today and Efforts to Address the Colonial Legacy

There is a direct link between the history and experience of colonial health care in B.C. and the challenges of racism within the health care system today. Systemic racism, as we see in the health care system, is fuelled by structures, norms and patterns that often have been taken for granted for generations. Current generations often struggle to see even a glimmer of these patterns, let alone how rooted they are in decades of a race-based approach to health care, and the devaluing of Indigenous peoples' knowledge, bodies and life expectancies.

Imposition of colonial systems such as the *Indian Act* were intent on eradicating Indigenous peoples to make way for the priorities of settlers and settler governments, including expropriation and domination of lands and resources. Fulfilling this desire requires the oppression of Indigenous peoples and was premised on powerful assumptions about the inferiority of Indigenous peoples and the natural superiority of settlers and colonial governments. These assumptions centred around the genetic, cultural and intellectual inferiority of Indigenous peoples, thus enabling the state to enact policies to segregate, assimilate and govern all aspects of the lives of Indigenous peoples. Indigenous peoples were deemed to be weak and dying off, incapable and primitive, poor users of land without a proper land tenure system or social organization, thus requiring "civilization".

Such abhorrent racist beliefs and policies persist in BC and they have generated hatred and disdain toward Indigenous peoples in many places, including in the health care system. A lack of readily available factual information, knowledge and understanding about the history and experience of colonialism – including in education and the media – reinforces social ignorance. Racist assumptions endure about why certain social conditions and issues exist, and continue to be perpetuated. Negative social attitudes about Indigenous peoples thus continue to be held and expressed through discriminatory behaviours anchored in such beliefs. In turn, these general negative social attitudes enable the continuation of racist policies that serve to shame and blame Indigenous peoples for health issues and suggest they are less deserving of care. This cycle – the legacy of colonialism – serves to hold the status quo in place.

Groundwork for a New First Nations Health Governance Structure

Indigenous peoples have maintained their worldviews, laws, complex social structures and practices, which have served to support survival, resiliency and resistance to the imposition of colonialism. Throughout the history of Canada, Indigenous Elders, Matriarchs and Knowledge Keepers maintained Indigenous traditions of health and wellness, and First Nations leaders and communities maintained a long struggle to regain control over the well-being of their own children, families and members. This struggle played out – and continues to play out – in the courts, on the land, on the ground, in the negotiation room and in communities. Indigenous peoples have never accepted the stereotypes and racism that came with colonial impositions of rules, policies and settlement. There has always been an unbroken chain of resistance to this, and as a result, some deep punishment of Indigenous peoples for defending their lands, resources and ways of life.

Early advocacy by First Nations leaders for shifts in health began in the 1980s. In 1987, the federal government introduced the *Health Transfer Policy* with a goal of providing First Nations and Inuit communities with an increased ability to control community health services that had previously been delivered through the federal government. While a small step, and one still embedded within colonial systems and legislation including the *Indian Act*, this shift in federal health policy laid the groundwork for First Nations communities, individuals and organizations to more actively plan a future for First Nations health care controlled by First Nations.

In the 1990s and early 2000s, a number of events highlighted the need for change in Indigenous-Crown relations and for Indigenous peoples, including the Oka crisis¹⁹³ and other stand-offs, the release of the *Royal Commission on Aboriginal Peoples*,¹⁹⁴ and numerous court decisions on title and rights. In B.C., the emerging momentum resulted in a structural change in the collective work of First Nations through the establishment of a Leadership Accord amongst the three province-wide First Nations political organizations, and the formation of the FNLC. With this mechanism for collective advocacy by B.C. First Nations, work to shift government laws, policies, practices and institutions accelerated. The B.C. government entered into a New Relationship Vision (2005) with the FNLC, to enable a new government-to-government relationship based on respect, recognition and accommodation of Aboriginal title and rights, as well as to close gaps in standards of living between First Nations and other British Columbians, including in health.

¹⁹³ <https://www.thecanadianencyclopedia.ca/en/article/oka-crisis>

¹⁹⁴ <https://www.rcaanc-cirnac.gc.ca/eng/1100100014597/1572547985018>

The Transformative Change Accord and First Nations Health Governance

Soon after the formation of the FNLC and the New Relationship Vision, the *Transformative Change Accord (November 2005)* was signed by the federal government, provincial government and B.C. First Nations. The *Accord* committed the parties to achieve the goals of reconciling Aboriginal rights and title with those of the Crown, establishing a new relationship based upon mutual respect and recognition, and closing the social and economic gap between First Nations and other British Columbians in the areas of education, health, housing and economic opportunities over the next 10 years.

While the implementation of the *Accord* as a whole was stalled by a shift in the federal government, one area of work that maintained a focused approach was health. The FNLC and the B.C. government completed the *Transformative Change Accord: First Nations Health Plan* in 2006, which identified 29 actions to close the gaps in health status between First Nations peoples and other British Columbians. Through this plan, the Province acknowledged its responsibility to provide health services to First Nations, regardless of residence, and the importance of First Nations' involvement in the design and delivery of those health services. That comprehensive vision for tangible change was strengthened and broadened through the *Tripartite First Nations Health Plan Memorandum of Understanding (2006)* and the *Tripartite First Nations Health Plan (2007)* between First Nations, B.C. and Canada. The *Tripartite First Nations Health Plan* included an explicit purpose, through a principled framework – to develop and implement a new First Nations health governance structure to increase First Nations decision-making and control within health systems and services.

Establishment of a new B.C. First Nations health governance structure involved meaningful and sustained engagement through forums and pathways established by and for B.C. First Nations at local, nation, regional and provincial levels. In 2011 and 2012, this engagement culminated in collective decisions amongst B.C. First Nations to adopt a new First Nations health governance structure that would hardwire the participation of First Nations into decisions regarding the health policies, programs and services on which they rely. The new First Nations health governance structure was to assure accountability back to First Nations leadership through the established engagement process.

This First Nations health governance structure includes the FNHA, Tripartite Committee on First Nations Health (TCFNH) (inclusive of senior officials of federal and provincial governments and health authorities), the FNHC, and the First Nations Health Directors Association. It was given legal expression through an administrative contract, the *Tripartite Framework Agreement on First*

Nation Health Governance (2011). Through this agreement, a path was set to transfer federal health programs to the FNHA, authorizing the FNHA to plan, design, manage and deliver First Nations health programs, and influence provincial health services serving First Nations people in B.C. Two years were allotted to establish this governance structure and transfer federal health programs to the FNHA.

“We are at an important crossroads. There is tremendous opportunity to do the right thing for First Nations people in the province. There is remarkable work at regional levels to develop approaches that respect community-driven and Nation-based interests. The First Nations Health Authority is committed to continuing to work with our communities, regions and partners to make sure this opportunity results in real steps forward. As an organization we are committed to taking action, reflecting on lessons learned and doing better. This is based on the vision and seven directives provided as direction to FNHA by First Nations leaders.”

~ Richard Jock, Interim CEO, FNHA

FNHA Operations, Programs and Services

In October 2013, the FNHA assumed the programs, services and overall responsibilities previously managed through Health Canada’s First Nations Inuit Health Branch (FNIHB) Pacific Region.

The FNHA’s budget primarily consists of a province-wide benefits program and community-based (on-reserve) public health programs and services. These community-based services include nursing, health promotion and disease prevention programs (including mental health and wellness), environmental public health services and health infrastructure support. Within these program areas, there are some nursing and environmental public health services that the FNHA directly delivers. However, the vast majority of these in-community programs are delivered by the communities themselves, funded by the FNHA through community contribution agreements. At the time of transfer in 2013, FNHA replaced the federal government as one of the parties to the approximately 140 community contribution agreements that provide funding to communities to deliver local health services. This resulted in a two-way accountability relationship wherein the FNHA is accountable to First Nations through the community engagement process and health governance structure, and First Nations are accountable to the FNHA for funding received through community contribution agreements. This role of FNHA as funder and governance partner to communities has created both opportunities (such as new and enhanced funding for services) and challenges (such as reporting

compliance and lack of processes to guide disengagement) – these are well-documented in the FNHA evaluation technical case study report.¹⁹⁵

A major program relied upon by First Nations people on- and off-reserve is the Non-Insured Health Benefits (NIHB) program administered through the federal government's FNIHB. In July 2013, the FNHA assumed responsibility for the management and administration of the federal NIHB for eligible First Nations in B.C. This program provides benefit coverage for medical and dental services that are not covered by provincial, federal or third-party insurance plans to more than 140,000 eligible First Nations people¹⁹⁶ residing both on- and off-reserve. While the FNHA initially entered into an agreement with the federal government to 'buy back' NIHB program administration on behalf of eligible clients in B.C., the majority of drug benefit administration was transitioned fully to an arrangement with B.C. Pharmacare in 2017, and dental, vision care, medical supplies, equipment and limited pharmacy benefits transitioned to an arrangement with Pacific Blue Cross in 2019. Medical transportation benefits continue to be largely administered by communities and their mandated health service organizations through community contribution agreements.

Tripartite Work on Indigenous-Specific Racism

Addressing racism in the health care system through culturally relevant services was identified as a priority in the *Transformative Change Accord: First Nations Health Plan* in 2006. This included commitments to, among other things, make health services more culturally sensitive and tailored to the needs of First Nations, increase the number of First Nations people working in the health system and jointly develop curriculum for mandatory cultural 'competency' training for health sector staff, management and executive. These commitments were intended to address racism, discrimination and stereotyping across the health sector in B.C., while also creating opportunities for Indigenous health and well-being practices, philosophies and traditions to be incorporated across the health sector.

The core vision of First Nations was that the work of addressing Indigenous-specific racism had to be done by governments, structures, systems and individuals throughout the health care system. The logic was that the responsibility for creating a transformed environment throughout the health care system, where racism was forcefully rejected, lay with the system that had long allowed such attitudes and practices to fester. However, in undertaking this work, there should be accountability to First Nations for results.

¹⁹⁵ <https://www.fnha.ca/Documents/FNHA-Evaluation-Case-Study-Technical-Report.pdf>

¹⁹⁶ Eligible clients for the Non-Insured Health Benefits program are First Nations individuals with registered status under the *Indian Act*.

Using the concept of ‘reciprocal accountability’, a central principle of the various bilateral and tripartite health plans and agreements, First Nations health governance partnerships within the health system were leveraged to draw attention and a common language around this issue of racism, with the goal that this would then lead to focused action planning, implementation and accountability.

Reciprocal Accountability

“A defining characteristic of our partnership is reciprocal accountability. This means that we will work together at all levels in a collaborative manner to achieve our shared goals, living up to our individual and collective commitments. It means that each Partner is accountable to the others for its actions, and for the effective implementation and operation of their responsibilities and systems, recognizing that our work as Partners is interdependent and interconnected. It means that we strive not only to live up to one another’s expectations, but strive to exceed them.”¹⁹⁷

In 2015, an executive working group was formed to advance cultural safety and humility and reporting to the TCFNH. The working group prepared *Cultural Safety and Humility in Health Services for First Nations and Aboriginal people in British Columbia: A Guiding Framework for Action* and a *Declaration of Commitment to Cultural Safety and Humility in Health Services for First Nations and Aboriginal People in BC*. This *Declaration*, signed in 2015 by the Deputy Minister of Health and CEOs of the FNHA, PHSA and the regional health authorities, commits signatories to strengthen cultural safety and humility within organizations, service delivery and across the system. Since that time, many other provincial and national organizations have also signed similar declarations of commitment, acknowledging the negative impacts of Indigenous-specific racism, pledging to lead the change and to be accountable for results.¹⁹⁸ These signatory organizations across the health system independently advanced initiatives, action plans, campaigns, programs and resources all intended to enhance cultural safety in accordance with the *Framework for Action*.

In 2018, the TCFNH discussed the need for additional measures to understand the quality and impact of these efforts and hard-wire the change in a more systemic manner. Therefore, key pillars and initial actions for a *Cultural Safety and Humility Change Leadership Strategy* were developed in collaboration

¹⁹⁷ <https://www.health.gov.bc.ca/library/publications/year/2012/health-partnership-accord.pdf>

¹⁹⁸ Signatories include: Registrars of all colleges within BC Health Regulators (Declaration of Commitment: Cultural Safety and Humility in the Regulation of Health Professionals Serving First Nations and Aboriginal People in British Columbia, 2017); BC Coroners Service (2017); Interior Health Authority (2017); Providence Health Care (2017); Ministry of Mental Health and Addictions (2018); Health Canada and Indigenous Services Canada (2019); Emergency Management BC (2019); Doctors of BC (2019); BC Patient Safety and Quality Council (2019).

with MNBC, the BC Association of Aboriginal Friendship Centres, and the BC Patient Safety & Quality Council, and endorsed by the TCFNH. This document targeted initiatives at a strategic and system-wide change level, aimed to enhance coordination and assure quality and accountability for results. This included: updating of the *BC Quality Matrix* to reflect cultural safety and humility; the development of a *Cultural Safety & Humility Standard*; establishing a measurement framework for cultural safety and humility; and developing the backbone team to serve as a hub for knowledge exchange and maintain a proactive focus on systemic progress.

“First, I hold my hands up to Mary Ellen Turpel-Lafond and her team for taking on the task of examining and documenting systemic racism against Indigenous peoples in B.C. health care. Our health care system is one of many institutions that needs a comprehensive review to fight systemic, entrenched, and institutional racism. Her report has given voice and legitimacy to the experiences of First Nations people in the health care system. We no longer have to suffer the skepticism of the mainstream media or non-Indigenous public when we are marginalized by health care providers. The report found evidence of widespread systemic racism exists in the B.C. health care system; what’s worse, many actors inside the system knew about this racism and did nothing about it. Armed with this report, it’s time that the Government of British Columbia overhaul our health care system to eliminate racism against Indigenous peoples. The BCAFN and our allies will hold the province to account over this, and we will not rest until strong, definite action is taken to protect our peoples’ rights to safety, respect and dignity in seeking assistance from health care providers.”

~ Regional Chief Terry Teegee,
BC Assembly of First Nations, Takla Lake First Nation

In early 2020, the tripartite partners released a *Tripartite Evaluation Report* and accompanying documents, including a *Cultural Safety and Humility Case Study Report*. This report reveals scope and number of initiatives underway and the importance of the FNHA’s leadership in drawing initial focus to this issue. Through these leadership efforts, cultural safety and humility have emerged as clear and well-recognized concepts to address racism and stereotyping, providing cultural humility as an essential personal and professional practice to create cultural safety in the health care sector, including the elimination of interpersonal and systemic racism. As this Review has also found, the evaluation notes that further hard-wiring and systemic change is needed to consolidate gains and drill change to the front line of health care.

Health and the Human Rights of Indigenous Peoples

Parallel to this history of Indigenous health care in Canada has been the advancement of international and domestic human rights regimes, including the right to health and the right to the elimination of all forms of racial discrimination, including against Indigenous peoples.

A human rights lens is now a generally accepted framework for assessing the appropriateness and effectiveness of health care systems and for addressing specific challenges faced by historically marginalized populations such as Indigenous peoples. Indeed, the development of the *UN Declaration* took place because of a recognition of the need to specifically confirm and uphold the human rights of Indigenous peoples in the face of histories and abuses, such as those seen in the history of health care in Canada.

This Review, in analyzing findings and making recommendations, expressly seeks to reinforce the standards of a human rights framework to Indigenous health as the measure for progress that has been made, and what remains to be done.

The Human Right to Health

The fundamental relationship between health and human rights has been well established for decades. From the beginnings of the contemporary global understanding of human rights in the 1940s – of which Canada was a major advocate, participant and force – the right to health has been identified.

In 1946, the *Constitution of the World Health Organization* (WHO) recognized that “*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*”.¹⁹⁹ The definition of “health” in the WHO Constitution is broad and integrative – a “*state of complete physical, social, and mental well-being and not merely the absence of disease or infirmity*”.²⁰⁰

The *Universal Declaration of Human Rights* (1948) also identified the importance of the relationship between health and human rights in various ways, including in Article 25:

1. *Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.*

¹⁹⁹ https://www.who.int/governance/eb/who_constitution_en.pdf

²⁰⁰ https://www.who.int/governance/eb/who_constitution_en.pdf

2. *Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.*²⁰¹

In 1966, the *International Convention on Economic, Social, and Cultural Rights (ICESCR)* recognized in Article 12 the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

Canada has long been supportive of all these international institutions and legal instruments, including as a State Party to the *ICESCR*.

The Indigenous Right to Health

This fundamental relationship between human rights and health has been strongly re-enforced in the specific context of Indigenous peoples. Most notably, the *UN Declaration* re-affirms the right to health in Article 24 in the same terms as *ICESCR* while also making additional specific references to Indigenous health:

1. *Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.*
2. *Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.*²⁰²

The *UN Declaration* was completed in 2007 after a multi-decade deliberative process involving Indigenous peoples and state governments, including Canada. The *UN Declaration* was adopted by Canada with reservations in 2010 and, in 2016, the federal government removed these reservations.

The affirmation of the Indigenous right to health in the *UN Declaration* is a reflection of decades of studies, reports and data collection that affirm and re-enforce the necessity for a human rights-based approach to the health of Indigenous peoples, including to address the socio-economic gap between Indigenous and non-Indigenous peoples, and the enduring legacies of systemic racism and colonialism. The Indigenous right to health means that Indigenous peoples must be able to fully access appropriate health care services and

²⁰¹ <https://www.un.org/en/universal-declaration-human-rights/>

²⁰² <https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html>

ensure their individual well-being is cared for. To respect this right, such services must be free of obstacles and hindrances that don't exist for other people, and at the same time must be provided in ways that affirm and uphold the distinctive cultural and social context of Indigenous peoples.

“shíshálh Nation remains at the forefront of rights recognition and implementation in British Columbia, as evidenced by the long-term Foundation Agreement we completed in 2018 with the B.C. government. Through that agreement we are on a path of re-setting the relationship based on a clear human rights foundation, as articulated in the United Nations Declaration on the Rights of Indigenous Peoples.

Yet, the Foundation Agreement should not give any comfort that the hard work is done. Quite the opposite – the hard work has only just begun. Implementing human rights is a lot harder than merely acknowledging them. It demands change – in how we govern, make decisions, relate to each other, and think and act as individuals. This is as true as ever in health care, where I continue to frequently hear concerns from members about the care they received, a racist or insensitive comment or slight, or obstacles in accessing services to meet their basic health care needs. And then I look across the Province, and Canada, and see that while our Nation has agreed to a path for securing the implementation of our rights, and transforming our current reality, most First Nations remain facing enduring obstacles of rights denial, and lack of recognition of their laws and governments.

We all have an obligation, to honour the sacrifices made by past generations and do what we must for future generations, to ensure that implementing the basic human rights of Indigenous peoples, including the Indigenous right to health, is at the core of all we do. This is our shared work, and our call to action.”

~ hiwus (Chief) Warren Paull

Additionally, the Indigenous right to health includes the recognition and affirmation of the distinctiveness and diversity of Indigenous worldviews, knowledge, social systems and culture. An expression of systemic racism is the struggle Indigenous peoples have to access health care services that are responsive to, and reflective of, Indigenous worldviews and conceptions of health. As part of the right to health, Indigenous peoples should have full access to health care services in ways that reflect and are responsive to Indigenous worldviews and conceptions of health, without discrimination, hindrances or obstacles. Ultimately, the health care system must be one which Indigenous individuals feel trust and confidence to access, without reservation, and that their culture, worldview and individual integrity will be reflected and respected in the services they use.

The Indigenous right to health is also inextricable from the Indigenous right of self-determination and the inherent right of self-government. In many respects, the right of self-determination is viewed as a foundation for human rights of peoples, including how a human rights framework can respond to colonialism. Self-determination is reflected and upheld in the *Universal Declaration, ICESCR* and other instruments. It is also specifically upheld in the context of Indigenous peoples in the *UN Declaration* including in Articles 3, 4 and 5:

Article 3

Indigenous peoples have the right to self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

Article 4

Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, as well as ways and means for financing their autonomous functions.

Article 5

Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the State.²⁰³

Self-determination speaks to control by Indigenous peoples over their health and well-being, including through their own governing institutions, jurisdiction and laws. When understood in these terms, self-determination relates to how Indigenous institutions necessarily have roles to play in the B.C. health care system, as well as how individuals have a right to access health care in culturally appropriate ways that reflect Indigenous worldviews and conceptions of health. Colonialism imposed culturally-foreign systems of disempowerment – including the pass system, Indian hospitals and residential schools – that prevented Indigenous individuals from making their own health decisions. Implementing the right of self-determination must empower people to control their own health and wellness journeys, including in systems that are culturally appropriate.

²⁰³ <https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html>

The Requirement of a Human Rights Approach to Indigenous Health in Canada and B.C.

The centrality of the UN Declaration to addressing Canada's legacy of colonialism, including in relation to health, was highlighted by the Calls to Action of the Truth and Reconciliation Commission which identified the *UN Declaration* as “the framework for reconciliation”.²⁰⁴

Canadian governments have begun to act upon the centrality of the *UN Declaration* and the necessity for a human rights approach to Indigenous rights. In addition to fully endorsing the *UN Declaration*, the federal government released the *Principles Respecting the Government of Canada's Relationship with Indigenous Peoples*²⁰⁵ (10 Principles) to assist in the implementation of the *UN Declaration*, and has referenced or affirmed the *UN Declaration* in a number of new statutory provisions. The federal government has also committed to pass legislation to implement the *UN Declaration*.

B.C. has gone a step further. In addition to adopting the same 10 Principles as the federal government²⁰⁶ in November 2019, the provincial government passed the *Declaration on the Rights of Indigenous Peoples Act (DRIPA)*.²⁰⁷

Co-developed with Indigenous peoples, *DRIPA* has a number of provisions that are relevant to shaping approaches and steps to addressing systemic racism in B.C.'s health system:

- *DRIPA* affirms the application of the *UN Declaration* to the laws of B.C. (s. 2). This means, amongst other things, that the *UN Declaration* must be used – by law – as an interpretive tool when using and applying the existing laws of the province. Government and public institutions must consider the human rights of Indigenous peoples when determining how to act in accordance with B.C.'s laws, including in health.
- *DRIPA* requires the alignment of B.C.'s laws with the *UN Declaration* (s. 3). This means, amongst other things, that there is an obligation on B.C. to review existing laws, as well as new laws prior to adoption, for alignment with the *UN Declaration*. This includes laws related to health.
- *DRIPA* requires an action plan (s. 4) to meet the objectives of the *UN Declaration*. The objectives of the *UN Declaration* include ensuring that the human rights of Indigenous peoples are upheld, ending discrimination and creating

²⁰⁴ http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

²⁰⁵ <https://www.justice.gc.ca/eng/csjs-jc/principles-principes.html>

²⁰⁶ https://www2.gov.bc.ca/assets/gov/careers/about-the-bc-public-service/diversity-inclusion-respect/draft_principles.pdf

²⁰⁷ <https://www.leg.bc.ca/parliamentary-business/legislation-debates-proceedings/41st-parliament/4th-session/bills/first-reading/gov41-1>

greater conditions of social justice and equality for Indigenous peoples. Any action plan, therefore, must include measures to end discrimination against Indigenous peoples in health and uphold the Indigenous right to health.

- *DRIPA* confirms legislative space for agreements that recognize Indigenous governing bodies and implement the standard of free, prior and informed consent in the *UN Declaration* (s. 6 and 7). This provision enables opportunities for implementing aspects of the Indigenous right of self-determination, including in relation to control and jurisdiction over health.

Upholding the Indigenous right to health, including as reflected in the *UN Declaration*, is now firmly established as the legal and policy foundation for addressing discrimination and racism against Indigenous peoples in B.C.'s health care system. Such a human rights approach is also reinforced by a number of other foundational elements of Canada's domestic law. These include section 35(1) of the *Constitution Act*; the *Charter of Rights and Freedoms*; and human rights legislation in jurisdictions across Canada.

This human rights framework, and in particular the *UN Declaration* and *DRIPA*, form the framework for understanding the work that must be done today to address systemic discrimination in B.C.'s health care system. Specifically, a human rights framework means that the actions we take must facilitate the further development of a health care system where the Indigenous right to health is implemented. For the purposes of this Review, this means identifying what work must be done to support the implementation of the integrative and interconnected Indigenous understandings of health, with full access to culturally-appropriate health care services for Indigenous individuals, and to support Indigenous control in delivering health care – including through changes in laws, policies and practices, as well as roles for Indigenous institutions – consistent with Indigenous self-determination.

Human Rights and Anti-Racism

A human rights approach is also an anti-racist approach. Public discourse and policy development, as well as expert insights, have increasingly emphasized the necessity to adopt an anti-racist mindset and cultivate the skills of anti-racism. Anti-racism is the practice of identifying, challenging, preventing, eliminating and changing the values, structures, policies, programs, practices and behaviours that perpetuate racism. As Ibram X. Kendi, a leading scholar of anti-racism, states, it's not enough to be "not racist". "*The opposite of 'racist' isn't 'not racist',*" he writes. "*It is 'antiracist'.*"

To be anti-racist means to be taking action to fight racism, including acknowledging one's own place and role in a society with an enduring legacy of colonialism and racism. It means understanding history, and how the present lies upon these colonial and racist foundations, including in laws, policies and practices. It means everyone has a role to play in taking action to advance the transformation of laws, policies and practices that are rooted in the legacy of colonialism and racism, and create conditions of greater inclusion, equality and justice. Recognizing it is not the role of Indigenous or other racialized peoples to educate non-racialized people about colonialism and racism – and to educate oneself – is vital.

Anti-racist mindsets, tools and skills involve targeting the root causes of systemic discrimination – which lie in structures, patterns of behaviour and attitudes that are legacies of colonialism – and pursue transformative, and not merely superficial or incremental, change. This establishes a foundation for the expression and enjoyment of Indigenous human rights.

“The racism that Canadians are witnessing today in the health care system, such as the events surrounding the tragic death of Joyce Echaquan in a Montreal hospital, highlights that there remain issues with the way health care is governed and delivered to Indigenous populations in Canada. The problem of on-going racism in Canada towards Indigenous peoples in the health care system is an example of the on-going systemic racism that continues to inflict our country more generally. It is a necessary thing for all Canadians to experience the anger, sadness, and horror of racism that has always been present in our communities in order to fix it.

If we want to address systemic racism then we have to confront the racism that remains in our institutions, as reflected in our laws, policies and practices, including the Indian Act. Colonialism has created a gap between Indigenous and non-Indigenous health and wellness through disempowerment and interference in Indigenous governments and legal orders. To confront this legacy, and tangibly improve the lives of Indigenous children, families, and communities, we must implement Indigenous rights, including the right to self-determination, which includes the inherent right of self-government. This means Indigenous peoples having control over meeting the needs and well-being of their citizens under their own jurisdictions and laws, clear revenue streams to deliver services like any government, and systems and institutions for governing they have determined through their own laws and traditions.

Here in British Columbia, First Nations individually and collectively have taken important steps towards self-government and self-administration. This includes the creation of their own health institutions; but the work of building systems based on the inherent right of self-government is on-going. First Nations must continue to advance – indeed accelerate – rebuilding and strengthening their Nations and governments, as well as their institutions they determine to work on their behalf in health or any other sector. At the same time, governments must actually get serious about rights recognition and implementation. Confronting racism and colonialism is not enabled by lofty rhetoric. This is an arena of tangible action, and making the hard decisions – much of which we are yet to see. ”

~ Jody Wilson-Raybould (Puglaas)
Independent MP, Vancouver-Granville

Recommendations



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.

The 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*. Adopting the *DRIPA* obligates the B.C. government to have an action plan, developed co-operatively with Indigenous peoples, to achieve the "*objectives of the Declaration*".²⁰⁸ 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 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.

²⁰⁸ Section 4

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* refer 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.

“It’s time for our society to go beyond simply acknowledging that systemic racism is a part of our health care system. We need to ensure every recommendation in this report is fully operationalized in short order and that Métis and other Indigenous people no longer need to worry about being subject to racism if they require medical treatments. For far too long Métis people have not been treated fairly when it comes to the delivery of health services in British Columbia. We must use this report as a catalyst to ensure long-standing grievances are properly dealt with and that Métis people are once and for all treated with dignity and respect.”

~ Daniel Fontaine
MNBC Deputy Minister

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.²⁰⁹ 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.

²⁰⁹ <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 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 *British Columbia 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 to 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 to 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 mindset and skill-set 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 Canadian Institute for Health Information (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 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 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 it is 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 is 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.

Recommendations: 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.

“The numbers in the report are sobering. And the need for better measurement is clear. As a national health data organization, we believe that data is key to accelerating change. We are humbled to be named in this report and referenced as an organization who could bring our knowledge of data and indicators to support this important work, in partnership with the First Nations, Inuit and Métis.”

~ David O’Toole, President and CEO,
Canadian Institute for Health Information (CIHI)

~ Janet Davidson, Board Chair, CIHI

Appendices



Appendix A

Terms of Reference

Establishment of the Investigation

1. An independent investigation into systemic Indigenous-specific racism in health care in British Columbia is established by the Minister of Health.
2. Dr. Mary Ellen Turpel-Lafond (Independent Investigator) is the leader of the investigation.
3. Turpel-Lafond will independently select and assemble a team to carry out the work of the investigation.

Purposes of the Investigation

The purposes of the investigation are as follows:

1. to inquire into and report on alleged incidents of Indigenous-specific racism in emergency departments in B.C., situated and examined within a broader context of Indigenous-specific systemic racism in the health care system in B.C.
2. to make recommendations regarding the matters described in section 3.

Scope of the Investigation

1. The investigation is to study data and information, conduct hearings and interviews, and make findings of fact respecting Indigenous-specific systemic racism in B.C.'s health care system, including the following:
 - a. the veracity and extent of allegations of incidents of Indigenous-specific racism in Emergency departments, and the institutions in which they are housed, in B.C.;
 - b. the potential extent of Indigenous-specific systemic racism in the health care system in B.C.;
 - c. the acts or omissions of regulatory authorities or individuals with powers, duties or functions in respect of the health care sector, or any other relevant sector, to determine whether those acts or omissions have contributed to systemic racism in B.C.;
 - d. the scope and effectiveness of initiatives and investments to address systemic racism in Emergency departments and in health care, including by regulatory authorities or individuals with powers, duties or functions

- in respect of the health care sector, or any other relevant sector;
 - e. the barriers to addressing Indigenous-specific systemic racism in B.C.;
 - f. any other relevant and necessary matters.
- 2.** The investigation will make any recommendations it considers necessary and advisable, including recommendations respecting the following:
- a. Measures to eliminate systemic racism against Indigenous people accessing health care in B.C.
 - b. Measures to uphold the human rights of Indigenous peoples accessing health care in B.C., as articulated in the UN Declaration on the Rights of Indigenous Peoples, the Truth and Reconciliation Commission Calls to Action, and the Missing and Murdered Indigenous Women and Girls Inquiry Calls for Justice.
 - c. Measures to resolve barriers to addressing Indigenous-specific systemic racism in B.C.
 - d. Public and health professional education to address bias and eliminate Indigenous-specific racism in B.C. and create space for the exercise of Indigenous peoples' human rights.
 - e. The regulation of the health care sector or any other relevant sector to eliminate Indigenous-specific racism in B.C. and create space for the exercise of Indigenous peoples' human rights.
 - f. Processes required to implement the recommendations of the investigation.
 - g. Measures to ensure ongoing transparency, accountability and progress in eliminating Indigenous-specific racism in B.C. and creating space for the exercise of Indigenous peoples' human rights.
 - h. Any further inquiries or studies.
- 3.** The investigation will summarize the results of its work in a written report submitted to the Minister of Health by no later than Dec. 31, 2020. A phased approach may be taken to development and issuance of the reports.
- 4.** If the Independent Investigator has reasonable grounds to believe that any information obtained during the inquiry may be useful in the investigation or prosecution of an offence under the Criminal Code, or disciplinary action applicable to their regulated health profession, the Independent Investigator must forward that information to the appropriate authorities.

Privacy

1. Recognizing the potential vulnerability of affected individuals and key informants, and the sensitivity of information collected during the course of this investigation, the following measures will be taken:
 - a. The investigation will take all reasonable steps to collect information in a manner that protects the security of the person interviewed and respects their confidentiality.
 - b. The investigation will not disclose personal information of affected individuals without their informed consent.
 - c. All information will be treated confidentially and in accordance with B.C. privacy legislation.
 - d. Investigation records will be sealed and held by the Independent Investigator's law firm.

Data Governance

A core function of the investigation is to collect data and information to understand the presence and extent of Indigenous-specific discrimination in health services in B.C. All data and information which arises from the operating and reporting of this investigation, including surveys, individual incidents and testimonials, interviews, submissions and analysis of pre-existing sources of information are subject to these data governance provisions.

1. The Independent Investigator is the data steward and custodian of all data created as a result of this investigation, on behalf of the Indigenous peoples of British Columbia who own the data collectively.
2. The investigation has instituted processes that ensure access to data and information collected/created as part of fulfilling its mandate is limited to the investigation team, and its use and disclosure is in alignment with applicable provincial privacy legislation. All electronic and paper-based data and information is fully protected in a secure manner.
3. All data and information collected/created by the investigation is confidential, and privacy of individuals will be ensured through anonymous reporting in information products released externally, both informally and formally. In cases which describe individual incidents, the utmost care will be taken to remove any identifying features of the incidents in all reporting, and if reporting verbatim comments, that nothing in the comment, including content, vocabulary and/or style of writing, could serve to identify the individual respondent. Prior approval of the persons who submitted the

incident information will be obtained before reporting involving individual incidents.

4. All information and data which is published or otherwise distributed from the investigation is culturally appropriate and for the ultimate benefit of Indigenous people in British Columbia. The investigation team has developed specific policies and procedures to guide the review and disclosure of Indigenous information and data in investigation reports.
5. The Independent Investigator has overall accountability and responsibility to manage all data and information collected/created in this investigation.
6. Following the conclusion of this investigation and submission of the final investigation report, all data and information, including survey responses, will be sealed and will not be available for any use, including further analysis, editing, research or publication. All data and information used by team members in the course of their duties will be returned to the returned to the Independent Investigator.

Appendix B

Minister Delegation Letter



Aug 24 2020

1173399

Ms. Mary Ellen Turpel-Lafond
 'Addressing Racism' Investigation
 Woodward & Company Lawyers LLP
 200 - 1022 Government St
 Victoria BC V8W 1X7

Dear Ms. Turpel-Lafond:

On June 19, 2020, I, Adrian Dix, Minister of Health, appointed Mary Ellen Turpel-Lafond to lead an investigation into Indigenous-specific racism in the British Columbia health care system, to be conducted in accordance with the terms of reference attached as Exhibit A to this delegation letter (the "**Investigation**".)

For the purpose of the Investigation, I hereby delegate the minister's powers:

- (a) under section 10 of the *Ministry of Health Act*, including the power to determine whether the collection, use or disclosure of personal information is reasonably needed to fulfill a stewardship purpose, to Mary Ellen Turpel-Lafond, to be exercised as reasonable and necessary in the conduct of the Investigation (the "**Delegated Powers**");
- (b) to collect, use and disclose personal information under section 10(1) (a), (b) and (c) of the *Ministry of Health Act*, to the individuals listed in Exhibit B to this delegation letter, as necessary for the effective administration of the Delegated Powers.

This delegation will expire on December 31, 2020.

Sincerely,

Adrian Dix
 Minister

Attachments

Ministry of Health

Office of the Minister

Mailing Address:
 PO Box 9050 Stn. Prov. Govt.
 Victoria BC V8W 9L2

Location:
 Parliament Buildings
 Victoria

Appendix C

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 center 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, disability or other prote

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, favors, 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 individual who are members of that cohort as if they fit a present 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.

Appendix D

Data Sources and Limitations

Quantitative Data Sources

Data Linkages

Much of the Indigenous-specific data in this report has been sourced from databases which were linked to databases that are specific to B.C. First Nations or Métis populations.

- The First Nations Client File (FNCF) FNCF is a cohort of BC resident First Nations people registered under the *Indian Act*, and their unregistered descendants for whom entitlement-to-register can be determined, linkable through their BC Ministry of Health Personal Health Number (PHN).
- The MNBC Métis Citizenship Registry (MCR) is 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 is a provincial database that summarizes how people use provincial health services every year. The HSM divides the BC population into population groups according to their usage of available sources of health services data. It provides an overview of health service utilization of services representing approximately seventy per cent of all provincial health expenditures for individuals who have chosen/been able to access health services.

b. BC Chronic Conditions Registry

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

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

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 healthcare utilization. The population grouping methodology starts with everyone who is eligible for healthcare, including those who have not interacted with the healthcare system. It uses

diagnosis information from hospital and physician services over a 2-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 (BCPDR). The registry captures >99% 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% 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

Overdose death data is obtained from the BC Coroner's Service, Drug and Poison Information Centre, BC Emergency Health Services/Ambulance Service and ED visits at hospitals across BC. 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 healthcare use. It includes information on a 20% random sample of the general BC population, and a 65% 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 was obtained through linkages with the Discharge Abstract Database, National Ambulatory Care Reporting System and 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 BC. 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 15,000 First Nations participated from 122 B.C. First Nations communities.

Patient Reported Experiences Measurement Survey

Since 2003, the Ministry of Health and Provincial 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 hospitals, emergency departments, outpatient cancer care services, mental health in-patients and long-term care facility residents. All patient reported experience measures surveys include Indigenous self-identifier variables.

Qualitative Data Sources

Provincial Health Services Authority, San'yas

The San'yas Indigenous Cultural Safety Training is an online training course provided through the Provincial Services Health Authority 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 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?

Provincial Health Services Authority, BC Patient Safety and Learning System

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

FNHA

Patient complaints which were received by the FNHA since its inception in 2013 were forwarded to the investigation. These complaints related to FNHA-administered services, FNHA-funded services and provincial health services.

Regulated Health Colleges

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

Limitations of the Data

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 investigation's data governance protocol only allows the reporting of rates which have been derived from numerators of at least eleven or denominators of at least 21. Although larger numbers can be worked on and

reported, 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.

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 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 of the data being linked, some infants will be included only if parents can be identified as registered/eligible First Nations.²¹⁰ 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 0-5 age group in 2017/18 which have not been adequately investigated by time of publication. For this reason, age group specific data for 0-5 years has been drawn from 2016/17.

Existing privacy legislation in BC separates data in government/public institutions with non-governmental organizations and the private sector.

²¹⁰ 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 that are registered right away/infants whose registered parents can be easily verified and infants who are registered late or whose parental information is incomplete.

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 which can be accomplished, and makes data mining to completely understand the data and its initial findings impossible.

As with all data sources which 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 BC 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
- Joint Project Board projects
- 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 BC Cancer Agency, BC Renal Agency and the Ministry of Child and Family Development
- 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 inpatient mental health stays, inpatient rehab, home care and long term care.

Regional Health Survey

The survey is only able to reflect 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 BC. The percentage of respondents identifying as Aboriginal varies between sector surveys. In the 2018 Emergency Department survey, for example, 5.8 per cent of respondents self-identified as Aboriginal versus the 2016/17 Acute Inpatient survey, in which only 3 per cent of respondents identified as Aboriginal.

Opioid

FNHA reporting covers all unintentional drug toxicity deaths among First Nations people in British Columbia (accidental and undetermined) that occurred between January 1, 2016 and June 30, 2020, inclusive. It includes confirmed and suspected illicit toxicity deaths (inclusion criteria below). Data is subject to change as 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 rate of COVID-19 for First Nations population are

calculated 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 the respective region in 2019 (via BC 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 ARI Intake data base, there was no consultation with data base owners during the analysis process. This was intended to support the independence of the Investigation 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. Investigation time limits 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 E

Survey Approach and Methodology

Approach and Methodology – Indigenous Peoples Survey and Health Workers Survey

The IPS and HWS were developed by the Review team. The IPS was based on an instrument designed by PHSA; whereas the HWS utilized elements of instruments from Fraser Health Authority. Both surveys were reviewed and finalized in consultation with stakeholders and Indigenous leadership.

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 Independent Reviewer's 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 investigator'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 Investigation 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.²¹¹

²¹¹Factors limiting the analysis include the small number of Métis respondents (n=273), and the extremely small sample sizes for several of the Indigenous groups (i.e., Inuit, other North American Indigenous Nations, and Other Indigenous Nations).

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).

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., # 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 (e.g., # 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 (# persons with health condition 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% 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% confidence. Note: this is a conservative application of confidence intervals, as the technique

cannot establish with certainty, non-significance with respect to rates in some situations where a certain degree of intersection is observed.²¹²

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 wellbeing.

Age standardization

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

Small Cell Values

This report has followed the investigation's policy on privacy to ensure confidentiality of reported data. Accordingly, all data has 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. In addition, small cell counts may lead to unreliable estimates of the true measures in a population.

Qualitative Analysis

The qualitative analysis of Review Intake, San'yas discussion board, and complaint data was 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 the Review Intake data. 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

²¹² In the IPS and HWS analysis, 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, these survey responses' CIs were further assessed using p values, and significance (p<.05) determined on this basis.

grouped into broad themes. The relevance and fit of these themes and some sub-themes were confirmed with the investigation 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. Some key themes and sub-themes were re-coded and the frequencies of themes and sub-themes were calculated.

Métis Data

The Métis population is small, and the Métis Citizen Registry (MCR) used for data linkages includes only a portion of the total Métis population. The Other Resident population of BC 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.



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 practices 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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