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Highlights

- In 2017-2020, significantly higher proportions of First Nations people living off reserve (20.3%), Métis (17.9%) and Inuit (56.5%) across Canada reported being without a regular health care provider (RHCP), compared with their non-Indigenous counterparts (14.5%).
- Higher proportions of men and younger adults (18 to 34 years) did not have a RHCP, compared with women and older age groups, among all three Indigenous groups and non-Indigenous people.
- Regionally, around one-half of First Nations people living off reserve (52.2%) and Métis (49.3%) in the Territories reported not having a RHCP, while about one in ten reported the same in Ontario (12.3%; 11.8%E). Though at lower proportions, similar findings were seen among non-Indigenous people in the Territories (32.3%) and Ontario (9.5%).
- Among Inuit living inside Inuit Nunangat (excluding the region of Nunavik), over eight in ten (84.5%) did not have a RHCP, compared with 73.3% among non-Indigenous people. Around one in five Inuit (24.5%E) living outside Inuit Nunangat did not have a RHCP.
- About one-half of off-reserve First Nations people (50.4%) and Métis (51.7%E) living in very remote areas did not have a RHCP, as well as one-quarter in each group living in remote areas (26.6%; 25.8%). Among Inuit, about eight in ten (81.6%) of those living in very remote areas and close to two-thirds (64.5%) in remote areas did not have a RHCP. Comparatively, the proportions among non-Indigenous people were considerably lower (30.1%; 17.5%).
- The proportion of First Nations people and Métis reporting waiting for more than 2 weeks to see their RHCP in 2017-2020 was higher in the Atlantic provinces (19.7%; 20.9%E) and Quebec (17.7%E; 27.0%) compared to Ontario (12.9%; 13.6%) and more generally, to other regions.
- Roughly one-half of First Nations people living off reserve (47.6%) and Métis (51.4%) reported a doctor's office as their usual place of care in 2017-2020, followed by walk-in clinics. Among Inuit, one-fifth (21.2%) reported using a doctor's office, whereas about double that proportion (41.8%) reported using community health centres. In contrast, around six in ten (57.5%) non-Indigenous people used a doctor's office as their usual place of care.

Introduction

For most people, primary health care (PHC) services are generally the first and main point of contact with the health care system (Health Canada, n.d.). PHC services are usually provided by family doctors or nurse practitioners who diagnose and treat common diseases and injuries as well as provide referrals to and coordination with other levels of care (e.g., hospitals and specialist care) (Health Canada, n.d.). Having a PHC provider serves an important role in maintaining a patient's health as early diagnosis and appropriate treatment reduce the chance of complications and prevent deterioration of disease, thus avoiding unnecessary hospitalizations. By preventing unnecessary hospitalizations and emergency room (ER) use, it lowers the costs for the health care system and improves efficiency. Therefore, improved access to PHC has been linked with better outcomes both for patients and the health care system (Organisation for Economic Co-operation and Development (OECD), 2020).

A stronger PHC system is also linked to lower mortality rates and better outcomes for people with chronic physical and/or mental health conditions through its emphasis on preventative care such as immunizations, early detection and counselling. Research has also shown that PHC is better placed to improve the equity of health care as there is generally less income-related inequality in establishing access to PHC services (e.g., General Practitioner visits) than to specialist services (OECD, 2019).

Indigenous people have experienced long-standing health disparities compared to the non-Indigenous population (Loppie & Wien, 2022; Public Health Agency of Canada, 2018) including issues with access to health care that have likely worsened with severe shortages of primary health care physicians across Canada (Angus Reid Institute, 2022). The health care needs of Indigenous people are of particular concern because of poorer reported physical and mental health status, and a higher prevalence of chronic conditions (e.g., asthma and diabetes) as well as disabilities compared to non-Indigenous people (Hahmann & Kumar, 2022; Hahmann et al., 2019). In addition, the life expectancy of First Nations people, Métis and Inuit has been shown to be consistently and significantly lower than that of the non-Indigenous population (Tjepkema et al., 2019).

It is important to understand these health disparities within the context of the wider historical, political, social, and economic conditions that have impacted Indigenous people's health in Canada (Public Health Agency of Canada, 2018). Colonization, and its related policies such as forced displacement to remote communities, resulted in limited opportunities for economic development and disconnection from traditional lands, culture and resources, including access to traditional medicine and healing practices. In addition, factors such as forced cultural assimilation through colonial policies, social and economic deprivation, as well as discrimination continue to negatively impact the health of Indigenous people (Wilk et al., 2017).

Indigenous people continue to experience systemic racism and discrimination when accessing the health care system, which has contributed to a lack of trust and perception of the health care system as unsafe (Loppie & Wein, 2022). This is an important barrier related to health care access and points to the need for health care that is respectful, free from discrimination, and supports culturally specific care to meet the needs of Indigenous people (Nelson & Wilson, 2018).

Using annual data from the 2017 to 2020 cycles of the Canadian Community Health Survey (CCHS), this study examines the following indicators among First Nations people living off reserve, Métis and Inuit: access[1] to a regular health care provider and reasons for not having one; wait times for appointments when needing immediate care for a minor health issue; access to a usual place of care[2] and its type (e.g., walk-in clinic, hospital emergency room, etc.) as well as access to a PHC team, i.e., a team of health care professionals. The CCHS uses the term "regular health care provider" to refer to a primary health care provider, which is defined as a health professional that a person sees or talks to when they need care or advice about their health. This includes family doctors or general practitioners, medical specialists, nurse practitioners (or nurses in remote areas), pharmacists, physiotherapists and social workers.

These indicators are explored by various characteristics that have been shown in the literature to influence access to primary health care. They include sex[3], age, income, geographical location, and remoteness as well as the presence of chronic conditions and self-reported health status (Statistics Canada, 2020a; Statistics Canada, 2020b; Khan et al., 2008; Clarke, 2016).

Data Source

The Canadian Community Health Survey (CCHS) is an annual cross-sectional survey that provides detailed information on the health status, health care utilization and health behaviours of the Canadian population at the national, provincial, territorial and health region levels. It also collects information on sociodemographic characteristics such as income, education and labour market indicators.

1. In the context of this analysis, 'access' or 'lack of access' is used to refer to whether a respondent has a RHCP regardless of the reason in the case of not having one. For some people, the 'lack of access' to a RHCP is a result of their choice as they may feel they do not need one, however, this wording is used in a more general sense.
2. Usual place of care is where respondents usually go to when they need immediate care for a minor health problem.
3. As the CCHS only started collecting gender information from 2019 onwards, this study will use sex in order to keep the concept consistent across the time period of interest (2017-2020). In the context of the present analysis, the term "men" is used to refer to respondents who reported male sex and the term "women" is used to refer to respondents who reported female sex.

The CCHS covers the population aged 12 years and older living off reserve in all provinces and territories. It excludes full-time members of the Canadian Armed Forces, children in foster care, institutionalized persons, as well as those living in the Quebec health regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James. The survey uses the Labour Force Survey (LFS) area frame for sampling the adult population (18 years and older) and the Canada Child Benefit (CCB) frame for sampling those aged 12 to 17 for an annual sample of 65,000 individuals.

Response rates for the 2017 to 2020 annual cycles ranged from 54% to 63%, with the exception of the 2020 cycle, which was much lower at 30% due to pandemic-related data collection challenges (see below). In order to produce good quality estimates for those living in the Territories, data from two-year files were used for all provinces and regions, which combined four annual CCHS cycles (2017-18 and 2019-20).

Indigenous identity refers to whether a person identified as First Nations, Métis or Inuit. Indigenous people reporting multiple identities were not included in the analysis due to small sample sizes. In addition, the distinction between Status and non-Status First Nations people is not captured in the CCHS. Overall, there were 6,519 single-identity Indigenous respondents in 2017-2018; and 5,147 in 2019-2020.

It is important to note that in 2020, the COVID-19 pandemic disrupted data collection in the North. In-person interviews are typically the only mode of collection for remote areas in this region but were largely suspended due to the pandemic with data collection limited to only the three capitals in the Territories (i.e., Whitehorse, Yellowknife and Iqaluit).

These restrictions significantly lowered response rates, and as a result, the target population coverage for the 2019-2020 period was approximately 82% in the Yukon, 70% in the Northwest Territories and 56% in Nunavut, compared with 2017-2018 rates of 94%, 96% and 93%, respectively. In particular, response rates for the Inuit population were much lower in 2020.

There were adjustments made to overall survey weights to minimize bias, nonetheless, caution should be exercised when using these data.

Methods

Given these pandemic-related impacts on response rates in the North in 2020 and to allow for further disaggregation, this analysis uses the combined 2017-2020 CCHS data, i.e., combining the 2017-2018 and 2019-2020 two-year files.

This study also uses Statistics Canada's Remoteness Index (RI) and related classification to categorize all Census Subdivisions (CSDs) into varying levels of remoteness, based on their proximity to population centres[4] (within a 200 km radius) as a proxy for concentrations of population and economic activities as well as a general measure of service accessibility (Alasia et al., 2017; Subedi et al., 2020).

The manual method is used to classify respondents' place (CSD) of residence into 5 categories based on RI thresholds established by Subedi et al. (2020)[5]: **easily accessible** (e.g., Calgary, Alberta; Port Hope, Ontario); **accessible** (e.g., Halifax, Nova Scotia; Shediac, Quebec); **less accessible** (e.g., Sunnyside, Newfoundland and Labrador; Wickham, New Brunswick); **remote** (e.g., Yellowknife, Northwest Territories; Thunder Bay, Ontario); and **very remote** areas (e.g., Boyer 164, Alberta; Cambridge Bay, Nunavut).

Comparisons with the non-Indigenous population are provided when necessary for context, and testing was conducted at the 0.05 significance level to indicate any statistically significant differences between groups and

4. The term "population centres" refers to the Statistics Canada definition of an area with a population of at least 1,000 and a density of 400 or more people per square kilometre; the population centres defined by Statistics Canada are used in the computation of remoteness index scores (for a detailed definition see Population centre).
5. Remoteness Index (RI) values are usually calculated based on existing Census-based CSD geography and are updated accordingly for new census cycles. The classification of remoteness for CSDs in this combined 2017-2020 CCHS dataset was done using RI values and thresholds based on Census 2016 CSD geography. As such, the assigned values and remoteness class may not reflect the current accessibility profile of a CSD but that seen in 2016.

across various characteristics within groups. The CCHS sample and bootstrap weights were used to calculate estimates and associated variances for producing 95% confidence intervals and statistical testing outputs.

In addition, a multivariate logistic regression analysis was conducted to examine the impact of socio-demographic and health-related factors on access to a regular health care provider among Indigenous people in 2017-2020.

Per the CCHS recommended confidentiality guidelines for the release of proportions, estimates that were not based on a minimum unweighted sample size of 10 respondents in the domain with the characteristic and 20 respondents in the total domain of interest were suppressed (indicated with an "X"). In addition, all estimates or proportions having coefficients of variation (CV) greater than 15.0% but less than or equal to 35.0% were assigned with the data quality indicator (DQI) of "E" and should be used with caution. Those with a CV of greater than 35.0% were assigned a DQI of "F" and were not reliable enough to be published.

Results

Study population

Table 1 below presents the characteristics of the population represented by the sample of First Nations people living off reserve, Métis, Inuit and non-Indigenous people from the combined 2017 to 2020 CCHS cycles.

The proportion of women was larger than men among First Nations people living off reserve and Inuit whereas the reverse pattern was seen among Métis. Age-wise, just over one in ten First Nations people (11.9%), Métis (10.6%) as well as Inuit (13.4%) were aged between 12 and 17 years, compared to only 7.0% of their non-Indigenous counterparts. Likewise, around one-third of First Nations people (34.6%), Métis (33.5%) and Inuit (36.5%) were aged 18 to 34 years, while only one-quarter of non-Indigenous people (26.2%) were within that age group.

Geographically, the highest proportions of First Nations people living off reserve resided in Ontario (34.3%), followed by British Columbia (17.5%) and Alberta (11.7%). Among Métis, the pattern was similar—Ontario had the largest proportion (23.0%), followed by Alberta (20.5%) and British Columbia (15.4%) (Table 1). Among Inuit, more than half (53.4%) lived in Inuit Nunangat (excluding the Nunavik Region) with the majority (86.4%) living in Nunavut.

In 2017-2020, 68.0% of Inuit lived in remote or very remote areas compared to 13.5% of First Nations people, 10.5% of Métis, and 3.3% of non-Indigenous people.

Around six in ten Inuit (59.0%) reported having no chronic conditions[6] reflecting their younger age structure and other possible factors such as under-diagnosis due to barriers to health care services including diagnostics, under-reporting related to stigma and normalization of ill health (Horrill et al., 2019; Smylie, Firestone, Spiller, & Tungasuvvingat Inuit, 2018). Just under one-half of First Nations people (46.2%) and Métis (46.0%) reported the same, while among non-Indigenous people, 54.9% reported having no chronic conditions. A similar pattern was seen among the various groups for self-rated health.

While household income distribution[7] was fairly similar across quartiles for Métis and non-Indigenous people, the distribution was skewed towards lower quartiles of income among First Nations people and Inuit. Around one-third (33.0%) of Inuit and two-fifths (39.8%) of First Nations people had household incomes within the lowest quartile (Table 1).

6. Respondents were asked if they had been diagnosed with any of the following chronic conditions by a health professional: asthma, arthritis (excluding fibromyalgia), high blood pressure, chronic obstructive pulmonary disease (COPD), diabetes, heart disease, cancer, suffering from the effects of a stroke, Alzheimer's Disease or any other dementia, a mood disorder such as depression or an anxiety disorder such as panic disorder. The list of chronic conditions was limited to only those appearing on both the 2017-18 and 2019-20 CCHS cycles.
7. For household income quartiles, the quartiles were first calculated by province or region and then merged to create the overall distribution. This was done to account for differences in income by region due to factors such as differences in the cost of living.

Table 1
Percentage distribution of the study population aged 12 and older, by Indigenous identity and selected characteristics, Canada, 2017-2020

	First Nations people living off reserve	Métis	Inuit	Non-Indigenous
	percent			
Sex				
Male	46.3	51.6	45.8	49.4
Female	53.7	48.4	54.2	50.6
Age				
12-17 years	11.9	10.6	13.4	7.0
18-34 years	34.6	33.5	36.5	26.2
35-64 years	43.1	45.9	40.2	46.8
65 years and older	10.4	10.0	9.9[E]	20.0
Remoteness Classification (2016)				
Easily accessible	43.8	40.4	14.7[E]	70.7
Accessible	27.5	32.3	10.2[E]	18.9
Less accessible	15.2	16.8	7.1[E]	7.2
Remote	11.0	9.8	27.6	3.1
Very remote	2.5	0.7[E]	40.4	0.2
Province or region of residence				
Newfoundland and Labrador	5.5	1.2	..	1.4
Maritimes	5.6	5.5	..	5.1
Quebec[1]	8.6	11.0	..	23.3
Ontario	34.3	23.0	..	39.5
Manitoba	6.7	12.4	..	3.2
Saskatchewan	7.5	10.4	..	2.7
Alberta	11.7	20.5	..	11.4
British Columbia	17.5	15.4	..	13.3
Territories	2.6	0.7	..	0.2
Inuit Regions[1]				
Inside Inuit Nunangat	..	..	53.4	0.0
Nunatsiavut	..	..	X	X
Inuvialuit	..	..	13.0[E]	19.9[E]
Nunavut	..	..	86.4	79.8
Outside Inuit Nunangat	..	..	46.6	100.0
Chronic conditions				
None	46.2	46.0	59.0	54.9
One	24.2	24.6	21.3	24.2
Two or more	29.6	29.4	19.8	21.0
Perceived health				
Excellent/very good/good	81.8	84.1	86.5	89.4
Fair/poor	18.2	15.9	13.5	10.6
Household income quartiles				
First	39.8	28.9	33.0	24.6
Second	24.2	23.6	23.9	24.9
Third	22.3	25.2	24.3	25.1
Fourth	13.8	22.4	18.8	25.5

.. not available for 2017-2020
[E] use with caution
X suppressed to meet the confidentiality requirements of the *Statistics Act*
1. The Canadian Community Health Survey (CCHS) excludes persons living in the Quebec Health Regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James.
Notes: Responses 'not stated', 'don't know' and/or refusal are excluded from the calculation of the percentages. Due to rounding, totals may be different from the sum of all percentages.
Source: Statistics Canada, Canadian Community Health Survey (CCHS) combined two-year files (2017-2018 and 2019-2020) and Remoteness Index Classification (2016).

Among First Nations people living off reserve, Métis and Inuit, men and younger adults aged 18 to 34 were least likely to have a regular health care provider

Access to a regular health care provider (RHCP) plays an important role in preventative care and managing ongoing medical conditions. Respondents to the CCHS were asked whether they have a RHCP that they consult with regularly.

In 2017-2020, significantly higher proportions of First Nations people living off reserve (20.3%), Métis (17.9%) and Inuit (56.5%) reported being without a RHCP compared with the non-Indigenous population (14.5%).

Among Indigenous and non-Indigenous people, significantly more men than women reported that they were without a RHCP. For instance, among First Nations people, almost one-quarter of men (24.3%) did not have a RHCP, compared with 16.8% of women. Higher proportions for men as compared to women were also observed among Métis (23.0% vs. 12.5%), Inuit (62.4% vs. 51.5%) and non-Indigenous people (18.2% vs. 10.9%) (Table 2).

Younger adults aged 18 to 34 were least likely to have a RHCP in 2017-2020 when compared to all other age groups, with this being the case for approximately one in four First Nations (26.3%), Métis (24.7%) and non-Indigenous (25.1%) younger adults. Among Inuit, the proportion was much higher with around two-thirds (66.0%) of younger adults not having one. Across all groups, seniors (aged 65 and older) were the most likely to have a RHCP, particularly among Métis and non-Indigenous people. While a higher proportion of Inuit seniors had a RHCP compared to younger adults, about four in ten (41.7%[E]) still reported that they did not have one (Table 2).

Eight in ten Inuit and one-half of off-reserve First Nations people and Métis living in very remote areas in 2017-2020 did not have a regular health care provider

The proportion of people without a regular health care provider (RHCP) was highest among those living in very remote and remote areas. About one-half of off-reserve First Nations people (50.4%) and Métis (51.7%[E]) living in very remote areas in 2017-2020 did not have a RHCP, compared to less than one-third (30.1%) among non-Indigenous people. In remote areas, around one-quarter of First Nations people and Métis reported not having a RHCP (26.6% and 25.8% respectively), while the corresponding proportion among non-Indigenous people was 17.5%.

The highest proportions were seen among Inuit, with about eight in ten (81.6%) of those living in very remote areas and close to two-thirds (64.6%) of those in remote areas not having a RHCP (Table 2). Inuit communities in Canada's North are more geographically isolated with over two-thirds (69.0%) of the Inuit population in 2021 residing in Inuit Nunangat (the Inuit homeland) (Statistics Canada, 2021).

Access to a regular health care provider among off-reserve First Nations people and Métis is lowest in the Territories and highest in Ontario

Access to a regular health care provider (RHCP) was lowest in the Territories and highest in Ontario among First Nations people living off reserve and Métis. In the Territories, about one-half of First Nations people (52.2%) and Métis (49.3%) reported not having a RHCP, while around one in ten reported the same in Ontario (12.3% and 11.8%[E], respectively). Similar findings, albeit at lower proportions, were seen among non-Indigenous people in those regions (Table 2).

Among Inuit living inside Inuit Nunangat (excluding the region of Nunavik[8]), well over eight in ten (84.5%) did not have a RHCP, compared with one in five (24.5%[E]) of those living outside Inuit Nunangat.

8. The CCHS sample does not include those living in the health region of Région du Nunavik.

Table 2
Percentage of First Nations people living off reserve, Métis, Inuit and non-Indigenous people aged 12 and older without a regular health care provider, by selected characteristics, Canada, 2017-2020

	First Nations people living off reserve	Métis	Inuit	Non-Indigenous
	percent			
Sex				
Male†	24.3	23.0	62.4	18.2
Female	16.8*	12.5*	51.5*	10.9*
Age				
12-17 years	23.8	22.6	51.4	12.9
18-34 years†	26.3	24.7	66.0	25.1
35-64 years	16.4*	14.1*	53.1*	12.6*
65 years and older	12.4*	7.5E*	41.7E*	5.8*
Remoteness Classification (2016)				
Easily accessible†	19.2	15.9	X	14.7
Accessible	20.6*	18.2	X	13.7
Less accessible	13.4*	16.2	X	13.7*
Remote	26.6*	25.8*	64.6	17.5*
Very remote	50.4*	51.7E*	81.6	30.1*
Province or region of residence				
Newfoundland and Labrador	13.0E	23.2E*	..	12.6*
Maritimes	16.9E	15.3E	..	11.7*
Quebec[1]	22.6E*	17.1	..	21.0*
Ontario†	12.3	11.8E	..	9.5
Manitoba	25.7*	18.0*	..	15.4*
Saskatchewan	29.2*	19.7*	..	17.2*
Alberta	24.7*	21.7*	..	15.1*
British Columbia	24.6*	20.3*	..	18.0*
Territories	52.2*	49.3*	..	32.3*
Inuit Regions[1]				
Inside Inuit Nunangat†	..	..	84.5	73.3
Nunatsiavut	..	..	X	X
Inuvialuit	..	..	86.2	77.5
Nunavut†	..	..	84.6	72.5
Outside Inuit Nunangat	..	..	24.5E*	14.5*
Chronic conditions				
None†	24.8	25.0	63.7	19.5
One	20.5	13.9*	53.4	10.4*
Two or more	13.1*	10.1*	38.5E*	6.2*
Perceived health				
Excellent/very good/good†	20.4	19.1	57.2	15.1
Fair/poor	19.8	11.3E*	51.9	9.8*
Household income quartiles				
First†	25.0	20.6	58.8	18.8
Second	20.6	18.9	58.5	14.7*
Third	14.7*	17.4	56.6	13.0*
Fourth	15.2E*	13.9*	49.6	11.7*

.. not available for 2017-2020
† reference category
E use with caution
X suppressed to meet the confidentiality requirements of the *Statistics Act*
* significantly different from reference category ($p < 0.05$)
1. The Canadian Community Health Survey (CCHS) excludes persons living in the Quebec Health Regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James.
Notes: Responses 'not stated', 'don't know' and/or refusal are excluded from the calculation of the percentages. Due to rounding, totals may be different from the sum of all percentages.
Source: Statistics Canada, Canadian Community Health Survey (CCHS) combined two-year files (2017-2018 and 2019-2020) and Remoteness Index Classification (2016).

First Nations people living off reserve, Métis and Inuit with two or more chronic conditions nearly twice as likely as those with none to have a regular health care provider

Among First Nations people living off reserve, a higher percentage of those without chronic conditions reported being without a regular health care provider compared to those with two or more chronic conditions (24.8% vs. 13.1%, respectively). Similar findings were seen among Inuit, although at much higher proportions (63.7% vs. 38.5%E). Among Métis, one-quarter (25.0%) of those without chronic conditions did not have a RHCP, compared to 13.9% of those with one condition and 10.1% of those with two or more conditions.

Among those with two or more chronic conditions, First Nations people (13.1%), Inuit (38.5%E) and Métis (10.1%) were more likely to be without a RHCP than non-Indigenous people (6.2%) (Table 2).

Proportion with a regular health care provider lower among First Nations people living off reserve and Métis in lower-income households

Higher percentages of those in lower income households reported not having an RHCP compared to those in higher income households. For example, one in four (25.0%) First Nations people living off reserve with household income in the lowest quartile reported not having an RHCP, compared to 15.2%E of those in the highest income quartile. Similar findings were seen among Métis and non-Indigenous people.

Among Inuit, no significant differences were seen in the percentage of people without a RHCP across household income groups (Table 2). This may be related to the fact that many Inuit live in small communities in remote and very remote areas, which have limited access to primary health care due to geographical constraints and challenges in recruitment of health care professionals (Young et al., 2017).

A logistic regression analysis confirmed the descriptive findings regarding the characteristics associated with not having a RHCP (Table A1 in the Appendix).

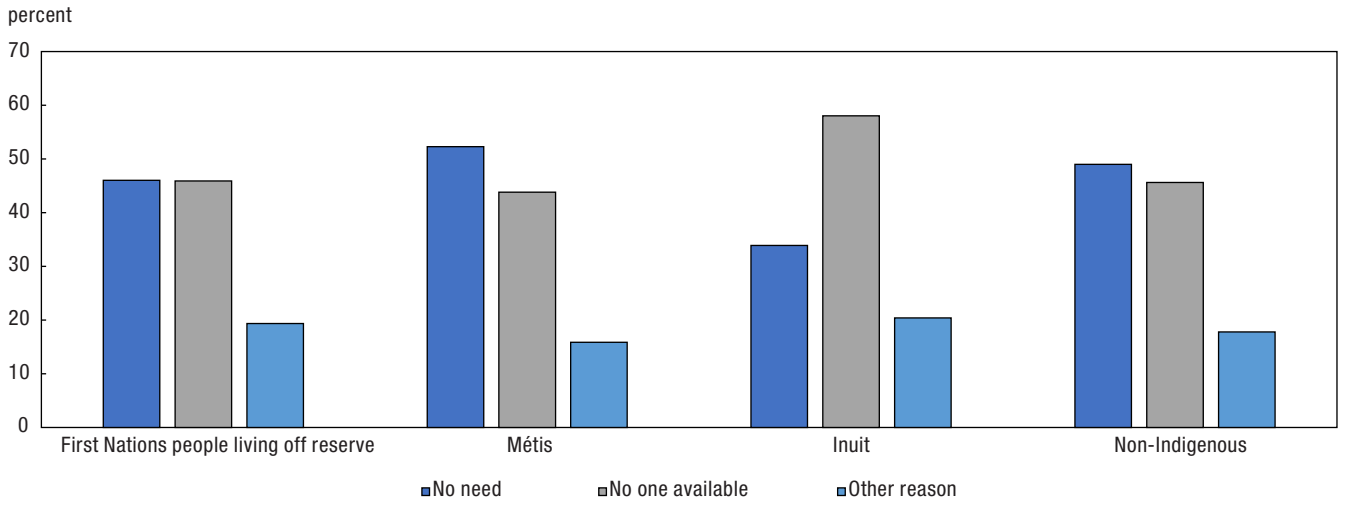
Lack of availability of a regular health care provider more commonly reported as the reason for not having one among off-reserve First Nations and Métis women and seniors

Those who reported that they did not have a regular health care provider (RHCP) were asked for the reasons why[9]. For this analysis, these categories were grouped as follows: (1) Lack of need (e.g., they do not need one, but they have a usual place of care, or they didn't try to find one); (2) Lack of availability (e.g., no one was available, no one was taking new patients in the area or their previous RHCP left or retired); and, (3) Other reasons (i.e., a catch-all category for reasons not included elsewhere in the question).

Overall, similar proportions of First Nations people living off reserve reported not having a RHCP due to lack of availability (45.9%) and not needing one because they had a usual place of care (46.0%). Among Métis, a higher proportion reported not having a RHCP because they did not need one (52.3%) compared to lack of availability (43.8%), which was also the case among non-Indigenous people (49.0% and 45.6%, respectively) (Chart 1). Among Inuit, lack of availability of RHCPs (58.1%) was the most prevalent reason for not having one, compared to lack of need (33.9%).

9. Response categories to the question "What are the reasons why you do not have a regular health care provider?" were (and multiple categories could be selected by each respondent): (a) Do not need one in particular, but you have a usual place of care; (b) No one available in the area; (c) No one in the area is taking new patients; (d) Have not tried to find one; (e) Had one who left or retired; and (f) Other.

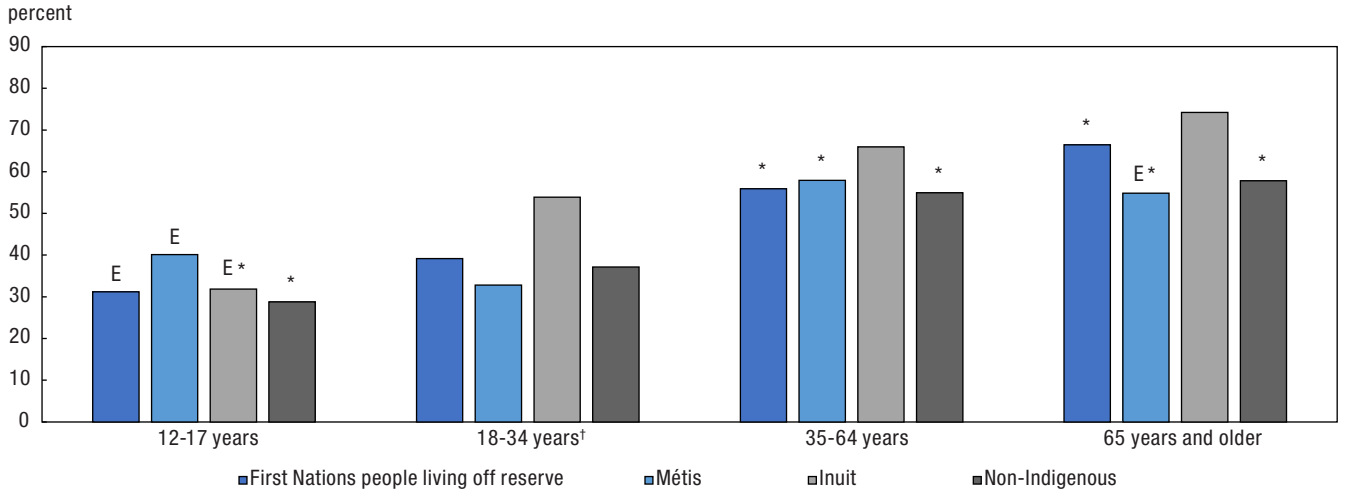
Chart 1
Reasons for not having a regular health care provider among First Nations people living off reserve, Métis, Inuit and non-Indigenous people aged 12 and older without a regular health care provider, Canada, 2017-2020



Notes: The "No need" category includes those who felt they did not need a regular health care provider but had a usual place of care, or those who have not tried to find one. The "No one available" category includes people who reported not having a regular health care provider because none were available in the area or no one in the area was taking new patients or they had a provider who left. Respondents to the question asking for the reasons for not having a regular health care provider could choose multiple response categories at once. As a result, the percentages seen here across categories do not add to 100%. Responses 'not stated', 'don't know' and/or refusal are excluded from the calculation of the percentages.
Source: Statistics Canada, Canadian Community Health Survey (CCHS) combined two-year files (2017-2018 and 2019-2020).

First Nations and Métis seniors (aged 65 and older) were more likely than younger adults (aged 18 to 34) to report not having a RHCP because none were available (Chart 2), whereas higher proportions of First Nations and Métis younger adults reported lack of need for one as the main reason. Similar findings were seen among non-Indigenous people.

Chart 2
Percentage of First Nations people living off reserve, Métis, Inuit and non-Indigenous people who reported lack of availability as a reason for not having a regular health care provider, by age group, Canada, 2017-2020



† reference category
E use with caution
* significantly different from reference category ($p < 0.05$)
Notes: "Lack of availability" includes people who reported not having a regular health care provider because none were available in the area or no one in the area was taking new patients or they had a provider who left. Responses 'not stated', 'don't know' and/or refusal are excluded from the calculation of the percentages.
Source: Statistics Canada, Canadian Community Health Survey (CCHS) combined two-year files (2017-2018 and 2019-2020).

Off-reserve First Nations people and Métis living in the Prairie provinces less likely to cite availability issues as a reason for not having a regular health provider compared to other regions

Over one-half of First Nations people living off reserve (51.0%) and Métis (51.6%[E]) in Ontario who did not have a RHCP reported that the reason why was lack of availability, compared with 42.9% among their non-Indigenous counterparts. In the Prairie provinces, the proportions were lower, with around one-quarter of First Nations people in Manitoba and Alberta (27.4%[E] and 24.1%[E], respectively) citing availability issues, while 26.1%[E] of Métis in Saskatchewan and 28.7%[E] in Alberta did so.

Like their non-Indigenous counterparts, significantly more Métis in the Atlantic region reported a lack of availability as a barrier compared to those in Ontario (76.5% vs. 51.6%[E]). Six in ten (60.1%) Inuit living in Inuit Nunangat cited this reason for not having a RHCP as well.

Among First Nations people living off reserve who reported not having a RHCP, those in very remote areas (61.3%) were much more likely than those in accessible (55.9%) and easily accessible areas (37.2%) to cite lack of availability as a reason.

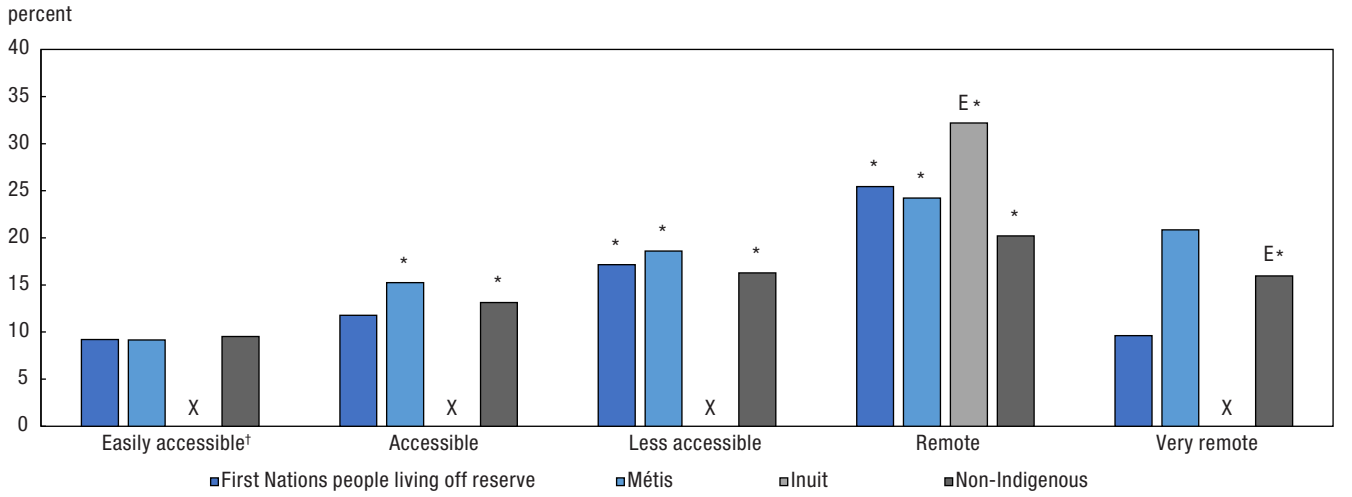
One-quarter of off-reserve First Nations people and Métis as well as one-third of Inuit living in remote areas reported waiting more than 2 weeks for an appointment with their regular health care provider

Respondents to the CCHS who reported that they had a regular health care provider (RHCP) were asked about the length of wait times for appointments with their provider or another provider in the same office for immediate care for a minor problem. For the purposes of analysis, responses to this question were grouped into the following four categories: Same day or next day; 2 to 6 days; 1 to 2 weeks and more than 2 weeks.

In 2017-2020, similar proportions of First Nations people living off reserve (12.9%), Métis (14.2%), Inuit (11.6%E) and non-Indigenous people (11.0%) reported waiting for more than 2 weeks for an appointment with their RHCP.

Those living in remote areas were much more likely than those living in easily accessible areas to report having to wait for more than 2 weeks. Around one-quarter of First Nations people (25.4%) and Métis (24.2%) living in remote areas indicated that they had to wait more than 2 weeks to see their RHCP, compared to one in ten for those in easily accessible areas (Chart 3).

Chart 3
Percentage of the population aged 12 and older who reported having to wait more than 2 weeks for an appointment with a regular health care provider, by Indigenous identity and remoteness category, Canada, 2017-2020



† reference category
E use with caution
X suppressed to meet the confidentiality requirements of the *Statistics Act*
* significantly different from reference category ($p < 0.05$)
Notes: Wait time analysis applies to those who reported having a regular health care provider. The remoteness category for respondents' place of residence was determined using the manual classification method as outlined in Subedi et al. (2020). Responses 'not stated', 'don't know' and/or refusal are excluded from the calculation of the percentages.
Source: Statistics Canada, Canadian Community Health Survey (CCHS) combined two-year files (2017-2018 and 2019-2020) and Remoteness Index Classification (2016).

A higher proportion of First Nations people living off reserve, Métis and non-Indigenous people in easily accessible areas than in remote areas reported being able to see their RHCP within the same or next day. Interestingly, among off-reserve First Nations people, those living in very remote areas (54.1%) were more likely to be able to book same or next day appointments than those in easily accessible areas (42.4%), which was not the case among Métis or non-Indigenous people.

Wait times of more than two weeks for immediate care needs more commonly reported among First Nations people living off reserve and Métis in the Atlantic region and Quebec

The proportion of First Nations people living off reserve and Métis reporting the longest wait times of more than 2 weeks to see their regular health care provider (RHCP) was higher in the Atlantic provinces (19.7% and 20.9%[E] respectively) and Quebec (17.7%[E] and 27.0%, respectively), relative to Ontario (12.9% and 13.6%, respectively). Similar findings were seen among non-Indigenous residents of Quebec (22.7%) and the Atlantic region (17.1%), compared to those in Ontario (7.8%).

In contrast, those living in Alberta, Saskatchewan and British Columbia were the least likely to report waiting for more than 2 weeks among off reserve First Nations people, Métis and non-Indigenous people. The general similarity in regional patterns across groups speaks to the jurisdictional aspect of the public health care system in Canada, delivered primarily by provincial and territorial governments.

Off-reserve First Nations, Métis and Inuit men and those younger than 35 years were less likely to have a usual place of care

Having a usual place of care has also been shown to be significantly associated with greater odds of receiving preventive and screening services such as flu shots and pap tests (Blewett et al., 2008). The CCHS asked respondents if there was a place that they usually go to and if so, the type of place it was. There were 6 categories to choose from: (1) Doctor's office; (2) Hospital outpatient clinic; (3) Community health centre (or CLSC[10]); (4) Walk-in clinic; (5) Hospital emergency room; and (6) Other.

10. CLSCs (centre local de services communautaires) are free clinics and hospitals run by the government of Quebec.

Around one in ten First Nations people living off reserve (11.7%), Métis (12.5%) and Inuit (10.1%) reported not having a usual place of care for minor health problems, similar to non-Indigenous people (11.4%). A higher proportion of men than women reported not having a usual place of care across all Indigenous groups and among non-Indigenous people.

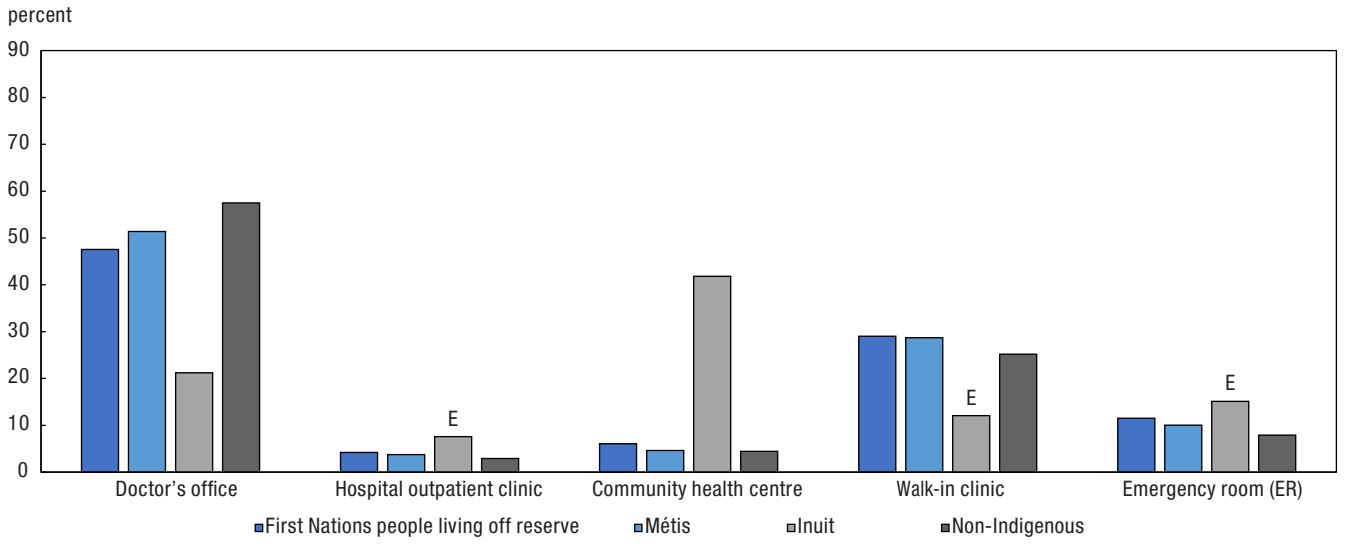
When examining the absence of a usual place of care by age group, a similar pattern emerged among all groups where younger people reported not having a usual place of care more so than older adults. For instance, 14.3% of First Nations people aged 18 to 34 did not have a usual place of care compared to 8.8% of those aged 35 to 64. Age-based differences were most extreme among Inuit where the youngest age group, aged 12 to 17, were nearly three times more likely to not have a usual place of care compared to those aged 18 to 34 (24.6%[E] vs. 9.2%[E]).

By remoteness level, a higher proportion of Métis in easily accessible areas (13.9%) reported not having a usual place of care, compared to those in very remote areas (2.9%). A similar observation was noted among non-Indigenous people (12.0% and 8.0%, respectively). In contrast, a higher percentage of Inuit living in very remote areas (10.6%) reported that they did not have a usual place of care compared to those in easily accessible areas (2.5%).

About half of First Nations people living off reserve and Métis in 2017-2020 reported a doctor's office as their usual place of care while two-fifths of Inuit reported using community health centres

Roughly one-half of First Nations people (47.6%) and Métis (51.4%) reported using a doctor's office as their usual place of care for minor health problems, followed by walk-in clinics. Among Inuit, one-fifth (21.2%) reported using a doctor's office while about double that proportion (41.8%) used community health centres. In contrast, around six in ten (57.5%) non-Indigenous people used a doctor's office as their place of care (Chart 4).

Chart 4
Percentage distribution of the type of usual place of care among First Nations people living off reserve, Métis, Inuit and non-Indigenous people aged 12 and older who had a usual place of care, Canada, 2017-2020



[E] use with caution
Notes: Responses to the question on type of usual place of care included a category for "Some other place" of care which is not shown as a result of data suppression to meet Statistics Canada confidentiality guidelines. Responses 'not stated', 'don't know' and/or refusal are excluded from the calculation of the percentages.
Source: Statistics Canada, Canadian Community Health Survey (CCHS) combined two-year files (2017-2018 and 2019-2020).

Indigenous women and adults aged 35 and over were more likely than men and younger adults to report a doctor's office as their usual place of care

Across the three Indigenous groups and the non-Indigenous population, a higher proportion of women than men reported that they received their usual care from a doctor's office. Among First Nations people living off reserve,

over one-half of women (52.1%) reported using a doctor's office compared to four in ten men (41.9%). The reverse was seen for the use of a walk-in clinic, with fewer First Nations women (26.1%) reporting it as a usual place of care, compared to men (32.6%).

Similar patterns were seen among Métis and Inuit men and women, though at higher proportions among Métis and lower proportions among Inuit. In addition, a higher proportion of Métis men used an emergency room (12.1%) as their usual place of care, compared to women (8.0%).

While the more commonly reported place of care among Inuit was community health centres, significantly more men (49.0%) than women (36.2%) reported them as their usual place of care.

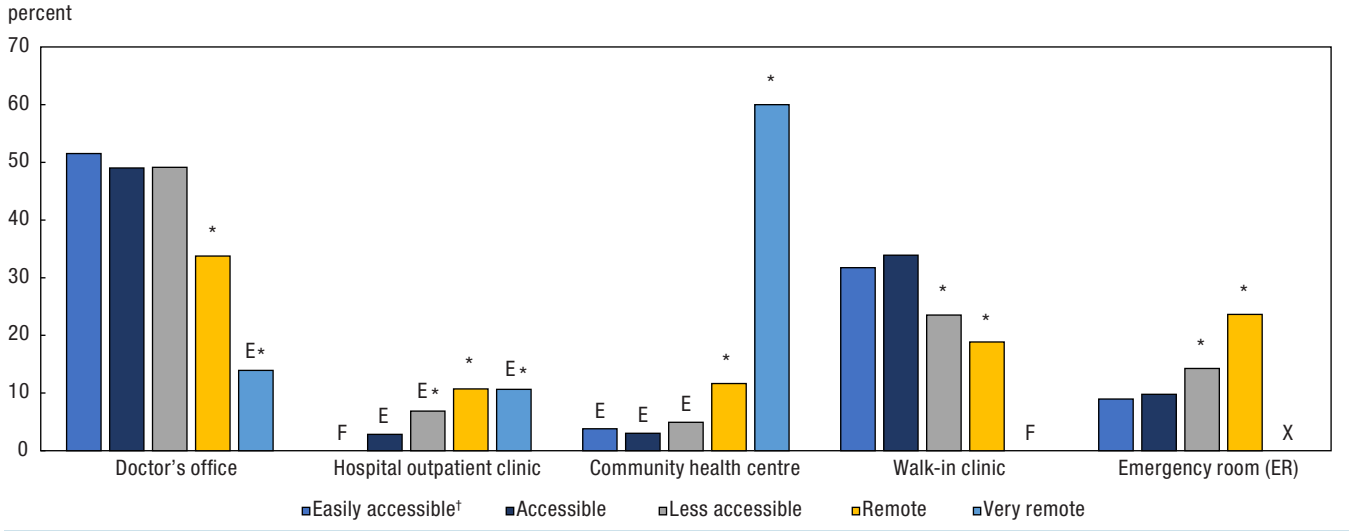
In general, Indigenous and non-Indigenous adults aged 35 and older were more likely to report a doctor's office, and less likely to report a walk-in clinic, as their usual place of care than those aged 18 to 34. Emergency room (ER) use as a usual place of care was significantly higher among Métis youth aged 12 to 17 compared to older age groups.

Off-reserve First Nations people, Métis and Inuit living in more remote areas were more likely to report that their usual place of care was a community health centre or emergency room

Among First Nations people living off reserve, over half (51.5%) of those living in easily accessible areas reported a doctor's office as their usual place of care compared to 13.9%[E] of those living in very remote areas.

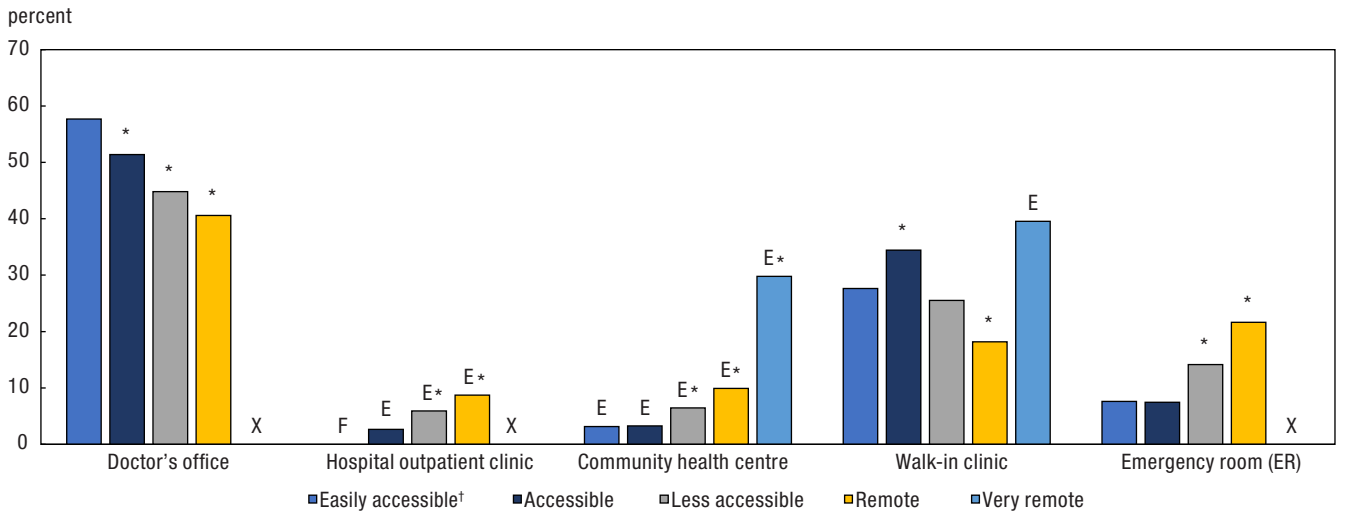
In contrast, six in ten (60.0%) First Nations people in very remote areas reported using a community health centre as their usual place of care compared with 3.8%[E] of those in easily accessible areas. Those living in remote areas were also more likely to use an ER (23.7%) than those in easily accessible areas (9.0%), and less likely to use a walk-in clinic (18.9% and 31.7%, respectively) (Chart 5). Generally, similar findings were also seen among Métis (Chart 6).

Chart 5
Percentage distribution of the type of usual place of care among First Nations people living off reserve aged 12 and older who had a usual place of care by remoteness category, Canada, 2017-2020



† reference category
[E] use with caution
X suppressed to meet the confidentiality requirements of the *Statistics Act*
F too unreliable to be published
* significantly different from reference category ($p < 0.05$)
Notes: Responses to the question on type of usual place of care included a category for "Some other place" of care which is not shown as a result of data suppression to meet Statistics Canada confidentiality guidelines. The remoteness category for respondents' place of residence was determined using the manual classification method as outlined in Subedi et al. (2020). Responses 'not stated', 'don't know' and/or refusal are excluded from the calculation of the percentages.
Source: Statistics Canada, Canadian Community Health Survey (CCHS) combined two-year files (2017-2018 and 2019-2020) and Remoteness Index Classification (2016).

Chart 6
Percentage distribution of the type of usual place of care among Métis aged 12 and older who had a usual place of care by remoteness category, Canada, 2017-2020



† reference category
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* significantly different from reference category ($p < 0.05$)
Notes: Responses to the question on type of usual place of care included a category for "Some other place" of care which is not shown as a result of data suppression to meet Statistics Canada confidentiality guidelines. The remoteness category for respondents' place of residence was determined using the manual classification method as outlined in Subedi et al. (2020). Responses 'not stated', 'don't know' and/or refusal are excluded from the calculation of the percentages.
Source: Statistics Canada, Canadian Community Health Survey (CCHS) combined two-year files (2017-2018 and 2019-2020) and Remoteness Index Classification (2016).

Inuit had the largest difference between the use of a doctor's office and a community health centre across levels of remoteness. While 80% of Inuit in accessible areas usually received care from a doctor's office, 91.6% of those living in very remote areas reported using a community health centre.

One-quarter of First Nations people living off reserve and one-third of Métis using a doctor's office as a usual place of care had access to a primary health care team

Respondents who had a doctor's office as a usual place of care were asked about the type of office (practice) it was. Response categories were: (1) a doctor working in solo practice; (2) a doctor working with a team of health care professionals[11]; (3) multiple doctors working independently; and (4) other.

Approximately 24.9% of First Nations people living off reserve whose usual place of care was a doctor's office reported that it comprised of a team of health care professionals, similar to their non-Indigenous counterparts (26.0%). The proportion was higher among Métis, with one in three (32.8%) having access to a primary health care team.

Off-reserve First Nations people and Métis in easily accessible areas were much more likely to have team-based care than those in less accessible or remote areas

Among First Nations people living off reserve, the proportion of those who had a primary health care team at their doctor's office in easily accessible areas (32.8%) was almost double that seen in accessible areas (17.0%[E]). Among Métis, around four in ten (38.5%) of those living in easily accessible areas had access to team-based care, compared to 17.1%[E] of those living in remote areas and 22.3%[E] of those living in less accessible areas. Similar findings were seen among non-Indigenous people, although the differences across remoteness categories were smaller.

11. The differentiation between doctors working with a team of health care professionals or independently (i.e., 2nd and 3rd categories) may not have been clear to respondents so results should be interpreted with caution.

Discussion

This study used data from the Canadian Community Health Survey (CCHS) from 2017 to 2020 to examine access to primary health care providers (or regular health care providers (RHCP) in the CCHS), team-based care, usual places of care and wait times among First Nations people living off reserve, Métis and Inuit. Indigenous people in Canada experience significant health disparities, such as higher incidence of chronic conditions, and higher prevalence of risk factors related to social determinants of health, including access to quality health care (Kim, 2019).

In 2017-2020, the proportions of First Nations people living off reserve (20.3%), Métis (17.9%) and Inuit (56.5%) without a RHCP were significantly higher than among non-Indigenous people (14.5%). First Nations, Métis and Inuit men, as well as younger adults (18 to 34 years) were significantly more likely to report not having a RHCP, compared with women or older age groups. Differences by sex with women being more likely to use health care services, including primary care, are well-documented in the literature (Bertakis et al., 2023; Wang et al., 2013). This has been attributed to factors such as the need for reproductive care, lower self-reported health status and more psychological openness to seeking care (Bertakis et al., 2023; Mackenzie et al., 2006; Kazanjian et al., 2004).

Higher proportions of Indigenous people with one or more chronic conditions reported having a RHCP, compared to those without a chronic condition, suggesting that higher-need patients were more able to access care. However, First Nations people, Métis and Inuit with two or more chronic conditions were more likely to be without a RHCP, relative to their non-Indigenous counterparts.

Health care access is impacted by many factors including geographic location and the economic conditions under which people live. The Truth and Reconciliation Commission of Canada (2012) called for greater equity across the health care system to improve Indigenous health, especially for those in underserved rural and remote communities, who are also more likely to have ambulatory care sensitive conditions (Canadian Institute for Health Information, 2012) and poorer health outcomes (Sibley & Weiner, 2011; Fleet et al., 2018).

Findings from this study corroborate that primary health care access issues are greater in remote and very remote areas, which have the highest proportions of Indigenous people without a RHCP. This is further highlighted by the fact that those living in the Territories were most likely to lack a RHCP, while those living in Ontario were least likely. Although these patterns by remoteness and region were also seen among non-Indigenous people, the proportions of those without a RHCP were consistently lower overall than among Indigenous people.

Remoteness and economic deprivation are interrelated factors impacting health care access. Indigenous people with lower household incomes were more likely to be without a RHCP, compared to those with higher incomes. Barriers to health care for persons living in low-income conditions can include a difficult living environment, adverse interactions between health care providers and underserved patients, and difficulty navigating complex health care systems (Loignon et al., 2015). These issues are particularly pronounced among Indigenous populations who face a patchwork of health care systems, jurisdictions, and eligibility criteria (National Collaborating Centre for Indigenous Health, 2019).

There is also increased public attention to wait times for health care among Canadians in general (Moir & Barua, 2022). Wait times can have longer term health consequences, which include the development of new or worsening conditions. This study found variations in wait times according to remoteness and region. Those living in remote areas were much more likely than those living in easily accessible areas to report having to wait for more than two weeks to see their RHCP or another provider in the same office. This was more commonly reported by First Nations people living off reserve and Métis in the Atlantic region as well as Quebec and less commonly reported in Alberta, Saskatchewan and British Columbia.

Interestingly, Inuit living inside, rather than outside, Inuit Nunangat (excluding the region of Nunavik) and First Nations people in very remote areas, were more likely to report being able to see their RHCP within the same or next day. However, for many Inuit living in small, scattered communities across the North, primary health care services are provided by nurses rather than physicians, which is more common in the rest of Canada (Young et al., 2017). Nurses in remote areas have had to be adaptable coping with a lack of resources and equipment and sometimes confronted with challenges outside their scope of expertise (MacKinnon & Moffitt, 2014).

The CCHS also asked respondents if they had a usual place of care for immediate care of minor health concerns. Most Indigenous people reported that they had such a place, although paralleling the findings around access to RHCP, women and older adults were more likely to do so. Findings around usual place of care also offer critical insights on where Indigenous people are accessing care and the composition of that care.

Overall, roughly half of First Nations people living off reserve and Métis in 2017-2020 reported a doctor's office as their usual place of care, while 41.8% of Inuit reported using community health centres. Among all three Indigenous groups, a higher proportion of women and older adults reported receiving their usual care from a doctor's office. On the other hand, Indigenous men and those under 35 years of age were generally more likely than women and older adults to seek care from a walk-in clinic or ER.

There are important variations in the type of usual place of care accessed by Indigenous people by differing levels of remoteness. Indigenous people living in more remote areas were generally less likely to report receiving care from a doctor's office or using walk-in clinics, and more likely to have received care from community health centres and ERs. Rural community health centres and ERs face challenges in delivering high quality, accessible and efficient services due to factors including distance from referral centres, access to specialists, human resource procurement and retention, and infrastructure deficiencies (Fleet et al., 2020; Oosterveer & Young, 2015; Jull et al., 2021).

In addition, the CCHS asked respondents whose usual place of care was a doctor's office whether the practice included a team of health care professionals. There is documented evidence of the health benefits of primary health care teams. A systematic review synthesizing the available empirical evidence from various countries, including Canada, found that a multidisciplinary, team-based primary health care model is associated with improved disease screening and preventive services, improved chronic disease management and decreased hospital use (Wranik et al., 2019). However, in 2017-2020, only one-quarter of First Nations people living off reserve and one-third of Métis using a doctor's office as their usual place of care had access to a primary health care team, with greater likelihood of such care among those living in easily accessible areas.

The recent COVID-19 pandemic has deepened an already existing capacity crisis in primary care, owing to a range of factors. This included patients presenting to primary care with more complex conditions as various medical services were delayed, and rising burnout rates among physicians as they juggled multiple roles, including supporting public health and surge capacity in ER's (Ontario COVID-19 Science Advisory Table, 2022). These factors accelerated existing trends such as increasing demand from a growing and aging population, declining supply from an aging physician workforce as well as shifts away from comprehensive primary care to other specialties among new graduates and practicing physicians.

The pandemic also exposed many deep-seated health and social inequities, as it had a disproportionate impact on marginalized populations, including Indigenous people (Power et al. 2020; Hahmann & Kumar, 2022), such as worsened overall health, particularly mental health (Arriagada et al., 2020; Hahmann, 2021) compared with non-Indigenous people. A recent report on the State of Public Health Care in Canada during COVID-19 provided insights from First Nations, Métis, and Inuit community members. To mitigate some of the health care access barriers experienced by Indigenous people, it cited the need for increased funding for Indigenous public health programming and the development of specialized services in the North to improve access and Indigenous control in health care (Mashford-Pringle et al., 2021).

Limitations

Data from the Canadian Community Health Survey (CCHS) are not weighted to the Indigenous populations, so they may not reflect the specific characteristics of these populations (e.g., geographic and/or age distribution). Demographic information for Indigenous populations is best obtained from the Census of Population. In addition, the distinction between Status and non-Status First Nations people is not captured in the CCHS.

Due to confidentiality and data quality considerations, some distinctions-based estimates could not be provided at the regional level and across remoteness categories particularly for Inuit. The CCHS did not sample people living on reserves, in the Quebec health regions of Région des Terres-Cries-de-la-Baie-James as well as Région du Nunavik. These exclusions restrict the ability of this report to draw conclusions for Indigenous people more broadly.

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Appendix

Table A1

Predicted marginals, adjusted odds ratios and 95% confidence intervals (CI) for Indigenous people[1] aged 12 and older without a regular health care provider, by selected characteristics, 2017-2020

	Predicted Marginal (%)	Odds ratio (OR)	95% CI (OR)
Sex			
Male†	24.5	1.00	...
Female	16.5	0.57*	(0.48-0.68)
Age			
12 to 17 years	22.8	0.86	(0.65-1.13)
18 to 34 years†	25.3	1.00	...
35 to 64 years	17.6	0.60*	(0.49-0.73)
65 years or older	12.4	0.38*	(0.28-0.50)
Province or region of residence			
Atlantic Region	17.4	1.50*	(1.06-2.12)
Quebec[2]	22.3	2.09*	(1.44-3.03)
Ontario†	12.6	1.00	...
Manitoba	20.7	1.88*	(1.37-2.57)
Saskatchewan	24.0	2.31*	(1.60-3.35)
Alberta	22.6	2.12*	(1.55-2.91)
British Columbia	23.6	2.26*	(1.64-3.12)
Territories	50.6	8.51*	(5.95-12.17)
Remoteness Classification (2016)			
Easily accessible area†	20.3	1.00	...
Accessible area	19.1	0.92	(0.71-1.19)
Less accessible area	15.4	0.69*	(0.53-0.90)
Remote area	26.5	1.48*	(1.16-1.90)
Very remote area	39.5	2.90*	(1.94-4.33)
Chronic conditions			
None†	24.8	1.00	...
One	19.1	0.69*	(0.55-0.86)
Two or more	14.1	0.46*	(0.36-0.58)
Perceived health			
Excellent/very good/good†	20.4	1.00	...
Fair/poor	20.7	1.02	(0.77-1.35)
Household income quartiles			
First†	25.9	1.00	...
Second	21.3	0.75*	(0.60-0.93)
Third	17.2	0.55*	(0.43-0.71)
Fourth	14.6	0.44*	(0.34-0.58)

... not applicable
† reference category
* significantly different from reference category ($p < 0.05$)
1. Excludes First Nations people living on reserve and those reporting multiple Indigenous identity groups (e.g., First Nations and Métis).
2. The Canadian Community Health Survey (CCHS) excludes persons living in the Quebec Health Regions of Région du Nunavik and Région des Terres-Cries-de-la-Baie-James.
Note: Responses 'not stated', 'don't know' and/or refusal are excluded from the calculation of the percentages.
Source: Statistics Canada, Canadian Community Health Survey (CCHS) combined two-year files (2017-2018 and 2019-2020) and Remoteness Index Classification (2016).