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Unmet health care needs during the pandemic and resulting impacts among First Nations people living off reserve, Métis and Inuit

By Tara Hahmann and Mohan B. Kumar

It is well documented that Indigenous peoples in Canada experience significant health disparities, such as higher incidence of chronic conditions, and higher prevalence of related risk factors (Kim, 2019). Contributing factors include proximal determinants of health such as poverty, food insecurity, lack of employment opportunities, and suitable housing; intermediate ones such as a lack of access to timely, adequate and culturally appropriate health care (Davy, Harfield, McArthur, Munn, & Brown, 2016; Tjensvoll Kitching et al., 2020); and distal determinants such as colonialism, racism and social exclusion (Loppie Reading & Wien, 2013). These determinants work together to impact the health of Indigenous people in Canada. With respect to health care, Indigenous people also often have to navigate a patchwork of health care systems, jurisdictions and eligibilities. For example, while status First Nations people and Inuit have some coverage through Non-Insured Health Benefits (NIHB), non-status First Nations people and Métis do not. Even for those having coverage through NIHB, they experience uncovered medical costs and lack of knowledge of coverage (National Collaborating Centre for Indigenous Health, 2019).

The pandemic has had significant social, economic and health impacts on Indigenous people (Arriagada, Hahmann, & O'Donnell, 2020; Bleakney, Masoud, & Robertson, 2020; Statistics Canada, 2020). In particular, Indigenous participants, including those with disabilities and long-term conditions, reported worsened overall health and in particular mental health (Arriagada et al., 2020; Hahmann, 2021) at rates higher than non-Indigenous participants. Less is known about the impacts of the pandemic on access to health care services and the potential effects of unmet health needs among First Nations people, Métis and Inuit. Reduced access to and utilization of health care services may have had disproportionate impacts on the health of Indigenous people, potentially exacerbating pre-pandemic health care disparities (King, Smith, & Gracey, 2009). Given existing health care gaps among Indigenous people, understanding how the pandemic may have furthered disparities is an important topic of inquiry.

This paper provides an overview of how Indigenous people's health care was impacted during the COVID-19 pandemic using data from the 2021 Survey on Access to Health Care and Pharmaceuticals During the Pandemic (SAHCPDP). More specifically, it explores the reported need for health care services, unmet health care service needs, health service appointment disruptions and delays, and the effects thereof on First Nations people living off reserve, Métis and Inuit in the past year. As the survey does not cover the population living on reserve or in the territories, the study findings cannot be generalized to First Nations people living on reserve and Inuit in the territories due to potential differences in the prevalence of chronic conditions and availability of health care services. Data on non-Indigenous people is provided for context.

Study population

The Indigenous population covered by the survey includes First Nations people living off reserve, Métis and Inuit in the provinces and aged 18 years and older. It should be noted that roughly 40% of First Nations people lived on reserve in 2016 (Statistics Canada, 2017) and most Inuit in Canada live in Inuit Nunangat, the Inuit homeland, which is made of northern regions of Yukon, Northwest Territories, Quebec and Newfoundland and Labrador, as well as all of Nunavut. The study population, thus, excludes First Nations people living on reserve and the territories,



Métis in the territories and Inuit living in Inuit Nunangat with the exception of Nunavik. The median age among the populations covered by this survey was lowest among Inuit at 37 years, followed by First Nations people at 40 and Métis at 43. Among non-Indigenous people the median age was 47 years. Men (49%) and women (51%) were equally represented among First Nations and non-Indigenous people. Among Métis, 58% were men, and among Inuit, 41% were men. Three-quarters of First Nations people (75%), 73% Status and 80% non-Status First Nations people, and Métis (74%) lived in urban areas while one in three Inuit lived in urban areas (34%^E) in the provinces. Among non-Indigenous people, 88% lived in urban areas. Residence in urban and rural areas was determined based on the second digit of the postal code provided by respondents (details in the methods section).

Indigenous people continued to experience higher rates of multiple chronic conditions during the pandemic

Chronic conditions and disabilities have previously been shown to be more prevalent among Indigenous people (Hahmann, Badets, & Hughes, 2019; Hayward, Cidro, Dutton, & Passey, 2020; Lix, Bruce, Sarkar, & Young, 2009). Indigenous people continued to report higher prevalence of chronic conditions during the pandemic compared with their non-Indigenous counterparts. A higher percentage of First Nations people living off reserve (15%) and Métis (16%) reported having been diagnosed with two chronic conditions compared with non-Indigenous people (12%). A greater percentage also reported having three or more chronic conditions: 14% of First Nations people and 14% of Métis compared with 8% of non-Indigenous people.

The most commonly diagnosed chronic conditions among First Nations people, Métis and Inuit were mental health conditions, high blood pressure, arthritis, asthma and diabetes (Chart 1). For many of these conditions, the prevalence was higher among the three Indigenous populations compared with non-Indigenous people.

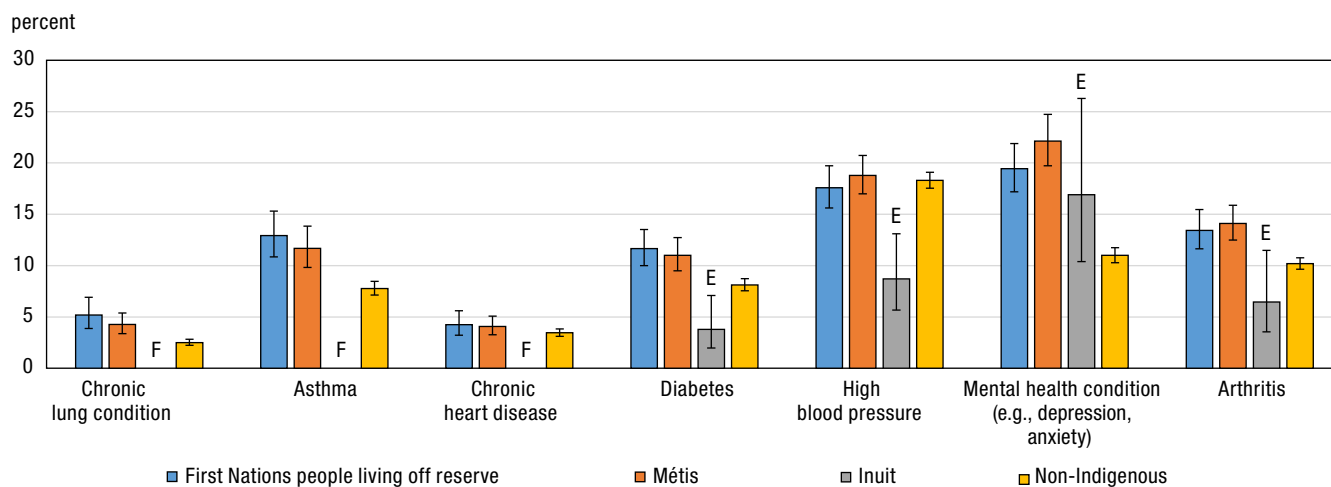
Mental health conditions such as depression and anxiety were the leading chronic conditions reported with about one in five Indigenous adults reporting these compared with one in ten non-Indigenous adults (Chart 1). A similar proportion of First Nations people (18%), Métis (19%) and non-Indigenous people (18%) reported high blood pressure; however, Inuit were nearly half as likely (9%^E) to do so. More than one in ten First Nations people and Métis said they have arthritis, diabetes or asthma, higher than among non-Indigenous people.

In addition to chronic conditions, more First Nations people (20%), Métis (20%) and Inuit (23%^E) identified as a person with a disability than non-Indigenous people (11%).

The lower prevalence of some of the chronic conditions among Inuit should be interpreted in the context of the small sample size for this population, survey coverage which excludes the majority of Inuit, their younger age distribution (Statistics Canada, 2018), barriers to health care services including diagnostics, stigma relating to reporting and internalization and normalization of ill health (Horrell et al., 2019; Smylie, Firestone, Spiller, & Tungasuvvingat Inuit, 2018) and other factors.



Chart 1
Percent of First Nations people living off reserve, Métis, Inuit and non-Indigenous people with chronic conditions during the first year of the pandemic, by chronic condition, 2021, Canada (provinces only)



E use with caution.

F too unreliable to be published.

Source: Survey on Access to Health Care and Pharmaceuticals During the Pandemic.

Women were more likely to report chronic conditions than men. A higher percentage of First Nations (25%), Métis (29%) and non-Indigenous (15%) women reported mental health conditions than First Nations (13%), Métis (17%) and non-Indigenous (7%) men. Women (15%, 17% and 13% among First Nations people, Métis and non-Indigenous people, respectively) were more likely than men (11%, 12% and 7%) to report having arthritis. Métis women (15%) were more likely to have asthma than Métis men (9%) as were non-Indigenous women. Métis women (8%) were also twice as likely as Métis men to have a weakened immune system as a result of disease or medication (4%^F). Poorer health among Indigenous women is tied to greater health disparities driven by economic and social inequities associated with colonialism, racism and sexism, such as greater vulnerability to victimization and poverty, intergenerational impacts of trauma from colonial policies, and barriers to accessing quality and culturally appropriate health care (Halseth, 2013).

First Nations people and Métis more likely to indicate need for specific health care services than non-Indigenous people

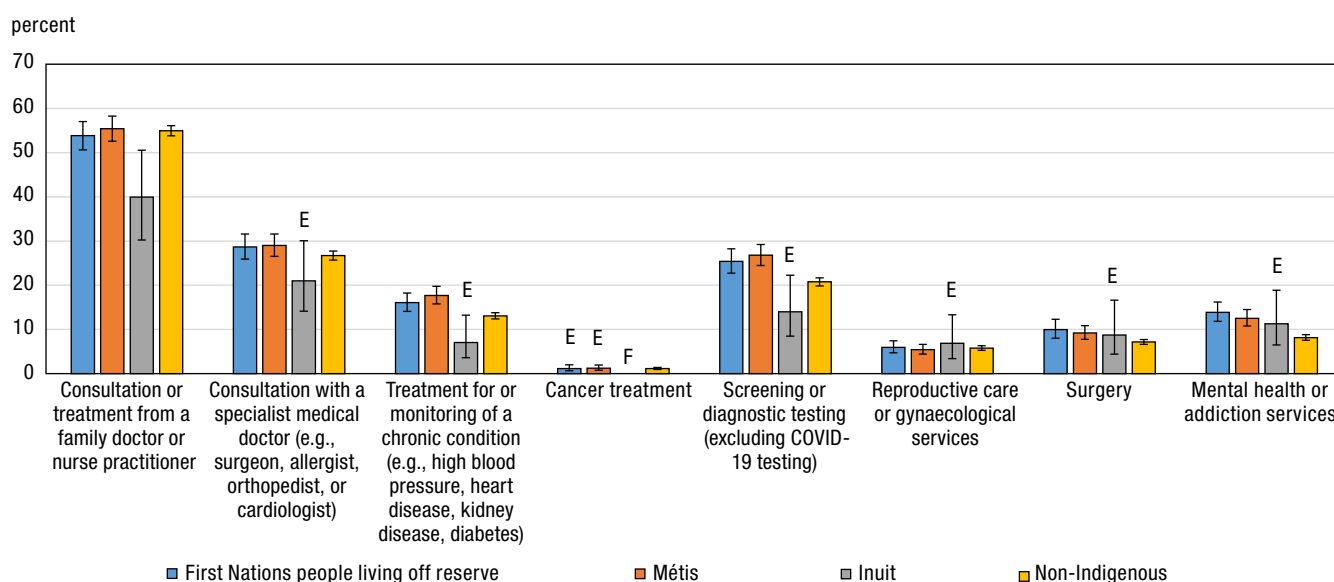
The higher prevalence of chronic conditions and disabilities suggests a greater need for health care services among Indigenous people. Indeed, First Nations people living off reserve and Métis were more likely than non-Indigenous people to indicate that they needed treatment and monitoring of a chronic condition; screening or diagnostic services; surgery; and mental health or addiction services such as counselling or therapy in the first year of the pandemic.

About one in four First Nations people (25%), Métis (27%) and one in seven Inuit (14%^E) reported needing screening or diagnostic services (excluding COVID-19 testing) during the first year of the pandemic (Chart 2). These percentages were higher among First Nations people and Métis compared with non-Indigenous people (21%).



Inuit were less likely to report needing consultation or treatment from a family doctor or nurse practitioner compared with their non-Indigenous counterparts. This may be related to the lower levels of reporting of chronic conditions described previously. Furthermore, for many health care services, estimates had a large variability reflecting the smaller sample size for Inuit and should be used with caution.

Chart 2
Percent of First Nations people living off reserve, Métis, Inuit and non-Indigenous people reporting need for health care services during the first year of the pandemic, by type of health care service, March 2020 to May 2021, Canada (provinces only)



E use with caution.

F too unreliable to be published.

Source: Survey on Access to Health Care and Pharmaceuticals During the Pandemic.

First Nations people more likely than non-Indigenous people to experience unmet need for health care services during the first year of the pandemic

Previous literature has suggested that the COVID-19 pandemic has exacerbated inequities relating to access to health care among Indigenous people (Hahmann, 2021; Power et al., 2020). The findings from the SAHCPDP data shed some light on this.

First Nations people living off reserve (21%) were more likely than non-Indigenous people (15%) to report an unmet need for such services in the first year of the pandemic. The prevalence of unmet health needs was not significantly different between Status (20%) and non-Status (25%) First Nations people. No significant differences in prevalence were seen among Métis (17%) and Inuit (21%^E) and non-Indigenous people (15%) in the first year of the pandemic.

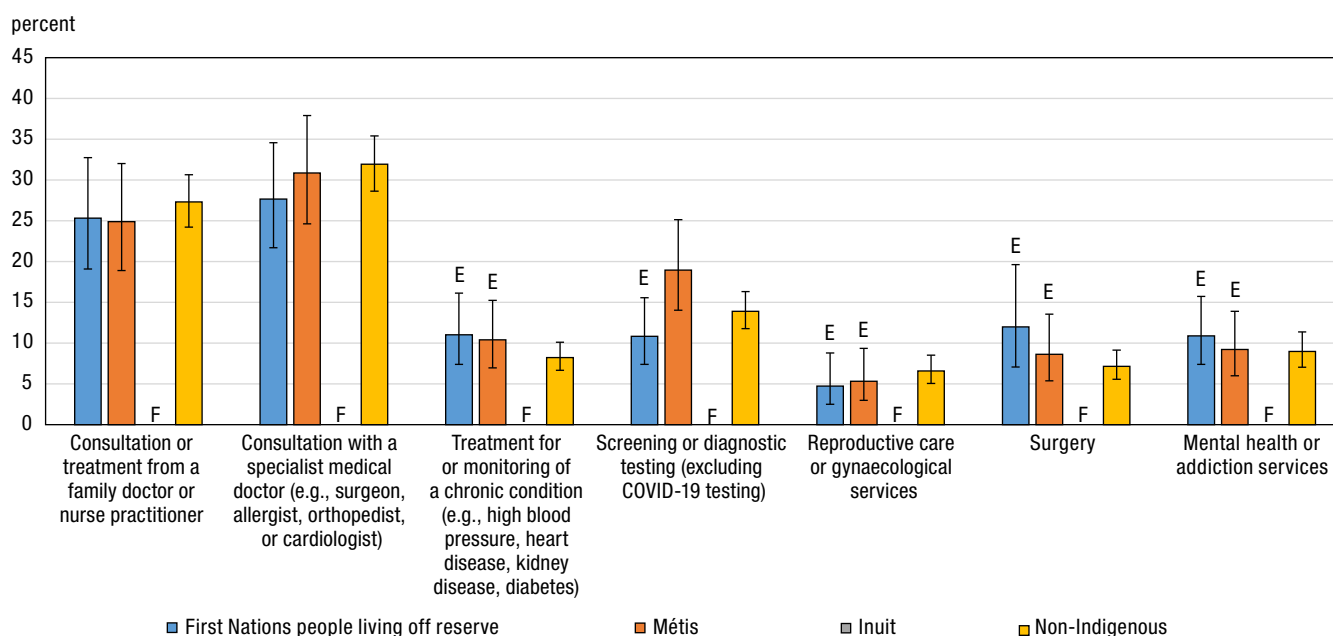
Some differences between men and women were identified. While rates were similar for First Nations men (19%) and women (22%), they were higher when compared with their non-Indigenous counterparts (14% and 17%, respectively). Métis women (21%) were significantly more likely to experience unmet health care service needs than Métis men (13%).



The health care services that were most frequently reported as needed but not received in the past year among First Nations people and Métis included consultation with a specialist medical doctor (28% and 31%, respectively), consultation or treatment from a family doctor or nurse practitioner (25% and 25%) and screening or diagnostic testing, excluding COVID-19 testing (11%^E and 19%). One in ten First Nations people and Métis who needed health care services did not receive mental health or addiction services such as counselling or therapy (11%^E and 9%^E), surgery (12%^E and 9%^E) or treatment for or monitoring of a chronic condition (11%^E and 10%^E) (Chart 3). One in twenty First Nations people (5%^E) and Métis (5%^E) did not receive reproductive care or gynaecological services.

Availability and accessibility of health care services vary by urban and rural areas in Canada. For example, previous research has suggested that individuals in Census Metropolitan Areas have more access to specialist physician consultations while those in the most rural areas have more access to a regular medical doctor (Sibley & Weiner, 2011). Among First Nations people, Métis, Inuit and non-Indigenous people covered by the SAHCPDP, no significant differences in rates of unmet health care needs were seen by urban and rural areas.

Chart 3
Percent of First Nations people living off reserve, Métis, Inuit and non-Indigenous people who experienced unmet health care needs during the first year of the pandemic, by type of health care service, March 2020 to May 2021, Canada (provinces only)



E use with caution.

F too unreliable to be published.

Source: Survey on Access to Health Care and Pharmaceuticals During the Pandemic.



Indigenous people more likely to have problems scheduling mental health services as a result of the pandemic

While the questions on the SAHCPDP relating to unmet health care needs do not allow one to determine if the reasons for these gaps in services are the result of the pandemic, survey questions on problems with scheduling needed health care appointments as a result of the pandemic may shed light on the impact of the pandemic.

Almost half of First Nations people living off reserve (43%), Métis (42%) and Inuit (43%) who required health care services in the past year experienced problems with scheduling appointments. In comparison, 37% of non-Indigenous people experienced such problems. Métis (47%) and non-Indigenous women (40%) were more likely than Métis (39%) and non-Indigenous men (34%) to report such difficulties. While not all problems were directly related to COVID-19, roughly 7 in 10 of those who had problems scheduling appointments attributed it to cancellations, rescheduling or delays due to the COVID-19 pandemic.

The health care services that were most frequently reported as being cancelled, rescheduled or delayed due the COVID-19 pandemic mirrored the patterns seen for unmet needs. For instance, about a third of First Nations people, Métis, Inuit and non-Indigenous people (Table 1), reported consultation or treatment from a family doctor or nurse practitioner was cancelled, rescheduled or delayed due to the pandemic. And, about one in four First Nations people, Métis, and non-Indigenous people and four in ten Inuit indicated that consultation with a medical specialist was cancelled, rescheduled or delayed due to the pandemic. Approximately one in ten First Nations people, Métis and non-Indigenous people reported similar pandemic-related disruptions in treatment for monitoring of a chronic condition and surgery. First Nations people (10%^E) and Métis (9%^E) were about twice as likely as non-Indigenous people (5%) to report pandemic-related scheduling problems for mental health or addiction therapy and counselling services (Table 1).

Table 1
Percent of First Nations people living off reserve, Métis, Inuit and non-Indigenous people who reported health care services being cancelled, rescheduled or delayed due to the COVID-19 pandemic, by type of health care service, March 2020 to May 2021, Canada (provinces only)

	Consultation or treatment from a family doctor or nurse practitioner	95% CI	Consultation with a specialist or medical doctor (e.g., surgeon, allergist, orthopedist, or cardiologist)	95% CI	Treatment for or monitoring of a chronic condition (e.g., high blood pressure, heart disease, kidney disease, diabetes)	95% CI
percent reporting services cancelled, rescheduled, or delayed						
First Nations people living off reserve	31.2	(25.7-37.3)	26.8	(21.5-32.9)	8.9 ^E	(6.1-12.7)
Métis	33.8	(28.7-39.3)	27.3	(22.6-32.5)	8.9 ^E	(6.5-12.1)
Inuit	37.8 ^E	(17.6-63.2)	38.9 ^E	(19.1-63.3)	F	
Non-Indigenous	29.1	(26.8-31.5)	26.6	(24.4-29.0)	7.6	(6.4-9.0)

	Screening or diagnostic testing (excluding COVID-19 testing)	95% CI	Reproductive care of gynecological services	95% CI	Surgery	95% CI	Mental health or addiction services	95% CI
percent reporting services cancelled, rescheduled, or delayed								
First Nations people living off reserve	13.4 ^E	(9.8-17.9)	4.3 ^E	(2.9-6.4)	12.0 ^E	(7.6-18.4)	9.8 ^E	(6.5-14.7)
Métis	13.6	(10.5-17.5)	4.3 ^E	(2.7-6.9)	9.2 ^E	(6.6-12.6)	9.4 ^E	(6.4-13.5)
Inuit	F		F		F		F	
Non-Indigenous	12.5	(11.0-14.2)	4.8	(3.8-6.1)	7.1	(5.9-8.5)	4.6	(3.6-5.8)

^E use with caution.

F too unreliable to be published.

Source: Survey on Access to Health Care and Pharmaceuticals During the Pandemic.



Indigenous people report a lack of health services in their area and discrimination by health care professionals during the pandemic

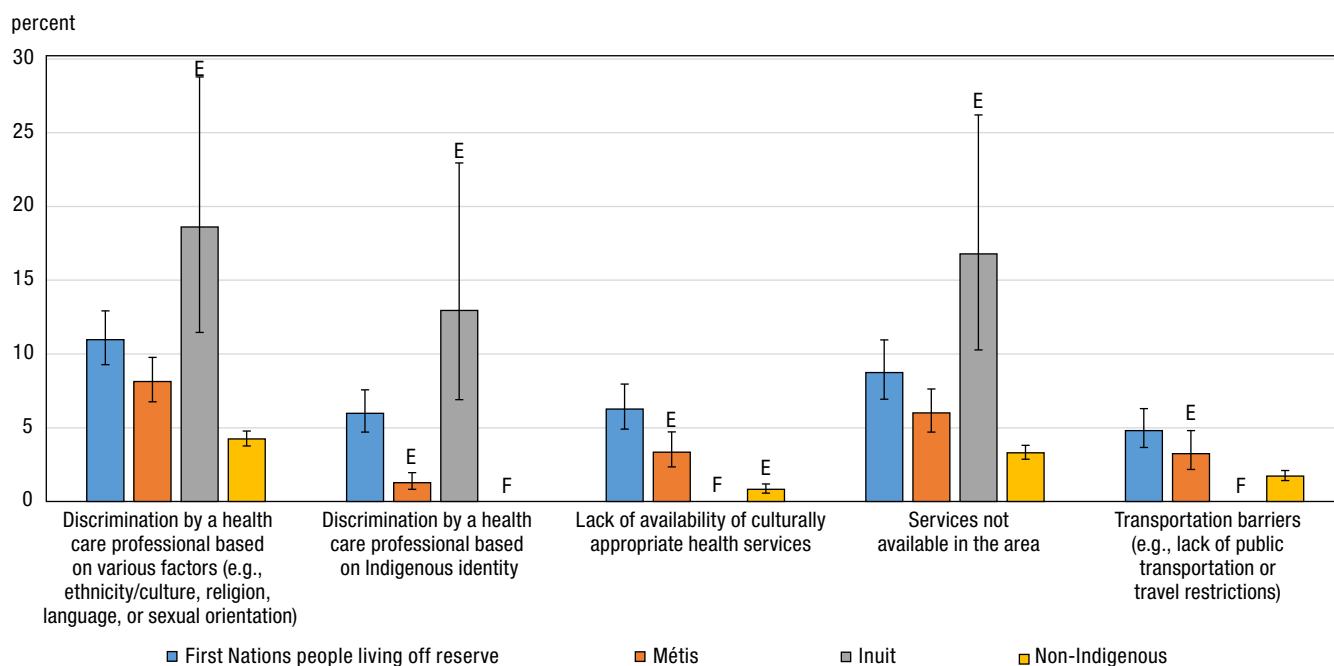
Unmet health care needs are the result of a myriad of barriers faced by Indigenous people in Canada. Despite more availability of health care services in urban areas, research has shown that urban Indigenous people experience substandard quality of care, long wait times, racism and discrimination when accessing these services (Nelson & Wilson, 2018). Research has also shown that culturally appropriate and competent health care can improve health outcomes and quality of care by offering health services in an environment that respects cultural difference and is free from racism and stereotypes, but this type of care may not be available to all Indigenous people (O'Sullivan, 2013). Location and distance issues may impose additional challenges in accessing health services among Indigenous people (Davy et al., 2016).

During the pandemic Indigenous people experienced barriers to accessing services. First Nations people living off reserve (9%), Métis (6%), and Inuit (17%^E) were more likely than non-Indigenous (3%) people to report a lack of available health services in their area. Similarly, transportation-related issues (e.g., travel restrictions, lack of public transportation) in accessing health care were more likely reported by First Nations people (5%) and Métis (3%^E) than non-Indigenous people (2%). Six percent of First Nations people and 3%^E of Métis reported a lack of access to culturally appropriate health services and other traditional healing services.

The survey asked respondents if they felt that any health care professional held negative opinions or treated them unfairly during the pandemic. First Nations people (11%), Métis (8%) and Inuit (19%^E) were about two to five times more likely than non-Indigenous people (4%) to report exposure to some form of discrimination in health care for reasons including, but not limited to, ethnicity/culture, race, religion, physical appearance, sexual orientation, age and/or physical or mental disability (Chart 4). Approximately 6% of First Nations people, 1%^E of Métis and 13%^E of Inuit reported that health care professionals held negative opinions or treated them unfairly due to their Indigenous identity during the pandemic.



Chart 4
Percent of First Nations people living off reserve, Métis, Inuit and non-Indigenous people who reported health care barriers during the first year of the pandemic, by barrier type, March 2020 to May 2021, Canada (provinces only)



E use with caution.

F too unreliable to be published.

Source: Survey on Access to Health Care and Pharmaceuticals During the Pandemic.

Difficulties getting health care services and delays are affecting the health of Indigenous people

The higher prevalence of chronic conditions, the greater need for some health services and the higher level of unmet needs during the pandemic may have an impact on Indigenous people's mental and physical health. Compared to before the COVID-19 pandemic, roughly one-quarter of First Nations people living off reserve (27%), Métis (27%), Inuit (24%^E) and non-Indigenous people (25%) reported "somewhat worse" or "much worse" physical health and over one-third of First Nations people (38%), Métis (37%) and non-Indigenous people (36%) reported "somewhat worse" or "much worse" mental health while 26%^E of Inuit reported this. While prevalence of worsened mental and physical health were similar across groups, higher prevalence of chronic conditions and disrupted services and supports may have further exacerbated pre-pandemic health inequalities (Gouldhawke, 2021; Ndugga & Artiga, 2021).

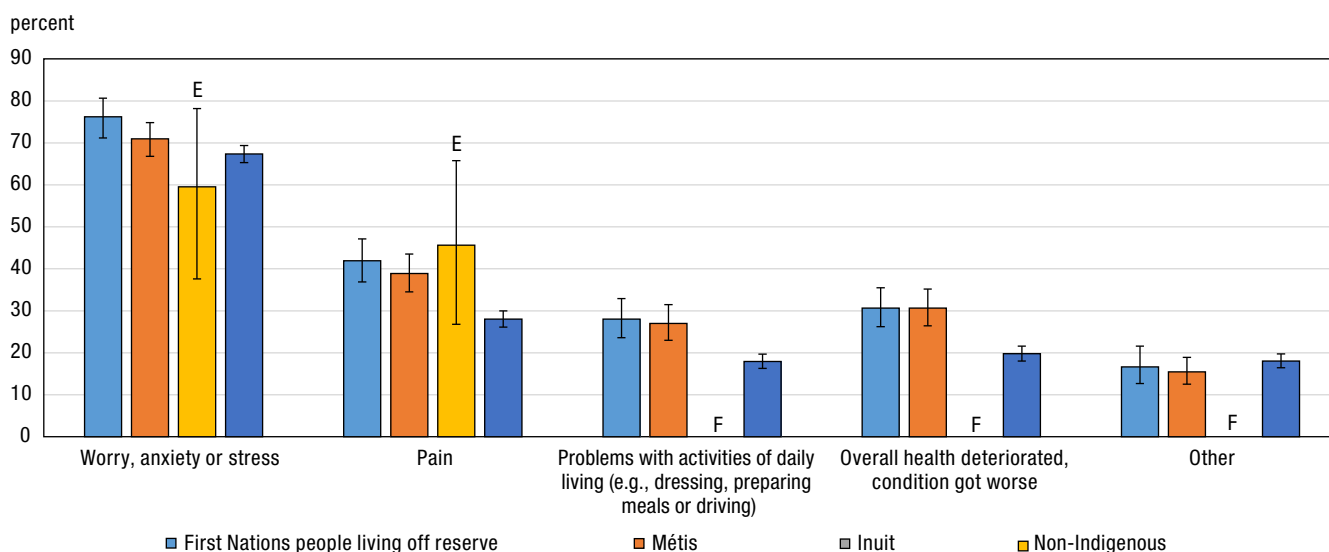
When asked about the impact of the pandemic-related difficulties and delays in receiving health care services on mental and physical health, disparities between Indigenous and non-Indigenous people were evident. First Nations people (42%) and Métis (39%) were more likely than non-Indigenous people (28%) to say these difficulties or delays caused them pain (Chart 5). Among Status First Nations people 38% reported this compared with 54% of non-Status First Nations people. First Nations people (28%) and Métis (27%) were also more likely than non-Indigenous people (18%) to say they had problems with activities of daily living such as dressing, preparing meals or driving. A higher percentage of First Nations people (31%) and Métis (31%) than



non-Indigenous people (20%) reported the deterioration of their overall health or worsening of a condition. There were no differences between prevalence among Status and non-Status First Nations people; both were more likely than non-Indigenous people to report such impacts (data not shown).

Around three-quarters of First Nations people and Métis and over half of Inuit reported that the past-year difficulties getting health care services or having to wait to receive needed services led to worry, anxiety or stress whereas two-thirds of non-Indigenous people reported this (Chart 5). There was no significant difference between Status and non-Status First Nations people (74% and 83%) although the latter were more likely than non-Indigenous people to report worry, anxiety or stress impacts. Non-Status First Nations people (9%^E) were less likely to report other impacts compared with Status First Nations people (19%) and non-Indigenous people (18%). No differences were observed between Indigenous men and women for any of the reported impacts of difficulties and delays in getting health care services with few exceptions. Among First Nations people, women were more likely to report worry, anxiety or stress than men; however, men were more likely to report other impacts than women.

Chart 5
Percent of First Nations people living off reserve, Métis, Inuit and non-Indigenous people who reported impacts of difficulties getting health care services or having to wait to receive them during the first year of the pandemic, by type of impact, March 2020 to May 2021, Canada (provinces only)



E use with caution.

F too unreliable to be published.

Source: Survey on Access to Health Care and Pharmaceuticals During the Pandemic.



Summary

Using the SAHCPDP data, this paper examined the health care service needs, disruptions to care, and the related impacts experienced by First Nations people living off reserve, Métis and Inuit in the provinces during the first year of the COVID-19 pandemic.

First Nations people and Métis reported higher percentages of chronic conditions than non-Indigenous people reflecting previously documented disparities (Lix et al., 2009). Prevalence of chronic conditions among Inuit in the provinces was lower or not significantly different compared with non-Indigenous people. However, these should be interpreted in the context of the small sample size for Inuit which resulted in greater variance and non-coverage of territories where most Inuit live and experience persistent barriers to equitable health care access (Oosterveer & Young, 2015). Other barriers to the detection and diagnoses of chronic conditions may include a lack of culturally-safe specialized health services, negative bias relating to reporting and internalization and normalization of ill health among other factors (Horrell et al., 2019; Smylie et al., 2018).

Despite higher prevalence of chronic conditions and the accompanying need for health care, Indigenous people faced unmet health service needs. Researchers have noted that challenges to health care provision during the pandemic may have a disproportionate impact on Indigenous people in the context of existing health care disparities, including access barriers (Richardson & Crawford, 2020). Findings from this study revealed several types of unmet service needs, including consultation with a specialist and non-COVID-19 screening or diagnostic testing, which is a key concern for Indigenous people who carry a greater combined burden of chronic conditions and related risk factors. Additionally, Indigenous people reported COVID-19-related disruptions and delays to counselling and treatment for mental health and addiction which may have contributed to reported worsened mental health during the pandemic as found here and to a larger extent in analysis of crowdsourced data collected in the early months of the pandemic (Arriagada et al., 2020). Indeed procedural backlogs and other health care delays and interruptions have been documented (Deloitte & Canadian Medical Association, 2021) as have the potentially negative repercussions on mortality, morbidity, mental health and quality of life (Papautsky et al., 2021).

The findings cannot be generalized to First Nations people living on reserve and Inuit in the territories, as the data do not account for differences that could exist in the prevalence of chronic conditions and availability of health care services among people living on reserve and in the territories.

Methods

Proportions presented in the article were generated excluding missing values from the denominator for all variables. Estimates with a coefficient of variation (CV) between 15% and 35% are indicated with an E and should be used with caution. Estimates with CVs over 35% are not published. Variance and 95% confidence intervals were calculated using 1000 bootstrap weights. Significance testing at $p < 0.05$ was used to identify statistically significantly different estimates.

Urbaneness or rurality of residence of individuals was determined using postal code provided by respondents. If the second digit of a postal code is "0" it is a rural area, otherwise it is an urban area. Postal codes were missing for 7% of Indigenous and 27% of non-Indigenous respondents.

Prevalence estimates for various chronic conditions are based on reporting of conditions that were diagnosed by a health care professional, and which had lasted six months or more at the time of the survey.



About the Survey on Health Care Access and Pharmaceuticals during the Pandemic (SAHCPDP)

The Survey on Health Care Access and Pharmaceuticals during the Pandemic (SAHCPDP) was designed to better understand how health care service disruptions are affecting Canadians during the COVID-19 pandemic. The target population was persons 18 years of age or older living in private dwellings in the ten provinces outside of reserves and other Indigenous settlements. Data were collected between March 8 and May 15, 2021 either through an electronic questionnaire or through computer assisted telephone interviewing. The reference period for the survey was the past 12 months. The main sample consisted of individuals selected from 40,000 households selected from a list frame of dwellings. An oversample of 15,000 Indigenous persons was allocated with the goal of producing equal quality estimates across the provinces for the Indigenous subpopulation. The sampling frame for the latter was individuals who identified as Indigenous in the 2016 Census of Population. The overall response rate was 46.2%. The final sample included 25,268 participants 18 years of age and older of which 4907 were Indigenous: First Nations people (2159), Métis (2504) and Inuit (198).

The SAHCPDP was administered to those in private dwellings, thus, it excluded those who were in collective dwellings such as hospitals, jails, shelters and group homes. Since the frame used for oversampling Indigenous people was people identifying as Indigenous in the 2016 Census, those who were not enumerated in that cycle were excluded from the in-scope population. Furthermore, since the survey was administered by electronic questionnaire and CATI, those without internet or telephone access would have been excluded. The findings may not be representative of First Nations people living on reserve and Inuit since the survey was not administered on reserves and in the territories, where most Inuit live.



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