Aboriginal Health Needs Assessment

within the

Central West and Mississauga Halton Local Health Integration Network Service Areas

Final Report

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Prepared for the Central West LHIN and Mississauga Halton LHIN by:

Johnston Research Inc.

96 Serene Way, Vaughan, ON L4J 9A2
TEL: 905-889-4430
FAX: 905-889-9961

andrea@johnstonresearch.ca
www.johnstonresearch.ca

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Executive Summary

This report represents a comprehensive study of the health care needs of Aboriginal residents of the Central West LHIN area and the Mississauga Halton LHIN area. The timing of this assessment is optimal as the Aboriginal population in the LHIN service areas is increasing rapidly. The perspectives of residents and health care professionals were ascertained through multiple lines of inquiry. These included Statistics Canada profiles (Aboriginal Peoples Survey and Census, 2006) of the First Nations, Métis and Inuit ancestry residents of the LHIN areas, resident focus groups, resident questionnaires, and health and social service provider questionnaires supplemented by interviews.

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

The demographic characteristics of the Aboriginal population in the LHIN services area were based on the Aboriginal Peoples Survey 2006 and were as follows:

- Between the 2001 and 2006 Canada Census, the number of self-identified Aboriginal people increased by 40.5% in the Peel Region and 54.9% in Brampton. This was a much greater increase than for City of Toronto (19.7%) or Ontario (28.8).
- Most Aboriginal people in the LHIN service areas self-identified as having First Nations ancestry (85%) and/or Métis (26%) ancestry. Few people in either the APS or in the Aboriginal Resident Survey self-identified as Inuit. Given the lack of an identifiable Inuit perspective, the views in this report focus primarily on First Nations and Métis residents.
- A greater proportion of the Aboriginal population was under 55 years of age compared to the non-Aboriginal population.

Aboriginal Ancestry: Aboriginal Population of Both LHIN Service Areas (15 years +) - APS 2006

	LHINs	Central West LHIN	Mississauga Halton LHIN
Aboriginal population (N)	14,170	5,890	8,280
First Nations Ancestry (%)	85%	82%	87%
Métis ancestry (%)	26%	25%	27%
Inuit ancestry (%)	1%	n/a	n/a

Gender, Age: Aboriginal and Total Populations of Both LHIN Service Areas (15 years +) – APS 2006

	Aboriginal Population			**Total Population (Census, 2006)**		
	LHINs	Central West LHIN	Missis-sauga Halton LHIN	LHINs	Central West LHIN	Missis-sauga Halton LHIN
Females	48%	53%	45%	49%	49%	48%
Males	52%	47%	55%	51%	51%	52%
15-24	21%	22%	20%	17%	18%	17%
25-54	61%	55%	66%	58%	58%	57%
55 and over	18%	23%	15%	25%	24%	26%
Total (N)	**14,170**	**5,890**	**8,280**	**1,371,175**	**570,665**	**800,510**

Health needs were assessed according to four aspects: health status, health care service usage, perceived access to healthcare, and perceived appropriateness of health care. Health care was defined to include traditional and wholistic health and wellbeing, as well as mainstream and alternative/complementary options. Traditional and wholistic health and wellbeing care includes services of traditional healers, Elders and counsellors, traditional ceremonies, participation in traditional activities, and other healing rituals/practices. Personal health was defined to include the concept of balance of the physical, emotional, mental (cognitive) and spiritual aspects of the self.

Based on Statistics Canada data, there were some relatively large health disparities in the Aboriginal community with regards specifically to non-traditional tobacco use, and long-term health conditions. A substantial minority of APS respondents reported not receiving care for some of those long-term conditions.

Health status (APS 2006; Census,2006): There were observable differences in some health status indicators. More Aboriginal than non-Aboriginal adults reported daily smoking (29% vs. 11%), arthritis/rheumatism (20% vs. 14%), asthma (15% vs. 7%), and diabetes (9% vs. 4%). Of those who had five of the six top long-term conditions (excluding diabetes), half to three quarters reported receiving treatment.

These results were somewhat surprising given the relative equity (to non- Aboriginal residents) on standard measures of socio economic status. Further, given the relative youthfulness of the Aboriginal population, we would have expected lower rates of long-term health conditions.

Health care service usage: There was high health care service usage of mainstream services. There was a small minority of focus group participants and respondents to the Resident Survey who used traditional Aboriginal health care services, although many had to travel distances to do so. There was great cultural diversity of Aboriginal people in the LHIN service area and a corresponding variety of opinions and experiences in terms of health care access and appropriateness.

Health care access: Access issues included locating appropriate care options, wait times, express visits, reliance on prescription drugs, crisis rather than prevention orientation, affordability of drugs, glasses, dentist care, etc. Some focus group participants were greatly frustrated by lack of knowledge of how to navigate the mainstream health care system. Even for those eligible for Non-Insured Health Benefits[1], affordability was an issue because of the need for payments to providers prior to receiving care or reimbursement.

Many people in the focus groups reported frustration with the lack of **local** access to traditional medicines and healers. Almost half reported wanting to access traditional medicine, but were unable to do so due to lack of knowledge or lack of local availability.

Health care appropriateness: The focus of this enquiry was to determine if the residents were satisfied that available health care met their expectations including an understanding and utilization of traditional health care options by mainstream providers, if desired by the client. Based on focus group discussions and resident questionnaires, in a perfect, culturally appropriate world, health care providers would act in a manner that earns them the Aboriginal client's trust, think wholistically about the health of a client (physical, emotional, mental, spiritual), have sufficient time to apply that knowledge at each visit, and be able to coordinate with a healthcare team that included alternative/complementary providers and traditional Aboriginal providers (covered under the Ontario health insurance plan). Focus group participants indicated a strong acceptance of personal responsibility for their health care that led them to use multiple sources of information about health matters and being proactive in seeking providers of their choice.

[1] Non-Insured Health Benefits (NIHB) are provided to Status First Nation individuals only. It provides reimbursement for out-of-pocket expenses such as dental work, eye care related needs, and prescription drugs. See for more details: <http://www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php>.

Conclusions: There was an obvious need for more attention to health practices (smoking), pre-conditions (housing), long-term health conditions, more clients seeking care for those long-term conditions, and easier access to mainstream providers. There was an equally important need for access to cultural health care options. Mainstream providers acknowledged that they lacked depth of experience as well as understandings of First Nation, Métis and Inuit ways of knowing and communicating.

The need, as envisioned by Aboriginal residents, focuses on First Nations, Métis and Inuit residents having the tools necessary to support healthy lifestyle choices, as well as locate and improve access to appropriate health care. Specifically, Aboriginal residents expressed a preference for a central source to both access and share health information and obtain advocacy services. Examples of preferred data and information would include: availability of mainstream care providers who are accepting of individual and cultural preferences, location and availability of traditional care providers, information on Aboriginal approaches to health care, and links to general health information. An advocate role is envisioned as being a personal approach to help individuals navigate the health care system. Finally, working with local organizations the LHINs could use multiple media to communicate with the Aboriginal communities including community forums, community events, the internet, and brochures.

Recommendations

1. That the two LHINs jointly work with appropriate organizations to provide coordinated information and resources to …

    - provide health education and health promotion opportunities to specifically address non-traditional tobacco use, high rates of arthritis/rheumatism, asthma, high blood pressure and diabetes, and to inform Aboriginal residents about the benefits of consulting health care providers about those and other long-term conditions.
    - adequately navigate mainstream services, and
    - locate appropriate cultural and alternative health care providers.

2. That information about Aboriginal culture, demographics, health needs, and ways of knowing should be shared with local health and social service providers through existing community engagement and diversity committees (when available) to help them provide better client-centered care for First Nations, Métis and Inuit clients.

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1. Introduction

In the 2009/10 fiscal year, the Central West Local Health Integration Network (CWLHIN) and the Mississauga Halton Local Health Integration Network (MHLHIN) partnered to manage the implementation of a needs assessment and overall Aboriginal health strategy within the geographic area of the two LHINs. Johnston Research Inc. was contracted to carry out this work. The purpose of this research project was two fold: a) provide a demographic profile, health needs priority, and health status of Aboriginal people living within the CWLHIN and MHLHIN service areas according to the residents and service providers, and b) determine the community needs and strategic directions for addressing the health needs.

Health status and needs were explored through a staged process employing multiple methods. The findings from each stage informed subsequent steps in the research process. Secondary analysis of custom tabulations for the two LHIN service areas included the Aboriginal Peoples Survey (2006) (APS) and the Census (2006). Following a review of the valid data from Statistics Canada two focus groups with Métis and First Nations residents were conducted. The findings of the secondary analysis and the focus groups helped to shape the Aboriginal Resident Survey and the Health Service Provider Survey. The latter led to interviews with service providers.

In addition to information about the health status and health care experiences of First Nations and Métis residents of the two LHIN service areas, the needs and wants of these residents focused on difficulties accessing appropriate services and the quality and appropriateness of the services that they successfully accessed. Looked at through a cultural filter, many constraints shared by all urban users of the system can become cultural barriers.

Accordingly, this report is structured to provide information about:

a) the demographic and socio-economic characteristics of this urban Aboriginal population including some comparisons to other regions and/or the non-Aboriginal populations in the same regions,
b) the health status indicators,
c) health care usage patterns,
d) access needs,
e) quality and appropriateness needs, and
f) providers' points of view.

The information in these sections is followed by a set of relevant conclusions and recommendations.

1.2 Methodology

The approach used to determine the health needs of the Aboriginal population in the MHLHIN and CWLHIN included the integration of data from five sources. These five lines of inquiry are woven together in the pages that follow to provide an understanding of health status and needs of Aboriginal people living in the CWLHIN and MHLHINs. While the census and APS were the most rigorous data sources because of their representative nature, the focus groups, Resident Survey and Service Provider Survey, provide the context or lens to view the statistics and to begin to understand the pathway forward from the perspective of the people within the community. Other than Inuit residents included in the Statistics Canada data (1% of the Aboriginal population in the LHINs) only one Inuit resident responded to the Resident Survey. Most findings, therefore, should be limited to First Nation and Métis residents. Given the multiplicity of sources, references are provided to ensure that readers are aware of the origin of the data thereby enhancing the ability to make the appropriate interpretations.

The five data sources have afforded a detailed view of health needs in the two LHIN service areas. While each of the sources offers a unique perspective or specific strength it should also be noted that there are limitations to the data that are discussed below. The next five subsections provide a description of the methods that were undertaken during this study.

1.2.1 The Aboriginal Peoples Survey –2006

The APS was a comprehensive cross sectional survey of Aboriginal people, 15 years and older, living off reserve in Canada. The APS was the most representative source of data for Aboriginal people living off reserve in Canada. It has been implemented every five years following the Census. Topics include: Aboriginal identity and ancestry, education, language, labour force activity, income, health, communication technology, mobility, housing and family background.

A custom data request was submitted to Statistics Canada. Variables of interest were cross-tabulated by geography (including MHLHIN, CWLHIN and both LHINs combined), age, and gender. Ten Census Sub-divisions were included. CWLHIN included: Brampton, Caledon, Dufferin County, Orangeville, and Shelburne. The MHLHIN included: Mississauga, Halton Hills, Oakville, and Milton. Five communities were excluded from the analysis due to issues with historical community names in that Statistics Canada could not provide data below Census sub-divisions, and there was significant overlap between two or more LHIN jurisdictions. These communities included:

- Bolton, Malton, Rexdale and Woodbridge (CWLHIN)
- South Etobicoke (MHLHIN)

1.2.2 The Canadian Census - 2006

A second custom tabulation was requested to provide comparison data between the Aboriginal and non-Aboriginal 15 years and older populations in the LHIN service areas on housing, education, and income variables. Twelve Census Sub-divisions were included. CWLHIN included: Bolton, Brampton, Caledon, Dufferin County, Orangeville, Shelburne, and Woodbridge. The MHLHIN included: Mississauga, Halton Hills, Oakville, and Milton. Three communities were excluded from the tabulation due again to issues with historical names of communities and overlap between LHIN jurisdictions. The excluded communities include:

- Malton and Rexdale (CWLHIN)
- South Etobicoke (MHLHIN)

Interpreting Statistics Canada Census and APS data.
All data presented in the tables and figures in this report should be interpreted and understood according to the following guidelines:

- Blue figures should be used with caution, as advised by Statistics Canada. Their concern was that the numbers of people on which the estimate was based was small, subject to errors, and might be unstable.

- Red figures were estimated because the cell was blank.
  - If it was a 'yes/no' question there is no notation about the source of the estimate. Generally, one cell in the original table was filled in with a large majority and so the empty cell was calculated as the difference from 100% or the appropriate total. Sometimes, missing data reduced the total to 99% or 98%.
  - If it was a multiple-answer question, the estimate was obtained by subtraction only when one answer cell was blank. If more than one answer option was blank, estimates were approximated by considering the range of answers in adjacent/similar urban areas. Occasionally, it was necessary to make estimates from larger geographical areas such as Ontario or Canada.

- u/a = unavailable.

1.2.3 Focus Groups

Two focus groups were held, one in each of the LHIN service areas. A total of 34 First Nations and Métis people participated in the two-hour sessions including 28 adults and six youth. There were no Inuit participants. In each session, participants were asked to provide feedback on three types of questions:

1. What works well when you are looking for health care? What works well when you are getting the services?
2. What hasn't worked well when you are trying to find or get help? What doesn't when you're getting help with your health needs?
3. What factors do you think are important in accessing and providing high quality wholistic care?

The focus group process encouraged a participatory approach by asking all participants to write two comments for each of the questions. Participants then circulated around the room and posted their comments below the appropriate questions and, if appropriate, noted their agreement with comments made by other participants. The ensuing facilitator-led discussion centered on understanding the stories behind the comments and the level of group consensus for emergent themes within the question groupings.

While efforts were made to encourage discussion of wholistic health, the participants' comments focused primarily on the body or physical health.

1.2.4 Resident Survey

A total of 99 residents of the MHLHIN and CWLHIN service areas participated in a Resident Survey. Surveys were conducted both online and by paper. The survey results were intended only to enhance the statistically representative data provided by both the Census and the APS and were not considered representative of the views of Aboriginal residents in either service area. The following describes the 99 respondents to the Resident Survey and provides some comparisons to the APS distributions.

Aboriginal Ancestry

- 52% Métis, 38% First Nations Status, 8% First Nations non-Status, 1% Inuit and 1% mixed. Métis respondents were more common in the Resident Survey compared to the APS.

Gender and Age

- Respondents were 15 years of age and over as was true for the APS and Census data sets.
- There were a greater number of female respondents in the Resident Survey (63% of 99 respondents). This was very different from the APS data (48% of 14,170).

- 16% of respondents were ages 15-24, 64% were in the 25-54 age range, and 20% were 55 and over. This was similar to the APS distributions in the LHIN areas.

Education

- The APS sample and Resident Survey respondents were relatively consistent on measures of post secondary attainment of a degree, certificate or diploma (University degree 24% vs. 19%, college 16% vs. 17%, and trades 9% vs. 10%).
- More APS respondents had less than a high school education (19% vs. 8.2%) while a greater number of Aboriginal Resident Survey respondents (44%) were identified as having a high school diploma as the highest level of education achieved as compared to APS respondents (26%).

Labour Force Participation

- 69% were working for pay with 24% of those working part time (<30 hours/week) and most (77%) working full time (30 + hours/week). 31% were not working for pay.

House Hold Income

- 10% reported a Household income under $19,999, 24% at $20K - $49,999, 19% at $50K – $69,9999, 30% in the $70K-$99,999 range, 16% at $100K+.

Family/Household Composition

- 48% married, 26% single, 14% common law, 9% separated/divorced, and 2% widowed.
- 38% had children less than 15 years of age. Households commonly had 1-2 children living in the home (40%) and 10% of households had three or more children living in the home. Half of households had no children living with them.
- 38% of households had 2 adults living in the home at least half of the time.
- 41% had three or more adults living in the home at least half of the time.

1.2.5 Health Service Provider Online Survey and Telephone Interviews

The final line of inquiry involved ascertaining the perspectives of health service providers in the two service areas. While over 60 people completed the online provider survey, only 44 indicated that the servicing of Aboriginal clients applied to them. Of those, 10 participated in the subsequent interview process that gathered more in-depth perspectives. Given the relatively small respondent group and the fact that many providers reported providing services within both jurisdictions it is impossible to separate perspectives for each of the service areas.

The questions aimed to understand everyday interactions with Aboriginal clients and the willingness of service providers to learn more about the needs of Aboriginal clients in their service areas. This group included people working in hospitals, clinics, social service agencies, and Aboriginal organizations.

1.3 Demographics

Articulating the demographics of a population can provide great insight into understanding and anticipating the health needs of a community or population. In Canada, the Aboriginal population is estimated by the 2001 Census data to represent 4.4% of the total population. The Canadian Aboriginal population tends to be younger due to a later baby boom, peaking in 1967 compared to 1957. That being said, the population is also aging due to increasing life expectancy albeit at a slower pace than the general population. The Canadian Aboriginal population is also growing at a faster rate as compared to the general population due to higher fertility rates, improved infant mortality and an increasing propensity for people to self-identify as Aboriginal (Statistics Canada, 2001).[2]

So how does this compare to the demographics of the population of the MHLHIN and CWLHIN Service Area? First of all, the data provided in this report provide only a snapshot in time. As a result, it was not possible to distinguish patterns over years or decades. Further, due to the fact that the Aboriginal population in the LHINs seems to be quite divergent from the Aboriginal populations generally in terms of socioeconomic patterns it is unlikely that national demographic patterns can be extrapolated to the LHIN population.

Between the 2001 and 2006 Canada Census, the number of self-identified Aboriginal people increased by 40.5% in the Peel Region and 54.9% in Brampton. This was a much greater increase than for City of Toronto (19.7%) or Ontario (28.8%).

The most commonly identified ancestry was First Nations (85%) followed by Métis (26%) (overlap was due to reporting of multiple ancestries). Because there were few identified Inuit living in the service area, the opinions and data provided in this report are only generalizable to First Nations and Métis populations. (Table 1.3.1).

Generally speaking the Aboriginal residents in the LHIN service areas were younger than the non-Aboriginal residents although the differences were not as pronounced as they were nationally. In 2006, 75% of the non-Aboriginal adult population was between the ages of 15 and 54 as compared to 82% of Aboriginal adults with the difference observable in the 55 and older age category (Table 1.3.2).

[2] Statistics Canada. (2001). Census Data 2001: Aboriginal Peoples of Canada. Retrieved May 2010 from: http://www12.statcan.ca/english/census01/Products/Analytic/companion/abor/canada.cfm#1.

1.3.1 Aboriginal Ancestry

In the Central West LHIN and Mississauga Halton LHIN service areas there was a small, but rapidly increasing, population self-identifying in the 2006 census as having Aboriginal ancestry and of those, the majority were non-Status First Nations and/or Métis. The Aboriginal self-identifying population increased by 40.5% from 2001 to 2006 in the Peel Region.

Table 1.3.1: Aboriginal Ancestry: Aboriginal Population of Both LHIN Service Areas (15 years +) - APS 2006

	LHINs	Central West LHIN	Mississauga Halton LHIN
Aboriginal population (N)	14,170	5,890	8,280
First Nations Ancestry (%)	85%	82%	87%
Métis ancestry (%)	26%	25%	27%
First Nations Ancestry (N)	12,010	4,800	7,200
Status (%)	19%	15%	22%
Non-status (%)	79%	85%	78%

From APS tables 03 and 14 plus Census tables.

1.3.2 Gender and Age

In general, the Aboriginal population in Canada as reported by the 2006 census had more women than men. For example, for ages 15 + in Canada, the percentage of women was 55%. In Ontario it was 53% and in the nearby Toronto CMA excluding the LHINs, it was 53%.

The Central West LHIN pattern followed that of larger jurisdictions with 53% women (see Table 1.3.2). On the other hand, the Aboriginal population in the Mississauga Halton LHIN area was very different with more males than females (55% vs. 45%). This change in pattern dominated the totals for both LHINs.

The male-female pattern in the general population was less variable (48-49% vs. 45-53%) and there were more males (51-52%).

In general, most Aboriginal populations in Canada as reported by the 2006 census had more youth (ages 15-24) and fewer older adults (ages 55+) than the general population. For example, for ages 15-24 in Canada, the Aboriginal percentage was 23% and for Ontario it was 22%.

The LHINs' Aboriginal age pattern was similar to Ontario and Canada with 21% (ages 15-24) and this compared with 17% for the general population (see Table 1.2). On the other hand, the Aboriginal population in the other two age groups (25-54 and 55+) differed in each of the LHINs with

- Central West LHIN resembling the general population (CW: 55%, 23% compared to 58%, 24%)
- while the Mississauga Halton LHIN area was very different. In the MHLHIN there were more adults ages 25-54 (66%) and many fewer in the 55+ age group (15%). This change in pattern dominated the totals for both LHINs.

Table 1.3.2: Gender, Age: Aboriginal and Total Populations of Both LHIN Service Areas (15 years +) – APS 2006

	Aboriginal Population			**Total Population**		
	LHINs	Central West LHIN	Missis-sauga Halton LHIN	LHINs	Central West LHIN	Missis-sauga Halton LHIN
Females	48%	53%	45%	49%	49%	48%
Males	52%	47%	55%	51%	51%	52%
15-24	21%	22%	20%	17%	18%	17%
25-54	61%	55%	66%	58%	58%	57%
55 and over	18%	23%	15%	25%	24%	26%
Total (N)	**14,170**	**5,890**	**8,280**	**1,371,175**	**570,665**	**800,510**

(APS tables 01 and 02)

1.3.3 Mobility/Stability

The Aboriginal population in the LHINs had mobility patterns that varied along gender and age lines as one would expect and for reasons that would be expected. See Tables 1.3.3-1.3.5.

- Most residents have moved into the area from outside (79%). The MHLHIN service area has a slightly higher percentage of Aboriginal residents who have lived in the same community than the CWLHIN service area (23% vs. 19%). Males have a slight edge on living in the same community for all of their lives (24% vs. 18%). Younger respondents had, as would be expected, lived in the community for their entire lives (39% vs. 18%).

- The average number of times that residents were temporarily away in the previous 12 months was 1.4 and did not vary much by gender or age. The MHLHIN service area has a slightly higher number of temporary absences (1.7 vs. 1.1).

- The average number of times that residents moved in the past five years was 2.2 and the only variation noted was for the oldest age group with an average of 1.8 moves. This suggests high mobility from residence to residence.

- Reasons for the last move were dominated by employment (39%) and family (37%) and there were distinct patterns of gender differences[3].
    - CWLHIN residents cited employment reasons slightly more often than MH residents (42% vs. 38%). More males than females moved because of employment (46% vs. 32%). Youth moved for this reason (21% vs. 42-43%)
    - MHLHIN residents cited family reasons much more often than CWLHIN residents (40% vs. 32%). More women than men moved because of family (44% vs. 30%). Youth also moved for this reason (43% vs. 35-36%).

- Housing and school reasons for moving were given only by a small minority (less than 10%).

[3] There were insufficient data to determine differences in reasons for the different age groups.

Table 1.3.3: Mobility/Stability: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	14,170	7,320	6,850	2,940	8,640	2,590
Lived in community for entire life (% yes)	21%	24%	18%	39%	18%	n.a.
Average number of times temporarily away in past 12 months	1.4	1.5	1.3	1.6	1.3	n.a.
Average number of times moved in past five years	2.2	2.3	2.2	2.1	2.3	1.8
Reasons for last move:						
Work/find job	39%	46%	32%	21%*	42%	43%
Family	37%	30%	44%	43%	36%	35%
Better housing	9%	10%^	8%			
Housing less expensive	6%					
School	3%					
More housing available	1.5-3%*					
Availability of services	1.5-3%*					

** Estimated from data for larger jurisdictions in Ontario.*
^ *Estimate based on difference between total and females.*
From (APS tables 17 + 26) (APS tables 18 + 27) (APS tables 19 + 28).

Table 1.3.4: Mobility/Stability: Gender and Age Patterns: Aboriginal Population of Central West LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	5,890	2,730	3,150	1,310	3,220	1,350
Lived in community for entire life (% yes)	19%	21%	18%		18%	
Average number of times temporarily away in past 12 months	1.1	u/a	1.2			
Average number of times moved in past five years	2.0	2.2	1.9	2.2	1.9	2.1
Reasons for last move:						
Work/find job	42%	53%	32%			
Family	32%	19%*	43%			

** Estimate based on difference between total and females.*

Table 1.3.5: Mobility/Stability: Gender and Age Patterns: Aboriginal Population of Mississauga Halton LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	8,280	4,590	3,690	1,530	5,420	1,230
Lived in community for entire life (% yes)	23%	26%	18%	47%	19%	n.a.
Average number of times temporarily away in past 12 months	1.7	1.8	n.a.	n.a.	n.a.	n.a.
Average number of times moved in past five years	2.3	2.3	2.4	2.0	2.5	n.a.
Reasons for last move:						
Work/find job	38%	42%	32%			
Family	40%	37%	44%			

1.4 Socio-economic Status

While the Aboriginal residents were not the statistical equals of the non-Aboriginal residents of the LHINs, there was a great deal of overlap of the two groups in education achieved, labour force participation, personal and household income, and home ownership.

- Considering percentages of high school graduates Aboriginal compared to non-Aboriginal people in the service area (equivalent at 28% and 27%), less than high school graduation (27% vs. 20%), and post-secondary (46% vs. 53%) there was a 93% overlap.
    - The most significant difference is at the University degree level where the difference was 10% (13% vs. 23%).

- Aboriginal adults had higher labour force participation rates than non-Aboriginal adults (77% vs. 71%) and higher employment rates (72% vs. 66%).
    - Equivalence was noted for unemployment rates (6.9% vs. 6.2%), median personal total income ($30,825 vs. $28,748) and median household income ($84.7K vs. $84.9K).

- The only obvious differences from these patterns in the individual LHINs were that
    - the post secondary accomplishments of non-Aboriginal adults in the MHLHIN was greater than the Aboriginal adults by 9% (58% vs. 49%)
    - the unemployment rate for Aboriginal adults in the Central West LHIN was 8.1% (vs. 6.5% non-Aboriginal)

- Gender differences were noted for social-economic status, favouring Aboriginal females in education, and all males for labour force participation rates, and median personal incomes.

- Age patterns followed expected directions for both Aboriginal and non-Aboriginal adults with youth having lowest educational attainment and median incomes. Adults ages 55 and over had the lowest labour force participation rates and employment rates. Adults ages 25-54 had the highest educational attainment, labour force participation rates, employment rates and median incomes. Differences between Aboriginal and non-Aboriginal were mainly in the oldest age group as the non-Aboriginal group has a greater age range beyond retirement and that affects employment rates and income which were lower than for Aboriginal residents.

1.5 Housing

From Census tables that allow comparison between Aboriginal and non-Aboriginal residents of the two LHINs,

- More non-Aboriginal than Aboriginal residents owned their homes (82% vs. 67%). The pattern was similar in both LHINS.
- Fewer homes of Aboriginal respondents had regular maintenance (64% vs. 74%) and more needed minor (26% vs. 22%) or major (10% vs. 4%) repairs.

1.6 Family Structure, History and Responsibilities

From Census tables that allow comparison between Aboriginal and non-Aboriginal residents of the two LHINs,

- In terms of household types, there were the same percentage of households with children (54-55%), but more Aboriginal households with children that had only one parent (12% vs. 7%). Non-Aboriginal households had more multiple family households (10% vs. 4%) with most of the difference observable in the Central West LHIN (15% vs. 5%).

1.7 Traditional Activity Participation

Some residents of the LHIN service areas reported traditional activities in the previous 12 months in the Statistics Canada Aboriginal Peoples Survey.

- The most popular was fishing (31%), followed by gathering wild plant food (17%). Few reported hunting and almost none reported trapping. It was not uncommon for residents to travel to less urban areas to participate in these traditional activities.

- There was a gender difference in participation in fishing (males, 41% vs. females, 19%) with a greater difference for the CWLHIN residents (48% vs. 18%) than for the MHLHIN residents (37% vs. 21%).

- There was more fishing done by young adults than older residents (48% vs. 28% vs. 16%).

Table 1.7.1: Participation in Traditional Activities in Previous 12 Months: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	14,170	7,320	6,850	2,940	8,640	2,590
Fished	31%	41%	19%	48%	28%	16%*
Gathered wild plant food	17%	17%	18%	18%*	19%	12%*
Hunted	3-4%*	7%*	0%^			
Trapped	u/a					

** Estimated based on data from Toronto CMA.*
^ Estimate based on difference between total and females.
From APS tables 21 and 30 (hunting, fishing, trapping, gathering in past 12 months).

Table 1.7.2: Participation in Traditional Activities in Previous 12 Months: Gender and Age Patterns: Aboriginal Population of Central West LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females
N	5,890	2,730	3,150
Fished	32%	48%	18%
Gathered wild plant food	19%	14%*.	22%

** Estimate based on difference between total and females.*

Table 1.7.3: Participation in Traditional Activities in Previous 12 Months: Gender and Age Patterns: Aboriginal Population of Mississauga Halton LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females
N	8,280	4,590	3,690
Fished	30%	37%	21%
Gathered wild plant food	15%	17%	n.a.

1.8 Familiarity with LHIN

According to the resident survey, most Aboriginal residents (65%) were not at all familiar with the LHIN, 19% were somewhat familiar, 6% very familiar and 10% did not know.

1.9 Self-identification

Respondents in the Resident Survey were asked whether they self-identified as Aboriginal when seeking health care. Half said that they did self-identify (28% did and 22% sometimes), and the other half did not self-identify.

Common reasons for not self-identifying were consistent with focus group participants. Those who did not self-identify felt that identifying would not have made a difference in the care received, or felt as though self-identification might have negatively affected their care. Those who did not expect it to make a difference were of the opinion that they would receive their care based on their health status and not social status. Those who expected that it might affect them negatively were expecting discrimination whether deliberate or inadvertent. Given that many stereotypes are not flattering, their expectations were that it would not improve their care.

2. Health Status

2.1 Personal Assessment of Health

Overall, 62% of the residents of the two LHIN service areas (APS) rated their own health as *excellent* or *very good*, while 25% said *good* and 13% said *fair* or *poor*.

- The Mississauga Halton pattern for *excellent* or *very good* was consistent across the gender and age categories.
- The Central West patterns for *excellent* or *very good* were noticeably lower for men and ages 55+ (46% and 26%, respectively).
- The Central West patterns for *fair* or *poor* were noticeably lower for men than women (10% vs. 17%).
- With both the *excellent* or *very good* and *fair* or *poor* answers lower for men in the Central West LHIN service area, the *good* answer was necessarily higher (44% compared to 25% for all).

Table 2.1.1: Self Reported Health Status: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	14,170	7,320	6,850	2,940	8,640	2,590
Excellent or Very Good	62%	57%	67%	61%	67%	43%
Good	25%	31%	18%	32%	20%	35%
Fair or Poor	13%	11%	15%	8%*	12%	22%*

* *Estimate based on remainder after subtracting the other two percentages from 100%.*

From APS tables 4, 33 and 34 (perceived health status).

Table 2.1.2: Self Reported Health Status: Gender and Age Patterns: Aboriginal Population of Central West LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	5,890	2,730	3,150	1,310	3,220	1,350
Excellent or Very Good	56%	46%	65%	65%	66%	26%^
Good	30%	44%	18%*		21%	
Fair or Poor	14%	10%*	17%		13%*	

* *Estimate based on remainder after subtracting the other two percentages from 100%.*

^ *Estimate based on difference between total and other service area.*

Table 2.1.3: Self Reported Health Status: Gender and Age Patterns: Aboriginal Population of Mississauga Halton LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	8,280	4,590	3,690	1,530	5,420	1,230
Excellent or Very Good	66%	64%	68%	56%	69%	62%
Good	21%	23%	19%		19%	
Fair or Poor	13%	13%*	14%		12%	

* *Estimate based on remainder after subtracting the other two percentages from 100%.*

As mentioned previously, the Resident Survey respondents were apparently less healthy than the APS respondents. As this has an impact on answers to subsequent sections about access and appropriateness needs, the Resident Survey answers about perceived health status and health challenges will be reviewed here. For the 99 respondents,

- 34% said that they had *excellent* or *very good* health, half had *good* health (48%), and 17% said *fair* or *poor*.
- 44% had one or more physical challenges *often* and/or a long lasting physical health condition
- 30% had one or more emotional/mental health challenges *often* and/or a long lasting emotional/mental health condition
- 26% had one or more spiritual challenges *often* and/or a long lasting spiritual deprivation
- 68% had one or more physical, emotional/mental or spiritual challenges *often* or reported a long lasting condition.
  - Of these, 27% said that they had *excellent* or *very good* health, and half had *good* health (49%)

2.2 Community

The APS included a question about respondents' perceptions of problems that they believed exist in their communities and asked them to rate six options. Fewer than one in four persons noted each of the problems with

- *alcohol abuse* chosen more than the other problems (24%)
- *drug abuse* and *unemployment* were noted by almost 20%
- *family violence, sexual abuse and suicide* were noted least (14-7%).

In general more men than women noted each problem with the differences in the 7-9% range.

- The greatest differences were noted by men and women in the Mississauga Halton LHIN service area (9-14%).

There were insufficient data to observe age patterns.

Table 2.2.1: Perceived Community Problems: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) - APS 2006

	Total	Males	Females
N	14,170	7,320	6,850
Alcohol abuse	24%	28%	20%
Drug abuse	19%	23%	15%
Unemployment	19%	23%	14%
Family violence	14%	17%	10%
Sexual abuse	10%	14%	6%
Suicide	7%	10%	4%^
Other	8%	8%*	8%

* *Assumed due to lack of variation.*
^ *Estimate based on difference between total and males.*
From APS tables 16 and 25 (perceived problems in Aboriginal community).

Table 2.2.2: Perceived Community Problems: Gender and Age Patterns: Aboriginal Population of Central West LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females
N	5,890	2,730	3,150
Alcohol abuse	28%	28%	28%
Drug abuse	20%	24%^	17%
Unemployment	21%	27%	16%
Family violence	15%		
Sexual abuse	10%*		
Suicide			
Other	11%		

^ *Estimate based on difference between total and females.*

Table 2.2.3: Perceived Community Problems: Gender and Age Patterns: Aboriginal Population of Mississauga Halton LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females
N	8,280	4,590	3,690
Alcohol abuse	22%	28%	14%^
Drug abuse	19%	23%	14%^
Unemployment	21%	27%	14%^
Family violence	13%		
Sexual abuse	10%		
Suicide	n.a.		
Other	11%		

^ *Estimate based on difference between total and males.*

2.3 Health Risk Behaviour

APS data on health risk behaviours include alcohol consumption and smoking.

Alcohol consumption

LHIN Aboriginal residents were almost evenly divided between those who drank one or more times per week and those who drank less (44% vs. 45%). These were the same frequencies reported for the total Ontario population in the Canadian Addictions Survey, 2004.

The mean average for LHIN Aboriginal residents was 3.1 drinks per day of drinking.

- MHLHIN residents tended to be more frequent drinkers than CWLHIN residents (47% vs. 38% one or more times per week).
- On average, men drank more than women on days that they drank (3.8 drinks per day vs. 2.3). Men in MHLHIN had the higher average (4.1 vs. 3.3).
- Youth ages 15-24 drank more than average (4.3 vs. 3.1) and the residents aged 55 and older drank less than average (1.8 vs. 3.1).

Table 2.3.1: Perceived Community Problems: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Area (15 years +) - APS 2006

	Both LHINs	Central West LHIN	Mississauga Halton LHIN
How often drink:			
< 1x month	22%	28%	18%
1-3x month	33%	34%	32%
1-3x week	31%	24%	35%
4-7x week	13%	14%	12%
Average # alcoholic beverages per occasion:			
All	3.1	2.9	3.2
males	3.8	3.3	4.1
females	2.3	2.5	2.1
15-24	4.3	5.2	3.7
25-54	3.0	2.4	3.4
55 and over	1.8	2.0	1.8
Total N	14,170	5,890	8,280

From APS tables 32 (how often drink), 49 and 50 (avg. #s alcoholic beverages).

Smoking

Almost 2/3 of the APS respondents did not smoke. Most of the smokers reported that they smoked daily (29% of the total). Figures for the general population show many fewer smokers (11% daily, 7% occasional). (Total Population of the City of Toronto Health Unit (12 years +) − Canadian Community Health Survey 2005 from *Statistics Canada, CANSIM Table 105-0327.*

There were two exceptions to the non-smoking pattern.

- Fewer youth in the Central West LHIN area *do not smoke* (56%)
- More who are ages 55+ *do not smoke* (77%)

About 30% of men *smoke daily* in both LHIN areas, but the women vary by LHIN area.

- Only 22% of the women in the Central West LHIN *smoke daily*.
- 35% of the women in the Mississauga Halton LHIN *smoke daily*.

Table 2.3.2: Frequency of Smoking: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) – APS 2006

	Total	Males	Females	15-24	25-54	55+
N	14,170	7,320	6,850	2,940	8,640	2,590
Smoke daily	29%	30%	29%	28%	30%	27%
Smoke occasionally	6%	6%*	5%*	9%*	6%	1%*
Do not smoke	64%	63%	66%	63%	63%	71%

* *Estimate based on remainder after subtracting the other two percentages from 99%.*

From APS tables 47 and 48 (freq of smoking).

Table 2.3.3: Frequency of Smoking: Gender and Age Patterns: Aboriginal Population of Central West LHIN Service Area (15 years +) – APS 2006

	Total	Males	Females	15-24	25-54	55+
N	5,890	2,730	3,150	1,310	3,220	1,350
Smoke daily	25%	30%	22%		27%	
Smoke occasionally	8%*	7%*	8%*		7%*	
Do not smoke	65%	62%	69%	56%	65%	77%

* *Estimate based on remainder after subtracting the other two percentages from 99%.*

Table 2.3.4: Frequency of Smoking: Gender and Age Patterns: Aboriginal Population of Mississauga Halton LHIN Service Area (15 years +) – APS 2006

	Total	Males	Females	15-24	25-54	55+
N	8,280	4,590	3,690	1,530	5,420	1,230
Smoke daily	32%	29%	35%		32%	
Smoke occasionally	4%*	6%*	1%*		5%*	
Do not smoke	63%	63%	63%	66%	62%	64%

* *Estimate based on remainder after subtracting the other two percentages from 99%.*

2.4 Long-term Health Conditions

The top 5 diagnosed health conditions that LHIN Aboriginal residents reported (in APS) included: Arthritis/rheumatism (20%), asthma (15%), high blood pressure (14%), diabetes (9%), and heart problems (8%).

These rates were relatively consistent between the LHINs with one exception:

- More Aboriginal residents in the CWLHIN as compared to MHLHIN reported arthritis/rheumatism (24% vs. 17%).

- Aboriginal resident rates for three of the four top conditions were considerably higher than for non-Aboriginal rates.
  - 20% for arthritis or rheumatism vs. 13-14% for the total population of the LHINs
  - 15% for asthma vs. 6-7%.
  - 9% for diabetes vs. 4%.

- Rates for high blood pressure were comparable at 14-15%.

In the Resident Survey, 39% of respondents reported one or more *long lasting physical health conditions such as diabetes, congestive heart failure, arthritis, etc*. About two-thirds reported that they were *often limited* by one or more physical, mental/emotional or spiritual situations, or had one or more *long lasting conditions*.

Table 2.4.1: Long-term Health Conditions: Aboriginal Population of Both LHIN Service Areas (15 years +) – APS 2006

	Both LHINs	Central West LHIN	Mississauga Halton LHIN
N	14,170	5,890	8,280
Arthritis or rheumatism	20%	24%	17%
Asthma	15%	15%	16%
High blood pressure	14%	15%	13%
Diabetes	9%	10%**	8%**
Heart problems	8%		
Stomach problems or intestinal ulcers	7%		
Chronic bronchitis	5%		
Kidney disease	2%*		
Effects of stroke	2%*		
Hepatitis	1%*		
Emphysema	1%*		
Any other long-term condition^	16%		

* *Estimate based on data from adjacent urban areas.*
** *Estimate based on subtracting 'does not have diabetes' from 99%.*
+ *Estimate based on difference between total and males.*
^ *Includes diabetes.*
From APS Tables 8 (Type of long-term health condition) and Table 37 (Type of diabetes).

According to the APS, 8.7% of LHIN Aboriginal residents had diabetes and 5.4% had Type 2 diabetes specifically (Table 2.4.2a-2.4.2c).

- Not surprisingly, frequency of diabetes diagnosis increased by age. More Aboriginal residents 55 years and over (30.9%) reporting having diabetes as compared to 15-24 year olds (1.1%) and 25-54 year olds (4.9%).

Table 2.4.2: Diabetes: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	14,170	7,320	6,850	2,940	8,640	2,590
Has diabetes^	8.7%	8.9%**	8.4%**	1.1%**	4.9%**	30.9%
Type 1	1.1%*					
Type 2	5.4%					
Borderline or pre-diabetic	0.5%*					
Does not have diabetes	90.4%	90.2%	90.7%	98.0%	94.2%	69.1%

^ *The umbrella category of 'Has diabetes, was greater than the sum of the types.*
* *Estimate based on data from Ontario, adjusted for higher rate of diabetes.*
** *Estimate based on subtracting 'Does not have' from 99.1%.*
From APS Tables 37 and 38(Type of Diabetes).

Table 2.4.3: Diabetes: Gender and Age Patterns: Aboriginal Population of the Central West LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	5,890	2,730	3,150	1,310	3,220	1,350
Has diabetes^	9.6%*	10.1%*	8.9%*	1.4%*	3.1%*	32.4%*
Does not have diabetes	89.5%	89.0%	90.2%	97.7%	96.0%	66.7%

* *Estimate based on subtracting 'Does not have' from 99.1%.*
From APS Tables 37 and 38(Type of Diabetes).

Table 2.4.4: Diabetes: Gender and Age Patterns: Aboriginal Population of the Mississauga Halton LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	8,280	4,590	3,690	1,530	5,420	1,230
Has diabetes^	8.0%*	8.2%*	8.0%*	1.5%*	5.9%*	26.7%*
Does not have diabetes	91.1%	90.8%	91.1%	97.5%	93.2%	72.3%

* *Estimate based on subtracting 'Does not have' from 99.1%.*
From APS Tables 37 and 38(Type of Diabetes).

2.5 Absence from Work or School

APS tables 20 and 29 (there is no detail for the total column for both LHINS. The following is based on the Toronto CMA.

Reasons for temporary absence (any detail on duration or time period) from work or school are listed below.

- Because of family 6%
- Because of work 4%
- To go to school 3%
- To go hunting, fishing, trapping or gathering wild plant food 2%
- To be out on the land 2%
- Because of illness 1%
- For some other reason 5%

3. Health Care Background: Current Health Practices, Health Care Team and Service Usage

3.1 Health Care Team/Patterns

Nearly all Resident Survey respondents had a regular family doctor (94%) with 6% having no family doctor. These findings are exactly the same as the reports from Canadians in 2007 (Canadian Institute for Health Information, *Health Care in Canada, 2008*, p. 73).

- Common reasons for not having a family doctor included: currently on waiting list, doctor not available or have not looked for one.

3.2 Personal Supports for Accessing Care

Most Aboriginal residents reported having social supports available to them all or almost all of the time; however there were variations by gender and age (Tables 3.3.1a-c).

- The three most commonly reported social supports available *all or almost all of the time* for all Aboriginal LHIN residents were: someone who shows you love and affection (94%), someone to take you to the doctor (90%), and someone to have a good time with (89%) (Table 3.3.1a).

- Overall, gender differences were small, however differences were noted within and between the LHINs. In the CWLHIN more Aboriginal men (85 - 97%) than women (83 - 90%) reported having social supports available *all or almost all of the time* (Table 3.3.1b). This pattern was reversed for the MHLHIN, where more women (86% -98%) than men reported similar supports (Table 3.31c).

- Generally, more youth and fewer adults ages 55+ reported having social supports available *all or almost all of the time*. Adults ages 25-54 fell in the middle (Table 3.3.1a). The largest differences were observed on the following supports (15-24, 25-54, 55 + years):
  - someone to give you advice (96% vs. 87% vs. 75%)
  - someone to confide in (94% vs. 88% vs. 78%)
  - someone who shows love and affection (99% vs. 96% vs. 85%).

- Over 25% of the Aboriginal adults ages 55+ in MHLHIN indicated lack of support on two items:
  - someone to give you advice (27%)
  - someone to confide in (31%).

Table 3.2.1: Social Supports Available *all or almost all of the time*: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) – APS 2006

	Total	Males	Females	15-24	25-54	55+
N	14,170	7,320	6,850	2,940	8,640	2,590
Someone you can count on to listen to you when you need to talk	87%	86%	87%	91%	87%	82%
Someone you can count on when you need advice	87%	86%	87%	96%	87%	75%
Someone to take you to the doctor or a nurse if you need it	90%	89%	91%	93%	89%	91%
Someone who shows you love and affection	94%	95%	94%	99%	96%	85%
Someone to have a good time with: All or most of the time	89%	90%	88%	92%	89%	84%
Someone to confide in or talk about yourself or your problems	87%	88%	86%	94%	88%	78%
Someone to get together with for relaxation	u/a					

From APS Tables 15and 24 (Available Social Supports).

Table 3.2.2: Social Supports Available *all or almost all of the time*: Gender and Age Patterns: Aboriginal Population of the Central West LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	5,890	2,730	3,150	1,310	3,220	1,350
Someone you can count on to listen to you when you need to talk	89%	95%	85%	98%	87%	87%
Someone you can count on when you need advice	85%	85%	84%	98%	82%	78%
Someone to take you to the doctor or a nurse if you need it	89%	94%	85%	92%	86%	96%
Someone who shows you love and affection	93%	97%	90%	100%	92%	89%
Someone to have a good time with: All or most of the time	89%	97%	83%	97%	87%	87%
Someone to confide in or talk about yourself or your problems	91%	96%	86%	96%	90%	87%

From APS Tables 15and 24 (Available Social Supports).

Table 3.2.3: Social Supports Available *all or almost all of the time*: Gender and Age Patterns: Aboriginal Population of the Mississauga Halton LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females	15-24	25-54	55+
N	8,280	4,590	3,690	1,530	5,420	1,230
Someone you can count on to listen to you when you need to talk	85%	81%	90%	85%	87%	76%
Someone you can count on when you need advice	88%	87%	90%	94%	90%	73%
Someone to take you to the doctor or a nurse if you need it	90%	87%	95%	94%	90%	86%
Someone who shows you love and affection	96%	94%	98%	98%	98%	82%
Someone to have a good time with: All or most of the time	88%	85%	92%	88%	90%	82%
Someone to confide in or talk about yourself or your problems	85%	84%	86%	91%	87%	69%

From APS Tables 15and 24 (Available Social Supports).

3.3 Current Services Usage

Service usage data cover types of health care professionals consulted, treatment received for long-term conditions, overnight stays, and flu shots.

Family Doctors/General practitioners (76%) and *dentists/orthodontists* (67%) were the most commonly consulted health care professionals in the LHIN service areas (Table 3.4.1) in the 12 months previous to the survey.

- 24-27% had consulted *other medical doctors* and 21-22% had consulted *nurses*.
- First Nations and Métis traditional healers were the least commonly consulted care providers (5%). Other less commonly consulted practitioners included physiotherapists (16%), chiropractors (12%), and social workers/counselors or psychologists (10%).

- More Aboriginal people in MH compared to CWLHIN received care from social and mental health professionals (14% vs. 6%).

Table 3.3.1: Health Care Professionals Consulted in the Past 12 Months: Aboriginal Population of Both LHIN Service Areas (15 years +) - APS 2006

	Both LHINs	Central West LHIN	Mississauga Halton LHIN
N	14,170	5,890	8,280
Family doctor or general practitioner	76%	74%	77%
Dentist or orthodontist	67%	65%	68%
Eye doctor	33%	33%	33%
Other medical doctor (surgeon, orthopedist, allergist)	26%	24%	27%
Nurse	21%	21%	22%
Physiotherapist or occupational therapist	16%	17%	15%
Chiropractor	12%	12%	11%
Social worker, counselor or psychologist	10%	6%	14%
FNMI traditional healer	5%*		

* *Estimate based on data from adjacent urban areas.*

From APS Table 6 (Type of health care professional consulted in the past 12 months)

There are two ways of looking at who does and does not get treatment for existing long-term conditions. One focuses on demand on the system reflected in the percentage of the Aboriginal population who receive treatment. The second approach spotlights those with the health conditions who do and do not obtain treatment (whatever the reason).

As reported previously, arthritis/rheumatism, asthma and high blood pressure were each reported by more than 10% of Aboriginal adults (15+) in the two LHIN areas. Diabetes, heart problems, stomach/intestinal problems and chronic bronchitis were reported by 5-9%. Four other specific conditions were each reported by less than five percent of the target population.

- About 10% of the population was treated for each of the first three conditions.
- About 5% was treated for the second set of conditions (diabetes treatment was not queried).
- Less than 1% was treated for the last set of specific conditions.

Of people who reported the condition,

- three conditions had the highest treatment rates: high blood pressure (78%), heart problems (73%), stomach or intestinal ulcers (66%). More people with high blood pressure in the CWLHIN area than in the MHLHIN area received treatment (88% vs. 70%).
- Half (51%) of residents with arthritis/rheumatism and 62% with asthma were getting treatment for these conditions.

Table 3.3.2: Treatment Received for Long-term Health Conditions: Aboriginal Population of Both LHIN Service Areas (15 years +) – APS 2006

	Condition	Treatment: Percentage of the Population	Treatment: Percentage of those with condition
N	14,170		
Arthritis or rheumatism	20%	10%	51%
Asthma	15%	9%	62%
High blood pressure	14%	11%	78%
Diabetes	9%	n.a.	n.a.
Heart problems	8%	6%	73%
Stomach problems or intestinal ulcers	7%	5%	66%
Chronic bronchitis	5%	4%*	
Kidney disease	2%*	<1%**	
Effects of stroke	2%*	<1%**	
Hepatitis	1%*	u/a	
Emphysema	1%*	<1%**	
Any other long-term condition^	16%	10%	58%

Condition columns:

**   Estimate based on data from adjacent urban areas.*
*** Estimate based on subtracting 'Does not have' from 99.1%.*
^ Includes diabetes.
From (APS table 08 and 37).

Treatment columns:

**   Estimate based on data from adjacent urban areas.*
***Estimate based on data for larger jurisdictions.*
From APS Tables 8 (Type of long-terms health condition), Table 37 (Type of diabetes), and Table 51(Received treatment for long-terms condition)

Table 3.3.3: Treatment Received for Long-term Health Conditions: Aboriginal Population of Each LHIN Service Area (15 years +) - APS 2006

	Central West LHIN			Mississauga Halton LHIN		
	% with Condi-tion	Treatment: % of the Population	Treatment: % of those with condition	% with Condi -tion	Treatment: % of the Population	Treatment: % of those with condition
N	5,890			8,280		
Arthritis or rheumatism	24%	12%	50%	17%	9%	53%
Asthma	15%			16%	11%	67%
High blood pressure	15%	13%	88%	13%	9%	70%

*** Estimate based on subtracting 'Does not have' from 99.1%.*
From APS Tables 8 (Type of long-terms health condition), Table 37 (Type of diabetes), and Table 51(Received treatment for long-term conditions).

The APS data for the two LHINs indicated that few Aboriginal adults (9%) had an overnight stay in a hospital, nursing home, convalescent home, health centre or nursing station in the year prior to the survey (Table 3.4.3). This is only slightly above the Canadian rate of 8.2%.

- Aboriginal women and adults ages 55 and over reported higher rates of overnight stays (14%, 18%).
- The highest use group was the age group 55 years + in the Mississauga Halton LHIN (25%).

Table 3.3.4: Overnight Stay in a Hospital, Nursing Home, Health Centre or Convalescent Home (Past 12 Months): Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) - APS 2006

	Both LHINs	Central West LHIN	Mississauga Halton LHIN
N	14,170	5,890	8,280
All	9%	9%*	9%
Males	5%*	4%*	5%*
Females	14%	13%*	14%*
15-24	4%*	7%*	3%*
25-54	8%	9%*	7%*
55 and over	18%*	9%*	25%*

* *Estimate based on subtracting 'no' respondents from 99%.*
From APS Tables 43 and 44 (Been a Patient overnight in a hospital, nursing home , convalescent home, health centre or health nursing station in the past 12 Months)

About 2/3 of Aboriginal residents reported having had *ever received a flu shot* (63%) and 39% had a flu shot *less than 1 year prior* to the census (Tables 3.3.5-3.3.6). This is comparable to total population rates in these LHINs with 61% having received a flu shot and 37% having had it within one year (Statistics Canada, CANSIM table 105-0445 for 2005).

- More MH than CW Aboriginal residents reported *ever having a flu shot* (69% vs. 59%). More Aboriginal adults ages 55 + than younger adults reported having had a flu shot (71% vs. 61%).
- In terms of timing of flu shot, 39% of Aboriginal people in the two LHIN service areas who had ever had a flu shot, had it *less than 1 year ago*. More Aboriginal residents in MH than in the CWLHIN reported having had a flu shot *less than 1 year ago* (45% vs. 31%) and fewer reported having had a flu shot *over two years ago* (19% vs. 37%).

Table 3.3.5: Ever Received a Flu Shot: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) – APS 2006

	Both LHINs	Central West LHIN	Mississauga Halton LHIN
N	14,170	5,890	8,280
All	63%	59%	65%
Males	64%	63%	64%
Females	61%	57%	66%
15-24	61%	u/a	71%
25-54	61%	58%	62%
55 and over	71%	73%	68%

From APS Tables 41 &42 (Ever had a flu shot).

Table 3.3.6: Length of Time Since Receiving Last Flu Shot: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) – APS 2006

	Both LHINs	Central West LHIN	Mississauga Halton LHIN
N	9,060	3,560	5,490
< 1 year ago	39%	31%	45%
1 to <2 years ago	32%	30%	34%
2+ years ago	26%	37%	19%

From APS Table 11 (Timing of Last Flu Shot)

4. Health Needs: Access

4.1 Perceived Availability of Mainstream Health Care

Most respondents to the various surveys and participants in the focus groups had their own family doctors or had a regular source of health care. There was a minority, however who did not have a family doctor and they tended to feel strongly about the challenge.

Comments from focus group participants around perceived access to mainstream care included the following:

1. Finding a local doctor
   - *How is an orphan patient who is elderly supposed to find a family physician?*
   - Not knowing where to find the right kind of care and *having to be charged with the responsibility of finding those one in a million doctors.*

2. Lack of access due to incomplete, insufficient or lack of coverage through the Non Insured Health benefits Program (NIHB) and General Health Care:
   - A commonly experienced problem occurs when the children of Status Indians are not covered.
   - Alternative medicines and care are not covered, such as naturopathic doctors, chiropractors, massage and physiotherapy.
   - Eye tests are not covered annually.

3. Lack of Access due to administrative aspects of the NIHB program
   - Specifically with dentists where patients are required to cover the direct cost of care in advance, limiting their ability to access dental services.
   - Coverage rates have not kept pace with inflation. For example, coverage of items such as glasses at too low of a rate.
   - Clients reported less access to care due to jurisdictional debates between the NIHB program and private service providers and or the province.
   - Urban Aboriginal people living in the GTA seem to be at a particular disadvantage because the population is relatively dispersed and care providers (dentists) do not want to deal with the paperwork. Whereas in areas where there are greater proportion of Status Indians in the population, physicians and dentists have a greater understanding of the issues and are more likely to accommodate the NIHB program.
   - Long waiting periods for prior approval and/or reimbursement through the NIHB program.

4. Need to have flu clinics in the public school system.

4.2 Perceived Availability of Traditional Health and Healing Practices

Few Aboriginal residents of the Central West and Mississauga Halton LHIN service areas knew of the availability of traditional medicines, healing or wellness in their communities (Tables4.2.1-4.2.3).

- A small percentage of Aboriginal people (12%) reported that traditional medicines, healing or wellness practices were available.
- A much larger percentage (42%) reported that they did not know about the availability of traditional medicines, healing or wellness practices.

- More people in the MHLHIN reported that traditional medicines, healing or wellness *were available* than in the CWLHIN (14% vs. 8%). More men than women reported availability (15% vs. 8%).

- A greater percentage of Aboriginal people in the CWLHIN than in the MHLHIN reported that traditional medicines, healing or wellness practices *were not available* (56% vs. 39%).

- More Aboriginal residents in the MHLIN than in the CWLHIN reported that they *did not know* about availability (46% vs. 35%).

Table 4.2.1: Availability of First Nations, Métis or Inuit Traditional Medicines, Healing or Wellness Practices: Gender and Age Patterns: Aboriginal Populations of Both LHIN Service Areas (15 years +) - APS 2006

	Total	Males	Females
N	14,170	7,320	6,850
Yes	12%	15%	8%
No	46%	44%	49%
Don't know	42%	41%	42%

From APS Tables 35 and 36 (Availability of traditional medicines, healing or wellness practices in the town or city where you live).

Table 4.2.2: Availability of First Nations, Métis or Inuit Traditional Medicines, Healing or Wellness Practices: Gender and Age Patterns: Aboriginal Populations of Central West LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females
N	5,890	2,730	3,150
Yes	8%*	11%*	6%*
No	56%	55%	57%
Don't know	35%	33%	37%

** Estimate based on remainder after subtracting the other two percentages from 99.5%.*
From APS Tables 35 and 36 (Availability of traditional medicines, healing or wellness practices in the town or city where you live).

Table 4.2.3: Availability of First Nations, Métis or Inuit Traditional Medicines, Healing or Wellness Practices: Gender and Age Patterns: Aboriginal Populations of Mississauga Halton LHIN Service Area (15 years +) - APS 2006

	Total	Males	Females
N	8,280	4,590	3,690
Yes	14%	16%*	10%
No	39%	37%	42%
Don't know	46%	46%	47%

** Estimate based on remainder after subtracting the other two percentages from 99%.*
From APS Tables 35 and 36 (Availability of traditional medicines, healing or wellness practices in the town or city where you live).

In the focus groups, the discussion around traditional medicines centered on lack of local access and a general lack of information about local availability of traditional practices. Almost half of the participants were either accessing some level of traditional services, or were interested in accessing services and were prevented from doing so as a result of lack of availability or lack of information. Further, clients who reported accessing traditional health care felt as though the cost and travel associated with accessing care in Toronto were preventing them from getting the level of care that they preferred.

4.3 Personal Supports for Accessing Care

According to the APS, 90% of residents of both LHINs felt that they had someone that they could count on to take them to medical appointments.

4.4 Satisfaction: Positive Access Experiences

Not surprisingly there is a great amount of diversity in individual interactions and experiences with the mainstream health care system. Half of the Resident Survey respondents were *very satisfied* or *satisfied* with their health care with another 39% *somewhat satisfied.* Eleven percent rated their care as *unsatisfactory* or *very unsatisfactory.*

There were four aspects of health care access that many focus group participants identified as 'working well'.

1. Most participants agreed that the availability of 24-hour medical care was something that they appreciated about the mainstream medical system.

2. Accessing prescription medicines: Some identified that receiving medicine that works was working well.

3. Tele-Health

   - One third of focus group participants had used the Ontario Tele health service and found it to be useful and effective.
     - *Tele-Health has saved us so many times from going to the emergency, it calmed us down and helped with a temporary solution to get us through the night.*

4. Referrals to medical specialists by family doctors were prompt and the specialists' responses were within a reasonable timeframe.

The majority (64%) of Resident Survey respondents felt that they had the same level of access to health care as Canadians generally. A further 10% felt that they had less access and 18% did not know.

4.5 Service Gaps

The APS asked participants to say whether or not they had been unable to access needed medical care in the previous year.

Most Aboriginal adults in the two LHIN areas (95% to 96%) stated that they received needed treatment.

Data sufficiency issues prevent further analysis of age and gender differences.

Table 4.5.1: Did Not Receive Needed Care in Past 12 Months: Gender and Age Patterns: Aboriginal Population of Both LHIN Service Areas (15 years +) - APS 2006

Needed care but did not get it…	Both LHINs	Central West LHIN	Mississauga Halton LHIN
N	14,170	5,890	8,280
All	4%*	5%*	4%*
15-24	8%*	12%*	4%*
25-54	4%*	3%*	4%*
55 and over	2%*	3%*	0%*

** Estimated based on remainder after subtracting the other two percentages from 99%.*
From APS Tables 45 and 46 (Need health care but not get it).

Typically, when focus group participants said that things were working well, they would provide some qualifications.

1. Some focus group participants who were appreciative of the availability of 24-hour medical care indicated that they sometimes experienced barriers in accessing some of these services.

2. Accessing prescription medicines: many focus group participants would also like to receive more natural medicines and would like to have more choice in what prescription drugs are available to them.

3. Tele-Health

    - Some participants who had used the Ontario Tele health service suggested that the end result was the same in that they were typically referred to a physician.

4. Referrals to Specialists by family doctors were sometimes characterized as inflexible with long wait times that acted as access barriers.

4.6 Current Access Issues

Access issues include getting on patient lists, waiting times, affording prescriptions, affording dentist, vision and hearing care, transportation and child care costs, and locating and getting transport to traditional care options.

Respondents to the Resident Survey were asked about problems with accessing health care. Some of the items had cultural significance and others were more general. Starting first with the general items,

- 32% said that waiting lists were too long or health providers were not accepting patients
- 22% observed that needed health services were not available in the area
- 15% had issues with access to or cost of transportation
- 14% did not know about Tele Health
- 12% had child care costs as barriers.

For the cultural items, 13% of residents had no difficulties accessing traditional care approaches. A further 10% did not want to access traditional care. Other residents felt that access to traditional care was hampered by the following factors:

- Not knowing where to get them 50%.
- Lack of knowledge about traditional approaches 41%.
- Services not available 31%.
- Not available through mainstream health care 28%.
- Lack of local regular and convenient access 13%.
- Services offered are not specific to my culture 13%.
- Not covered by NIHB 13%.
- Cost 10%.

- Residents felt that it was *very important* to have local access to a...
  - Aboriginal Health Centre 45% (27% important, 27% not important)[4]
  - Traditional Healer 38% (31%, 30%)

Most respondents (73%) stated that their primary care provider stayed the same over the past year, 12% reported a provider change one time over the past year and 7% at two times or more. A further 8% had no provider in the past year.

In the focus group session, participants were asked to identify elements of an ideal and wholistic health care system. Participants identified four central elements of an ideal health care access scenario. Two related directly to the issues of access to traditional care while a third related to problems with the federal reimbursement plans. A fourth was focused on general problems with the current access in Ontario and were not specific to Aboriginal issues.

1. Difficulty navigating the health care system, especially if seeking Aboriginal-appropriate care.
   - Not knowing which health care professionals might have the ability and/or training to relate to clients in a manner that uses Aboriginal ways of knowing and being.
   - Not knowing where or how to access traditional health care in a reasonable geographic range.
   - Lack of options of referrals to traditional care from western practitioners.
   - Not knowing which health care professionals might know how to easily bill NIHB and who do not insist Aboriginal Status clients pay in advance.
   - Not fully understanding the NIHB supports and difficulty filling out forms.
2. Difficulty and complexity of accessing Aboriginal-appropriate care within a reasonable distance.
   - Traditional options are often distant and cost more than can be afforded for travel and time lost from work.
   - The separation of mainstream and traditional care means that the providers have difficulty being aware of the whole spectrum of care.

[4] For comparison, 78% felt it was *very important* to have local access to a dentist/orthodontist, 30% for an alternative health care provider, and 26% for a nurse practitioner.

3. Lack of full coverage for health services at the point of care:
    - Traditional and natural medicines should be covered.
    - Breakdown jurisdictional issues that disadvantage urban Aboriginal people living in the Greater Toronto Area from fully accessing health care. This issue was raised specifically in relation to dentists who require payment upfront from Non Insured Health Benefit (NIHB) clients acting as a barrier to access for dental care for some Status First Nations.
    - Physicians need a system to process health claims directly so that clients are not expected to pay for care up front or spend a lot of time trying to process their own claims.
    - Level of coverage needs to be on par with inflation. For example, eyeglass coverage needs to reflect current price points.
    - Support for travel with Elders for visits to urban specialists.
4. Difficulty access needed health services, especially within a reasonable amount of time:
    - There are often long wait times at clinics and for some family physicians as well.
    - Frustration with the inflexibility of the specialist referral system. Citing long wait times and a lack of choice in appointment times.
    - Restrictions on coverage for complimentary care.

4.7 Vision of Ideal/Best Case Access Scenario

In the focus group session, participants were asked to identify elements of an ideal and wholistic health care system. The discussion fell into two areas: solutions for accessing more culturally appropriate and/or traditional health care, and structural changes in the services to which they had access.

1. Aboriginal Health Access Agency, accessible by phone and on the internet, to help Aboriginal clients navigate the health care system. These types of agencies exist in northern Ontario (Thunder Bay) and Alberta. Provided services could include
    - Information to the community on where to access health care in a wholistic setting.
        - A directory of 'Aboriginal friendly' physicians, dentists, and other health service providers who are known to have the ability and/or training to relate to

clients in a manner that uses Aboriginal ways of knowing and being.
    - Directory of providers of traditional Aboriginal wholistic health care.

- A directory of 'Aboriginal friendly' health care providers who know how to easily bill NIHB and that do not insist Aboriginal Status clients pay first.
- Advocacy for NIHB including detailed and easily available information on the full-coverage of NIHB.
- General support for filling out NIHB documents.

2. Examples of structural alternatives that could improve access to appropriate care.
    - More Nurse Practitioners with specializations appropriate to Aboriginal health care. The quality of care from a nurse practitioner was perceived to be better because he/she generally has more time to spend with the patient thus facilitating a better relationship
    - Mobile Health Van that includes Aboriginal health care services-to facilitate Aboriginal health access (similar to the Hamilton Health Van).
    - A one-stop building with mainstream, complimentary and traditional services.

5. Health Needs: Quality and Appropriateness

The interest in appropriateness may be defined as understanding the ways in which patients would like their Aboriginal background to affect the manner of receiving health care. It is assumed that there will be great variety from those who want only western medical care to those who want a mix of the best of many approaches – mainstream, complimentary and traditional. The interest in quality is because quality of care is assumed to be linked to appropriateness in the views of residents.

Cultural appropriateness in mainstream health care has many dimensions. The following are examples.

- Knowledge of Aboriginal traditional health care practices and when they are indicated.
- Willingness to make referrals to and have respect for traditional and complimentary health care providers.
- Understanding the more traditional communications patterns that sometimes require patience and time to get to the root problem.
- Understanding that trust of the provider is not granted automatically and has to be earned by showing respect for the patient and his/her individual circumstances/health history.
- Attentiveness to the emotional as well as physical aspects of health.
- Less reliance on pharmaceuticals and more on traditional substances.
- Understanding the changes in self-care practices that have resulted from transitioning from traditional and/or rural environments to urban environments.

5.1 Perceived Quality and Appropriateness of Mainstream Health Care

Focus group participants stated that many aspects of the health care delivery were working well for them. Some felt as though the appropriateness of care that they received could be improved.

1. There was a general lack of understanding of Aboriginal ways in interactions with physicians and other health care providers:
   - There appeared to be prejudices and inappropriate assumptions about First Nations and Métis cultures.

- Some patients had differences of opinions concerning traditional and mainstream approaches. Two examples from focus groups demonstrate this below.
    - *Doctors don't ask if I am Aboriginal, and I don't know if I should be telling them because I don't think that they would do anything differently.*
    - *If doctors don't know our medical history and heritage, they may not be tuned into genetic factors that may predispose us to specific conditions.*

2. Lack of a wholistic approach by physicians (were expressed by focus group respondents). Two examples are below.
    - Do not spend time dealing with emotional needs.
    - Typically rely on pharmaceuticals and rarely support natural approaches to health care.

3. Specifically, some participants felt that the quality of service could be improved in the following areas, as expressed by focus group respondents.
    - Insufficient duration of physician visits, included:
        - Some health concerns may go unaddressed because clients feel rushed, and
        - Some physicians limit the number of issues and concerns that you can bring to them in one appointment.
    - During extended emergency room wait times there is a lack of support and respect for patients who are waiting for emergency care – including information about wait times, understanding of medical conditions, and levels of discomfort.
    - Lack of continuity of care, included:
        - Changing doctors and having doctors that do not understand my medical history, and
        - Lack of electronic health records to ease the transitions.
    - Lack of Consideration and Support for Clients who have high levels of anxiety in medical care situations.
        - Some participants believed that more could be done to support clients with the emotional aspects of seeking and getting care. For example, there should be support for clients who are feeling anxious about specific procedures.

5.2 Perceived Quality and Appropriateness of Traditional Health Care

For those few focus group participants who reported accessing traditional care, all felt as though it was having a positive impact on their health. However, most participants were not accessing traditional health care.

5.3 Satisfaction: Positive Quality and Appropriateness Experiences

Half of Resident Survey respondents (50%) felt that the health care that they have received has met their needs, 39% reported that it somewhat met their needs, 5% revealed that it was better than expected, and 3% said that the care was unacceptable.

In the focus groups, facilitators noted that those who perceived that they had a high quality of care were those individuals who had a consistent family physician for a period years, who felt as though they could trust their physician, who felt that they were understood by their physician, and who had a degree of flexibility in their care including support for homeopathic approaches and complementary modalities in general. Focus group participants stated that the following were 'working well' in terms of the quality and appropriateness of care that they received. Once again there was a great diversity in responses, but there was a level of agreement on having a good relationship with one's doctor and taking personal responsibility for one's health.

1. Having a good relationship with their physician. Almost half of participants reported having a good relationship with their physician. Qualities of a good doctor are listed below.
    - One who you have had for a long time.
    - Relationship have been formed.
    - Has good bedside manner.
    - Is good with children.
    - Understands culture.
    - Flexible care- access to a female doctor when needed, accessibility of other doctors, who have access to your medical records, in a clinic situation.
    - Knows your health history, is a part of a clinic where another doctors could see you when needed and have full access to your chart, listens to your questions.

2. Assuming Personal Responsibility for Health

   - Half of the attendees said that "taking charge of their health care is working" for them.

   - Strategies that attendees reported using to take control of their own health are listed below.
     - Using the internet to learn about health conditions and available resources. *Over half of the attendees reported that they had used the internet in the past year to access health information.*
     - Bringing written notes to the doctor to ensure that all questions and concerns were addressed and to ensure that the physician's advice was remembered.
     - Getting a second opinion.

5.4 Quality and Appropriateness Barriers

Quality and appropriateness barriers that had the most discussion involved trust, being known as a unique individual, time spent and the opportunity to discuss all aspects of health in a visit. From a traditional way of communicating, these four aspects are integrated and neither cannot be addressed in isolation.. Other important aspects were the integration of alternative and traditional health care solutions, the understanding of Aboriginal ways of knowing and being, and the availability of health care providers and advocates.

The issue of trust is complicated when interpreted culturally. It may be expressed as a time or attention issue. An important element of trust is that one is listened to until all important concerns are presented. The experience of one non-Aboriginal physician in a northern urban Aboriginal health centre was that for some clients, the most important facts or concerns were raised after the visit seemed to be finished. A cultural interpretation of that pattern was that it took that long for the client to decide to trust the physician.

Respondents to the Resident Survey were asked about problems with receiving health care and the importance of certain aspects of care. Some of the items had cultural significance and others were more general. Starting first with the general items,

- 26% said that the health care provided was inadequate.

- 16% have used Tele-Health and that the service was unhelpful.

- Residents felt that it was *very important* that
  - 79% … their health care provider knows them as a person and not as a number or a chart (14% *important*, 7% *not important*),
  - 48% ... provider prescribes drugs (36%, 16%),
  - 48% … an advocate is available to ensure that all needed care is obtained (33%, 19%),
  - 44% ... provider is available at all times, including after hours (34%, 21%),
  - 41% … an advocate is available to get needed information (41%, 17%), and
  - 32% … a Nurse Practitioner is available when an MD is not (43%, 24%).

For the cultural items,

- 29% said that they had difficulty in getting culturally based traditional care,
- 24% felt that health care services did not meet their cultural needs, and
- Residents felt that it was *very important* that
  - 87% ... provider acts in a way that you feel you can trust (10% *important*, 3% *not important*).
  - 58% … provider prescribes alternative medical solutions in addition to drugs (31%, 11%).
  - 40% … provider prescribes traditional medicines / natural remedies (33%, 26%).
  - 34% … their health care provider is understanding of Aboriginal ways of knowing and being (35%, 30%).
  - 31% ... their provider is Aboriginal and well versed in Aboriginal health care needs (31%, 37%).
  - 25% … their provider is non-Aboriginal and well versed in Aboriginal health care needs (36%, 38%).

The focus group participants felt that there was a general lack of knowledge and attitudes among health care providers that reflected well on their Aboriginal backgrounds. They also shared many of the barriers with non-Aboriginal people with regard to the time spent in their visits and the lack of opportunity to explore all the aspects of their health problems. These perceived deficiencies have cultural interpretations as described above.

5.5 Vision of Ideal/Best Case Quality and Appropriateness Scenario

The focus groups discussed the ideal health care approach that took into account their Aboriginal backgrounds and although the picture was not complete, it had some of the following elements.

1. That it would be safe to reveal their Aboriginal roots in health care settings without fear of discrimination, stereotyping or ignoring their shared and individual preferences.

2. That they could find (easily) a mainstream health care provider source that they stayed with long enough to develop a mutual respect and trust relationship.

3. That they could request referrals to traditional health care options when the mainstream sources could not provide appropriate wholistic approaches or that they could reveal their involvement in traditional healing practices, and that these traditional practices would be respected and that the traditional practitioners could be part of their health care teams.

6. Provider Points of View

Service providers were generally unaware of serving Aboriginal clients although they were open to increasing the options if possible. The preferred methods of informing Aboriginal clients of the options (including cultural health care) were print and other provider-supplied information. Although there was some willingness to read about cultural issues as they pertain to health care, the felt need was low because of the lack of visibility of Aboriginal clients.

For 44 service providers who indicated that it was relevant to their organizations,

- very few were aware of their organization providing services for Aboriginal people as frequently as *weekly* or *monthly* (2 health and 4 social support/service)
- just under half indicated *less frequently than monthly*, and
- most *did not know* the frequency.

All 44 thought it was likely to some degree that someone in their organization would take a day to learn more about serving Aboriginal clients appropriately.

- 18 thought it *very likely* (11 health, 7 social)
- 13 thought it *likely* (10 health, 3 social)

There was slightly less expectation of gaining the knowledge through reading.

Of 42 respondents who answered the question, 30 were of the opinion that it was *important* that or *very important* that health care providers in the two LHIN areas learn how to meet the health needs of Aboriginal clients appropriately.

Various approaches were suggested for health care providers to meet the health needs of Aboriginal clients and two were given the highest rating (first choice) by over half of the respondents who considered the question relevant.

- 25 gave first choice to *Use a brochure (for self-identifying clients) that provides information on and how to utilize Aboriginal- specific/sensitive* current health care options
- 23 … *Cooperate with health care advocates that are working with Aboriginal clients to ensure they gain the maximum benefit from the services available*

Two of the suggestions … first choice … by 15-19 of the respondents

- *Attend education forums specific for health care providers on incorporating Aboriginal ways of knowing and being into daily practices and routines, regardless of clientele being serviced.*

- *Mentor and/or support Aboriginal health students in securing employment by assisting in furthering their education.*

The three remaining suggestions … first choice … by 10-12 of the respondents

- *Learn from an Aboriginal health care provider through distant consultations.*
- *Shadow (for a day) a health provider at an Aboriginal health care centre.*
- *Provide support to Aboriginal traditional healers on local health care teams.*

Shadowing was the suggestion rejected most by respondents (14). Mentoring, distance consultations and supporting traditional healers were rejected by 6-7 each.

Likelihood of organization's personnel talking with Aboriginal clients about topics that might increase their health care options:

- the value of nurse practitioners (*very likely*, 17 of 37; *likely,* 12)
- referrals to Aboriginal cultural care (17; 10)
- what holistic health care means (6; 25)
- services at Anishnawbe Health Toronto (8; 16)
- about alternative health specialists (7; 16)
- benefits of natural traditional medicines (6; 14).

In addition to the online health service provider survey, telephone interviews were conducted with 11 health service providers. The 11 providers can be classified as follows:

- Organization Type
  - 8 in health care administration or service provision
  - 2 in social services
  - 1 Aboriginal specific cultural and support organization

- Geography
  - MHLHIN Service Area – 5
  - CWLHIN Service Area –3
  - Both LHIN Service Areas – 3

In summary, the service provider interviews can be understood in terms of four overreaching themes:

- *Understanding – most of the non-Aboriginal interviewees felt that the needs assessment was a good first step. They identified that they did not have much knowledge about Aboriginal health needs and were eager to learn more about the needs of Aboriginal clients in their service areas.*

- *Partnership – Most service providers emphasized the need for any strategies or opportunities to be planned and implemented in partnership with*

Aboriginal organizations (for those activities aimed at the Aboriginal community) and with existing 'cultural diversity' staff within local health organizations or existing committees.

- *Empowerment – Some providers felt that strategies should be aimed at empowering the Aboriginal community through education, local events, web-based resources, and web-based resources.*
- *Commitment and Flexibility – A few providers felt that strategies arising from the needs assessment must be supported by appropriate resources to avoid building up unreal expectations. Further, the strategy should be a 'living strategy' in the sense that it should be regularly reviewed to ensure that it keeps pace with the diverse and changing needs of the Aboriginal community.*

Consistent with the online survey, many of the service providers were not aware of how many of their clients were Aboriginal. Most felt as though they served few Aboriginal clients. However, many were interested in knowing the population demographics for Aboriginal people in the area.

Providers stated that while they felt training and information sessions on meeting the needs of Aboriginal clients could be useful in supporting patient-centered care, they were also concerned with how the training would be carried out and the value of the training for providers given the relatively small population. Some perceived barriers to training and information sessions for providers included:

- Competition for time and resources
- May not get high attendance because Aboriginal clients have not been identified as a high need group
- One organization was concerned with who would provide training as experience and connection to culture can be a very personal matter. Along this line, many organizations identified that they support client-centered care that is not based on culture, but on what the clients want and need.
- Another emphasized the need for partnerships in planning training and information sessions to ensure that these opportunities would be supported by relevant organizations and agencies.

Most felt that implementing a strategy in Aboriginal health would be a good idea, but the following were given as cautions:

- Caution should be taken in ensuring that any evolving strategy be backed up by appropriate resources and does not set up unreal expectations.
- Any strategy should encourage reciprocal relationships.
- One respondent felt that a strategy [targeting health care providers] should be at a high level …not just targeting one cultural group and that any strategy should be developed in collaboration with the diversity core action group at the CWLHIN.

When asked to determine health priorities for Aboriginal people most respondents did not know and were interested in learning more about Aboriginal health needs. Other emphasis centered on providing the Aboriginal community with opportunities to learn more about health services, health care, health conditions through multiple mediums including websites, events, and focus groups. To increase the likelihood of success it was recommended that the LHIN partner with existing organizations to co host/support events in multiple locations, be open to all age groups and provide free events. Ideas for web content included: where to find a doctor, how to get support for medical coverage, general health information, identify local Elders/spiritual advisors/traditional healers in the area, and advertise health events. One Aboriginal organization recommended having annual or semiannual meetings between the LHINs and local Aboriginal organization to review priorities and plans.

7. Conclusions and Recommendations

7.1 Conclusions

The conclusions most relevant to the recommendations were:

- In the Central West LHIN and Mississauga Halton LHIN service areas there was a small, but rapidly increasing, population self-identifying in the 2006 census as having Aboriginal ancestry and of those, the majority were non-Status First Nations and/or Métis.

- While the Aboriginal residents were not the statistical equals of the non-Aboriginal residents of the two LHINs, there was a great deal of overlap of the two groups in education achieved, labour force participation, personal and household income, and home ownership.

- There were substantial minorities who had health risks and conditions at greater rates than the general population.
    - More non-Aboriginal than Aboriginal residents owned their homes (82% vs. 67%).
    - Fewer homes of Aboriginal respondents had regular maintenance (64% vs. 74%) and more needed minor (26% vs. 22%) or major (10% vs. 4%) repairs.
    - About 35% of the APS respondents did smoke. Most of the smokers reported that they smoked daily (29% of the total). Figures for the general population showed many fewer smokers (11% daily, 7% occasional).

  - The top 5 diagnosed health conditions that LHIN Aboriginal residents reported (in APS) included: Arthritis/rheumatism (20%), asthma (15%), high blood pressure (14%), diabetes (9%), and heart problems (8%).
  - Aboriginal resident rates for three of the four top conditions were considerably higher than for non-Aboriginal rates.
    - 20% for arthritis or rheumatism vs. 13-14% for the total population of the LHINs
    - 15% for asthma vs. 6-7%.
    - 9% for diabetes vs. 4%.

With regard to health care patterns, the reports are generally positive although there are minorities with deficiencies:

- Nearly all Resident Survey respondents had a regular family doctor (94%) with 6% having no family doctor. There was a minority, however who did not have a family doctor and they tended to feel strongly about the challenge. These findings are exactly the same as the reports from Canadians in 2007.[5]
  - Common reasons for not having a family doctor included: currently on a waiting list, doctor not available, or having not looked for one.

- Most Aboriginal adults in these two LHIN areas (95% to 96%) stated that they received needed treatment, however there were many who reported long-term conditions who were not receiving treatment for those conditions.

  - Of those who had the top five long-term conditions (excluding diabetes), half to one quarters reported not receiving treatment.
- Most Aboriginal residents reported having social supports available to them *all* or *almost all* of the time; however there were variations by gender and age.
  - Over 25% of the Aboriginal adults ages 55+ in MHLHIN indicated lack of support on two items: someone to give you advice (27%) and someone to confide in (31%).[6]

- Half of Resident Survey respondents (50%) felt that the health care that they had received *met their needs*, 39% reported that it *somewhat met their needs*, 5% revealed that it was *better that expected*, and 3% said that the *care was unacceptable*.

The major issues of both access and appropriateness of care involved cultural aspects. A sizable minority were still involved in cultural activities despite living in urban areas.

[5] Canadian Institute for Health Information, Health Care in Canada, 2008.
[6] The percentages were lower in the CWLHIN.

- Some residents of the LHIN service areas reported traditional activities in the previous 12 months in the APS. The most popular was fishing (31%), followed by gathering wild plant food (17%).

- Respondents in the Resident Survey were asked whether they self-identified as Aboriginal when seeking health care. Half said that they did self-identify (28% did and 22% sometimes), and the other half did not self-identify.

- First Nations, Métis and Inuit traditional healers were the least commonly consulted care providers (5%). For those few focus group participants who reported accessing traditional care, all felt as though it was having a positive impact on their health.

- Few Aboriginal residents of the Central West LHIN and Mississauga Halton LHIN service areas knew of the availability of traditional medicines, healing or wellness care in their communities. A small percentage of Aboriginal people (12%) reported that such medicines or practices were available. A much larger percentage (42%) reported that they did not know about the availability of traditional medicines, healing or wellness practices. Based on the focus group discussions, half of those who did not know about what was available locally expressed an interest in locating such services, especially from local sources.

- Quality and appropriateness barriers that had the most discussion involved trust, being known as a unique individual, time spent, and the opportunity to discuss all aspects of health in a visit. From a traditional way of communicating, these four aspects are intertwined and should never be addressed independently. Other important aspects were the integration of alternative and traditional health care solutions, the understanding of Aboriginal ways of knowing and being, and the availability of health care providers and advocates.

Typically health service providers revealed low contact rates or that they did not know the degree to which they were providing services to Aboriginal clients. However, most felt that they could only benefit from learning about the needs of the Aboriginal people in their communities. Preferred modes of communication included brochures and liaisons with Aboriginal health care advocates. Generally, specific training on Aboriginal health care and cultural appropriateness were thought to be somewhat problematic due to a lack of time and the relatively small number of Aboriginal people in the area. Some felt that the continued support of client-centered care models would work to benefit Aboriginal and non-Aboriginal people alike.

7.2 Recommendations

1. That the two LHINs jointly work with appropriate organizations to provide coordinated information and resources to …
   - provide health education and health promotion opportunities to specifically address non-traditional tobacco use, high rates of arthritis/rheumatism, asthma, high blood pressure and diabetes, and to inform Aboriginal residents about the benefits of consulting health care providers about those and other long-term conditions.
   - adequately navigate mainstream services, and
   - locate appropriate cultural and alternative health care providers.

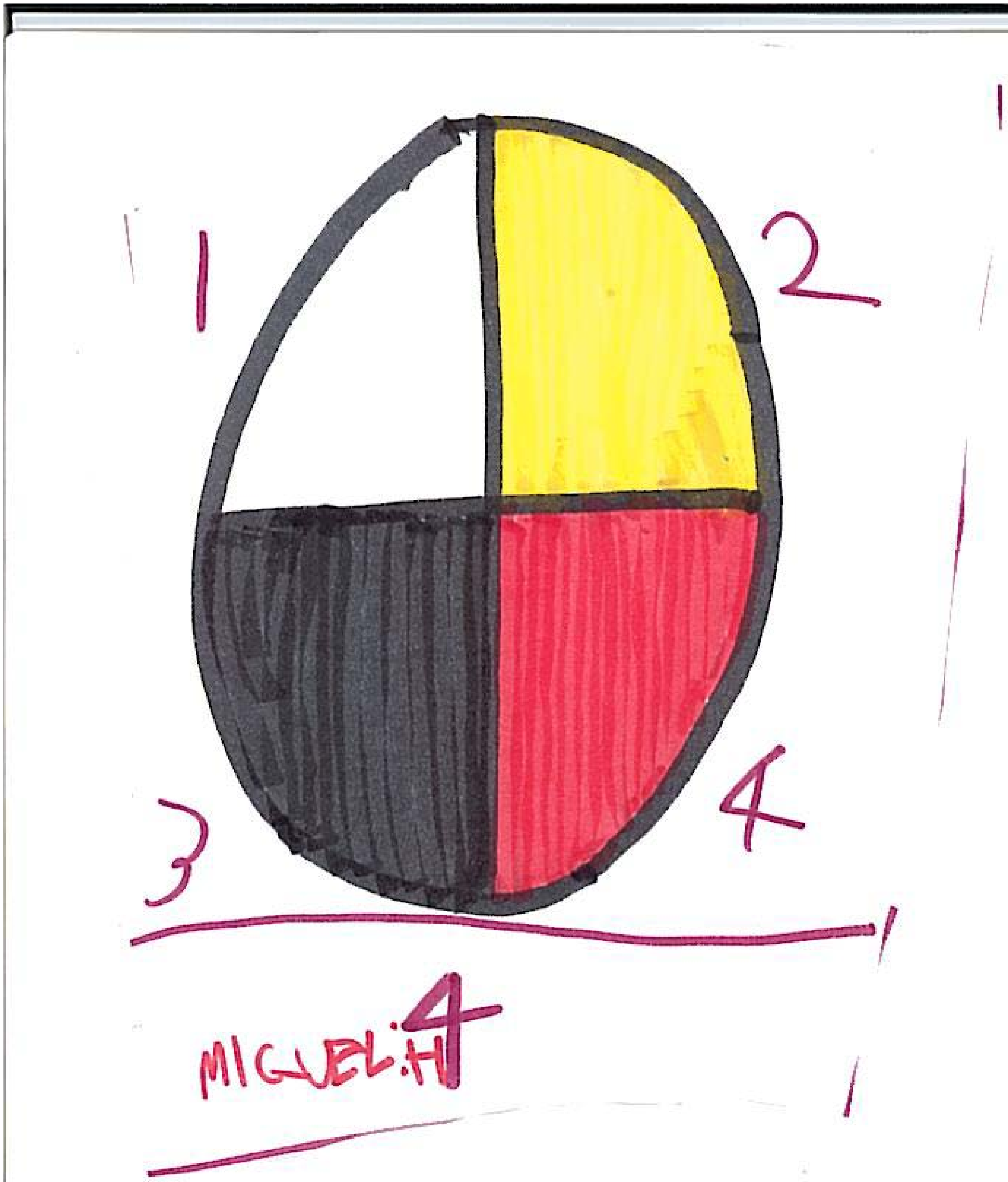
2. That information about Aboriginal culture, demographics, health needs, and ways of knowing should be shared with local health and social service providers through existing community engagement and diversity committees (when available) to help them provide better client-centered care for First Nations , Métis and Inuit clients.

Strategies for engaging communities are provided in the Complementary Community Engagement document.

Appendix A:

Drawings of Cultural/Good Health Care by an 11-Year Old Mètis Girl and a 4-Year Old First Nations Boy

Pharmacy
Nicole. Beauchemin*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Appendix B:

Survey Tools

SERVICE PROVIDER SURVEY

INTRODUCTION

Johnston Research Inc. is an experienced First Nation owned and operated company, contracted by the ***Central West*** and ***Mississauga Halton*** **Local Health Integration Networks** (LHIN) to assist with the development of health programming to better meet the needs of Aboriginal clients within these LHIN areas. Johnston Research Inc. will analyze this information that we gather in a culturally-safe manner. **Please take about 10 minutes to answer these questions that will help these LHINs develop a plan and process for addressing Aboriginal health concerns.** All information will be kept confidential and protected by the *Privacy Act*.

Cut here and keep top half.

INFORMED CONSENT

I understand that all of the information that I provide in this survey will be kept secure and confidential. My name will not be used in any way and protected by the *Privacy Act*. I understand that my participation in the survey is voluntary and I may choose to withdraw at any time. The information that I am providing will be used by the *Central West* and *Mississauga Halton* Local Health Integration Networks to develop a plan and process for addressing Aboriginal health concerns in the community which I work.

Signed

____

Print name

____

Phone # or email

____

REMOVE THIS PAGE AND SUBMIT BOTTOM HALF AS WELL AS SURVEY.

1. **What is the nature of the organization in which you work?**

   Please specify: ____

2. **Which geographical area most clearly describes your service area?**

   ☐ Central West Local Health Integration Network (Central West LHIN)
   ☐ Mississauga Halton Local Health Integration Network (Mississauga Halton LHIN)
   ☐ Greater Toronto Area
   ☐ Ontario-wide
   ☐ Other ____
   ☐ N/A

3. **How frequently do your organization's personnel service Aboriginal clients** *(we understand there may be times you are unaware and we are just trying to get an idea of the one's you are aware; to help the LHINs prioritize future relationship building in this area)*?

	Weekly	Monthly	Less often	Unknown
First Nation	☐	☐	☐	☐
Métis	☐	☐	☐	☐
Inuk	☐	☐	☐	☐

4. **How likely is it that someone within your organization could (and therefore would) take a day to learn more about better meeting the health needs of Aboriginal people in your area?**

	Very Likely	Likely	Somewhat Likely	Not Relevant
First Nation	☐	☐	☐	☐
Métis	☐	☐	☐	☐
Inuk	☐	☐	☐	☐

5. **How likely are personnel within your organization to have the time (therefore would) read literature on how to better meet the health care needs of Aboriginal people?**

	Very Likely	Likely	Somewhat Likely	Not Relevant
First Nation	☐	☐	☐	☐
Métis	☐	☐	☐	☐
Inuk	☐	☐	☐	☐

6. **Currently in the MH and CW LHIN area do you believe that health service providers could benefit from knowing more about how to better meet the health needs of Aboriginal people?**

   ☐ Definitely ☐ For the most part ☐ Somewhat
   ☐ Not really ☐ Not at all ☐ Refused

7. Which of these methods below are both desirable in your organizations' mind and feasible enough that your personnel could (and therefore would) do them? Number as follows: 1. first choices, M. maybes, and N. no goers
Please be honest on what could really work, it may impact LHIN spending, and would surely have time and financial implications to your organization.

_____ Cooperate with health care advocates that are working with Aboriginal clients to ensure they gain the maximum benefit from the services available

_____ Attend education forums specific for health care providers on incorporating Aboriginal ways of knowing and being into daily practices and routines, regardless of clientele being serviced

_____ Learn from an Aboriginal health care provider through distant consultations

_____ Shadow (for a day) a health provider at an Aboriginal health care centre

_____ Use a brochure (for self-identifying clients) that provides information on and how to utilize Aboriginal- specific/sensitive current health care options

_____ Mentor and/or support Aboriginal health students in securing employment by assisting in furthering their education and allure in these LHINs

_____ Provide support to Aboriginal traditional healers on local health care teams

_____ Engage Aboriginal clients in a conversation on the breadth services specific / sensitive to them and potentially open their eyes to these resources they may unknowingly be ignoring

_____ Other (please explain) ____

8. Which of the following ways to engage Aboriginal clients in a conversation on matters that may concern their health care access and knowledge would any one or more of your personnel actually do? Please rate options from 1 to 3, where 1 is *very likely*, 2 is *likely*, and 3 is *not likely*.

	Very likely	Likely	Non likely
Services at Anishnawbe Health Toronto	1	2	3
Ways to get involved and benefits of natural traditional medicines	1	2	3
Defining what holistic health care means	1	2	3
Informing them about alternative health specialists – naturopaths, nutritionists, Chinese medicine aboriginal healing	1	2	3
Educate them on value of Nurse practitioners	1	2	3
Make referrals to Aboriginal cultural care (traditional cultural healers, medicine men, ceremonies)	1	2	3
Other: ________________________________	1	2	3

9. Do you have any other comments and/or ideas on how the local LHINs can help make a difference in the health care service access and provision for First Nations, Métis and Inuit peoples?

Chi-Miigewtch, Marsee, Tansi, Thank-you.

We sincerely thank-you for taking this time to help us
in developing a plan and process for addressing
the First Nation, Métis, and Inuit health concerns in your community.

ABORIGINAL RESIDENT SURVEY

INTRODUCTION

Johnston Research Inc. is an experienced First Nation owned and operated company, contracted by the ***Central West*** and ***Mississauga Halton*** **Local Health Integration Networks** (LHIN) to assist with the development of health programming to better meet the needs of Aboriginal clients within these LHIN areas. Johnston Research Inc. will analyze this information that we gather in a culturally-safe manner. **Please take about 30 minutes to answer these questions that will help these LHINs develop a plan and process for addressing your health concerns.** All information will be kept confidential according to the *Privacy Act*. **If you are First Nation, Métis or Inuk and live in Mississauga, Brampton, Oakville or surrounding areas and you submit this bottom page and the survey you will be entered in a draw for $500, $300, and $200.**

Cut here and keep top half.

INFORMED CONSENT

I am First Nation, Métis or Inuk and live in the Mississauga, Brampton, Oakville or surrounding areas and understand that all of the information that I provide in this survey will be kept secure and confidential according to the *Privacy Act*. My name will not be used in any way. I understand that my participation in the survey is voluntary and I may choose to withdraw at any time. The information that I am providing will be used by the *Central West* and *Mississauga Halton* Local Health Integration Networks to develop an Aboriginal plan and process for addressing the health concerns in my community.

Signed ____

Print name ____

Phone # or email ____

REMOVE THIS PAGE AND SUBMIT BOTTOM HALF AS WELL AS SURVEY.

A. IDENTIFICATION

1. Are you...

- ☐ Status First Nation
- ☐ Non-status First Nation
- ☐ Métis
- ☐ Inuk
- ☐ Not First Nations, Métis, or Inuk
- ☐ Mixed of any above

2. Do any of your ancestors belong to any of the following Aboriginal groups?

	Yes	No
First Nation	☐	☐
Métis	☐	☐
Inuk	☐	☐

3. Do you currently live in...

☐ Milton	☐ Oakville	☐ Halton Hills
☐ Burlington	☐ Malton	☐ Mississauga
☐ Etobicoke	☐ Brampton	☐ Caledon
☐ Dufferin County	☐ Vaughan	☐ Other:

____

B. PERSONAL INFORMATION

4. Gender

- ☐ Male
- ☐ Female
- ☐ Two-Spirited (gay, lesbian, bisexual, transgender, and inter-sex)
- ☐ I prefer not to answer

5. Approximate Age

☐ 15-19 years	☐ 30-34	☐ 45-49	☐ 60-64	☐ 75-79
☐ 20-24 years	☐ 35-39	☐ 50-54	☐ 65-69	☐ 80 and over
☐ 25-29 years	☐ 40-44	☐ 55-59	☐ 70-74	☐ Prefer no answer

6. Present marital status

☐ Married	☐ Common law	☐ Separated	
☐ Divorced	☐ Widowed	☐ Single	☐ Prefer no answer

B. HEALTH STATUS

The following questions ask about four aspects of health and well-being for the "whole person"; including physical health, emotional health, mental health and spiritual health.

7. Do you have any difficulty hearing, seeing, walking, climbing stairs, bending or doing any similar activities?

☐ Yes, often

☐ Yes, sometimes

☐ No

☐ Don't know ☐ I prefer not to answer

8. Does a <u>physical condition or physical health problem</u> reduce the amount or the kind of activity you can do at…

Physical limits on the amount of activity in the following places...	Yes, often	Yes, sometimes	No	Don't Know	I prefer not to answer
Home	☐	☐	☐	☐	☐
At work or school	☐	☐	☐	☐	☐
In other activities	☐	☐	☐	☐	☐

9. Do you have a long lasting <u>physical health condition</u> you are living with (e.g. diabetes, congestive heart failure, arthritis, etc.)?

☐ Yes Go to 10.

☐ No Go to 11.

☐ Don't know ☐ I prefer not to answer

10. How confident are you in your ability to manage your long-term <u>physical health condition</u> (e.g. diabetes, congestive heart failure, arthritis, etc.)?

☐ Very confident ☐ I will probably need some help

☐ Reasonably confident ☐ I don't think that I can manage by myself

☐ Don't know ☐ I prefer not to answer

11. Do you have any difficulty low energy and interest in activities, or diminished ability to enjoy yourself, communicating, learning, or doing any similar activities?

- ☐ Yes, often
- ☐ Yes, sometimes
- ☐ No
- ☐ Don't know ☐ I prefer not to answer

12. Does a <u>mental or emotional condition</u> reduce the amount or the kind of activity you can do at…

Emotional or mental limits on the amount of activity in the following places...	Yes, often	Yes, sometimes	No	Don't Know	I prefer not to answer
Home	☐	☐	☐	☐	☐
At work or school	☐	☐	☐	☐	☐
In other activities	☐	☐	☐	☐	☐

13. Do you have a long lasting <u>mental or emotional condition</u> you are living with (e.g. addictions, depression, paranoia, mood swings, stress or anxiety, etc)?

- ☐ Yes Go to 14.
- ☐ No Go to 15.
- ☐ Don't know ☐ I prefer not to answer

14. How confident are you in your ability to manage your long-term <u>mental or emotional condition</u> (e.g. addictions, depression, paranoia, mood swings, stress or anxiety, etc)?

- ☐ Very confident ☐ I will probably need some help
- ☐ Reasonably confident ☐ I don't think that I can manage by myself
- ☐ Don't know ☐ I prefer not to answer

15. With regard to spiritual well-being, do you have any difficulty believing in yourself, believing in a greater meaning beyond yourself, connecting to your traditional beliefs or doing similar activities?

- ☐ Yes, often
- ☐ Yes, sometimes
- ☐ No
- ☐ Don't know ☐ I prefer not to answer

16. Does a <u>loss of spirituality or beliefs in self, others, and greater meaning</u>, reduce the amount or the kind of activity you can do at…

Spiritual limits on the amount of activity in the following places...	Yes, often	Yes, sometimes	No	Don't Know	I prefer not to answer
Home	☐	☐	☐	☐	☐
At work or school	☐	☐	☐	☐	☐
In other activities	☐	☐	☐	☐	☐

17. Do you have <u>long lasting spiritual deprivation</u> (e.g. loss of belief system, loss of connection spiritual teachers, healers, and helpers, etc.)?

☐ Yes Go to 18.
☐ No Go to 19.
☐ Don't know ☐ I prefer not to answer

18. How confident are you in your ability to manage your <u>long lasting spiritual deprivation</u> (e.g. loss of belief system, loss of connection to spiritual teachers, healers, and helpers, etc.)?

☐ Very confident ☐ I will probably need some help
☐ Reasonably confident ☐ I don't think that I can manage by myself
☐ Don't know ☐ I prefer not to answer

19. In general, would you say that your OVERALL health is:

☐ Excellent
☐ Very Good
☐ Good
☐ Fair
☐ Poor

20. What things do you currently do that can contribute to good health?
Mark all that apply.

<u>Physical Health</u>

☐ Keeping a good diet (low fat, high fibre, fruits, vegetables, etc.)
☐ Getting regular exercise/ Active in sports
☐ Getting adequate sleep / Proper rest
☐ Obtaining medical care from others when I need it

Mental and Emotional Health

- ☐ Reducing or managing stress
- ☐ Having social supports (family, friends, co-workers)
- ☐ Trying to be optimistic / happy / content
- ☐ Having a good/healthy home-life
- ☐ Obtaining health care or counselling for issues when I need it

Spiritual Health

- ☐ Going to First Nation or Métis or Inuk traditional services and/or ceremonies
- ☐ Practicing my traditions and spirituality
- ☐ Maintaining balance in my life (physical, emotional, mental, spiritual)

Access and Information

- ☐ Having transportation to get to needed health care services
- ☐ Using the Internet to help solve health problems
- ☐ Using the Internet to learn more about health prevention and care
- ☐ Having the money needed to pay for the services I want/need
- ☐ None, I think that I am generally unhealthy
- ☐ Other: ____
- ☐ Don't know ☐ I prefer not to answer

21. What things do you currently do/have that might make you unhealthy?
Mark all that apply.

- ☐ Making poor dietary choices (high fat, low fibre, few fruits/veggies, caffeine, etc.)
- ☐ Not eating enough food / feeling malnourished
- ☐ Doing not enough or irregular exercise/ Inactivity, no sports
- ☐ Lacking balance (physical, emotional, mental, spiritual)
- ☐ Having poor social supports (family, friends, co-workers)
- ☐ Poor sleep patterns / inadequate rest
- ☐ Feeling pessimistic / unhappy / discontent
- ☐ Having poor housing conditions *(e.g., overcrowded housing, housing needs repairs, heating system not working well or difficult to pay for, unsafe neighbourhood, etc.)*
- ☐ Smoking
- ☐ Drinking too much alcohol
- ☐ Having high stress
- ☐ Lack connection to your traditions and culture
- ☐ Not having the transportation you need to get to health care services
- ☐ None, I think that I am healthy
- ☐ Other: ____
- ☐ Don't know ☐ I prefer not to answer

22. Do you have children aged 15 and under?

☐ Yes Go to 23.

☐ No Go to 24.

☐ Don't know ☐ I prefer not to answer

23. In general, would you say the health status of your children is excellent, very good, good, fair, or poor? Please specify for each of your children aged 0-15 years and note their age.

Health of your children aged 0 - 15 years	AGE	Excellent	Very Good	Good	Fair	Poor
Child A		☐	☐	☐	☐	☐
Child B		☐	☐	☐	☐	☐
Child C		☐	☐	☐	☐	☐
Child D		☐	☐	☐	☐	☐
Child E		☐	☐	☐	☐	☐
Child F		☐	☐	☐	☐	☐
Child G		☐	☐	☐	☐	☐

C. ACCESS TO HEALTH CARE

24. Are you familiar with the local health integration network (LHIN) in your area?

☐ Yes, very knowledgeable ☐ Yes, somewhat knowledgeable

☐ Not at all knowledgeable

☐ Don't know ☐ I prefer not to answer

25. When using health care services, do you self-identify as an Aboriginal Person?

☐ Yes, Always Go to 27.

☐ No, Never Go to 26.

☐ Sometimes

☐ Don't Know ☐ I prefer not to answer

26. If you do not always identify as an Aboriginal person when using health care services, why not?

☐ Don't feel that it will make a difference *(or it is not important)*

☐ Feel like it will negatively affect the care that I receive

☐ Other: ________________________________

☐ Don't Know ☐ I prefer not to answer

27. Over the past year, when needing health care services how often did you see or use… (Choose 1 -*Every time* to 6 - *None of the times*)

	Every time	Almost every time	Most times	Some of the time	A few of the times	None of the times
A family doctor	1	2	3	4	5	6
A hospital care provider	1	2	3	4	5	6
A specialist	1	2	3	4	5	6
A dentist or orthodontist	1	2	3	4	5	6
A Nurse practitioner	1	2	3	4	5	6
Aboriginal Health Centre	1	2	3	4	5	6
A traditional healer	1	2	3	4	5	6
A traditional healer/Elder/Helper	1	2	3	4	5	6
An alternative health care provider *(e.g., naturopath doctor, acupuncturist, Chinese medicine specialist, homeopathy)*	1	2	3	4	5	6
A Chiropractor	1	2	3	4	5	6
A Dietician	1	2	3	4	5	6
A Midwife	1	2	3	4	5	6
Hospice care (palliative care)	1	2	3	4	5	6
Physiotherapist or occupational therapist	1	2	3	4	5	6
Social worker, counselor or psychologist	1	2	3	4	5	6
Eye doctor, such as an ophthalmologist or optometrist	1	2	3	4	5	6
Other medical doctor, such as surgeon, allergist or orthopedist	1	2	3	4	5	6
Tele-Health	1	2	3	4	5	6

28. How satisfied are you with the kind of health care you currently use?

☐ Very satisfied ☐ Satisfied ☐ Somewhat satisfied

☐ Unsatisfied ☐ Very Unsatisfied ☐ Don't know / I prefer not to answer

Why or why not?

29. How would you rate the level of access to health services available to you as compared to Canadians generally?

☐ Same level of access ☐ Less access ☐ Better access
☐ Don't know ☐ I prefer not to answer

30. Over the past 12 months, where did you use the following types of care?

	Local (within 20km)	Over 20 km Away	Don't Know	Don't use this type of care
Family Doctor's office	☐	☐	☐	☐
Medical Walk-in Clinic	☐	☐	☐	☐
Traditional Health Care *(Aboriginal healer, participated in ceremonies, traditional medicines)*	☐	☐	☐	☐
Alternative health care *(naturopath, acupuncturist, Chinese medicine specialist, chiropractor, homeopathy)*	☐	☐	☐	☐
Culturally Safe health care *(A care environment where a person with Aboriginal heritage feels comfortable with health care providers knowing of, being knowledgeable about and respecting cultural ways/values whether the care providers themselves are Aboriginal or not.)*	☐	☐	☐	☐
Health Nurse Practitioner *(nurse who completed advanced training program as a primary direct provider of health care and can prescribe some medications)*	☐	☐	☐	☐

31. If you travelled outside of the community to receive care, please indicate why you travelled to receive that care Mark all that apply.

	Service not available within 20km	Local service was not culturally related	Local service was culturally related	Other, *Please specify*	Don't use this type of care
Family Doctor's office	☐	☐	☐		☐
Medical Walk-in Clinic	☐	☐	☐		☐
Traditional Health Care	☐	☐	☐		☐
Alternative health care	☐	☐	☐		☐
Culturally Safe health care	☐	☐	☐		☐
Health Nurse Practitioner	☐	☐	☐		☐

32. When you need health care, where do you usually go?

- ☐ Family doctor's office
- ☐ Walk in Clinic
- ☐ Emergency Room
- ☐ Aboriginal Healer
- ☐ Alternative or traditional services
- ☐ Nowhere / don't bother
- ☐ Other, Specify ______________________________
- ☐ Don't Know ☐ I prefer not to answer

33. Do you have a regular family doctor?

- ☐ Yes Go to 35.
- ☐ No Go to 34.
- ☐ Don't know ☐ I prefer not to answer

34. If you do not have a regular family doctor, why not?
***MARK ALL THAT APPLY*.**

- ☐ Family doctor not available
- ☐ Currently on a waiting list
- ☐ Don't know how to find a family doctor
- ☐ Don't know how to find walk-in clinics
- ☐ Don't know how to find First Nation, Métis or Inuk medicine people
- ☐ Have not looked for any of the above
- ☐ Use alternative or traditional services instead
- ☐ Other Specify: ______________________________
- ☐ Don't Know ☐ I prefer not to answer

35. Over the past 12 months, how often has your primary health care provider (family doctor, RN/Nurse practitioner, alternative doctors, traditional healer) changed?

- ☐ Haven't had a primary health care provider in the last 12 months
- ☐ Two times or more
- ☐ Once
- ☐ Stayed the same
- ☐ Don't Know ☐ I prefer not to answer

36. In the past 12 months, have you been a patient overnight in a hospital, nursing home or convalescent home, health centre or nursing station?

- ☐ Yes
- ☐ No
- ☐ Don't know ☐ I prefer not to answer

37. During the past 12 months, have you experienced any of the following problems with receiving health care? Read each item and answer yes or no.

NIHB *refers to the Non Insured Health Benefits program* ***only to Status American Indians with a status card*** *that provides financial support to help cover health care costs: medications, dental care, vision care, medical supplies/equipment, etc.*

Access Barriers	Yes	No	Don't Know	I prefer not to answer
Doctor or nurse not accepting new patients	☐	☐	☐	☐
Waiting list too long	☐	☐	☐	☐
Health facility not available in my area.	☐	☐	☐	☐
Unable to arrange transportation	☐	☐	☐	☐
Difficulty in getting culturally based traditional care	☐	☐	☐	☐
Denied coverage by Non Insured Health Benefits (NIHB)	☐	☐	☐	☐
Health care provider refused to use Non Insured Health Benefits (NIHB)	☐	☐	☐	☐
Could not afford the direct cost of care/service	☐	☐	☐	☐
Could not afford transportation	☐	☐	☐	☐
Could not afford childcare costs	☐	☐	☐	☐
Felt health care provided was inadequate	☐	☐	☐	☐
Needed service was not available in my area	☐	☐	☐	☐
Didn't know about Tele-Health	☐	☐	☐	☐
Have used Tele-Health and service was unhelpful	☐	☐	☐	☐
Felt service did not meet my cultural needs	☐	☐	☐	☐

D. QUALITY / APPRORIATENESS OF CURRENT HEALTH CARE

38. How appropriate was the kind of health care you received over the past year?

☐ Better than I expected ☐ Met my expectations

☐ Somewhat met my expectations ☐ Was unacceptable ☐ Don't know / I prefer not to answer

39. How important is it to you that you have local access to…(Choose 1 -*Very Important* and 3 - *Not important*)

	Very important	Important	Not important
A family doctor	1	2	3
A hospital care provider	1	2	3
A specialist	1	2	3
A dentist or orthodontist	1	2	3
A Nurse practitioner	1	2	3
Aboriginal Health Centre	1	2	3
A traditional healer	1	2	3
A traditional healer/Elder/Helper	1	2	3
An alternative health care provider	1	2	3
A Chiropractor	1	2	3
A Dietician	1	2	3
A Midwife	1	2	3
Hospice care (palliative care)	1	2	3
Physiotherapist or occupational therapist	1	2	3
Social worker, counselor or psychologist	1	2	3
Eye doctor, such as an ophthalmologist or optometrist	1	2	3
Other medical doctor, such as surgeon, allergist or orthopedist	1	2	3
Tele-Health	1	2	3

40. Have you had any of the following difficulties when wanting/trying to access traditional First Nations, Métis, Inuk health care approaches? .

MARK ALL THAT APPLY

- ☐ No difficulties
- ☐ Not available through mainstream health care
- ☐ Don't know where to get them
- ☐ Not covered by Non Insured Health Benefits (Health Canada)
- ☐ Can't Afford it
- ☐ Not interested
- ☐ Didn't want to and/or didn't try
- ☐ Don't know enough about them
- ☐ Concerned about effects
- ☐ Services not available locally
- ☐ Services or sessions offered locally are very infrequent and not always convenient
- ☐ Services available are not offered by a person from my specific culture (i.e. Ojibway, Cree, Iroquois, Mohawk, Métis, Igloolik, etc.)
- ☐ Don't Know ☐ I prefer not to answer

41. How important to you is it that your health care provider …(Choose 1 -*Very Important* and 3 - *Not important*)

Importance that your health care provider...	Very important	Important	Not important
Is understanding of Aboriginal ways or knowing and being	1	2	3
Aboriginal and well versed in Aboriginal health care needs	1	2	3
Non-Aboriginal and well versed in Aboriginal health care needs	1	2	3
Knows you as a person and not as number or chart	1	2	3
Acts in a way that you feel you can trust	1	2	3
Prescribes drugs for your ailments/health needs	1	2	3
Listens to and considers your OVERALL health during each visit	1	2	3
Prescribes alternative medical solutions in addition to the drugs (e.g., prevention and lifelong health)	1	2	3
Prescribes traditional medicines / natural remedies	1	2	3
Is available at all times, including after hours	1	2	3
Makes available a Nurse Practitioner when you cannot see a doctor	1	2	3
Makes available a person who can act as an advocate to get you the information you need	1	2	3
Makes available a person who can act as an advocate that will get you all the care you need	1	2	3

E. EDUCATION

42. Did you graduate from high school?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ I prefer not to answer

43. Other than elementary and secondary grades, what education have you completed?
Check all that apply.

- ☐ Some trade, technical, or vocational school
- ☐ Some community college or CEGEP
- ☐ Some university
- ☐ Diploma or certificate from trade, technical or vocational school
- ☐ Diploma or certificate from community college, CEGEP, or university
- ☐ University degree
- ☐ Master's degree
- ☐ Earned doctorate (PhD)
- ☐ Other (such as training)

____

____

- ☐ Don't know
- ☐ I prefer not to answer
- ☐ None

F. EMPLOYMENT AND INCOME

44. During the year ending December 31, 2009, did you receive income from any of the following sources? *Specify for each income source.*

	Yes	No	Don't Know	I prefer not to answer
Paid employment (wages/salary)	☐	☐	☐	☐
Earning from self-employment	☐	☐	☐	☐
Employment Insurance	☐	☐	☐	☐
Social assistance	☐	☐	☐	☐
Basic Old Age Security	☐	☐	☐	☐
Ontario Disability Support Program (ODSP)	☐	☐	☐	☐
Workman's comp (WSIB)	☐	☐	☐	☐
Benefits from Canada or Quebec Pension Plan	☐	☐	☐	☐
Royalties, trusts and land claims payments	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐

45. Are you currently working for pay (wages, salary, self-employment)?

- ☐ Yes
- ☐ No
- ☐ Don't know ☐ I prefer not to answer

46. On average, how many paid hours do you work per week?

____ ____ Number of hours

G. OTHER PERSONS IN THE HOUSEHOLD

47. How many children usually live in this household?
Include all children 15 or under who reside in the household at least half of the time (3-4 days a week). If none, mark "0".

___ ___ Number of children ages 0 -15 years old

☐ I prefer not to answer

48. Including yourself, how many adults usually live in this household?
Include all adults, 16 years and over, who reside in the household at least half of the time (3-4 days a week).

___ ___ Number of adults aged 16 and up

☐ I prefer not to answer

49. For the year ending December 31, 2009, please think of the total income, for all *household members*, including yourself, before deductions, from all sources. *Please look at these categories and tell me which range it falls into.*

- ☐ No income
- ☐ $1-$4,999
- ☐ $5,000-$9,999
- ☐ $10,000-$14,999
- ☐ $15,000-19,999
- ☐ $20,000-24,999
- ☐ $25,000-$29,999
- ☐ $30,000-$39,999
- ☐ $40,000-$49,999
- ☐ $50,000-$59,999
- ☐ $60,000-$69,999
- ☐ $70,000-$79,999
- ☐ $80,000 and over
- ☐ Don't know
- ☐ I prefer not to answer

☐ Income loss *(if you are a business owner or self-employed or earn income off the stock-market this mean that you lost more money than you made)*

H. WRAP-UP

50. Do you have any additional comments about the quality or access to health care services for you or your family?

Chi-Miigwetch, Marsee, Tansi, Thank-you.

We sincerely thank-you for taking this time to help us
in developing a plan and process for addressing
the First Nation, Métis, and Inuk health concerns in your community.