

I like to acknowledge the (Musqueam and) Coast Salish peoples for allowing us to gather on their traditional territory. I would also like to thank Chief Leonard George of the Tsleil-Waututh First Nations, also the President of Healing Our Spirit B.C. Aboriginal HIV/AIDS Society, for the Opening Prayer. Good morning, I am Dr. Perry Kendall, the province's Provincial Health Officer. Welcome to the release of the 2001 Provincial Health Officer's Annual Report.

On the panel with me today is Chief Leonard George, whom you have already met and Ms Shaunee Point, Executive Director of the First Nations Chiefs' Health Committee. (Also with us is Ms Deborah Schwartz, Strategy Consultant with the BC Tobacco Strategy Working Group and Ms Lisa Allgaier, Director of Aboriginal Health from the Ministry of Health Planning and several members of government and voluntary organizations intimately involved in initiatives for Aboriginal people.)

The 2001 PHO report provides an update on British Columbia's progress toward the goal of improved health for Aboriginal people. The report was developed over a two-year period, with input and assistance from the Provincial Aboriginal Health Services Strategy Steering Committee, the First Nations Chiefs' Health Committee, the Provincial Metis Council, other Aboriginal groups and organizations, and many individuals involved in the Aboriginal health field. I hope that this report reflects their collective wisdom and that it will be used to improve the lives and health of Aboriginal People in British Columbia.

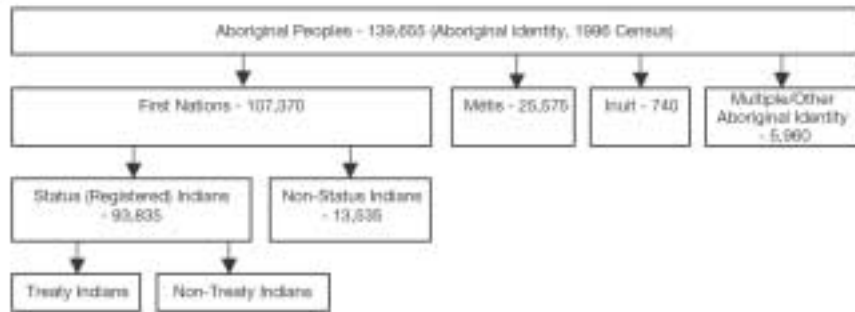
Indicators of Aboriginal Health and Well-Being

Health Status			
Well-Being	General Health	Health Conditions	Deaths
Community Environments			
Employment	Income	Educational Attainment	Participation and Social Integration
Healthy Growth and Development			
Healthy Child Development	Learning Opportunities	Healthy Choices	Healthy Connections
Physical Environment			
Housing and Infrastructure	Air	Water	Environmental Change
Health Services			
Accessibility	Doing the Right Things Right	Culturally-Appropriate Services	
Disease and Injury Prevention			
Non-Communicable Disease	Communicable Disease	Injuries	

The statistics in this report have been drawn from a variety of published and unpublished sources. We used sixty indicators to assess health status, community environments, healthy growth and development, the physical environment, health services, and disease and injury prevention. Where possible, both provincial and regional data are presented, along with information to support development of specific objectives and targets for improvement. Throughout the report, there are examples of programs and strategies that are innovative and have been effective in improving the health of Aboriginal people, in British Columbia or elsewhere in the world.

**Fig.
21**

Terminology Used to Describe Aboriginal People in Canada and B.C. Population, 1996

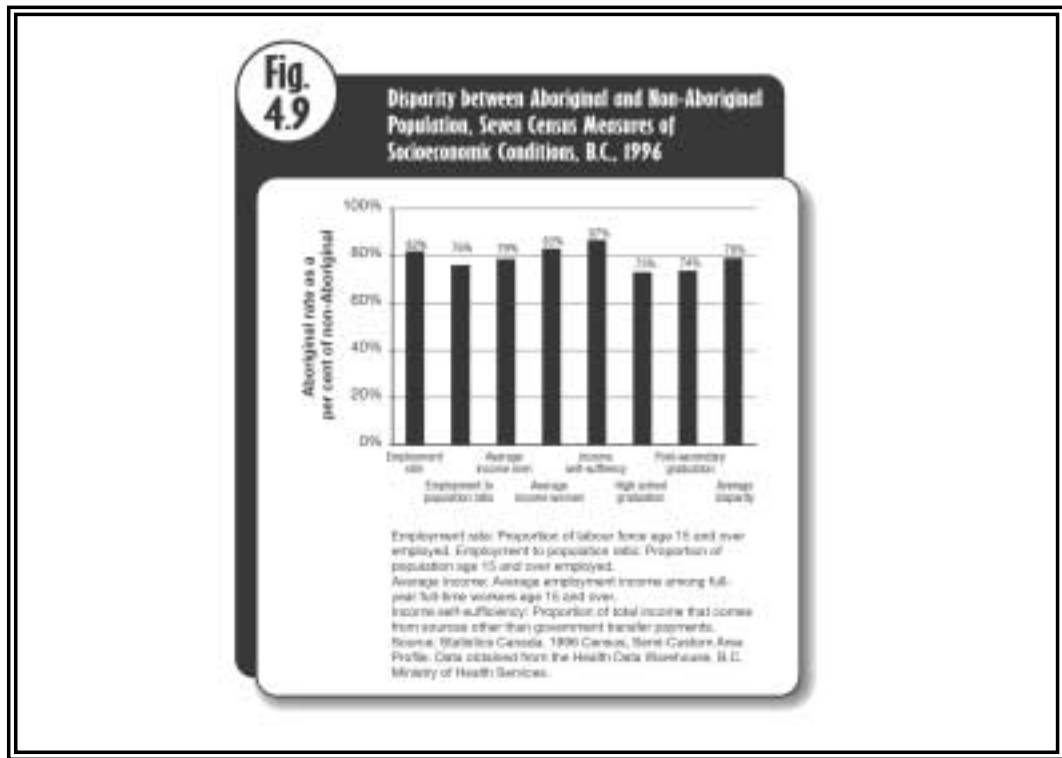


Source : BC Stats., 1996 Census Fast Facts, Focus on BC Aboriginals: Aboriginal Identity, January 1998

Aboriginal people identify themselves in a number of ways based on ancestry, culture, language and legal status. The majority of statistics available to us are gathered on Status (Registered) Indians - representing about 2/3 of the Aboriginal population.

We know much less about non-Status Aboriginal people, Metis or Inuit.

We have therefore had to make assumptions that what we know about some First Nations people can be generalised to others. And this may not be true. It would certainly be helpful to have better, more specific information than we do now.

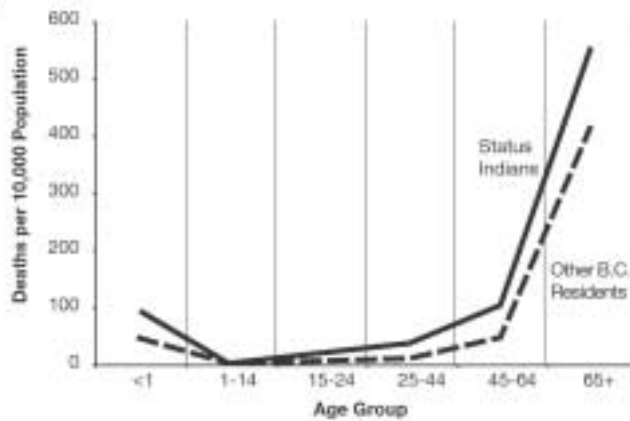


So what do the indicators show?

If you are an Aboriginal person living in British Columbia, your standard of living is likely to be 20 per cent below the provincial average, based on measures such as income, employment, educational attainment, and housing adequacy. Poor housing may be the most serious environmental issue facing Aboriginal people on reserves.

**Fig.
3.7**

**Mortality Rates by Age Group, Status Indians
and Other B.C. Residents, 1991 - 2000**



Deaths (all causes) per 10,000 population in each age group.
Source: B.C. Vital Statistics Agency, Unpublished tables, June 2002.

As a child you are more likely to be in care, and to do worse in school.

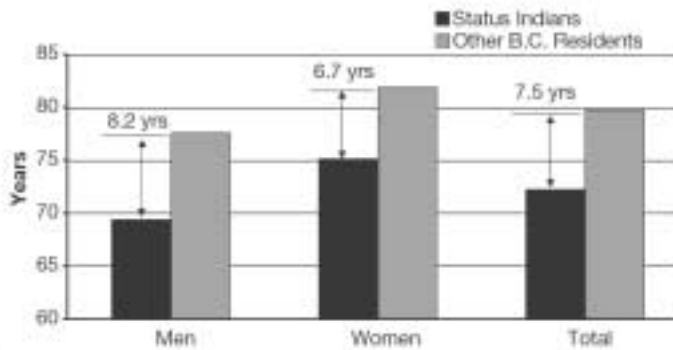
As a youth you are more likely to encounter the justice system.

As an adult-think of any disease or health condition – from diabetes, pneumonia, or HIV/AIDS to injuries caused by a motor vehicle crash – and your chance of experiencing it will be greater than your non-Aboriginal counterparts.

This graph shows how, at virtually every age, the mortality rates for Status Indians exceed that for the general population

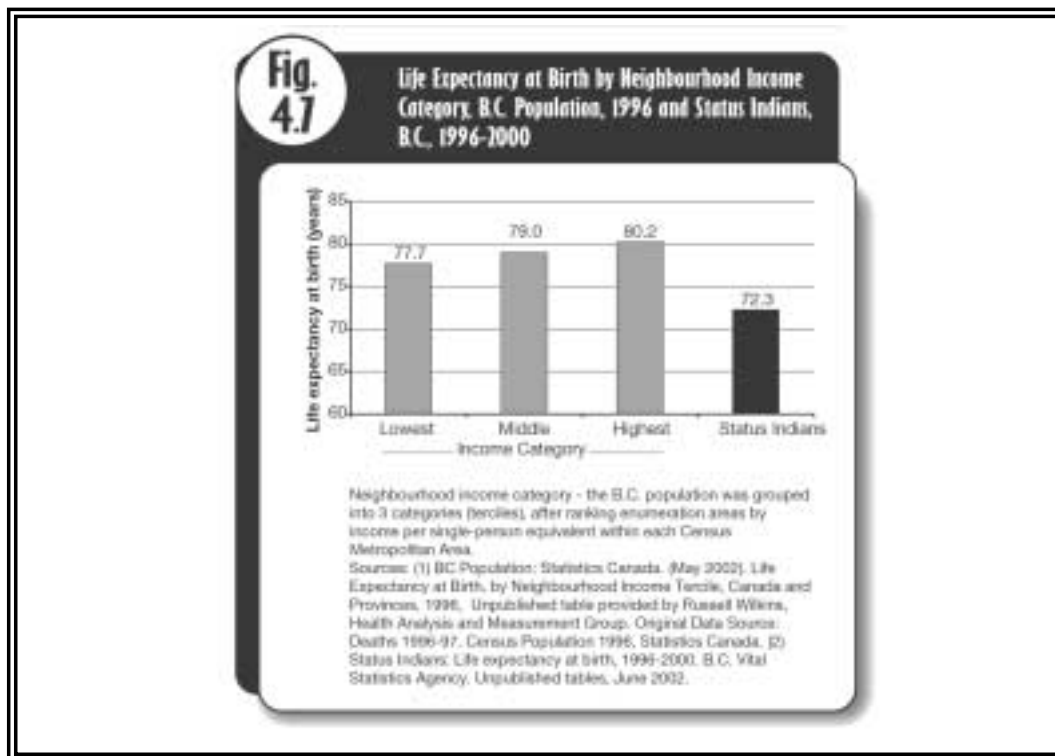
**Fig.
3.8**

**Life Expectancy at Birth, Status Indians and
Other B.C. Residents, 1996 - 2000**



Source: B.C. Vital Statistics Agency. Unpublished tables, June 2002.

As a result, if you are a Status Indian, you can expect to live 7.5 years less than other British Columbians.



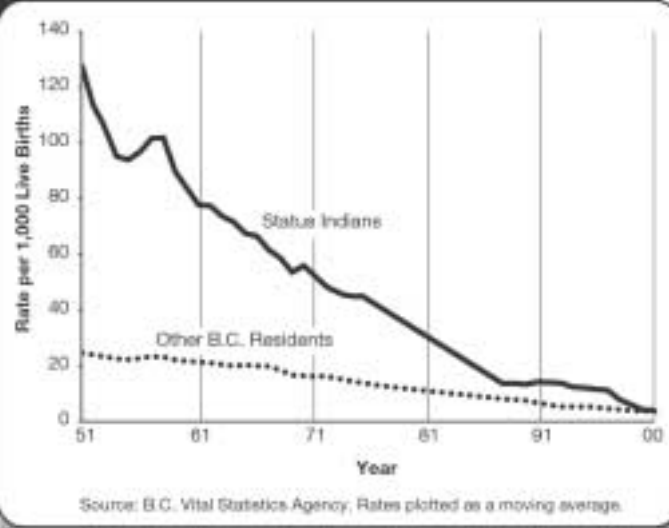
You can also expect a shorter life span- by 5.4 years- than the poorest one third of British Columbians.

These facts are certainly not new. They describe a well-known and longstanding inequality in health and social status – an inequality that affects indigenous people in Canada and around the world.

Many statistics about the Aboriginal population are grim, yet this report is not a litany of grief.

Fig. 3.1

Infant Mortality Rate, Status Indians and Other B.C. Residents, 1951 - 2000

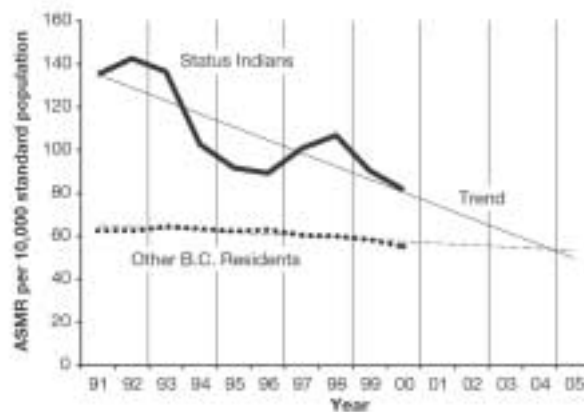


The data show that over the past few decades, there has been a huge recovery in the health status of Aboriginal people.

In the past 50 years, Aboriginal infant mortality has dropped about 50 folds, to a rate that now approximates that of the BC non-Aboriginal population.

**Fig.
3.4**

Mortality Rates for All Causes of Death, Status Indians and Other B.C. Residents, 1991 - 2005 (projected)

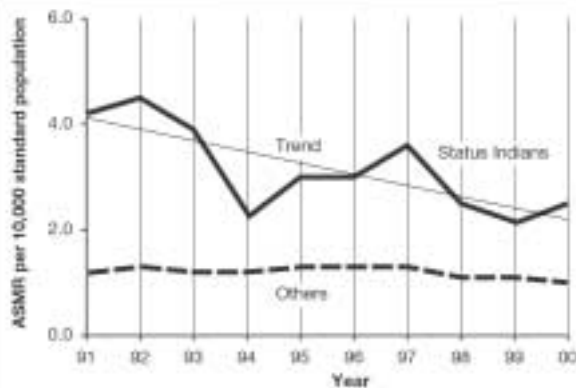


Age standardized mortality rate per 10,000 standard population
(Canada 1991 Census).
Source: B.C. Vital Statistics Agency, Unpublished tables, June 2002.

For all-cause mortality, death rates are improving steadily. As you can see, improvement that exceeds the provincial average.

**Fig.
8.9**

Suicide Death Rates, Status Indians and Other Residents of B.C. 1991 - 2000

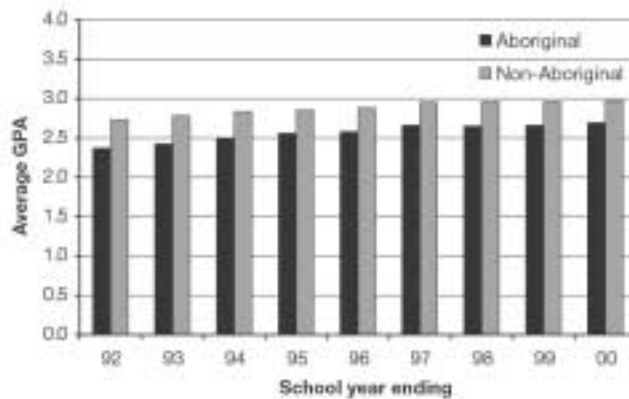


Age standardized mortality rate per 10,000 standard population (Canada 1991 Census).
Source: B.C. Vital Statistics Agency. Unpublished tables, June 2002.
Note: The downward trend for Status Indians is statistically significant at the 5 per cent level.

Nearly all cause-specific death rates are declining too. This graph shows suicide death rates for Status Indians. Many of these rates are also declining more rapidly than for the non-Aboriginal population.

**Fig.
5.11**

**Grade Point Average of High School
Graduates, 1992 - 2000**



Average GPA of students receiving Dogwood Certificates.
Source: B.C. Ministry of Education, How are we Doing? An Overview of
Aboriginal Education Results for Province of BC 2001.

Some other measures of what we term the determinants of health, like educational attainment are improving as well. These improvements are both objective and reported by First Nations people themselves.



Health Indicators

- **20 are improving; health-related areas like heart disease and stroke, respiratory diseases and non-health related areas like housing quality, community control and high school graduation.**
- **7 stayed the same; youth in justice system immunizations, dental procedures, mental health follow-up, TB, lung cancer and arthritis.**
- **3 have worsened; percent and number of children in care, alcohol related deaths and HIV/AIDS deaths.**
- **25 are without trend data**
- **5 relate to health care utilization and suggest deficiencies**

Of the 60 measures discussed in the report, 20 show an improving trend (or are already at a very low rate). Seven indicators have not shown much, if any, improvement, and only three are worsening - alcohol and HIV/AIDS deaths and children and youth in care

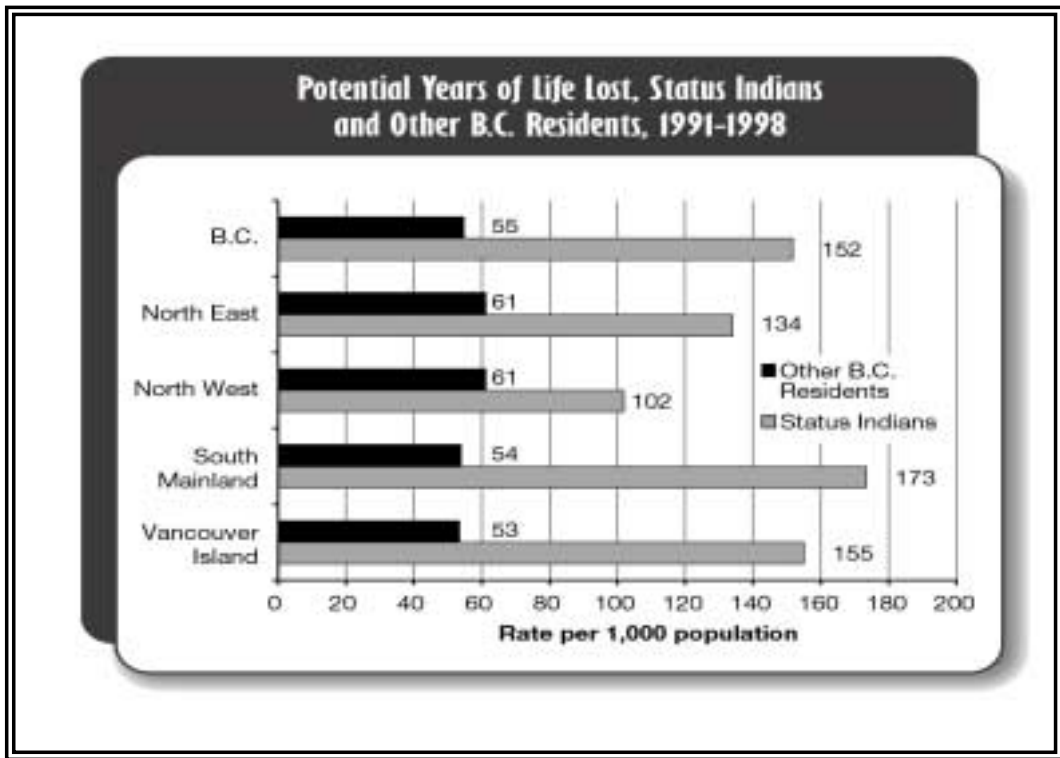
Five indicators that describe usage of doctors, hospitals, and other health care services suggest that access to appropriate primary care services is problematic.

Regrettably, trend data are not available for 25 of the remaining indicators.

These improvements have occurred in spite of Aboriginal people having a standard of living 20% less than is enjoyed by other British Columbians. If 1990s trends continue by these measures, Status Indians, and perhaps other Aboriginal People, could achieve a level of health comparable to other British Columbians some time during the next decade.

These huge gains in health, made under adverse conditions, speak to:

- the extraordinary resilience and capacities of Aboriginal peoples;
- the cultural and political resurgence among Aboriginal people; and,
- the success of targeted programs and services and some improvements in socio-economic conditions (housing on reserve, educational attainment).



We found some surprises when we compared Aboriginal health status in different regions in B.C.

As measured by Status Indian rates of premature death, the Northern and Interior regions of North West, Peace Liard, Okanagan Similkameen, and Thompson have the highest health status.

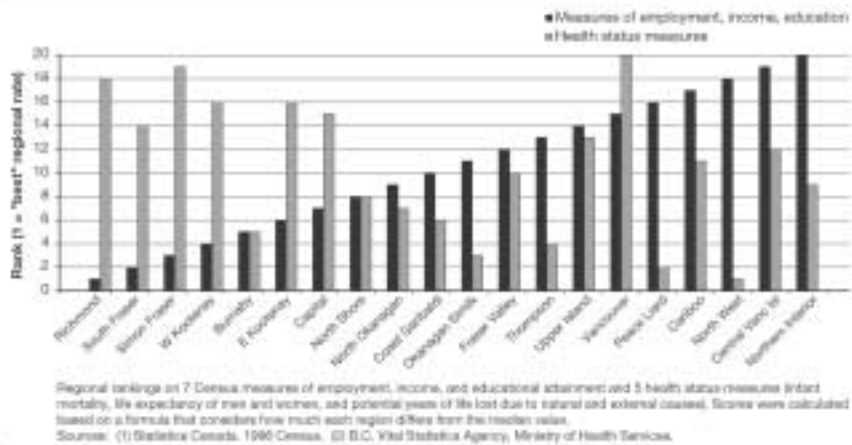
Vancouver and Simon Fraser regions have the poorest Aboriginal health, based on these particular measures.

We are not the only province to find this trend. A recent report on Aboriginal Health in Manitoba found the same.

This pattern differs from the pattern among other B.C. residents, which show higher levels of health in the southern part of the province.

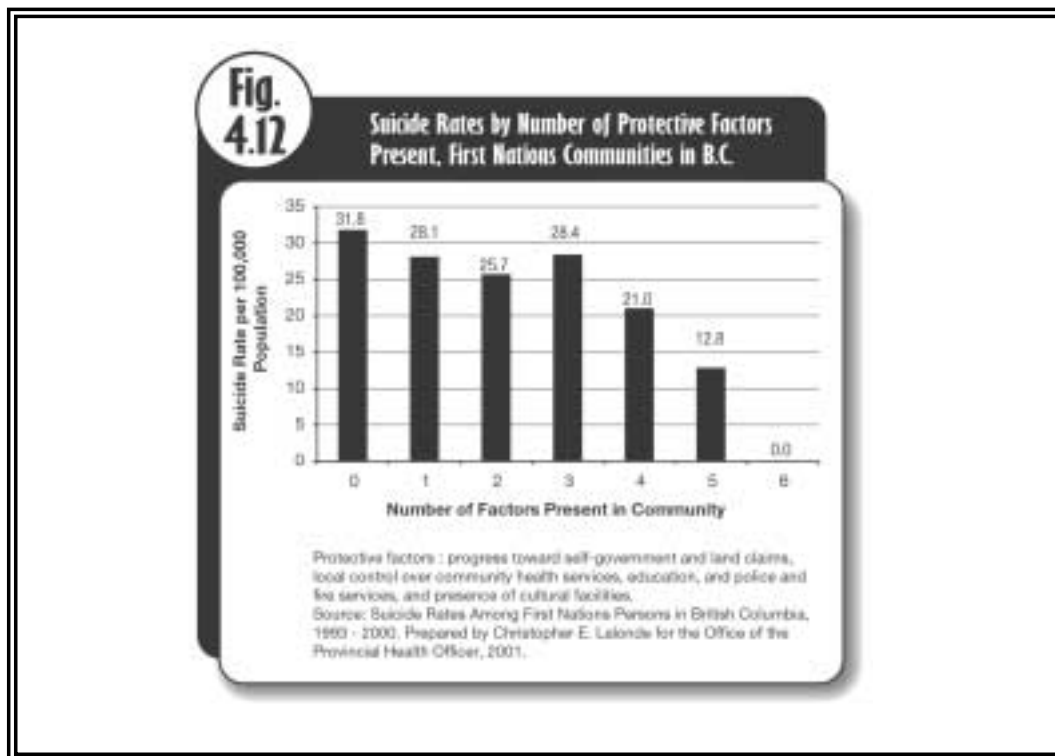
Fig. 4.10

Relationship between Socioeconomic Measures and Health Status, Aboriginal Population B.C. Health Regions



For the Aboriginal population, a region's health status does not seem to be clearly linked to socioeconomic conditions, based on Aboriginal census data on employment, income, and educational attainment. North West, Peace Liard, Okanagan Similkameen, and Thompson regions, which have the best health status rankings, are at or below average in terms of socioeconomic measures.

The lack of a relationship between socioeconomic conditions and health could be due to problems with data quality and/or problems with the measures used.



Or, and I believe this to be the case, it could point the importance of cultural and political integrity as a primary health determinant.

This does not mean that it is unhealthy for Aboriginal people to grow and live in Vancouver, Simon Fraser, or elsewhere in the Lower Mainland.

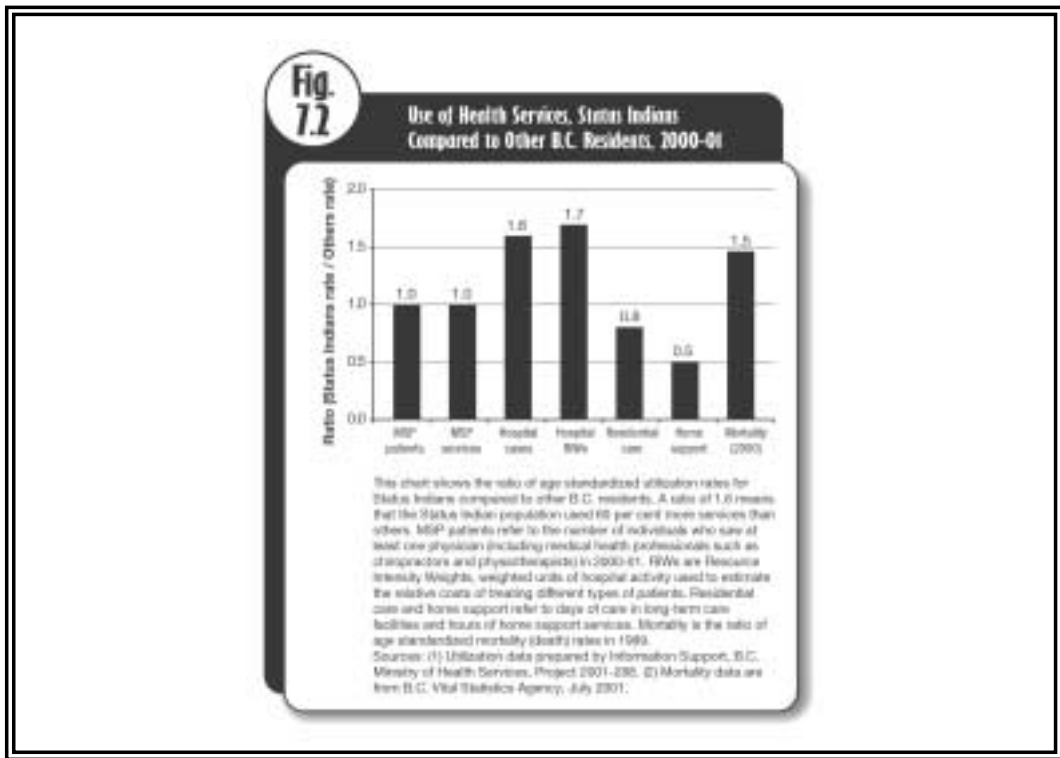
Vancouver's ranking, for example, is affected by the number of people who have moved to its inner city neighbourhoods from other parts of British Columbia and Canada. Overdose deaths and deaths from external causes contribute significantly to the excess mortality.

It does however mean that these regions are facing particular health problems.

Having described Aboriginal health status and examined the trends, I asked what could and should be done to hasten the pace of improvements in the health and well-being of Aboriginal peoples? As in other of my other reports, we must conclude that simply providing more money or more hospitals is not the answer.

For one thing, Aboriginal health status seems to be highest in the northern areas of the province, where income levels are lower and formal health care services are less available.

The lowest Aboriginal health status is found in Vancouver, where major hospitals and other services are more plentiful.



Furthermore, contrary to expectations the data show that Status Indians are using the health care system at rates equal to or greater than the average British Columbian, at least in terms of physician visits and admissions to hospital.

As I will show later however, there are serious questions about adequacy and appropriateness of the health services received.



Solutions

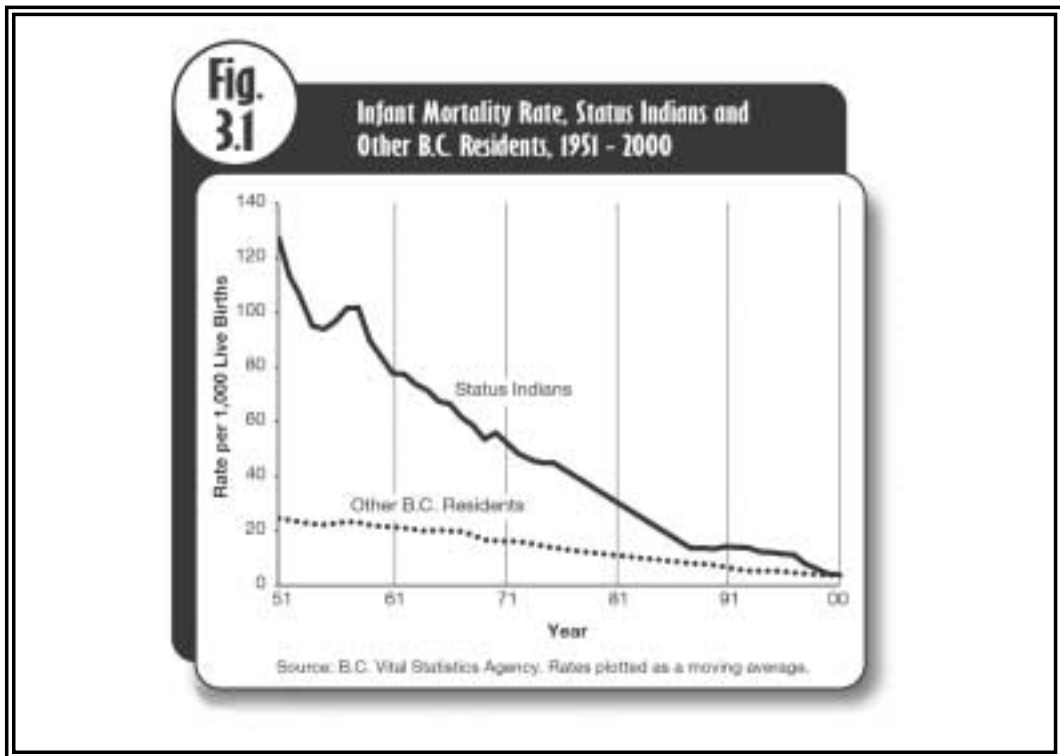
- Formal Commitments to achieve comparable health status
- Improve Standard of Living
- More Recognition and Respect
- More Holistic Approach
- More Autonomy
- More Representation

Many Aboriginal organizations provided input throughout the development of this report. Their suggestions, our data and the international experience support the broad based recommendations to:

1. Formally commit to improve Aboriginal health status. With New Zealand as an example, a formal commitment, with targets should enable us to speed up the trends to better health.
2. Improve the standard of living of Aboriginal people. We have seen the gains that have been made with only marginal improvements. Better economic prospects and decent housing are two foundations for further improvement.
3. Recognize the issues and challenges faced by Aboriginal people, work to understand and overcome them.
4. Take a more holistic approach to health. Pay attention to non-medical, cultural and spiritual determinants of health- encourage research and identify meaningful Aboriginal indicators.
5. Support self determination and control.
6. Encourage greater participation in design, delivery and governance of programs, especially those at the community level.

In addition the report provides more than 40 examples of actions that can be taken to make continued improvements in the health of Aboriginal people in British Columbia.

However, in my view, there are seven areas where the greatest immediate health gains can be made.

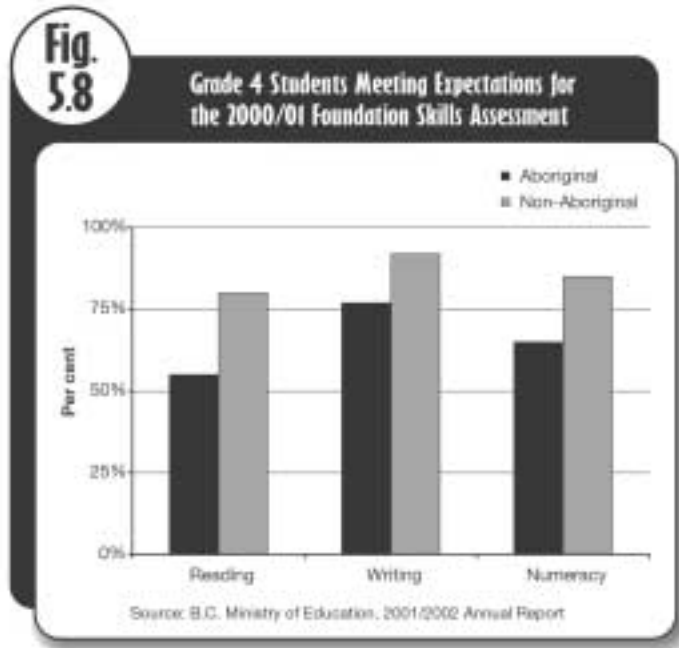


The first is to focus on early childhood development. Status Indian infant mortality rates have nearly reached the low rate experienced by the general population.

In fact from birth to age one month for the past ten years, Status Indians have had the same mortality experiences as non-Aboriginal babies.

This represents a major and I suspect, unrecognized achievement.

These improvements should be celebrated. They must also be sustained.



Major efforts should be directed to the promotion of healthy growth and development during early childhood – the period from birth through age five. Healthy children are the foundation for a healthy future and we must close the gap in educational achievement that starts at an early age and launch Aboriginal kids at their full potential.

**Fig.
5.12**

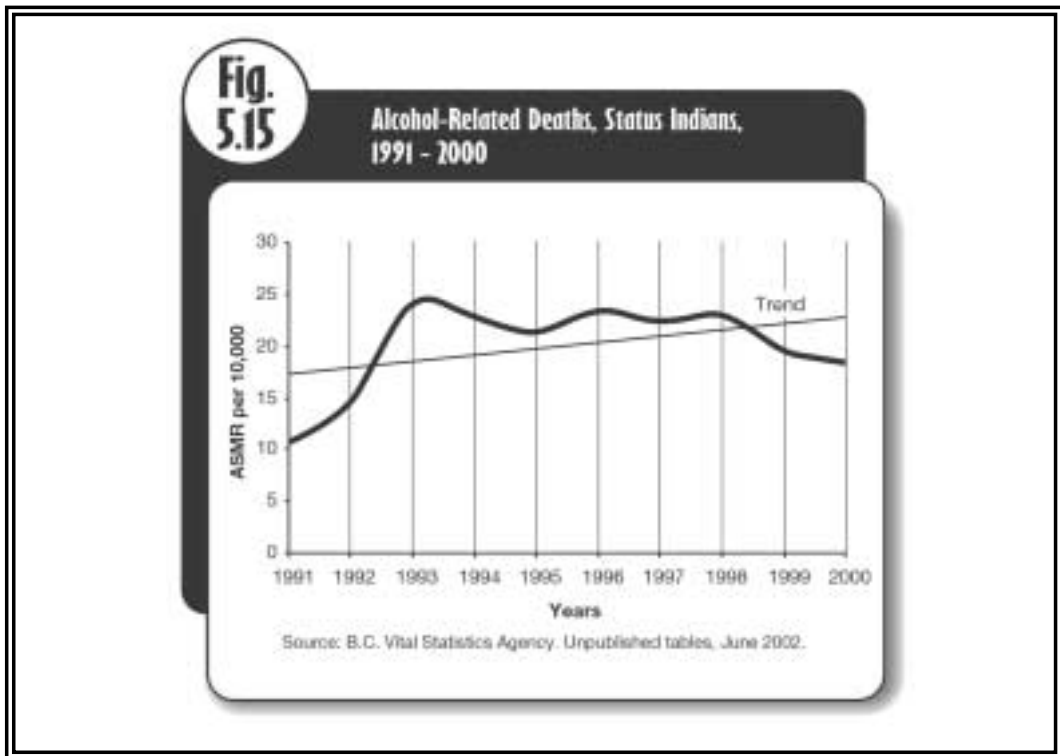
**Age When Started Smoking, Current Smokers
Age 12 and Older, B.C., 1997**



Source: Tobacco Use in BC 1997, Heart and Stroke Foundation of B.C. and Yukon.

The second area is tobacco. Aboriginal Smoking rates are about twice the rate in the general population (23 per cent) and as the chart shows Aboriginal children start earlier and more of them smoke than their non Aboriginal peers.

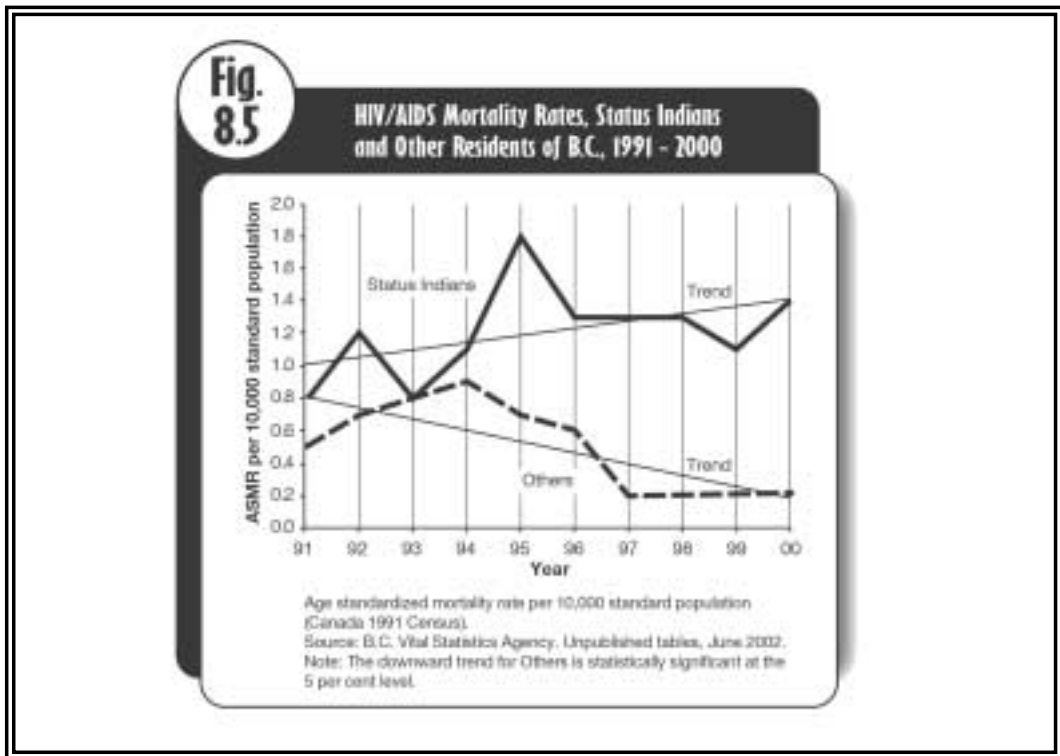
Major efforts are under way to reduce the use of tobacco in British Columbia. Education programs, cessation services, and community awareness activities aimed at Aboriginal youth and families should assist Aboriginal communities to bring down their high rates of smoking and smoking-related illnesses.



The third area is alcohol and drugs. Alcohol and illicit drugs continue to take a huge toll on the lives and health of the Aboriginal population, in spite of resources being devoted to these problem areas.

Although Aboriginal people consume less alcohol than other British Columbians, they suffer more from it. Like other high-risk behaviours, alcohol and drug misuse reflects social and cultural stresses, which impact people's ability to cope with life in healthy ways. Alcohol and drug problems can only be solved through comprehensive efforts addressing predisposing social conditions, preventing and treating substance abuse when it occurs, and reduction of the harms that accrue when prevention and treatment fail.

British Columbia should enhance comprehensive initiatives such as the Four Pillars Approach in Vancouver, with a focus on culture-based services specific to the Aboriginal population.



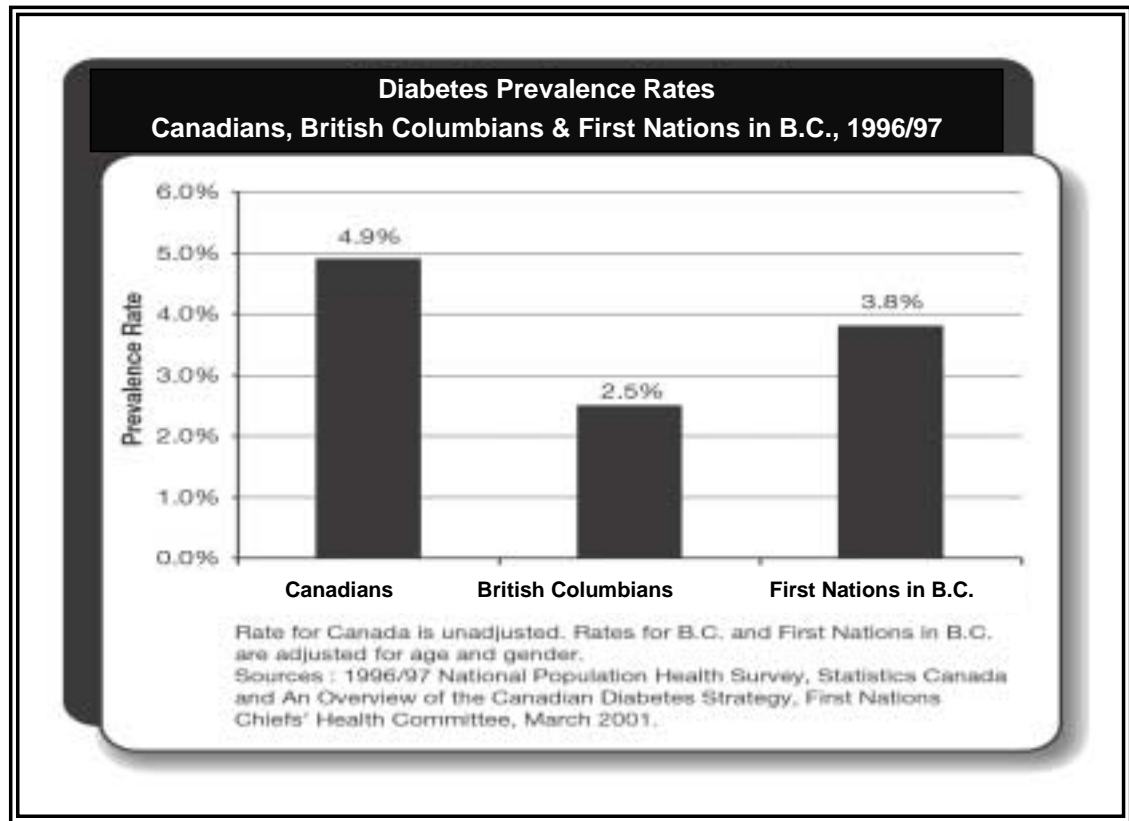
The fourth area is HIV/AIDS. Death rates due to HIV/AIDS are increasing among Status Indians, while rates in the general population are declining.

Infection rates in Aboriginal communities are increasingly of concern.

This is one of the few causes of death where the health status gap is widening. British Columbia has one of the most comprehensive HIV/AIDS programs in Canada, but improvements are necessary when it comes to reaching the Aboriginal population. *The Red Road*, an Aboriginal strategy for HIV and AIDS in B.C., made 50 recommendations to address Aboriginal HIV/AIDS. The response to these recommendations should be strengthened and implemented.

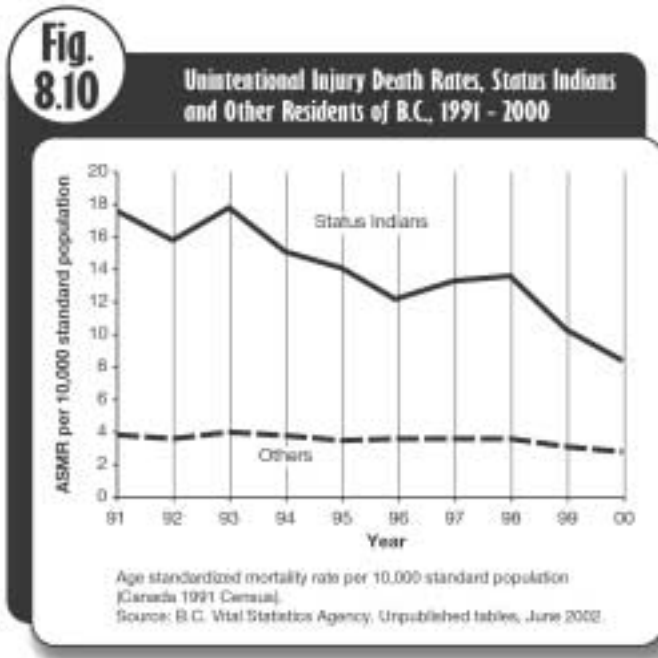
In addition, Aboriginal women are clearly especially vulnerable and I recognize the efforts of First Nation Chiefs' Health Committee (FNCHC) and First Nations and Inuit Health Branch (FNIHB of Health Canada) to bring attention and awareness to this situation.

The gap shown here is almost certainly due, in large part to lack of access to ART's.



The fifth area is diabetes. Diabetes is a critical issue in Aboriginal communities where prevalence rates are 2 to 3 times that of the non-Aboriginal and reportedly climbing. A national Aboriginal Diabetes Initiative is under way to prevent diabetes and to manage the disease better through improvements to treatment and care.

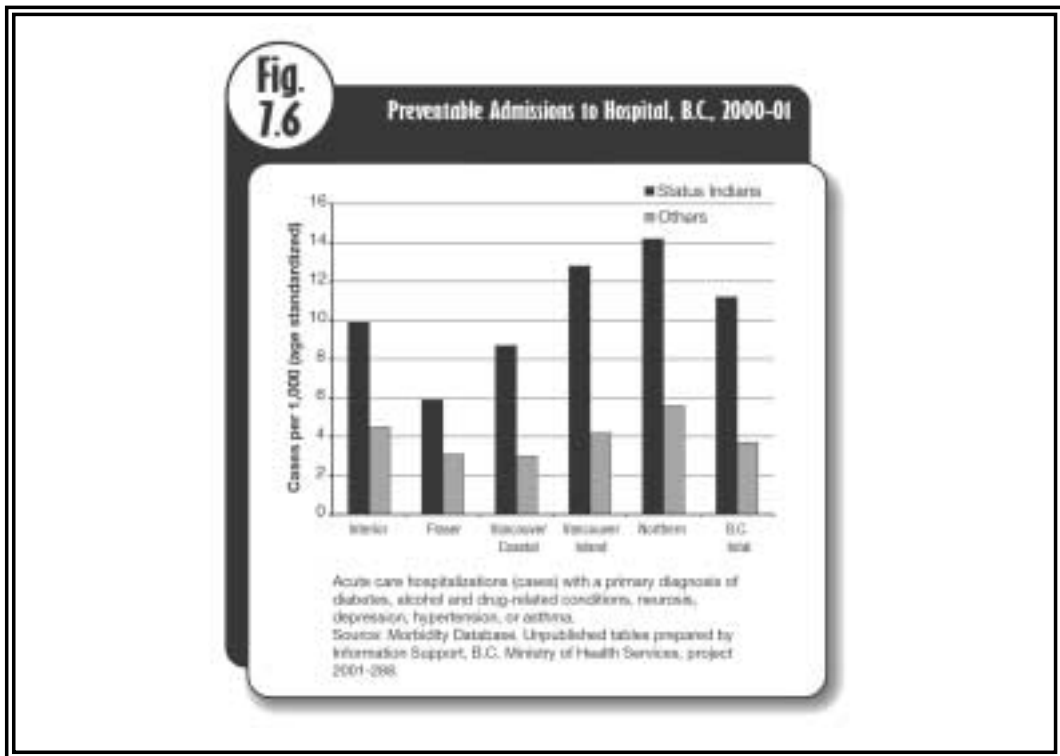
Diabetes can be prevented, or its onset delayed, through healthy eating, maintaining a healthy body weight, and increased physical activity. Children and youth are important groups to target for promotion of healthy eating and physically active lifestyles, in order to slow the numbers with diabetes in future decades.



The sixth area is injuries. Injuries are the most common cause of death for Aboriginal people, accounting for 40% of PYLL's.

Injury death rates among Status Indians fell dramatically – more than 50 per cent – in the 1990s. However, death rates from injuries remain high, accounting for more than one-quarter of all Status Indian deaths and more than 40 per cent of Potential Years of Life Lost.

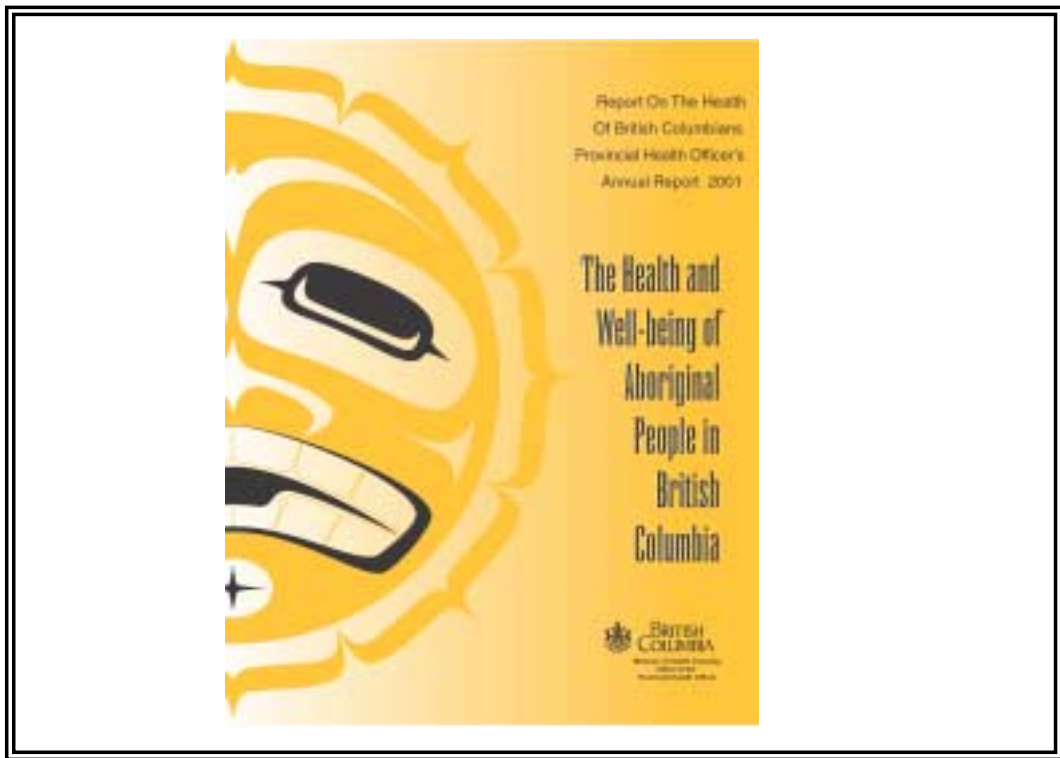
Motor vehicle crashes, accidental poisoning (which includes drug overdose deaths), suicide, falls, fires, and drowning are the leading causes of injury death. Almost all injuries are preventable. Injury prevention plans can be developed to address risk conditions at the community level.



The seventh area is primary care. Most (83 per cent) Status Indians visit a doctor or other health practitioner in a given year, compared to 87 per cent for the rest of the population.

Available data provide a glimpse at overall utilization, but they do not tell us whether Aboriginal people are receiving the services they need. We have indications for example the higher rates of admission for preventable conditions, that primary care services for aboriginal communities are less than optimal.

British Columbia needs better information about the quality and outcomes of health services provided. Critical to improving primary care access and quality is to improve the participation of Aboriginal people in health care professions. Universities and colleges are working to increase the number of Aboriginal students enrolled in the health care professions, and these efforts should be encouraged and sustained.



Lastly, regarding information, we must not only make better use of the information we do have at the regional level in regional Aboriginal health plans, we must get more and better information. Without the ability to measure, we cannot be sure that things are getting better or know where to focus finite resources.

Currently there is a patchwork of information. We know the most about the Status Indian population – roughly two-thirds of the Aboriginal population. Birth and death-related statistics in this report are for Status Indians on and off-reserve combined. We know much less about non-Status First Nations, Metis people and Aboriginal people living in urban areas.

Health databases should record information about the Aboriginal population. They should contain information that Aboriginal people want and information that the health system needs. They should be complete, comparable, and useful for planning purposes.

These recommendations, including the setting of targets for improvement and ongoing monitoring if acted upon should enable us, by working together and focusing our energies, achieve the goal of improving and sustaining Aboriginal health in British Columbia.

I hope this report will be a useful tool in our communities. Thank you.