COHP

BRITISH COLUMBIA MEDICAL ASSOCIATION

SUBMISSION TO THE ROYAL COMMISSION ON ABORIGINAL PEOPLES

From the Committee on Aboriginal Health
British Columbia Medical Association
Presented in Vancouver, BC on June 3, 1993

The BC Medical Association believes society needs aboriginal health professionals, and that the question of the land issue must be settled as soon as possible.

The most cogent reason for this is the poor health status of aboriginal peoples. Additional reasons are that other Canadians have much to learn from aboriginal people, and to repair past injustices.

The poor health status of aboriginals is well documented:

- Life expectancy of aboriginal children born in the 1980's is 68 years, compared with 76 years for all Canadians.
- Aboriginal infant mortality is approximately twice that of all Canadians.
- Aboriginal stillbirth rate is three times higher than the all-Canadian rate.
- The post-neonatal mortality rate, known to be sensitive to social, environmental, and socio-economic factors, is four times greater for aboriginals than the all-Canadian figures.
- Death due to injuries is six times greater than the all-Canada rate in the 1- to 4-year-old age group among aboriginals.
- Deaths from suicide are seven times the all-Canada rate for the 10- to 19-year-old age group. [1]

When compared with figures for all of Canada:

- Crude birth rates are twice as high for aboriginal women.
- Total death rates from injury and poisoning are four times higher.
- Deaths from motor vehicle accidents are four to six times higher.
- Tuberculosis incidence is as much as fifteen times higher. [2]

While equally poor health can be found among individuals, families, or groups who are not aboriginal, and while many aboriginals are well off and in good health, there is no other single ethnic group in our society that is so disadvantaged.

COUNCIL ON HEALTH PROMOTION
115 - 1665 West Broadway, Vancouver, B.C. V6J 5A4 Telephone [604] 736-5551 / FAX [604] 736-4566

Why is this?

The BCMA believes that there is a clear link between physical ill-health, psychiatric ill-health and loss of self respect and identity, both personal and cultural.

To improve these disgraceful health status statistics, more than simple solutions imposed from without are necessary.

The best example is perhaps the biggest problem.

Alcoholism and other drug dependencies are the underlying cause of much disease among aboriginal people. Basic reasons for this include acculturation, loss of identity, loss of self-respect, and a resulting sense of hopelessness, despair, and abuse of self and others.

This occurs on a large scale. Some entire communities are dysfunctional, and to attempt to address this with outside imposed programs, however well intentioned, is frequently a waste of time, money, and effort.

The basic causes must be addressed. One cannot treat loss of identity with surgery or a pill, not even with counselling, although this may help somewhat. The real cure comes from within. The learned helplessness must be unlearned and the pride of self must be grasped again.

To do this, a community needs strong leaders in every walk of life. The aboriginal community needs lawyers, artists, doctors, politicians, religious leaders, teachers, and engineers to fire the imagination of its young people. However, it is important that aboriginal professionals not be limited in their work only to aboriginal communities, but that they also be encouraged to share their special insights with non-aboriginal people. Non-aboriginals should facilitate the training of aboriginal leaders, instead of trying to provide all the solutions themselves. In the past, physicians and other health care workers have been guilty of paternalism and of imposing solutions instead of facilitating the development of solutions by the concerned aboriginal communities themselves.

Aboriginal people have much to share. As physicians we are not willing to abandon scientific principle or proven successful treatment; but there are aboriginal ways of teaching understanding, values, and attitude that the rest of us can profitably learn. We need to think about greater respect for people of all

ages, the extended family, the concept of time, the idea of the potlatch, different methods of reward and punishment, and respect for the environment and for all.

Those are some answers to the question "why?"

The "who" and the "how" I will leave to my co-presenters, except for two points.

First, it is necessary to encourage a wide diversity of health and other professionals among aboriginal people - physicians, nurses, social workers, counselors, etc. - and most importantly, not to insist that each one must work in some distant reserve or downtown ghetto. As I have said, it is important to facilitate successful aboriginals in whatever spheres they choose.

The second issue, which has been a stumbling block for our committee, is that probably the most difficult work needs to be done, not at the university level, but at the grade schools. The dropout and failure rates are unacceptably high. Without adequate grounding, further education is impossible.

Lastly, I would like you to know what the medical profession is doing to help. At the June 1991 annual meeting, the BCMA passed the following resolutions:

BE IT RESOLVED:

1 **That** the BCMA lobby Health and Welfare Canada and the Government of BC for further funding for aboriginal medical students.

2 **That** the BCMA develop an aboriginal medical student scholarship fund.

The Board made the following amendment to this resolution:

That the "BCMA Aboriginal Medical Student Scholarship Fund" (as proposed by the Council on Health Promotion) be designated from one of the existing ten $1,000 BCMA bursaries when an appropriate individual is available.

3 **That** the BCMA draw to the attention of the federal and provincial governments the operation of aboriginal alcohol and drug programs and treatment centres in BC as examples of how aboriginal health autonomy, as community-based initiatives, can successfully address local health problems.

4 **That** the BCMA recommend to the Dean of Medicine and the Faculty Executive Committee at UBC, and to the RNABC and other appropriate professional bodies, that students and workers in the health care fields be educated about aboriginal culture, beliefs, and traditional health practices.

5 **Whereas** the health status of aboriginals is consistently lower than that of the rest of Canadians, and

Whereas there are clear links between physical ill health, psychiatric ill health, and loss of personal and cultural identity and self-respect, and

Whereas the local examples of aboriginal health autonomy have proved successful in reducing health problems,

Be it resolved that the BCMA call upon the governments of British Columbia and Canada to settle the issue of land use and self-determination for aboriginal people as soon as possible.

6 **That** the BCMA advise the BC Ministry of Health and all BC hospitals that, in order to maximize aboriginal well-being and appropriate utilization of health services, aboriginals must be incorporated into the hospital system as social support and spiritual providers, as part of the health care team.

Resolutions presented to the 1992 BCMA General Assembly:

BE IT RESOLVED:

1 **That** the BCMA recommend to UBC that a Chair of Aboriginal Health Studies be established within the Faculty of Medicine.

2 **That** the BCMA recommend to the provincial government that it set up, as soon as possible, an Aboriginal Health and Social Services Commission, comprising aboriginal leaders, to address social and health-care problems and their possible solutions.

3 **Whereas** the health status of aboriginals is consistently lower than that of the rest of Canadians, and

Whereas there are clear links between physical ill health, psychiatric ill health, and loss of personal and cultural identity and self-respect, and

Whereas this loss is clearly linked to the loss of self-determination and the issues of land use,

Be it resolved:

a) **That** the BCMA recommend to the provincial and federal governments that, in order to improve aboriginal health, the issues of lands and resources be resolved and the agreed-upon lands and resources be in aboriginal hands as soon as possible; and

b) **That** the BCMA recommend to the provincial and federal governments that there be aboriginal involvement in provincial and federal environmental reviews; and

c) **That** the BCMA recommend to the provincial and federal governments that federal and provincial environmental laws be made compatible.

4 **That** the BCMA recommend to the provincial government, the BC Health Association, and all hospital boards that aboriginal representation on hospital boards be encouraged, consistent with the proportion of aboriginal consumers served by those hospitals.

5 **That** the BCMA reiterate the value of the self-directed and community-based aboriginal health initiatives to the provincial and federal governments.

All of these resolutions were passed by the BCMA's General Assembly, ratified by the Board of Directors, and have been acted upon. Discussions with the government are currently ongoing along these lines.

In addition, in response to motions presented by the BCMA, the Canadian Medical Association has now created a bursary for aboriginal students and an "Aboriginal Health Working Group" that will soon be producing more recommendations.

I have touched only on part of the necessary work to correct these sometimes appalling inequities. I am unfortunately unable to attend the meeting with you on June 3rd, due to a prior commitment to the BCMA Annual Meeting, but the members of the Committee on Aboriginal Health will speak clearly and in depth to these and other issues with you.

We look forward to the Royal Commission on Aboriginal Peoples addressing not only the immediate problems, but also the fundamental issues, many of which are political, in clear, unavoidable terms.

Respectfully submitted,

Granger Avery, MB BS
Chair, BCMA Committee on Aboriginal Health
Council on Health Promotion

References:

1 Avard D, Hanvey L. *The Health of Canada's Children: A CICH Profile*. Ottawa: Canadian Institute of Child Health, 1989.

2 *Annual Reports, 1985, 1987, and 1989*. Vital Statistics, Statistics Canada, 1985, 1987, and 1989.