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A PROGRAM FOR RESEARCH ON

SOCIAL AND ECONOMIC DIMENSIONS OF AN AGING POPULATION

Older Aboriginal Peoples in Canada
Demographics, Health Status and Access to Health Care

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Requests for further information may be addressed to:
Secretary, SEDAP Research Program
Kenneth Taylor Hall, Room 426
McMaster University
Hamilton, Ontario, Canada
L8S 4M4
FAX: 905 521 8232
e-mail: sedap@mcmaster.ca

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OLDER ABORIGINAL PEOPLES IN CANADA – DEMOGRAPHICS, HEALTH STATUS AND ACCESS TO HEALTH CARE[*]

By

Dr. Mark W. Rosenberg[1], Dr. Kathi Wilson[2], Dr. Sylvia Abonyi[3], Adam Wiebe[4] and Kelsey Beach[5]
with Robert Lovelace[6]

1. Department of Geography, Department of Community Health and Epidemiology, Queen's University, Kingston, Ontario, Canada, K7L 3N6, mark.rosenberg@queensu.ca.
2. Department of Geography, University of Toronto Mississauga, 3359 Mississauga Road, Mississauga, Ontario, Canada, L5L 1C6, kathi.wilson@utoronto.ca
3. Department of Community Health and Epidemiology, University of Saskatchewan, 107 Wiggins Road, Saskatoon, Saskatchewan, S7N 5E5, sylvia.abonyi @usask.ca.
4. Department of Community Health and Epidemiology, University of Saskatchewan, 107 Wiggins Road, Saskatoon, Saskatchewan, S7N 5E5.
5. Department of Geography, Queen's University, Kingston, Ontario, Canada, K7L 3N6
6. Department of Global Development Studies, Queen's University, Kingston, Ontario, Canada, K7L 3N6

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Abstract

This paper takes advantage of 2006 Census data, the Aboriginal Peoples Survey (APS) and the Canadian Community Health Survey (CCHS) to highlight some basic demographic trends among Older Aboriginal Peoples, their health status and their use of health services in the first part of this paper. In the second part of the paper, we connect the findings to what has been specifically written about Older Aboriginal Peoples, their health status and use of health services. Not surprisingly both the data analysis and literature are limited because the preponderance of data, analyses and the literature have focused on younger Aboriginal Peoples. In essence, this underscores the need for more in-depth research on Older Aboriginal Peoples as the demographics and health status of Aboriginal Peoples.

Résumé

Ce document exploite les données du Recensement de 2006, de l'Enquête auprès des peuples autochtones (EAPA) et de l'Enquête sur la santé dans les collectivités canadiennes (ESCC) afin de mettre en évidence, dans un premier temps, certaines tendances démographiques des ainés des peuples autochtones, leur état de santé et leur utilisation des services de santé. Dans un deuxième temps, nous mettons en relation les résultats de notre analyse avec la littérature existante. Il n'est pas surprenant que les données et leur analyse ainsi que la littérature disponible soient limitées car ces dernières se sont surtout focalisées sur l'étude des jeunes Autochtones. En substance, ce document souligne la nécessité d'entreprendre des recherches plus approfondies sur les aînés.

Key Words : Older Aboriginal Peoples, First Nations, Inuit, Metis, health, health care, demographics

JEL Classification : I10

Introduction

Older Aboriginal Peoples have received little attention either in academic research or public policy forums. The main explanation for this oversight is that most researchers and policy-makers continue to see Aboriginal Peoples as a demographically young population and are focused on the high profile challenges that younger Aboriginal Peoples face. While the challenges facing younger Aboriginal Peoples must be a priority, paradoxically success in addressing the issues facing younger cohorts means that the number and relative size of the older age cohorts of Aboriginal Peoples will continue to grow in the future raising a new set of policy and service challenges for Aboriginal Peoples and the non-Aboriginal population as well.

The lack of research on Older Aboriginal Peoples to date needs also to be seen within the context of the general expansion of research on Aboriginal Peoples as evidenced by growth in importance of publications such as *Canadian Journal of Native Studies* founded in 1981, *Native Studies Review* founded in 1984, the publication of such seminal works *Aboriginal Health in Canada* (Waldram et al., 1995) and the *Statistical Profile of First Nations in Canada* (Health Canada, 2003). A search of *Web of Science* – Social Science Section between 1995 and 2005 generated 111 articles on Aboriginal health, but only 3 focused on Older Aboriginal Peoples. The lack of research on Older Aboriginal Peoples has led Buchignani and Armstrong-Esther (1999, p.7) to comment that "major reports on older Native people continue to be based almost entirely on anecdotal evidence." A key focus of the paper is to summarize what has been previously published and examine some basic statistical relationships from the 2006 Census, the 2001 Aboriginal Peoples Survey (APS) and the Canadian Community Health Survey (CCHS) Cycle 1.1.

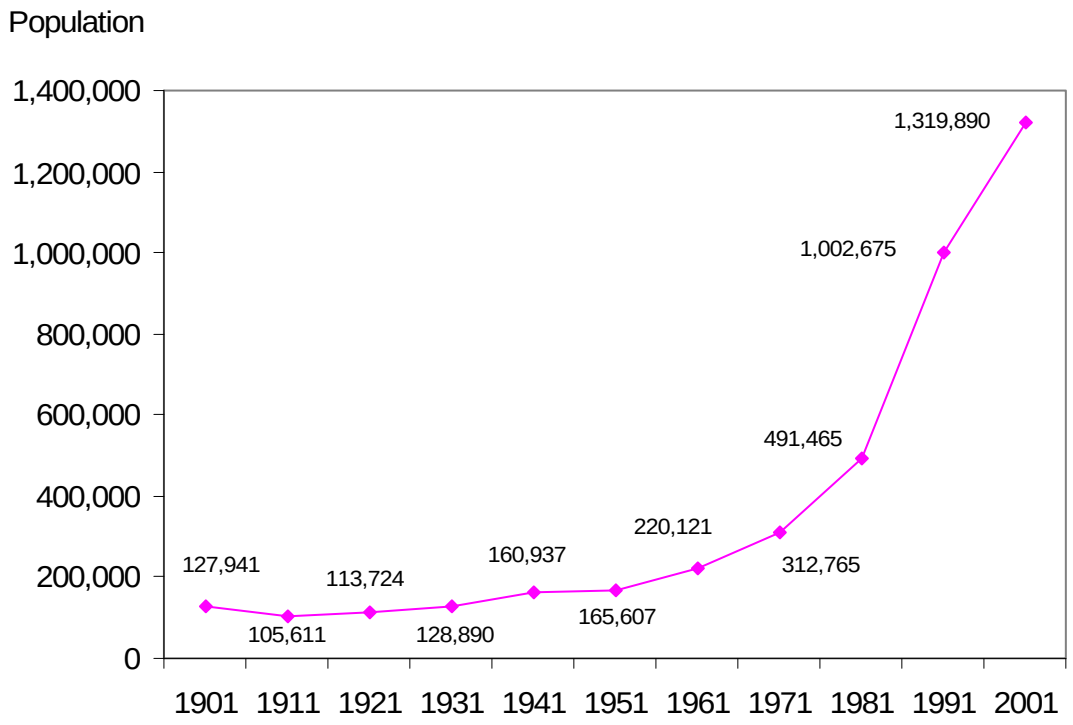
The remainder of the paper is divided into three parts. Part One takes advantage of the recently released but limited data from the 2006 Census to provide some basic demographic information about Older Aboriginal Peoples in contrast to younger Aboriginal Peoples and the non-Aboriginal population. Part Two, relies on data from the APS (2001) and the CHS Cycle 1.1, and compares differences in health status and health care utilization of Aboriginal and non-Aboriginal older populations. Part Three uses a review of existing literature to highlight issues and challenges in improving the health outcomes of older Aboriginal Peoples as we move forward.

Part One – The Demographics of Older Aboriginal Peoples in Canada

In keeping with the general distinction normally drawn between younger and older persons in demographic analyses, the focus in this section is mainly on the population aged 65 and over, but in some instances we include information on Aboriginal Peoples aged 55 and over to show what will likely change in the near future.

Statistics Canada draws a distinction between Aboriginal ancestry (people who identified having an Aboriginal ancestor) and Aboriginal identity, people who identified themselves either as North American Indian, Métis or Inuit. In the recently released 2006 Census, 1,172,785 individuals identified themselves as Aboriginal Peoples or 3.8 per cent of the total population of Canada.

Figure 1 – Growth in the Aboriginal Population 1901 to 2001 using the Aboriginal Ancestor Definition



Source: Statistics Canada, 2001 http://www12.statcan.ca/english/census01/Products/Analytic/companion/abor/canada.cfm

Figure 1 using the Aboriginal Ancestor definition highlights the trend in the growth of the Aboriginal Population between 1901 and 2001.

Of those who answered the Aboriginal identity question, 81,095 are between the ages of 55 and 64 (6.9% of the total Aboriginal population) and 56,460 are aged 65 and over (4.8% of the total Aboriginal population). Between 2001 and 2006, the 55 to 64 age

cohort had the largest percentage increase of any age cohort among the Aboriginal population (53.8 %) followed by the 45 to 54 age cohort (48.9%). The aged 65 and over cohort increased by 43.0 per cent. Looking at the sex ratio as expressed as females to males, in the 55 to 64 cohort, the ratio is 1.06 while in the aged 65 and over cohort, the ratio is 1.20. No doubt if the age cohorts beyond 65 and over could be disaggregated, the relative size of older female to male Aboriginal persons would be even more apparent.

Geographically, across most of the provinces (but not the northern Territories) the data look much the same as the national data (see Tables 1, 2 and 3). A key issue for Older Aboriginal Peoples is gaining access to services. Generally, there is likely to be more services, more specialized services, and better access to them in urban areas than in rural areas.[2] For example, there will be more physicians, more specialists, and better geographic access to hospitals in urban areas than in rural areas. As an indicator of the growing urban Aboriginal population in general and urban Older Aboriginal Peoples, Table 4 looks at the percentage of Aboriginal Peoples and Older Aboriginal Peoples living in census metropolitan areas (CMAs) and census agglomeration areas (CAs) in 2006. Almost 53 per cent of the Aboriginal population lived in CMAs or CAs in 2006. Over half of every age cohort except the youngest and oldest age cohorts lived in CMAs or CAs. Among Older Aboriginal Peoples, 48.3 per cent lived in CMAs or CAs in 2006, but in the age cohort, 55 to 64, the percentage jumps to almost 52 per cent. It is reasonable to expect that in the coming decades even the youngest and oldest age cohorts will become increasingly urbanized populations.

In sum, the Aboriginal population in general remained a demographically younger population in comparison to the non-Aboriginal population (median age of 26.5 years for the Aboriginal population in comparison to a median age of 39.2 years for the non-Aboriginal Population) in 2006. Within the Aboriginal population, what is changing is the relative size of the elderly population where Older Aboriginal Peoples were among the fastest growing age cohorts between 2001 and 2006 and their relative size in relation to the rest of the Aboriginal population is likely to continue to grow given the growth in age cohorts that are now 55 to 64 and 45 to 54. Similar to the non-Aboriginal population, female numbers dominate male numbers among Older Aboriginal Peoples. Geographically, to a large extent these demographic trends are occurring across Canada, and the growing urban nature of the Aboriginal population in general and Older Aboriginal Peoples will need to be taken into account in the coming decades.

[2] This does not necessarily imply that the services in urban areas will be more culturally sensitive to the needs of Older Aboriginal Peoples.

Table 1 - Population by age groups, sex and Aboriginal identity groups, 2006 counts, for Canada, provinces and territories - 20% sample data

Geographic name	Total	Age groups								Median age
		0 to 14	15 to 24	25 to 34	35 to 44	45 to 54	Total - 25 to 54	55 to 64	65 and over	
Canada	**1,172,785**	**348,900**	**212,010**	**161,570**	**169,465**	**143,285**	**474,320**	**81,095**	**56,460**	**26.5**
Newfoundland and Labrador	23,455	5,400	4,220	3,035	3,680	3,390	10,105	2,180	1,545	32.3
Prince Edward Island	1,730	600	275	235	230	210	675	105	70	24.1
Nova Scotia	24,175	6,305	4,335	3,220	3,630	3,520	10,370	1,935	1,230	29.5
New Brunswick	17,650	4,450	2,935	2,200	2,870	2,645	7,715	1,445	1,105	31.5
Quebec	108,425	27,520	17,785	14,435	16,005	14,775	45,220	9,915	7,990	31.1
Ontario	242,495	64,325	40,880	33,680	37,935	33,720	105,335	19,335	12,620	29.7
Manitoba	175,395	58,195	32,160	23,830	23,715	19,220	66,765	10,940	7,340	23.9
Saskatchewan	141,890	50,595	28,090	19,350	17,825	13,685	50,860	7,110	5,230	21.7
Alberta	188,365	58,620	36,200	28,745	26,530	20,435	75,715	10,700	7,130	24.8
British Columbia	196,075	55,250	34,815	25,610	29,620	26,430	81,655	14,420	9,930	28.1
Yukon Territory	7,580	2,065	1,250	985	1,230	1,050	3,270	580	420	30.1
Northwest Territories	20,635	6,170	3,875	2,770	3,010	2,345	8,130	1,330	1,125	26.0
Nunavut	24,915	9,410	5,190	3,475	3,185	1,855	8,515	1,100	705	20.1

Aboriginal Peoples Highlight Tables. 2006 Census. Statistics Canada Catalogue no. 97-558-XWE2006002. Ottawa. Released January 15, 2008.

http://www12.statcan.ca/english/census06/data/highlights/aboriginal/index.cfm?Lang=E (accessed March 27, 2008).

Table 2 - Population by age groups, sex and Aboriginal identity groups, percentage distribution (2006), for Canada, provinces and territories - 20% sample data

Geographic name	Total	Age groups							
		0 to 14	15 to 24	25 to 34	35 to 44	45 to 54	Total - 25 to 54	55 to 64	65 and over
Canada	**100.0%**	**29.7%**	**18.1%**	**13.8%**	**14.4%**	**12.2%**	**40.4%**	**6.9%**	**4.8%**
Newfoundland and Labrador	100.0%	23.0%	18.0%	12.9%	15.7%	14.5%	43.1%	9.3%	6.6%
Prince Edward Island	100.0%	34.7%	15.9%	13.6%	13.3%	12.1%	39.0%	6.1%	4.0%
Nova Scotia	100.0%	26.1%	17.9%	13.3%	15.0%	14.6%	42.9%	8.0%	5.1%
New Brunswick	100.0%	25.2%	16.6%	12.5%	16.3%	15.0%	43.7%	8.2%	6.3%
Quebec	100.0%	25.4%	16.4%	13.3%	14.8%	13.6%	41.7%	9.1%	7.4%
Ontario	100.0%	26.5%	16.9%	13.9%	15.6%	13.9%	43.4%	8.0%	5.2%
Manitoba	100.0%	33.2%	18.3%	13.6%	13.5%	11.0%	38.1%	6.2%	4.2%
Saskatchewan	100.0%	35.7%	19.8%	13.6%	12.6%	9.6%	35.8%	5.0%	3.7%
Alberta	100.0%	31.1%	19.2%	15.3%	14.1%	10.8%	40.2%	5.7%	3.8%
British Columbia	100.0%	28.2%	17.8%	13.1%	15.1%	13.5%	41.6%	7.4%	5.1%
Yukon Territory	100.0%	27.2%	16.5%	13.0%	16.2%	13.9%	43.1%	7.7%	5.5%
Northwest Territories	100.0%	29.9%	18.8%	13.4%	14.6%	11.4%	39.4%	6.4%	5.5%
Nunavut	100.0%	37.8%	20.8%	13.9%	12.8%	7.4%	34.2%	4.4%	2.8%

Aboriginal Peoples Highlight Tables. 2006 Census. Statistics Canada Catalogue no. 97-558-XWE2006002. Ottawa. Released January 15, 2008.

http://www12.statcan.ca/english/census06/data/highlights/aboriginal/index.cfm?Lang=E (accessed March 27, 2008).

Table 3 - Population by age groups, sex and Aboriginal identity groups, percentage change (2001 to 2006), for Canada, provinces and territories - 20% sample data

Geographic name	Total	Age groups							
		0 to 14	15 to 24	25 to 34	35 to 44	45 to 54	Total - 25 to 54	55 to 64	65 and over
Canada	**20.1%**	**7.6%**	**25.4%**	**8.9%**	**16.1%**	**48.9%**	**21.5%**	**53.8%**	**43.0%**
Newfoundland and Labrador	24.9%	6.9%	17.2%	3.9%	22.7%	48.6%	23.2%	107.1%	77.1%
Prince Edward Island	28.6%	34.8%	17.0%	48.4%	39.4%	16.7%	33.7%	23.5%	- 6.3%
Nova Scotia	42.1%	16.7%	44.5%	18.2%	47.9%	84.3%	46.2%	131.1%	83.6%
New Brunswick	3.9%	- 9.0%	4.1%	- 16.8%	1.1%	36.0%	3.8%	32.6%	46.4%
Quebec	39.4%	19.2%	41.9%	24.9%	34.7%	63.4%	39.2%	88.0%	82.2%
Ontario	28.3%	14.8%	32.5%	17.1%	19.0%	61.2%	29.2%	62.0%	46.6%
Manitoba	16.8%	7.5%	23.5%	4.0%	13.8%	44.3%	17.0%	47.6%	32.4%
Saskatchewan	9.0%	- 1.8%	17.2%	2.5%	9.0%	38.4%	12.8%	32.3%	24.1%
Alberta	20.3%	8.7%	26.0%	14.1%	18.4%	45.8%	22.9%	48.7%	39.5%
British Columbia	15.3%	6.2%	21.1%	0.5%	7.4%	40.0%	13.5%	41.7%	37.1%
Yukon Territory	15.8%	4.6%	22.0%	10.0%	0.0%	57.1%	17.0%	43.2%	20.3%
Northwest Territories	10.2%	- 3.1%	18.1%	2.6%	11.9%	40.0%	15.1%	35.5%	9.8%
Nunavut	9.7%	0.3%	23.0%	- 1.8%	23.2%	25.3%	12.0%	22.9%	12.8%

Source: Aboriginal Peoples Highlight Tables. 2006 Census. Statistics Canada Catalogue no. 97-558-XWE2006002. Ottawa. Released January 15, 2008.

http://www12.statcan.ca/english/census06/data/highlights/aboriginal/index.cfm?Lang=E (accessed March 27, 2008).

Table 4: Population by age groups sex and Aboriginal identity groups 2006 counts for Canada and census metropolitan areas and census agglomerations - 20% sample data

	Total	0 to 14	15 to 24	25 to 34	35 to 44	45 to 54	Subtotal 25 to 54	55 to 64	65 and over
Canada	1172785	348900	212010	161570	169465	143285	474320	81095	56460
CMAs & CAs	620915	173270	113335	92050	93585	79195	264970	41900	27285
% of Total	52.9	49.7	53.5	57.0	55.2	55.3	55.9	51.7	48.3

Source: Aboriginal Peoples Highlight Tables. 2006 Census. Statistics Canada Catalogue no. 97-558-XWE2006002. Ottawa. Released January 15 2008.

Part Two - Older Aboriginal Peoples: Health Status and Health Care Utilization

Considerable disparities exist between both the health status and health care utilization of Aboriginal Peoples and the rest of the Canadian population. Drawing on micro-data files from the Canadian Community Health Survey Cycle 1.1 (2001) and the Aboriginal Peoples Survey (2001) the following section reveals how these differences vary for older age cohorts.[3]

Health Status

Figure 1 compares the self-assessed health responses from the two surveys.[4] Both Aboriginal and non-Aboriginal populations show a similar relationship between age and an increased likelihood of self reporting "poor/fair" health. Even though the gap between the Aboriginal and non-Aboriginal population appears to decline with age, Aboriginal Peoples remain more likely than non-Aboriginal people to indicate "poor/fair" health in every age cohort.

Figure 1: Older Aboriginal and Non-Aboriginal Populations Reporting Poor/Fair Health Status

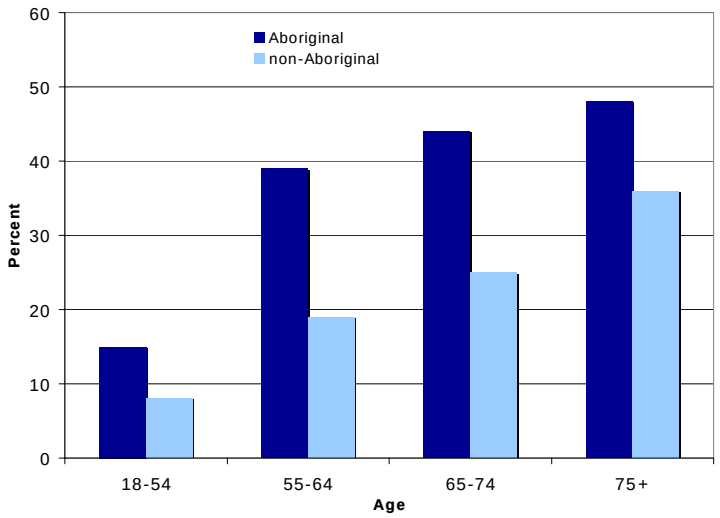


Table 1 reports the prevalence of reported chronic conditions. Again, the number of chronic conditions reported increases with age for both Aboriginal and non-Aboriginal populations, but Aboriginal Peoples are generally more likely to report more chronic conditions than the comparable non-Aboriginal population.

[3] These datasets were accessed through the McMaster University Research Data Centre – Statistics Canada-SSHRC Program.

[4] Both surveys asked respondents: "Compared to other people your age would you rate your health as excellent, very good, good, fair or poor?"

Table 1: Total Number of Chronic Conditions Reported by Older Aboriginal and Non-Aboriginal Populations Compared (%)

Chronic Conditions		18-54	55-64	65-74	75+
None	Aboriginal	60	26	16	15
	non-Aboriginal	72	42	28	21
1	Aboriginal	23	27	26	23
	non-Aboriginal	21	34	33	31
2	Aboriginal	10	19	20	22
	non-Aboriginal	5	15	23	26
3+	Aboriginal	7	28	38	41
	non-Aboriginal	2	9	16	23

The prevalence of specific chronic conditions presents a more complex picture. As seen in Table 2, the prevalence rates for a wide variety of conditions are higher for Aboriginal Peoples than for the non-Aboriginal population. The only exception is the 75+ cohort in which the prevalence of cancer is higher for the non-Aboriginal population than for Aboriginal Peoples. The reason for this anomaly remains unknown but the lumping together of all cancers likely masks a number of critical differences in comparing Older Aboriginal Peoples and the non-Aboriginal population.

Table 2: Older Aboriginal and non-Aboriginal Populations Reporting the Prevalence of Specific Conditions (%)

		18-54	55-64	65-74	75+
Diabetes	Aboriginal	6	21	26	23
	non-Aboriginal	2	9	13	13
Arthritis	Aboriginal	17	46	56	54
	non-Aboriginal	9	30	40	47
Cancer	Aboriginal	2	6	9	5
	non-Aboriginal	0.8	4	5	7
Stroke	Aboriginal	1	6	7	18
	non-Aboriginal	0.3	1	3	7
Heart Disease	Aboriginal	5	18	23	36
	non-Aboriginal	2	9	18	26
Stomach Problems	Aboriginal	10	17	18	15
	non-Aboriginal	3	4	4	5

		18-54	55-64	65-74	75+
Asthma	Aboriginal	11	13	13	11
	non-Aboriginal	8	7	7	7
Chronic Bronchitis	Aboriginal	5	12	8	11
	non-Aboriginal	2	4	5	6
Emphysema	Aboriginal	3	11	13	13
	non-Aboriginal	0.4	2	3	4

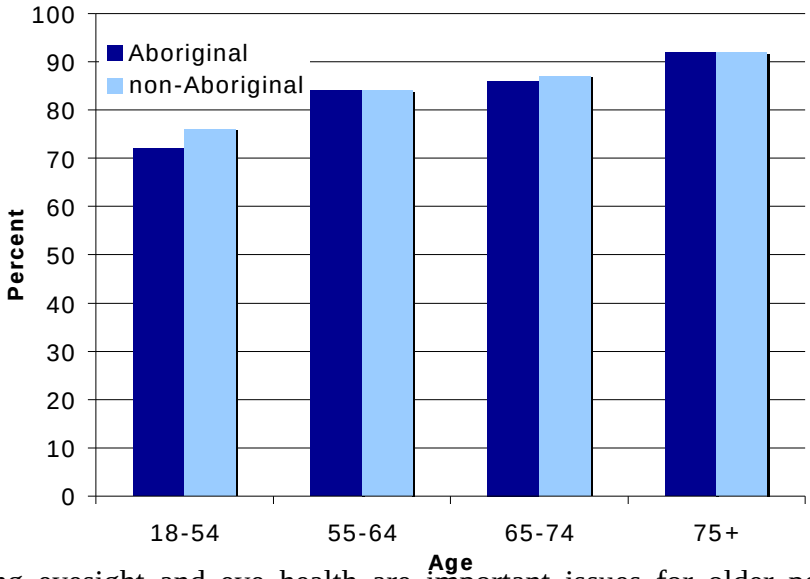
As one might expect, the prevalence rates for most conditions increase with age for both Aboriginal Peoples and the non-Aboriginal population. Similar to the results on self-assessed health, the gap between Aboriginal Peoples and non-Aboriginal population appears to narrow with age. Much more research is, however, needed if these trends are to be fully understood for Older Aboriginal Peoples at the disease-specific level.

Health Service Utilization

Three questions related to health utilization are comparable between the CCHS (2001) and APS (2001). These are whether individuals visited a physician in the previous 12 months prior to being surveyed, whether they visited an eye doctor in the previous 12 months prior to being surveyed, and whether they visited a nurse in the previous 12 months prior to being surveyed.

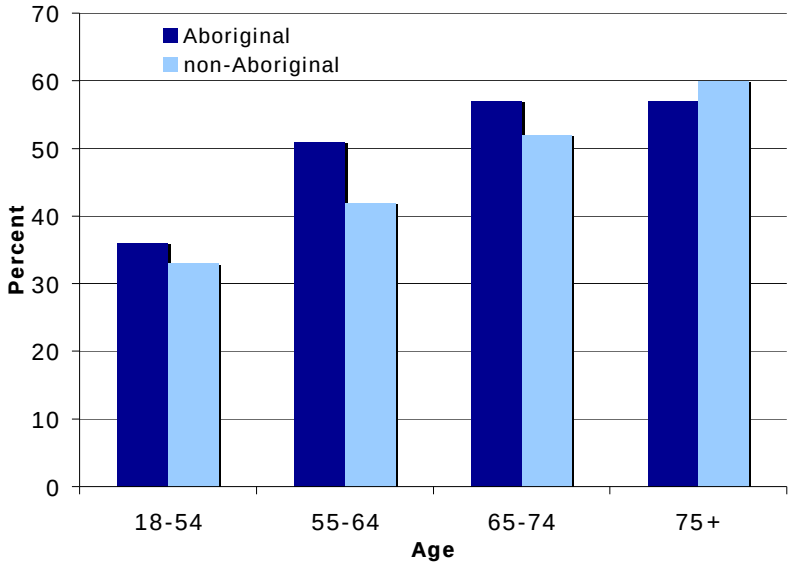
Figure 2 suggests that there is little difference between the utilization of healthcare by Aboriginal Peoples and the non-Aboriginal population in all age cohorts as measured by whether someone visited a physician within the past 12 months. These results should be read with caution since significant differences exist in comparing urban and rural utilization rates, frequency of visits, whether the visits are to a general practitioner or specialist, and whether the visits take into account cultural differences.

Figure 2: Visited a Physician within the Past 12 Months



Declining eyesight and eye health are important issues for older people in general, and are especially critical among Older Aboriginal Peoples where high rates of diabetes result in poor eye health. Figure 3 illustrates that significant differences exist between the utilization of this aspect of health care by older Aboriginal Peoples and their non-Aboriginal counterparts. Older Aboriginal People are accessing eye care more frequently than the non-Aboriginal population in all age groups except for the 75+ cohort. Whether these differences reflect differences in eye health or public funding of eye care for Aboriginal Peoples in younger age cohorts that might not exist for the non-Aboriginal population, more research is needed to understand these numbers.

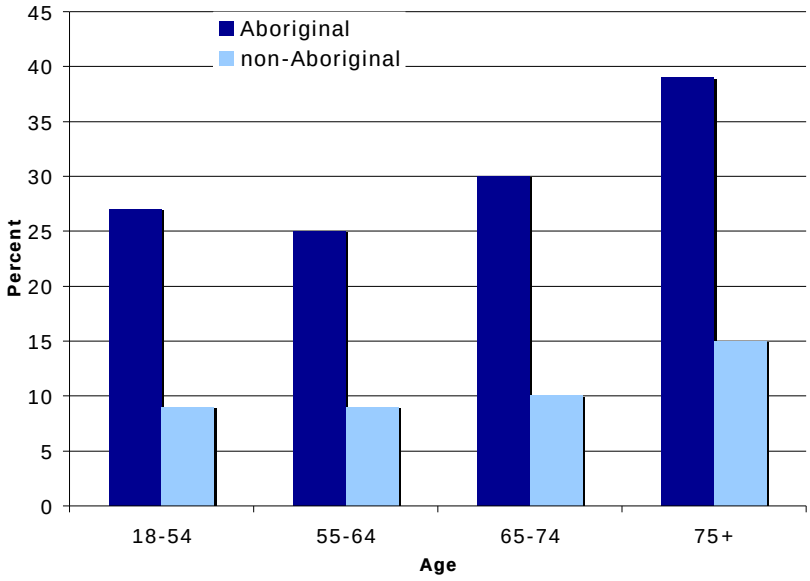
Figure 3: Visited an Eye Doctor within the Past 12 Months



The most notable difference in the health care utilization of Aboriginal Peoples and the non-Aboriginal population is in the use of nurses. Figure 4 shows that in all age categories Aboriginal Peoples are several times more likely to have visited a nurse in the past 12 months. This may be due in part to rural and on-reserve health centres being much more likely to be staffed by full-time nurses than by physicians and the discounting of nurse-patient interactions by the non-Aboriginal population.

Although the same general relationship between poor health and age exist for both Aboriginal Peoples and the non-Aboriginal population, older Aboriginal Peoples appear to suffer poorer health and have higher rates of many conditions than their non-Aboriginal counterparts. In this light, the challenges in health care provision are likely to become more acute as the number of Older Aboriginal Peoples continues to grow and the rate of growth increases.

Figure 4: Visited a Nurse within the Past 12 Months



Part 3 - Issues and Obstacles in the Provision of Health Care for Aboriginal Seniors

Older Aboriginal Peoples face a variety of unique health care issues not adequately addressed within existing literature on Aboriginal Peoples and the elderly. With many Older Aboriginal Peoples living in rural and remote geographies, common concerns about the quality and accessibility of formal healthcare are particularly amplified within this group. In all locations, higher rates of Older Aboriginal Peoples who are monolingual Aboriginal language-speaking complicate the interface between Older Aboriginal patients and their largely non-Aboriginal health care providers. Most noteworthy are cultural differences related to aging, medical treatment, and death that more frequently exist between Older Aboriginal Peoples and their healthcare providers. These differences affect not only the quality of healthcare available to Older Aboriginal Peoples but it also reduces their access to any formal services that are available. All of these factors have led to increased consideration of the role of informal homecare within Aboriginal communities. Unfortunately, the hollowed out demographic profile of many Aboriginal communities often makes it difficult to secure adequate homecare in their home communities leaving a growing number of Older Aboriginal Peoples with difficult choices about how to meet their healthcare needs.

Rural and Remote Geographies

With many Aboriginal Peoples living in remote and rural areas of the country, access to healthcare can be particularly problematic given the growing needs of Older Aboriginal Peoples. Given that formal healthcare services in isolated communities are already limited, difficulties in terms of quality and access are likely to only get worse as the number of Older Aboriginal Peoples living in these communities continues to increase. Furthermore, the provision of informal care can be particularly problematic as rural and remote communities tend to be comprised of a larger number of older and younger people with a relatively fewer number of people in the working-age ranges. A growing shortage of homecare workers in these communities will likely result in an increasing number of Older Aboriginal Peoples and their families who will need to make difficult choices whether to leave their communities to seek formal care elsewhere.

In general, rural and remote communities often experience problems in recruiting and retaining healthcare professionals. This can have a significant impact on the quality of care that is available to these communities. These problems are particularly amplified in Inuit communities where nurses tend to make up the fundamental framework of medical care. A high turn-over rate, combined with a nursing shortage in the rest of Canada, has made healthcare staffing in the north especially difficult. In the 1990s, the nursing shortage was so critical in the Inuvik region that health centres had to close (Archibald & Grey, 2000). The low staff levels contributed to higher rates of ‘burnout’, only adding to the nursing shortage problem.

Similar problems exist in the attraction and retention of physicians in northern communities. With few exceptions, only larger Inuit communities with hospitals staff physicians. Physician staffing is likewise plagued by high turnover rates that have a tremendous effect on the delivery

of health care. Even in cases where physicians are present, the high turnover has been found to have negative impact on healthcare utilization rates. One patient in the Inuit Tapiriit Kanatami evaluation (Archibald & Grey, 2000, p. 31) noted that:

> Turnover of personnel is a big, big problem. People don't want to come to a new doctor; they will wait for months to see if that doctor stays in the north, sometimes wait two years.

Language

With the bulk of healthcare being provided by non-Aboriginal health workers, language barriers can significantly affect the accessibility and quality of health care, especially for Older Aboriginal Peoples. Linguistic differences, for example, are often implicit in frequent misunderstandings of the formal health care system by older Inuit. According to Archibald and Gray (2000), Inuit elders often pay for services actually covered by the Non-Insured Health Benefits (NIHB) program as a result of language and cultural barriers. Lengthy appeals to the program are often carried out after the fact by elderly who later learn more about NIHB coverage.

Of course, cultural and linguistic issues are not limited to remote and rural areas. The supplement to *A Study of the Unmet Needs of Off-Reserve Indian and Metis Elderly in Saskatchewan: Conclusions and Recommendations* (1989) found that:

> in terms of language preference [amongst Saskatchewan off-reserve Indian and Metis elderly]…over a third of those surveyed in the south, and most of the elderly in the north, prefer to speak a combination of English and an aboriginal language or to speak totally in an aboriginal tongue."

The Cultural Gap

Although language barriers are certainly an issue, cultural differences remain the most significant obstacle between the Aboriginal seniors and health care providers. Aboriginal family-oriented decision-making, for example, can be a time-consuming process that palliative care practitioners may find difficult to understand. Kaufert (1999) found that the practitioners were, at times, not divulging all of the care options available to their patients in an effort to expedite patient decision-making. He notes that it remains very difficult to translate "biomedical explanations of diagnostic information into terms that could be understood by patients and their families…using language which would not be perceived as being culturally unacceptable by either the patient or the family" (p. 407). Kaufert also found resistance among some patients to the unwavering application of individual autonomy in medical decision-making. Instead, Aboriginal patients often seem to favour a less detailed prognosis and an increased involvement of family caregivers in the decision-making process.

When interpreters realize the situation, they frequently act as advocates for the patients, making them aware of their rights to make an informed decision and to take as much time as they want to make their decisions. Language interpreters are frequently left to fill the cultural gap and take on

the role of cultural mediator, patient advocate, counselor, and health educator (Kaufert & O'Neil 1991) and often need to explain both Aboriginal worldviews regarding health and death to health practitioners and Western medical practices and culture to Aboriginal patients and families.

Ellerby et al. (2000) have made efforts to put together a series of guidelines for communicating with and providing care to Aboriginal patients. They re-emphasize that Aboriginal perspectives on "holism, pluralism, autonomy, community- or family-based decision-making, and the maintenance of quality of life rather than the exclusive pursuit of a cure" (p. 845) can often conflict with Western medical, religious, and cultural values in treatment and palliative settings. In an effort to smooth the Aboriginal healthcare interface, these researchers suggest the following seven approaches:

- Respect for the individual: individuals are perceived as linked with family and community but have autonomy over their own health and 'healing journey'. Respect for the aboriginals (sic) is highly important and especially so for seniors and those with the status of elder.
- Conscious communication: Body language and speech must be paid much attention, as Aboriginal people are able to control their emotions well making it difficult to interpret their thoughts.
- Interpreters: As noted, interpreters often act as advocates and cultural mediators. So, if English or French fluency is not noted interpreters should be used.
- Family involvement: Family members can assist with understanding their ill loved one's beliefs and wishes and in reaching decisions. Sometimes, due to individual differences, family members should be approached with caution.
- Recognition of alternative approaches to truth-telling: As prognoses can be viewed as dictating future events, an uncertainty in future illness is something that is frequently more readily accepted by Aboriginal peoples.
- Noninterference: With the exception of not understanding, Aboriginal peoples should be informed of *all* treatment options and be allowed the time they need to reach those decisions. Consequently, their decisions must be respected and care taken to not attempt to persuade lest it be viewed as coercion.
- Aboriginal medicine: Elders, healers, medicine people or priests are important to the holism of Aboriginal concepts of health and healing and should be included in treatment. (Ellerby et al., 2000, p. 846)

These broad guidelines should be considered with care. Kaufert (1999), however, expresses hesitance about the use of these types of guidelines warning that they may result in "reductionist, decontextualised [accounts] of Aboriginal communities and descriptions of the ways in which Aboriginal people interpreted illness and death." (p. 408) One interpreter that Kaufert interviewed stated that it can be "dangerous to ask cultural mediators to provide 'cultural formulas' characterizing the perspectives of individuals or to develop generalizations about more inclusive cultural or linguistic groups." (p. 408)

Colonial histories have often been cited as the cause of considerable difficulties in the interface between Older Aboriginal Peoples and formal healthcare providers (O'Neil, Reading, & Leader

1998 & Ellerby et al. 2000). The 'colonial presence' of non-Aboriginal people in Canada, the power of non-Aboriginal physicians and the power structures inherent in Western medicine all act as a barriers to effective formal treatment. Traditional healing methods using nature as a base frequently conflict with the 'culture of colonization' associated with a medical system that uses complicated machines and advanced artificial treatments. By excluding the worldviews of Aboriginal Peoples, Western medical practices are often viewed by Aboriginal Peoples as dehumanizing as they separate Older Aboriginal Peoples from their communities and involve an individual-style decision making that can run contrary to traditional Aboriginal belief systems. These anxieties can be particularly amplified amongst Older Aboriginal Peoples due to the higher rates of those who are monolingual Aboriginal language-speaking and stronger attachments to traditional Aboriginal views on health and healing.

Aboriginal end of life decision making is one area that is often at odds with Western medical culture. Solomon (1997) notes that:

> From the growing literature on cultural diversity and clinical decision making, it is increasingly apparent that emphasis on individualism and solo decision-making is simply not of paramount importance in many cultures and, in fact, may run counter to deeply held notions of family and community and the respect, loyalty and protection children owe to their parents. In particular, recent reports by researchers who examined the ways in which cultural diversity interacts with end-of-life decision-making suggest that the relevant focus may not be on truth telling or ascertaining with precise certainly [sic] what the individual would want, but rather on love and care. Have I supported the patient? Have I been a good daughter or son? Have I given them hope, or protected them from distress?
>
> Many dying patients may not want to know the details of their prognosis nor want to make their own autonomously derived decision about their options for treatment or non-treatment. For them, family needs, obligations, and responsibility may be of greater importance. (p.89)

Increasingly, Older Aboriginal Peoples are dying both in hospitals and palliative care facilities. As Kaufert (1999) has shown, palliative care creates new support networks that de-emphasize the traditional family and community groups in favour of a network of specialized care professionals. Rituals that normally "integrated the family's experience of dying and grieving into the life of the community" are unable to be performed because of the treatment protocols that palliative care requires. The Canadian Palliative Care Association (1997) has recognized this concern noting that "for various reasons, Aboriginal palliative care needs are poorly understood and inappropriately addressed. Research on cultural and Aboriginal spiritual beliefs and practices are of particular importance as they are fundamental to care." (as cited in Kaufert, 1999, p. 406)

Similar studies done in Australia cite parallel concerns. In a study of palliative care and the Pitjantjatjara of Australia, Willis (1999) notes that significant conflicts exist between Western medical culture and the traditional Pitjantjatjara methods of dying. The Pitjantjatjara have traditionally provided palliative care through matrilineal kin structures in their places of

residence rather than through formal hospice care. Negative feelings of fear and isolation remain common among Aboriginal Australians transferred to urban hospitals for end-of-life care (Ramanathan & Dunn, 1998).

Of course, as long as the healthcare continues to be provided largely by non-Aboriginal health professionals, the need for interpreters and some sort of cultural orientation will remain. Several aging theories, namely disengagement theory (Cumming, Dean, Newell & McCaffrey, 1960; Cumming & Henry, 1961; Matcha, 1997; Novak & Campbell, 2001) and modernization theory (Cowgill, 1974; Matcha, 1997; Novak & Campbell, 2001; Vanderburgh 1987) have been used as frameworks for more in-depth discussions of the cultural differences between Older Aboriginal Peoples and non-Aboriginal healthcare providers.

However, several researchers have argued against the applicability of these theories in Aboriginal cultures. In many ways, traditional Aboriginal communities lend more support to activity theory. Coming about as a reaction to disengagement theory, activity theory posits that individuals continue to engage in society in an ever evolving capacity as they age. Their new roles are continuous with previous roles and are beneficial in that they sustain an individual's worth to society. The term 'successful aging' is used to describe a process in which life continues for the elderly with equivalent, albeit different activities.

In light of these three theories, it can be seen how traditional Aboriginal attitudes related to the traditional caregiver role typically held by the elderly may rub up against prevailing realities of modern Western medicine. In Inuit communities, for example, elderly women have traditionally taken on the role of midwife during childbirth (Archibald & Gray, 2000). The presence of the aged within a traditional health care system engages seniors in a meaningful way and affirms their value in the community. With this in mind, the adoption of Western style medicine may be seen to threaten the traditional roles of Older Aboriginal Peoples within their communities, devalue knowledge and skills traditionally associated with the elderly, and reinforce the disengagement of Older Aboriginal Peoples from their communities. Inuit elders "have a very different perspective on problems and solutions than [Western] health and social service professionals, as well as many younger Inuit" (Archibald & Gray, 2000, p. 35). Specifically, the Inuit elders speak of the barriers imposed by Canadian laws and regulations to traditional interventions to suicide prevention in youth. Similar barriers are experienced in other areas of Inuit social existence leading to a decrease in the role of elders in society and consequent increase in social problems.

Despite the dire predictions of disengagement and modernization theory, there is evidence that the role and value of Older Aboriginal Peoples remains strong in Aboriginal communities. For example, Vanderburgh (1987) argues that status of the elderly has actually increased amongst the Acinabe of Georgian Bay and the West Coast Salish in recent years. The role of older Acinabe has gone through some large transitions historically. Pre-contact, the role of Older Aboriginal Peoples was generally a respected one caught up in a cultural context of life-cycle status. But, with the emergence of Western settlement came reserves, residential schools, and a harsh institutionalized Christianity, each of which tended to denigrate the roles of the Older Aboriginal Peoples. During the 1960s and 70s, cultural change increased Aboriginal Peoples awareness of minority rights and a consequent renewal of Aboriginal culture has occurred. As Older

Aboriginal Peoples have the greatest knowledge of their culture, their status has increased as they take on a prominent role in cultural renewal. (Amoss, 1981; Vanderburgh, 1987).

Support can be found for a continued role for Older Aboriginal Peoples in healthcare as well. According to the Labrador Inuit Health Commission's Regional Health Survey (1999, p.3) "86% of adults think that a return to traditional ways is a good idea for promoting community wellness. They are particularly keen on traditional approaches to healing, revival of traditional roles for men and women, renewal of native spiritually [sic] and traditional ceremonial activity" (p. 34).

According to Buchignani & Armstrong (1999), Aboriginal communities typically look down on institutionalizing Older Aboriginal Peoples as they view institutions as "profoundly limiting, restricting their ability to care for others" (p. 18). This general desire to retain the role played by Older Aboriginal Peoples within their home communities as well as concerns related to the quality of care received in formal institutions are likely behind a push towards the creation and maintenance of Aboriginal informal care and homecare systems. According to Buchignani and Armstrong (1999), informal care is touted as "authentically Native and the main culturally appropriate way to fulfill the need for care" (p. 7). Such care is broad and "meaningfully deals with a diversity of needs: for example, for economic support, for assistance in everyday activities, and for psychological and social grounding" (Buchignani & Armstrong, 1999, p.22).

There are several notable attributes typically associated with traditional care within Aboriginal communities. The specificity of receipt of informal care is highly gender dependent. That is, whether one receives or one is the donor of informal care is chiefly dependent on the presence of women family members either in the home or near to the home of Canadian seniors in general. Women are typically the main caregivers.

The living arrangements of Older Aboriginal Peoples often greatly differ from those of the non-Aboriginal population. In Aboriginal households there tends to be stronger gender parity in residential family size and structure, fewer women living alone, and fewer Older Aboriginal Peoples living with only their partner. Additionally, Older Aboriginal Peoples are less likely to live in households that require independence. They are, however, more likely to live in households with young children who require Older Aboriginal Peoples to assist in their care. These points are not meant to diminish the fact that there are increasing numbers of Older Aboriginal Peoples living alone with a large minority not getting the informal care they require or getting none at all.

Given the important role of informal care in Aboriginal communities several programs have been created to increase the effectiveness of Aboriginal homecare. One example is the *U.S. Improving American Indian Eldercare* (IAIE) project. The IAIE project, with the primary objective of improving homecare for at-risk American Indians, instituted a three part plan that included: a paraprofessional homecare training curriculum at an American Indian college, planning grants to three American Indian postsecondary institutions, and the creation of a widely distributed newsletter on American Indian aging. A report by John, Dietz, Gittings, Roy, and Salvini (1996) testifies to the overall success of the program. The curriculum went over very well as the college chosen (Fond du Lac Tribal and Community College) had the resources to implement it and a high number of graduates are now involved in health care as nursing

assistants and home health aides. Dissemination efforts were said to be highly successful with many American sources becoming more aware of the issues facing older American Indians.

Concluding Comments

This background paper provides the reader with some basic information on Older Aboriginal Peoples in three key areas. First, it provides some recent basic demographic information on Aboriginal Peoples in general and more specifically on Older Aboriginal Peoples. It makes the case that Older Aboriginal Peoples are going to make up an increasing proportion of the Aboriginal Peoples population in Canada in the coming decades. Secondly, the general relationship between poor health and age is similar between Older Aboriginal Peoples and older non-Aboriginal people but that Older Aboriginal Peoples in general have poorer health status and suffer from more chronic health conditions than their non-Aboriginal counterparts. These basic data, however, provide only a limited picture of the differences between older Aboriginal peoples and older non-Aboriginal people. An in-depth multivariate examination of the relationships between health status and utilization, and demographic, socio-economic and geographic factors is needed. Thirdly, the paper shows what little has been written about Older Aboriginal Peoples where Older Aboriginal Peoples are the *explicit* focus of the research. Older Aboriginal Peoples are only now being recognized in the literature. Much research remains to be to be done, policy and services developed that take into account the experiences and knowledge of Older Aboriginal Peoples.

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Appendix 1: Comparing the 2001 Aboriginal Peoples Survey (APS) and the 2001 Canadian Community Health Survey (CCHS) Cycle 1.1

Although more recent cycles of CCHS exist, Cycle 1.1 was chosen as it allowed bettered comparison of Aboriginal and non-Aboriginal populations. This appendix provides a summary of the two surveys and how they compare. The 2006 APS was not yet available when this paper was written.

	2001 APS	2000/2001 CCHS
Targeted Population	• Post-censal survey • Aboriginal identity • Aboriginal ancestry • reserve/off-reserve • Private dwellings • 0-14 years • 15 years and older	• Individuals in private dwellings (not Aboriginal peoples with reserve-residency) • 12 years and older
Survey Questions	• education, income, language, labour activity, income, health, communication, mobility, housing • Metis, Children, Arctic	• physical/mental well-being, lifestyle, use of health care services, access to care • common & optional content
Respondents	98,649	130,827
Response Rate	84%	84.7%

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