

PRIMARY CARE SERVICES FOR INDIGENOUS PEOPLE: IMPLICATIONS FOR NURSE
PRACTITIONERS

by

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Abstract

Background: Indigenous people have a disproportionate burden of illness and social suffering with significantly higher morbidity and mortality rates in comparison to the Canadian population. Persistent health inequities and poor socioeconomic status are a consequence of discriminatory policies, colonization and marginalization enforced by the Canadian government in the last century, and these policies continue to negatively affect Indigenous people today. The rising cost of health care and increasing health disparities in marginalized populations has created a need for socially responsive health care professionals (HCP) to provide cost-effective health services to vulnerable populations, including Indigenous populations, among others. Nurse practitioners (NP) are regulated HCPs who integrate holistic nursing philosophy with medical knowledge, and have the authority and autonomy to provide primary health care services (PHC) in a culturally safe manner to the Indigenous population.

Objectives: The first objective of this project is to determine the PHC services available to the *urban* Indigenous population in British Columbia (BC) living both on and off-reserve within the Vancouver Coastal Health Authority (VCH) and Fraser Health Authority (FHA), as the urban population in BC resides primarily in these regions, with a view to considering how NPs might be mobilized in these contexts. A second objective of this project is to examine the factors influencing Indigenous peoples' access to health care, the implications, and discuss how NPs could address the factors identified to provide responsive, effective PHC.

Design: An environmental scan of the urban Indigenous population residing in the VCH and FHA region was completed using statistics obtained from surveys available on organizational websites. In addition, a comprehensive search of the literature was undertaken utilizing a variety

of approaches to identify relevant literature including qualitative and quantitative research methods and scholarly, peer-reviewed articles.

Findings: The environmental scan shows inequitable PHC services available to the urban Indigenous population across FHA and VCH. Analysis of the literature identified five main themes that influence Indigenous peoples access to health care: the historical impact of colonization and state interference on health care access; governmental power and authority; emotional responses to discrimination in mainstream health care; culturally appropriate health care is needed; and shifting towards cultural safety. The implications of persistent, inaccessible health care were two-fold; increased health care utilization and poor health outcomes in the Indigenous population. Four relevant areas of discussion were identified from the literature that supports the role of NPs in working with marginalized populations: NP's roles within health care reform; NP's distinction from medical practice; NPs as socially responsive professionals; and health care strategies in Indigenous populations.

Conclusions: These findings can inform development of NP positions to provide equitable, socially responsive and culturally safe PHC to the urban Indigenous population across FHA and VCH. Further research in this area is desperately needed with dissemination of findings to key stakeholders in Indigenous health. Empirical evidence on positive outcomes in both health and social status for Indigenous people is critical for appropriate allocation of resources to address health and health care inequities.

Keywords: Indigenous people, Aboriginal people, marginalized populations, nurse practitioner, primary health care, health inequity, social justice

Background and Purpose

Indigenous people¹ in Canada have significantly higher morbidity and mortality rates in comparison to the Canadian population (Health Canada, 2009; First Nations Information Governance Centre, 2009). These obvious health disparities are a result of a myriad of complex interrelated factors that include a lower status in nearly all determinants of health (Health Canada, 2009). Persistent health inequities and poor socioeconomic status is a consequence of discriminatory policies, colonization and marginalization enforced by the Canadian government in the last century, and these policies still continue to negatively affect Indigenous people today (Browne et al, 2011; Hole et al, 2015; Neufeld, 2014). Research indicates that the on-going intergenerational effects of historical policies and the residential school system have created significant barriers to accessing the health care system today (Browne et al, 2011; Hole et al, 2015; Neufeld, 2014; Shahid et al, 2016). The known barriers are complex and include geographical, cultural and linguistic differences, as well as lower socioeconomic status (Neufeld, 2014). Despite vast differences between rural, remote and urban populations of Indigenous people, they share similar experiences and barriers in accessing the health care system (Browne et al, 2011; Hole et al, 2015; Neufeld, 2014; Oster, Mayan & Toth, 2014; Shahid et al, 2016; Sherifali, Shea & Brooks, 2012). This phenomenon suggests that although physical location can be a significant barrier to accessing health care, negative social and cultural experiences are commonly experienced by Indigenous people.

¹ *In this paper, the term “Indigenous” or “Indigenous Peoples” will be used to refer to Aboriginal Peoples internationally, and in Canada specifically, to the original peoples and their descendants, and includes Indian (First Nations), Inuit and Métis groups (University of British Columbia, 2009).*

Culturally safe health care is essential to address the on-going institutional barriers faced by Indigenous people when interacting with the health care system. Cultural safety was originally conceptualized in New Zealand when working with Māori people, who share similar experiences of colonization; cultural safety moves beyond the well cited concept of cultural sensitivity to recognize the historical experiences of Indigenous people and examine the power imbalances present within health care interactions (Ramsden, 2002). Cultural safety is defined by the First Nations Health Authority (FNHA) as “an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care” (2016). Combining a culturally safe environment in a physically accessible location has the potential to promote positive health outcomes for Indigenous people.

Recruiting and retaining nurses and physicians to deliver high quality, culturally safe health services is a challenge for Indigenous communities. Health Canada, among other professional organizations, recognizes the need to increase the number of Indigenous health providers (Health Canada, 2016). I expect to be well positioned as a qualified, Indigenous NP to provide PHC, specifically targeting Indigenous health and the current challenges Indigenous people face when accessing health care. A thorough literature review and environmental scan of the urban Indigenous population both on and off-reserve in BC was necessary to demonstrate the complexity of Indigenous health care and the urgent nature of addressing the current health inequities as experienced by urban Indigenous people in BC. Thus, the objectives of this project are to examine the factors that influence how Indigenous people access health care and the implications, and to also discuss how a nurse practitioner (NP) could address the factors identified to provide responsive, effective primary health care (PHC). Then finally, based on the

environmental scan, I will develop a job letter (see Appendix) outlining how I can meet the current needs of the urban Indigenous population living both on and off-reserve within Fraser Health Authority (FHA) and Vancouver Coastal Health Authority (VCH).

Rationale for Project

In British Columbia (BC), there are five regional health authorities and two specialized health authorities including the FNHA. The urban Indigenous population of BC primarily lies in the FHA and VCH regions (Statistics Canada, 2011). Each of the identified health authorities have recognized the increasing health disparities Indigenous people in BC experience, and have committed to bridging this gap in health care. FNHA is responsible for providing province-wide health services to all Indigenous people in BC. A tripartite partnership was formed between Indigenous Peoples in BC, the province of BC and the Government of Canada, acknowledging Indigenous peoples' health disparities and declaring this inequity in health as no longer acceptable (FNHA, 2016). Similarly, the strategic priorities of the FHA Aboriginal Health team is to improve health outcomes and access to culturally-appropriate services for Indigenous people (FHA, 2010). VCH has also committed to strategic initiatives that help close the health status gap and work in collaboration with stakeholders involved in Indigenous peoples' health in BC (VCH, 2008). Each of these BC health authorities have identified accessible PHC services as a priority in improving health care for Indigenous people (FHA, 2010; FNHA, 2016; VCH, 2008). Despite this commitment, PHC services are not provided equitably among Indigenous communities in BC.

One strategy that has been used more generally for enhancing PHC and promoting health equity is the introduction of NPs. As I argue in this paper, supporting a NP position to provide PHC on-reserve to the urban Indigenous population would align with FNHA, VCH and FHA's

initiatives and would acknowledge inequities that currently exist between Indigenous communities in BC.

NPs are regulated, health professionals who integrate holistic nursing experience with the authority and autonomy to diagnose and treat acute and chronic conditions in a primary care setting (College of Registered Nurses in British Columbia, 2016). NPs could provide this vital service in a culturally safe manner that is specific to Indigenous people and acknowledges the social and systemic barriers that stem from their historical context. Furthermore, PHC must be inclusive of all levels of prevention that is accessible to Indigenous people. Primary, secondary and tertiary level prevention is essential in addressing the health disparities identified. NPs can provide this vital component of PHC and help close the gap between Indigenous people and the general population in BC.

Approach: Environmental Scan

An environmental scan was undertaken to support the introduction of a health authority-funded NP position to provide culturally safe, competent PHC services to the urban Indigenous population in BC. For the purpose of this project, the environmental scan focuses on the urban Indigenous population in BC living both on and off-reserve within FHA and VCH. The environmental scan determined the urban Indigenous population on and off-reserve and current PHC services available. The environmental scan also assisted in determining at what location and setting a NP would be most beneficial in providing service to the urban Indigenous population. For example, in Surrey there is a large urban Indigenous population, and a NP positioned in this community to offer PHC would be appropriate. Conversely, Squamish Nation in North Vancouver has a large on-reserve Indigenous population that may be better served with PHC services offered directly on-reserve. The environmental scan was done using organizational

websites and surveys, as well as direct consultation with the health department located on-reserve in the urban Indigenous communities in FHA and VCH. Based on the results of the environmental scan, current PHC service delivery shortfalls to the urban Indigenous population were determined across FHA and VCH.

Environmental Scan

An environmental scan was completed to report on the urban Indigenous population living both on and off-reserve within VCH and FHA region. Data was reviewed from websites including Indigenous and Northern Affairs Canada (INAC), FNHA, FHA, VCH, Statistics Canada and personal communication with Seabird Island, Sto:lo Nation, Musqueam First Nation (FN), Squamish Nation and Tsleil-Waututh FN. The most comprehensive and readily available data were used in Table 1 and 2 to show the urban Indigenous population and primary health care services available. Statistics varied across reports of the Indigenous population; some organizations reported the Aboriginal population while others reported on the Status Indian population. Data and discussion will use the terminology as per the respective organization. For clarification, Aboriginal identity includes people who identify themselves as a registered Indian or a Band member, or they claimed Aboriginal ancestry or belonging to an Aboriginal group; North American Indian (also known as First Nations), Inuit, or Métis (Fraser Health, 2012). Status Indian refers to those people who are defined as an Indian under the Indian Act, they are assigned a number that is recorded in the Indian Registry by the department of Aboriginal Affairs and Northern Development Canada (AANDC), the majority of Status Indians are a member of a Band (Fraser Health, 2012). In this environmental scan, Aboriginal or Status Indian will be used as defined above and Indigenous will be inclusive as per the definition earlier in this report.

Urban Indigenous populations are reported as on-reserve or off-reserve. On-reserve population refers to Status Indians living on-reserve land as defined by INAC:

As identified in the *Indian Act*, reserve land is “a tract of land, the legal title to which is vested in Her Majesty, which has been set apart by Her Majesty for the use and benefit of a band”. Reserve lands are different from other land in that: legal title to reserve lands is held by the Crown rather than by individuals or organizations; First Nations have a recognized interest in reserve land that includes the right to exclusive use and occupation, inalienability and the communal nature of the interest; the land cannot be seized by legal process or be mortgaged or pledged to non-members of a First Nation; and the Minister must approve or grant land transaction under the *Indian Act* (2013).

The Urban Indigenous population in Fraser Health Authority and Vancouver Coastal Health Authority. There were inconsistent population numbers reported between organizations. For the statistics reported data was primarily collected through surveys. The discrepancies identified reflect the fluid movement of Indigenous people, from on to off-reserve and between different reserves in BC. An accurate population count is difficult to achieve, but Table 1 gives a general overview of the approximate population living on-reserve and off-reserve from each Indian Band in FHA and VCH. The data does not take into account any other non-Band members who may be living on-reserve as well.

FHA provided an estimation of the urban “Aboriginal” population residing both on and off reserve. FHA reports roughly 38,105 or 2.7% of the FHA population are self-identified Aboriginal people (2012). Eastern FHA has the largest proportions of Aboriginal people compared with western FHA. Surrey has the largest actual number of Aboriginal people and finally, Chilliwack has the largest number of Status Indians. FHA estimates that nearly half of

Status Indians live off-reserve in the FHA region (FHA, 2012). Notably, FHA’s estimation of “self-identified” Aboriginal people (38,105) is strikingly higher than the reported number of Status Indians (8,926) in the area. Careful consideration is necessary when appraising evidence and statistics to recognize the difference between self-reported Aboriginal and Status Indians.

VCH does not report their self-identified Aboriginal population but provides estimations of the urban population of Status Indians. Within Vancouver, North Vancouver and Richmond, the estimated population of Status Indians is 16,585, but identifies that the actual number may be higher. The largest proportion reside in the downtown eastside followed by North Vancouver (Lysyshyn, M., 2014).

Discrepancies are visible in Table 1 and are a result of inconsistent data across organizations, but also reflects the transient movement, unstable housing and unknown addresses of many Indigenous people. The population totals for FHA and VCH are reported by FNHA (2017). Each separate Indian Band is listed within the urban areas of FHA and VCH, the population data is reported from the INAC (2017) website.

Table 1

Summary of Status Indian population currently living on or off-reserve in urban VCH and FHA

| Health authority | Indian Band | Status Indian | Population | |
|------------------|-----------------|---------------|--------------|--------------|
| | | population | On-reserve | Off-reserve |
| FHA | | 8,926 | 4,641 | 4,285 |
| | Kwikwetlem | 103 | 39 | 59 |
| | Katzie FN | 577 | 210 | 260 |
| | New Westminster | 14 | | 14 |
| | Kwantlen FN | 287 | 72 | 181 |
| | Matsqui | 264 | 100 | 148 |

| | | | |
|-------------------|-------------------|------------------|------------------|
| Tsawwassen FN | 367 | 185 | 177 |
| Semiahmoo FN | 98 | 51 | 40 |
| Seabird Island | 995 | 576 | 372 |
| Aitchelitz FN | 42 | 20 | 17 |
| Shxw̓ha:y Village | 416 | 59 | 308 |
| Leq'a:mel FN | 419 | 120 | 278 |
| Squiala FN | 220 | 111 | 73 |
| Matsqui FN | 264 | 100 | 148 |
| Sumas FN | 332 | 141 | 157 |
| Popkum FN | 12 | 1 | 11 |
| Tzeachten FN | 533 | 240 | 264 |
| Skawahlook FN | 91 | 7 | 80 |
| Yakweawkwoose | 72 | 33 | 37 |
| Skowkale FN | 260 | 157 | 75 |
| Union Bar FN | 130 | 7 | 120 |
| Chawathil | 617 | 304 | 232 |
| Shxw'ow'hamel FN | 198 | 81 | 90 |
| Chehalis FN | 1090 | 470 | 523 |
| Scowlitz | 266 | 81 | 152 |
| Kwaw-kwaw-Apilt | 45 | 30 | 11 |
| Soowahlie | 374 | 167 | 180 |
| Skwah | 571 | 236 | 236 |
| Cheam | 537 | 186 | 286 |
| Peters FN | 165 | 44 | 118 |
| Total | 9,359 | 3,828 | 4,647 |
| VCH | 15,959 | 9,183 | 6,776 |
| Squamish Nation | 4,216 | 2,231 | 1,789 |

| | | | |
|-----------------------|--------------|--------------|--------------|
| Tsleil-Waututh Nation | 588 | 286 | 255 |
| Musqueam FN | 1, 400 | 675 | 604 |
| Total | 6,204 | 3,192 | 2,648 |

Note. FN = First Nation. Adapted from INAC and Census, Statistics Canada (as cited in First Nations Health Authority. 2017. *Regions*. Retrieved from <http://www.fnha.ca/about/regions>); Indigenous and Northern Affairs Canada. (2017). *First Nations profiles*. Retrieved from <http://cippn-fnpim.aadnc-aandc.gc.ca/index-eng.html>

Although the data is inconsistent, it provides a snapshot of the approximate population of Status Indians within each region. The urban population of Indigenous people is difficult to quantify, but actual estimates of on-reserve population would be much higher to account for Indigenous people from Indian Bands across BC and even Canada or the US.

Primary health care services on-reserve. PHC services are “technically” available to urban Indigenous people, however, the literature review reveals the staggering factors that influence how Indigenous people access health care in general. Table 2 shows PHC services available directly on-reserve to serve Indigenous communities. Sto:lo Nation and Seabird Island also offer PHC services to off-reserve, non-Indigenous populations. FNHA categorizes Sto:lo Nation and Seabird Island as umbrella organizations that include a number of local Bands, and funds them accordingly to provide service to all of these Bands. Sto:lo Nation incorporates the following 11 Bands; Aitchelitz FN (First Nation), Shxw̓ha:y Village, Leq’a:mel FN, Squiala FN, Matsqui FN, Sumas FN, Popkum FN, Tzeachten FN, Skawahlook FN, Yakwekwioose FN and Skowkale FN. Seabird Island Health Services includes the following 11 Bands; Seabird Island, Scowlitz, Soowahlie, Kwaw’kwaw’apilt, Kwantlen FN, Shxw’ow’hamel, Chawathil, Cheam, Union bar FN, Chehalis FN and Skwah (FNHA, 2017). It was unclear from the organizational websites whether Peters FN was included under Seabird Island’s umbrella.

Table 2

Primary health care services available on-reserve in VCH and FHA

| Health authority | Indian Band | Status Indian population served | Health care Provider | Days of service |
|------------------|-----------------------|------------------------------------|-------------------------|--------------------|
| FHA | Sto:lo Nation | 989 | GP | 4 ½ days/week |
| | | | NP | 2 days/week |
| | Seabird Island | 2210 | 2 GPs | 5 days/week |
| | | | Psychiatrist | 1 day/2weeks |
| VCH | Squamish Nation | 2231 | NP | ½ day/week |
| | | | GP | ½ day/week |
| | Tsleil-Waututh Nation | 286 | NP | 1 day/week |
| | Musqueam FN | 675 | NP | 4 days/week |
| | | | GP | 1 day/week |

Note. Adapted from Community Health Representative of each Band, personal communication, January 30-February 3, 2017

The most striking feature in Table 2 is the large variability of HCP services per population served. Sto:lo Nation, Seabird Island, Tsleil-Waututh Nation and Musqueam FN are relatively similar in their population ratio to HCP. Conversely, Squamish Nation has an approximate on-reserve population of 2231, yet only has the equivalent of 1 day a week HCP available on-reserve.

The Bands that currently do not have any PHC services offered on-reserve are Kwikwetlem, Katzie FN, New Westminster, Tsawwassen FN and Semiahmoo FN. Each of these reserves are in the FHA. FHA recently posted two full-time positions for a NP to work in Aboriginal health to serve the urban population. One position is located at Kla-how-eya Healing Place in Surrey, BC and the other position is located in Chilliwack Home and Community Care center, Chilliwack, BC to serve surrounding Indigenous communities (Fraser Health, 2017). This

recent development is encouraging and shows FHA's commitment to serve their Indigenous population, but the data obtained does not show any consistency across Indigenous communities.

The funding models used in BC are very complex and incorporate many factors associated with population size, infrastructure and capacity of each Indigenous community. FNHA is at various stages of health transfer agreements with Indigenous Bands. In simplified terms, some communities receive funding to control all aspects of health care, in others, FNHA is responsible for delivering health care, and finally, some communities fall in between on this spectrum of health service management (2017). To further complicate the situation, NPs may be Band-employed from funds from FNHA or the role may be supported with Band revenue. NPs can also be employed by the local health authority such as VCH or FHA. Lastly, FNHA funds some positions for NPs, generally in rural or remote locations. It is difficult to discern who the decision-makers are in determining the positions and hours of work currently being offered, but it is clear that PHC is offered inequitably across the Indigenous communities in VCH and FHA.

Health care funding is allocated inequitably among the various communities and often, confusion arises between the Bands, FNHA and the local health authority as to where responsibility lies for providing health services. Based on the data in Table 2, the conclusion can be reached, in terms of on-reserve PHC, Squamish Nation, Kwikwetlem, Katzie FN, Tsawwassen FN and Semiahmoo FN are not receiving PHC equitably compared with other Bands in FHA and VCH.

Approach: Literature Review

To meet the objectives of this project, this literature review included three separate components: the factors influencing access to health care by Indigenous people; implications of

structural violence in health care; and how NPs are positioned to address the barriers to health care Indigenous people face. The scope of this literature review was limited to examining specific factors that influence how Indigenous people access PHC. The potential implications of inaccessible health care include poor overall health of Indigenous people in BC compared with the general population and significant costs to the health care system. For example, inappropriate use of urgent health care services and poor chronic disease management will persist leading to health complications and often, unnecessary hospitalization. Lastly, this literature review discusses why NPs are well positioned to be able to provide culturally safe PHC services, and specific strategies that are provided in the context of the historical injustices inflicted on Indigenous people.

Methods

For the purpose of this literature review, research studies and scholarly articles were sought to provide an overview of the factors that influence how Indigenous people access health care, the implications to Indigenous health status, and costs to the health care system with continued health and health inequities. In addition, this literature review examined the role of an NP, and discussed how an NP could address the factors identified to provide responsive, effective PHC. The intent of this literature review was not to provide an exhaustive report of all relevant research available, rather, it was to provide a summary of the literature regarding how Indigenous people access health care regardless of specific illnesses or location, and highlight the similarities across Indigenous populations.

The literature includes scholarly articles, qualitative and quantitative research studies conducted in Canada, United States and Australia, whose Indigenous populations all share similar historical experiences of colonization, and consequently face staggering health disparities

today. The literature was searched using the electronic bibliographic databases CINAHL and PubMed and examination of the reference lists of the articles acquired from the database search. The search strategy included the following keywords to meet the objectives of this literature review: First Nations, Aboriginal, health care, health care access, Australia, Canada, NP, implementation, potential, access, hospitalization, community, primary care with synonyms and Boolean operators (OR, AND) used as appropriate.

The inclusion criteria was a) between 2005 to 2017; to limit to the most recent literature, b) academic journals, c) English language, and d) original research studies done in Canada, US or Australia *or* scholarly articles that provided valuable context and had direct relevance to the research objectives. The initial search retrieved 131 articles. Titles were scanned for relevance to the project objectives; 49 articles were selected. Abstracts were scanned for relevance and quality of research methodology; 24 articles were selected. The reference lists of these articles were scanned to identify 2 additional scholarly articles for inclusion resulting in 26 scholarly articles selected for inclusion. 21 articles are original research studies and 5 are scholarly, peer-reviewed, non-research articles.

Findings

Literature Review

This literature review begins with an overview of the current ethical considerations specific to Indigenous research, a synthesis of the selected articles, highlighting themes identified from the literature, and ends with a discussion of the literature review in relation to the research objectives and future research directions to consider.

Research with Indigenous people has evolved over time from Indigenous people being subjected to research to more of a collaborative research strategy between researchers and Indigenous people (Government of Canada, Panel on Research Ethics, 2014). Respect for this shift is critical in current research studies and acknowledges the power and control Indigenous people now have over research studies.

Ethics. Indigenous people have typically been researched by non-Indigenous people in power and this has led to specific ethical guidelines in regards to Indigenous research (Government of Canada, Panel on Research Ethics, 2014). Opposed to further scrutiny and reporting on poor health and other conditions of Indigenous people that contributes to further stereotyping and distrust in the dominant society, researchers and Indigenous people in Canada developed explicit guidelines on ethical research with Indigenous people (Government of Canada, Panel on Research Ethics, 2014). The historical legacy is reflected in the guidelines for research that have evolved over time and aim to give Indigenous people the power over their research rather than being the product of further research. Basic tenets of Indigenous research includes respect for culture, collaboration in the research process, dissemination of information and benefit to the community if possible (Government of Canada, Panel on Research Ethics, 2014). This understanding and reciprocity between researchers and Indigenous participants is vital to acknowledge some of the damaging reports that have been done without benefit to Indigenous communities.

Factors influencing access to health care by Indigenous people. A variety of research studies and scholarly articles were chosen to be included in this review to uncover common themes present across a variety of disease processes, locations or health care settings. This approach was used to eliminate any themes that may be disease specific, location or health care

setting specific. Therefore, the articles reviewed included studies of Indigenous people's experience with diabetes type 2, gestational diabetes, cancer, dementia and obstetric care. The research setting varied and includes primary care or hospital settings and both urban and rural locations. This variation gives strength to the body of evidence and highlights the striking similarities in accessing health care despite the vast differences across Indigenous populations and health issues. Five main themes were identified on review of the literature: historical impact of colonization and state interference in health care access; governmental power and authority, emotional responses to discrimination in mainstream health care, culturally appropriate health care is needed and shifting towards cultural safety.

Historical impact of colonization and state interference on health care access. An overriding theme was the impact of historical relations with the dominant society and how this has negatively influenced how Indigenous people interact with mainstream health care (Shahid et al, 2016). Racism, discrimination and colonization is engrained in Indigenous peoples experiences, and causes distrust in government institutions such as health care (Allan & Smylie, 2015; Browne et al, 2011; Hole et al, 2015; Neufeld, 2014; Shahid et al, 2016; Thompson et al, 2015). The impact of colonialism continues as historical and intergenerational trauma that has profound negative effects on the health of Indigenous people (Allan & Smylie, 2015; Browne et al, 2012; Browne et al, 2016). The historical impact of colonization and state interference on health care access can further be sub-divided into: health and social inequities: A consequence of colonization and racism; stereotyping; racism and discrimination; and finally, attitudes and assumptions of HCPs and Indigenous people. Each cannot be viewed in isolation but rather, are intricately related and stem from government interference and the residential school system.

These barriers exist within the health care system and are a form of structural violence that overwhelmingly contributes to health inequities present in society (Thompson et al, 2015).

Health and social inequities: A consequence of colonization and racism. Health and social inequities negatively affect marginalized populations at higher rates than the general population (Browne et al, 2012). Examining the structural processes in relation to the social determinants of health (SDH) highlights the inequities present across populations and how they are distributed unequally in society, and therefore, are socially produced, avoidable and unjust (Newman, Baum, Javanparast, O'Rourke, & Carlon, 2015). Research has shown that Indigenous people have higher rates of social suffering that includes a lower socioeconomic status, poor housing, poverty, trauma, abuse, lower education, substance use and mental health issues (Canadian Institute for Health Information, 2008). These factors are forms of systemic discrimination that contribute to and sustain health inequities. Indigenous women are often further marginalized due to additional social conditions such as being a lone parent or with an unreliable partner, a history of foster care themselves, a lack of family or community support, homelessness or inadequate housing, violence and abuse, and a history of trauma (Denison et al, 2013). Health disparities are “directly and indirectly associated with social, economic, cultural and political inequities; the end result of which is disproportionate burden of ill health and social suffering” (Adelson, 2005, page S45). The health disparities Indigenous people face today are due to the overwhelming social and health inequities present in society in direct relation to the dominant, political ideology of neoliberalism.

The health disparities present between Indigenous people and the general population are often viewed from a neoliberalist perspective. Neoliberalist ideals explain poor health as being a consequence of individuals' bad life choices rather than placing the responsibility on historical

and socioeconomic processes that contribute to individuals having equal opportunity to access resources and a healthy life (Tang & Browne, 2008). Neoliberalism involves taking the burden of disease off of the government and placing it solely on the individual's shoulders (Ayo, 2012; 2011), which further magnifies the inequitable distribution of health care (Archibald & Fraser, 2013; Browne & Tarlier, 2008; Browne et al, 2012; Browne et al, 2016). "Blame the victim" is a common mentality and from that perspective, poor health is a result of making poor lifestyle choices (Ly & Crowshoe, 2015). Indigenous people face a disproportionate burden of illness due to systemic discrimination *not* as a result of poor lifestyle choices. Structural violence present in society is rooted in the historical injustices inflicted on Indigenous people. It is the long standing discriminatory policies that are responsible for the health and social inequities, and contribute to individual and structural racism Indigenous people face in society (Allan & Smylie, 2015; Browne et al, 2016; Tang & Browne, 2008).

Stereotyping. Negative images of Indigenous people are rampant in society and are often a result of little to no education or exposure to Indigenous history but can have devastating effects. Commonly held stereotypes of Indigenous people include being prone to alcoholism, poverty or low socioeconomic status, social problems, low education, sexual and domestic abuse, violence, criminals, lack of ambition, obesity, teen pregnancy, child neglect, depression and overall poor health (Larson, Herx, Williamson & Crowshoe, 2011; Ly & Crowshoe, 2015; Tang & Browne, 2008). These damaging images are often a result of ignorance, lack of education or little to no exposure to Indigenous issues (Larson et al, 2011; Ly & Crowshoe, 2015). Public health campaigns further contribute to stereotypes by featuring or linking Indigenous people with certain health issues. For example, fetal alcohol spectrum disorder perpetuates the stereotypes of Indigenous women being negligent or uncaring (Tang & Browne, 2008). These negative images

influence both public and professional perceptions of Indigenous people. Medical students in Ly and Crowshoe's study, stated Indigenous people often "live up" to their stereotype, and that stereotypes are in fact rooted in reality (2015). These commonly held stereotypes are a reality, therefore, Indigenous people are more apt to pay attention to non-verbal cues and attribute attitudes and cues to racism and stereotypes of alcoholics, drug addicts or drug-seeking (Browne et al, 2011; Neufeld, 2014). Stereotypes are closely related to processes of racism and discrimination, and contributes to the structural violence experienced by Indigenous people (Ly & Crowshoe, 2015).

Racism and discrimination. Racism and discrimination in health care is complex and often concealed, but remains a lived reality for Indigenous people. Racism in health care is a result of multiple, complex relationships between historical and contemporary racism, colonization, ethnicity, health care policies, structural violence and clinical biases (Allan & Smylie, 2015; Ly & Crowshoe, 2015). Heightened political correctness in society conceals or denies the existence of racism, which makes it challenging to address in health care (Ly & Crowshoe, 2015; Tang & Browne, 2008). The process of racialization influences provider beliefs and attitudes and how they interact with Indigenous people (Ly & Crowshoe, 2015; Tang & Browne, 2008). For example, Indigenous people struggle to find a general practitioner (GP), and believe they are refused based on their belief that they are undesirable patients, have chronic conditions and particularly discriminated against if addictions are involved (Crooks, Agarwal & Harrison, 2012). Acts of discrimination result from inadequate understanding of the historical and political context of Indigenous communities today (Larson et al, 2011). Indigenous people often avoid seeking health care due to racism and discrimination they have experienced personally or from stories of racism that they have heard from others accessing health care and

they therefore, have an expectation of being treated differently (Hole et al, 2015; Tang & Browne, 2008). Racism in the health care system has a direct impact on the attitudes and assumptions of both health care professionals (HCP) and Indigenous people.

Attitudes and assumptions of HCPs and Indigenous people. Health care interactions between Indigenous people and HCPs are influenced by their attitudes and assumptions and stem from inequities, stereotypes and racism. Larson et al. (2011) states, “attitudes incorporate personal belief, conceptions, stereotypical preconceptions, likes and dislikes, willingness towards and barriers against certain behaviours” (page 401). Embedded in this experience is how many research participants often believe the health care provider is making assumptions about them based on their visibility as an Indigenous person (Browne et al, 2011; Tang & Browne, 2008). Some HCPs make the assumption that Indigenous people do not care or do not want to bother managing their health conditions (Ly & Crowshoe, 2015). This assumption links back to the ideal of neoliberalism and *not* the conditions that shape the capacity of how people manage their health. Another commonly held assumption that influences the attitudes of HCPs is that all or most Indigenous people receive unfair advantages, special treatment and unfair practice which is a form of “reverse discrimination” (Ly & Crowshoe, 2015; Tang & Browne, 2008). These assumptions further discriminate against Indigenous people where HCPs believe everyone should be treated the same; a neoliberalist ideal (Tang & Browne, 2008).

These interlocking factors of history, stereotypes, racism, discrimination and assumptions marginalize Indigenous people in the health care system and further perpetuates health inequities (Hole et al, 2015; Tang & Browne, 2008). The on-going effects of colonization and state interference, such as the residential school system, continues to create a barrier to health care and

is closely related to the power inequalities historically and presently experienced by Indigenous people (Allan & Smylie, 2015; Browne et al, 2011; Hole et al, 2015).

Governmental power and authority. Indigenous people are vulnerable to power inequities due to Canada's forced assimilation practices for more than a century (Hole et al, 2015). When encountering HCPs, significant power imbalances exist in the patient-provider relationship (Oster et al, 2014). This power imbalance places the HCP in a position to be judgmental, use scare tactics and the power to determine whether the patient has a legitimate health concern or not (Hole et al, 2015; Neufeld, 2014; Oster et al, 2014). Indigenous people enter the health care system with this fear of being judged or not believed even when their visit is justified (Browne et al, 2011; Hole et al, 2015). Seeking health care can also be deterred when there is a threat of child apprehension. Involvement of the Ministry of Children and Families (MCFD) places Indigenous women in a powerless position where MCFD carry the power to apprehend their children and control the conditions in which they can regain custody (Denison et al, 2013). This added element of power further decreases the accessibility of health care. Browne et al (2011) points out that social suffering places Indigenous people in a position where they are likely to access health care in a greater proportion due to a higher burden of illness. Despite this reality, HCPs often induce fear into the patient or place judgement on the patient for not taking care of themselves (Hole et al, 2015; Neufeld, 2014; Oster et al, 2014). This paternalistic attitude of the current health care system exemplifies power inequalities and further marginalizes Indigenous people and inflicts emotional responses in Indigenous peoples that dictates how and when they seek medical care.

Emotional responses to discrimination in mainstream health care. Certain emotions dominate how Indigenous people experience accessing health care. Fear, shame, blame, self-

blame and guilt were the most common emotions expressed by Indigenous people within mainstream health care (Browne et al, 2011; Neufeld, 2014; Oster et al, 2014; Shahid et al, 2016). Fear was often felt in light of unknown health conditions, not being able to cope with lifestyle changes, judgement and fear of child apprehension (Denison et al, 2013; Neufeld, 2014; Oster et al, 2014). Neufeld states fear is the strongest motivator for not accessing health care (2014). Blame and self-blame were also a common emotion felt as a result of the dominant, neoliberalist attitudes present in society, and often conveyed by HCPs that result in the assumption that Indigenous people are not caring for themselves and are a direct result of their own choices (Browne et al, 2011; Neufeld, 2014; Oster et al, 2016). Similarly, shame and guilt was experienced when the patient was unable to follow the health care recommendations (Neufeld, 2014; Oster et al, 2014; Shahid et al, 2016). These emotions occur within a larger context and are intertwined with many factors associated with social suffering that impacts Indigenous peoples' ability to maintain proper care of self (Browne et al, 2011). The strong emotions invoked in Indigenous people is yet another factor that influences health care access and further highlights the urgent need for culturally appropriate health care.

Culturally appropriate health care is needed. Reflected in the research is the critical need for accessible, culturally appropriate health care. Accessible refers to holistic health care in this context and encompasses Indigenous culture, beliefs and spirituality (Oster et al, 2014; Sherifali et al, 2012). Westernized medicine fails to include traditional methods of healing both spiritually and emotionally (Sherifali et al, 2012). This is evident in hospital rules and policies that do not allow for Indigenous traditions such as smudging or limitations on visitors (Hole et al, 2015). How health education is delivered has also been identified as a barrier to health care. Education provided by mainstream health care does not take into account the unique

circumstances and challenges that many Indigenous people face (Oster et al, 2014). Lack of understanding of the realities of Indigenous personal experiences can place unrealistic expectations on them contributing to non-compliance and reluctance to see a HCP (Hole et al, 2015; Oster et al, 2014). Holistic health care with respect to Indigenous culture and recognition of the variety of challenges Indigenous people face due to intergenerational trauma is critical in the ability to provide accessible, culturally appropriate health care.

Shifting towards cultural safety. Cultural safety is based on respectful interactions between patient and HCP that address power imbalances, and provides a safe environment free of racism and discrimination (FNHA, 2016). A few studies were found that indicate culturally safe health care is possible, built on a trusting relationship between patient and HCP. Forbes et al (2013) reports that HCP's must take the time to build a relationship and understand the history and implications of the residential school system. Respectful interaction between the patient and HCP fostered trust and equal treatment (Hole et al, 2015); even a brief encounter that is supportive and accepting can have lasting effects on how Indigenous people view the health care system (Browne et al, 2011). HCPs that provide patient-centered care remove power imbalances and create an environment to support and empower Indigenous people (Forbes et al, 2013; Oster et al, 2014). This allows for partnership and knowledge sharing in the patient-provider interaction (Forbes et al, 2013). Forbes' research study conflicts with commonly reported Indigenous experiences in health care found in the literature. However, the results lend valuable information on how to model future strategies in addressing the primarily negative experiences of Indigenous people accessing health care.

The factors that influence how Indigenous people access health care are multifaceted and embedded in the historical influence of discriminatory policy that has resulted in structural

violence and health and social inequities. The themes identified are reported separately here, but are interwoven concepts that together provide insight into the multiple, complex processes that intersect and shape the way Indigenous people access health care. Social policies that reflect the political ideal of neoliberalism will perpetuate health disparities and social suffering of Indigenous people, ultimately leading to increased health care costs overall.

Structural violence in health care: What are the implications? Structural violence refers to the social structures and processes present in society that cause harm to individuals or groups of people. Discrimination, individual and institutional racism and social exclusion are all forms of structural violence and have a direct impact on health status and access to health care (Browne et al, 2012; Thompson et al, 2015). Persistent, inaccessible health care has serious implications for Indigenous people and the health care system. This includes poor overall health and growing health disparities of the Indigenous population and an increase in health care utilization with associated higher health care costs. Health inequities contribute to poor population health, and the increasing health disparities result in an increased use of emergent services and hospitalizations (Martin, Smith, Graudins, Braitberg & Chapman, 2013). The lack of effective PHC services means acute and chronic conditions are not being managed appropriately with poor health outcomes and direct implications to the cost and utilization of health care services.

Increased health care utilization. The current barriers to PHC, as experienced by marginalized populations, contribute to high health care costs and perpetuates health inequities. The most socioeconomically deprived populations with complex health issues have the least access to PHC due to underfunding, knowledge gaps and policies that do not address health inequities (Browne et al, 2012). Current health inequities contribute to growing health disparities

and increased health care utilization. The lack of effective PHC results in an increased use of walk-in clinics and emergency room (ER) visits (Crooks et al, 2012; Firestone, Smylie, Maracle, Spiller, O'Campo, 2014; Martin et al, 2013). Similarly, in Oddy et al.'s study, there are higher rates of chest infections and hospitalizations in Indigenous infants and children (2008). In Australia, Indigenous people in one study were also more likely to leave before treatment was started or completed (Martin et al, 2013). However, Martin et al. found no difference in triage, admission rates or length of stay (2013). This does not take into account the personal experiences of Indigenous people or provide an explanation as to the factors that lead to leaving before treatment. The lack of PHC leads to exacerbations of chronic conditions or acute conditions becoming serious requiring an ER visit or hospitalization (Crooks et al, 2012).

Additional issues that can lead to increased health care costs is the lack of preventative care, discontinuous medical records and no HCP to refer for specialists or surgery (Crooks et al, 2012). There is a potential for procedures or diagnostics being unnecessarily repeated or delayed requiring higher level treatment or hospitalization. Increased availability of good PHC reduces admission to hospitals, and those using PHC as their first source of care have lower health expenditures (Thompson et al, 2015). Accessible PHC has the potential to prevent and delay serious health conditions in Indigenous people. Conversely, inaccessibility of PHC will contribute to poor health outcomes.

Poor health outcomes in the Indigenous population. Systemic barriers to PHC are linked to the ever growing research available that demonstrates the increasing morbidity and mortality rates Indigenous people face. As discussed earlier in this paper, a myriad of health care barriers influence health care utilization by Indigenous people with devastating consequences. For example, in Manitoba, the mortality rate for breast cancer and the incidence and mortality

rate of colorectal cancer is higher among Indigenous people and they are more likely to be diagnosed at a later stage, whereas, in the general population, the rates have decreased (Decker et al, 2016). This is only one example of many research studies done with similar findings. The proposed explanation is linked to increased risk factors in Indigenous people, such as, tobacco, alcohol, physical inactivity and obesity (Decker et al, 2016). Risk factors are commonly identified in health research and disease processes, therefore, effective PHC would include prevention, education, health screening and health promotion to address risk factors.

Accessible PHC includes all levels of prevention and is essential to all aspects of health across the lifespan. Another common finding in the research is the observed differences in Indigenous women receiving obstetric services aligned with best practice guidelines compared with the general population. Due to ineffective or inaccessible PHC, appropriate antenatal care is not provided and leads to an increased risk of low birth weight, undetected pregnancy complications and stillbirth (Oddy et al, 2008; Riddell, Hutcheon & Dahlgren, 2016). Riddell et al. found Indigenous women were less likely to have an early ultrasound and at least four antenatal visits (2016). Consequently, Indigenous women have higher rates of stillbirth, neonatal and postnatal mortality (Riddell et al, 2016). These disparities can be attributed to lack of preventative care, decreased provision or quality of care by providers or low uptake of health care by Indigenous people (Crooks et al, 2012; Riddell et al, 2016). Similar findings in the research across all health indicators reflects the lack of effective PHC services for Indigenous people that would provide primary, secondary and tertiary level prevention to detect and manage conditions in a timely manner.

Empirical evidence demonstrates the poor health outcomes for Indigenous people, increased health care utilization and overall health care costs as a result of systemic violence that

leads to inaccessible PHC. To address the staggering health disparities of Indigenous people, approaches must take into account the factors that contribute to this violence and also have the ability to provide quality, competent PHC services.

Nurse practitioners working with marginalized populations. The rising cost of health care and increasing health disparities in Indigenous populations require action. NPs are well prepared to provide PHC service that is socially responsive and combines medical knowledge with nursing philosophy (Archibald & Fraser, 2013; Browne & Tarlier, 2008; DiCenso et al, 2007; Gould, Johnstone & Wasylkiw, 2007; Seale et al, 2005). Culturally safe health care is essential when working with Indigenous populations. NPs are uniquely positioned to meet the health and social challenges of marginalized populations, exercise the use of voice to influence policy makers in addressing the SDH that sustain health inequities, and play a key role in health care reform.

Nurse practitioner's roles within health care reform. Improving PHC is a cornerstone in improving population health and reducing costs overall to the health care system. NPs are one of the solutions to address escalating health care costs and provide preventative care and implement health promotion strategies (Archibald & Fraser, 2013; Browne & Tarlier, 2008; DiCenso et al, 2007). Numerous studies have shown there have been no notable differences in health outcomes between NPs and GPs (Archibald & Fraser, 2013; Seale, Anderson & Kinnersley, 2005). NPs can provide increased points of access to quality health care that is cost-effective and highly valued by patients, families, other HCPs and policy-makers (Archibald & Fraser, 2013; Browne & Tarlier, 2008). Accessible PHC has been shown to improve population health, reduce the risks and effects of acute and chronic conditions, lower ER use and hospital admissions and lower overall health care utilization (Browne et al, 2012). Therefore, NPs are a valuable, cost-effective,

asset in health care reform, and are positioned to work with vulnerable populations and combine medical knowledge and nursing theory to best serve this group.

Nurse practitioner's distinction from medical practice. NPs provide high-quality, competent medical care that is comparable to their GP colleagues, however, they are clearly distinct from medical practice by incorporating nursing philosophy, and often the ability to allow more time with patients. A holistic approach, which is central to nursing philosophy, enables NPs to address physical, social and emotional health and examine how these factors work together, not in isolation (DiCenso et al, 2007; Gould, Johnstone & Wasyliw, 2007; Seale et al, 2005). As advanced practice nurses, NPs use evidence-based practice, combining their medical role with a focus on education, health promotion and the SDH (Archibald & Fraser, 2013). NPs approach to care typically allows a longer visit which includes time to listen to client concerns, provide education on illness, prevention goals and adherence to prescribed regimens (Gould et al, 2007; Seale et al, 2005). NPs spend twice as long with patients and this extra time tends to lead to better outcomes and patient satisfaction (Gould et al, 2007; Seale et al, 2005).

NPs use critical analysis and consider all of the potential issues that impact health (Gould et al, 2007). The socioeconomic status of Indigenous people influences their capacity to follow healthy lifestyles, therefore, addressing these factors is vital in PHC. For example, NPs could use an interdisciplinary plan of care to address other health determinants such as housing, education, finances and mental health issues (Archibald & Fraser, 2013). A socially responsive approach with Indigenous populations is essential in reducing health inequities and thus, closing the gap in health disparities in comparison to the general population.

Nurse practitioners as a socially responsive profession. The influence of neoliberalism in today's health care system has perpetuated health inequities and as a result, marginalized and

vulnerable groups, such as the Indigenous population, carry a disproportionate burden of illness. NPs need to be socially responsive to this trend and view health and health care from a critical social justice perspective (Archibald & Fraser, 2013; Browne & Tarlier, 2008). Social justice is the fair distribution of goods and services that includes health care (Archibald & Fraser, 2013). Using a critical social justice perspective will require NPs to examine the social conditions that contribute and sustain disparities in health and social status (Archibald & Fraser, 2013; Browne & Tarlier, 2008). This broader perspective on health care gives NPs the opportunity to be a socially responsive profession that understands the complex relationship between the SDH in health care delivery and health outcomes (Archibald & Fraser, 2013). This focus on social justice is vital when providing health care to vulnerable and marginalized populations.

NPs have the capacity and potential to provide PHC services using critical social justice approaches at the individual level, and the opportunity to use their professional voice to challenge the social trends that contribute to health inequities in Indigenous populations. As frontline workers with individuals and communities, NPs must address biomedical needs in the context of the reality of Indigenous peoples' lives and examine the factors that shape their capacity to access resources required for healthy living. (Browne & Tarlier, 2008). Furthermore, NPs can make a profound impact in addressing health inequities by using their professional voice and leadership to work against racializing and marginalizing practices in health care, and challenge policies that perpetuate health inequities (Archibald & Fraser, 2013; Browne & Tarlier, 2008). Social justice is an ethical issue that NPs are able to respond to as a profession using critical analysis of the political trends, such as neoliberalism, and work towards decreasing current barriers that have direct implications to vulnerable populations.

Health care strategies in Indigenous populations. Specific strategies and approaches have been identified in the literature to provide guidance in working with disadvantaged populations and increase the capacity and knowledge of HCPs to reduce health and health care inequities. Larson et al stress the importance of education and exposure to Indigenous populations. Ignorance is a result of inadequate understanding of the historical and political context of Indigenous people and thus, training and support is necessary to educate HCPs on the social challenges and institutional racism present in health care (2011).

Browne et al. identify four foundational approaches to reduce health and health care inequities: inequity-responsive care, trauma and violence informed care, contextually-tailored care and culturally competent care (2012). Inequity-responsive care recognizes that the SDH are legitimate health concerns and should be addressed as routine aspects of PHC. Trauma and violence informed care recognizes that most disadvantaged populations are affected and continue to be affected by structural violence and other varying forms of violence and trauma, therefore, health care must be respectful and understanding of the on-going effects of trauma and violence. Contextually-tailored care moves beyond patient-centered care and services are provided in direct relation to the population served and local context. Lastly, Browne et al identify culturally competent care as an essential strategy in reducing health and health care inequities. This entails not only the cultural meaning of health and illness but includes how racism, discrimination and marginalization affect disadvantage populations health, life opportunities and access to health care (2012). Denison et al. expand on the concept of culturally competent care to include cultural safety as it brings attention to existing power imbalances and how these influence peoples' health (2013). These strategies must incorporate the historical and ongoing forms of structural violence

and discrimination that continue to shape Indigenous peoples health and access to health care (Browne et al, 2016).

In the wake of health care reform, NPs are a cost-effective solution to provide quality, holistic PHC to vulnerable and marginalized populations from a social justice perspective to challenge health and social policies that contribute to inequities.

Discussion and Recommendations

This literature review aimed to understand the factors that influence how Indigenous people experience access to health care in the context of overwhelming health disparities that far exceed the rest of the Canadian population (Health Canada, 2009). The negative experiences or barriers Indigenous people face are complex and multifaceted. The research studies indicate that health care experiences are still a reflection of the intergenerational colonial legacy, intertwined with power inequalities, negative emotions and lack of culturally appropriate health care (Browne et al, 2011; Forbes et al, 2013; Hole et al, 2015; Oster et al, 2014; Neufeld, 2014; Shahid et al 2016; Sherifali et al, 2012). Within the studies, a few positive interactions were reported that provide examples of health care that is culturally safe and patient-centered (Forbes et al, 2013). The interactions reported demonstrate that it is possible to impact how Indigenous people view health care simply by providing respectful care (Browne et al, 2012). Utilizing the strategies identified have the potential to minimize many of the barriers to health care access Indigenous people face (Browne et al, 2012; Denison et al, 2013; Larson et al, 2011). Acknowledgement of the numerous negative experiences and also the positive interactions reported are essential for knowledge translation, education of HCPs and have direct implications to NP practice.

The second aim of this literature review was to examine the implications of persisting health and health care inequities in the Indigenous population and the health care system. There is an abundance of research studies that demonstrate the greater burden of disease that Indigenous people carry with similar results that indicate the desperate need for effective PHC to be implemented in all levels of prevention. Research shows the growing health disparities in the Indigenous population, and without effective initiatives to address the health inequities, an assumption can be made that this trend will continue. Furthermore, the implications to the economy is affected with potentially avoidable ER usage and hospitalization and overall increased health utilization by marginalized groups who lack PHC.

Finally, this literature review examined how a NP could provide accessible PHC services to Indigenous people and start to bridge the gap between Indigenous people and the general population. NPs are positioned to provide high-quality, competent, socially responsive health care to the Indigenous population. Firstly, NPs can provide culturally safe health care and follow a patient-centered model of care that eliminates power imbalances in the patient-provider relationship and in turn creates health care that is accessible. Secondly, to see improvements in the health status of Indigenous people, prevention measures must be provided through education, awareness, screening, monitoring and timely interventions that can be provided by a NP. Accessible, culturally safe health care and prevention services must coexist to have any positive outcomes on Indigenous experiences or health status. If the service is not accessible or culturally safe, Indigenous people will not seek health care. Furthermore, if the prevention services are not provided to them, then health status cannot improve. As a final piece of the puzzle, NPs must assume a critical social justice lens to identify the social conditions that limits the ability of Indigenous people to live a “healthy” life. NPs must also critically examine the social trends that

perpetuate health inequities, and with the use of their professional voice, challenge those policies that contribute to health disparities.

The findings of this literature review provided valuable insights to the experiences of Indigenous people accessing the current health care system, the implications of non-responsive health care, and how NPs are positioned to provide effective PHC. However, there are gaps in the literature identified that should guide further research studies.

Many of the research studies identified in the literature either included Indigenous people in general, or were specific to Indigenous women. Research is needed that focuses on how Indigenous men access health care, as the experiences would be vastly different than the challenges women face and would reveal valuable insight in reaching this part of the population. Further research also needs to focus on successful strategies or initiatives, giving evidence of success and to guide PHC towards effective implementation.

The environmental scan revealed inconsistent data but was able to give a general overview of the urban Indigenous population residing in FHA and VCH. Relatively accurate numbers are reported for Status Indians living on or off-reserve. However, the urban Indigenous population is difficult to quantify. Even so, culturally safe PHC services directed at Indigenous health and health care issues is essential in highly populated areas of VCH (downtown east side, North Vancouver) and FHA (Surrey and Eastern FH, excluding Chilliwack area). Once FHA's new NP positions are filled, this will address some of the gaps in culturally safe PHC available to the urban Indigenous population. Furthermore, Squamish Nation, Kwikwetlem, Katzie FN, Tsawwassen FN and Semiahmoo FN are lacking on-reserve PHC services that are currently being offered to other Bands. Collaboration and communication is crucial between the local

Bands, FNHA and the local health authorities to address the gaps in service and ensure accessible PHC services are available to the urban Indigenous population.

Across Canada, Indigenous communities are at varying levels of health services transfer agreements which gives the communities autonomy in allocating health resources (Health Canada, 2013). Quantitative studies are needed to demonstrate if there are any improvements in health outcomes for Indigenous people with increased autonomy. Lavoie et al (2010) did a quantitative study in Manitoba, Canada that found Indigenous communities with local autonomy had lower rates of hospitalizations that continued to decline with each year since signing such an agreement. Also, those communities with local access to primary health services had lower rates of hospitalizations. Further research is desperately needed to show positive outcomes and accountability to stakeholders. For example, another initiative in Canada's Indigenous communities is the Children's Oral Health Initiative (COHI) that was implemented to address the challenges of dental caries in early childhood and increase access to preventative oral health on-reserve. Dental therapists and hygienists provide on-going, preventative dental care and a COHI aide was trained from the community to provide continuing education on-site. This initiative started with 41 communities across Canada and in 10 years, now provides service in 320 Indigenous communities (Mathu-Muju, McLeod, Walker, Chartier, & Harrison, 2016). Further research is necessary to report successful initiatives, such as COHI, and justify the cost to stakeholders and potential overall cost savings to the health care system.

Often in Indigenous communities, positive outcomes are only visible in the long-term and can be challenging to acquire funds to implement without empirical data. In Australia, the Aboriginal Community Controlled Health Services (ACCHS) model of service delivery is used across the country (Thompson et al, 2015). ACCHS delivers holistic, comprehensive, culturally

appropriate PHC that is delivered by the local Indigenous community. Thompson et al. states measures of effectiveness cannot be directly compared to other PHC in general, and must be interpreted in consideration of the socioeconomic challenges. Measures should not be restricted to biomedical indicators, but should include a broad range of indicators to measure success (2015). In Canada, there are similar challenges with funding and providing empirical evidence to indicate success. For example, reporting should include other determinants of health, such as employment, housing and education, and be considered on an equally important scale as biomedical indicators.

Further research is urgently needed to include social aspects of health alongside biomedical indicators with dissemination of findings to key stakeholders in Indigenous health. Empirical evidence to support positive outcomes in both health and social status for Indigenous people is critical for appropriate allocation of resources to address health and health care inequities.

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Appendix

March 31, 2017

Dear Xxxx Xxxxxx:

I am graduating in June 2017 with my Master of Nursing: Nurse Practitioner degree from the University of British Columbia. I expect to be well positioned as a qualified, Indigenous nurse practitioner to provide primary health care, specifically targeting Indigenous health and the current challenges Indigenous people face when accessing health care. I am writing to express my strong interest in a position with Xxxxx Health Authority working with the urban Indigenous population.

At every opportunity while completing my Master's Degree, my focus was on Indigenous health. Of particular importance, my final culminating project examined the factors that influence how Indigenous people access health care and the implications of persistent, inaccessible health care. The factors identified are multifaceted and embedded in the historical influence of discriminatory policy that has resulted in structural violence and health and social inequities. I have gained valuable insight into the multiple, complex processes that intersect and shape the way Indigenous people access health care. As a nurse practitioner, I will address the factors identified to provide primary health care that is equitable, socially responsive, culturally safe and specific to Indigenous people, and acknowledges the social and systemic barriers that stem from their historical context.

I also completed an environmental scan of the urban Indigenous population residing in Fraser Health Authority and Vancouver Coastal Health Authority. Based on the environmental scan, Squamish Nation, Kwikwetlem, Katzie FN, Tsawwassen FN and Semiahmoo FN are not receiving primary health care equitably compared with other Bands in Fraser Health and Vancouver Coastal Health Authority.

I am uniquely positioned to be able to meet the current needs of the urban Indigenous population as a person of Indigenous descent from Nakazdli First Nation combined with many years of nursing experience with Katzie First Nation. I had the extraordinary opportunity to observe the strength and resilience of the Indigenous population as well as the current health challenges, health inequities and poor access to health care that Indigenous people face. I will integrate holistic nursing philosophy with medical knowledge, and have the authority and autonomy to provide primary health care services in a culturally safe manner to the Indigenous population.

The chance to join your organization would be a tremendous opportunity. I believe that my academic and professional training, combined with my passion and dedication, make me a strong candidate for a position as a nurse practitioner in Indigenous health. I hope that you will allow me the chance to speak with you in person about the possibility of joining your organization. Thank you for your time and consideration and I would welcome the opportunity to speak with you further.

Sincerely,
Michelle Sam, RN, BScN