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Reviewing Inequities in Primary Care Received by Indigenous Peoples in Ontario

Heba Shahaed[1], Guneet Sandhu[2], Eric Seidlitz[3]
1. McMaster University, Honours Health Sciences, Class of 2021
2. McMaster University, Honours Health Sciences, Class of 2021
3. McMaster University, Assistant Professor, Ph.D.

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SUMMARY

High quality primary health care is important, as it often serves as the first point of contact for most Canadians with the health care system. The Indigenous peoples in Canada experience health inequities when compared to the non-Indigenous population. There is a great lack of literature on the quality of primary health care specifically regarding Indigenous communities in Ontario. This review collected information from available studies that investigated the state of primary health care in this population. To accomplish data collection, a specific search strategy and online databases were used to retrieve relevant articles. Numerous themes including inadequate cultural training of healthcare professionals, shortages of nurses and doctors, and inappropriate management of mental health, were identified. This data was used to make recommendations for how Ontario can improve the delivery of primary health care for this population. The recommendations that were made include strengthening the Indigenous healthcare workforce, providing comprehensive Indigenous cultural training, development of a preventative mental health policy and the integration of local Indigenous values, customs and beliefs into the primary care delivery model. Further research is needed in this field of study in order to outline all aspects of Indigenous primary health care in Ontario that requires improvement, and the necessary strategies to make this change.

ABSTRACT

Research has shown that Indigenous peoples in Canada experience health inequities when compared to the non-Indigenous population. High quality primary care has been described in literature; however, this has not been explored through the lens of Indigenous health. A scoping review was performed in order to investigate the quality of primary care received by indigenous peoples in Ontario. To conduct this review, a search of current literature on primary care in Indigenous communities in Ontario was performed. The studies examined in this review were derived from four different databases and many evaluated specific communities using a qualitative and quantitative approach. Several themes were identified including inadequate preparation and training of health care providers, physician and nursing shortages, strategies associated with improved quality of care, management of mental health, disparities in health service delivery station types and ineffective primary care impacts on hospitalizations. This literature search demonstrated a clear gap in the literature on the quality of primary care received by the Indigenous population in Ontario. Thus, further research is necessary in order to outline the current state of primary care being delivered to Indigenous populations in Ontario, and develop strategies to enhance the quality of care for this population.

Keywords: Indigenous, primary care, quality, Ontario, disparities

INTRODUCTION

The World Health Organization defines quality of care as "the extent to which health care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred".[1] These principles can be applied in any care provision context, regardless of the location or features of the patient population. The Government of Canada states that primary health care is where most Canadians first interact with the healthcare system.[2] It encompasses the delivery of services as patients first contact the health care system and involves the coordination of these services by healthcare providers. Through effective care coordination, patients are able to receive continuity of care and can consult with different specialists in the healthcare system with ease.[2] It is important to understand that the quality of primary care received by patients in Canada is not uniform.[3]

Social Determinants of Health (SDOH) such as gender, race, socioeconomic status and ethnicity, including Indigenous status, can impact the quality of care received by patients and play a vital role in their health outcomes.[4-7]

In Canada, there are health inequities between the Indigenous population and the non-Indigenous population.[8] Healthcare is described as being inadequate, underfunded and characterized by systemic racism and discrimination for this population.[7,9-11] Indigenous peoples also experience disparities related to workforce participation, socioeconomic status, education and quality of living conditions.[12] The disparities in these SDOH further impact the health outcomes of Indigenous peoples.[12] There is an urgent need to eliminate the inequities in health between Indigenous and non-Indigenous peoples.[12] At the global level, there has been significant development in public policy to address these inequities; however, there is an absence in Canadian healthcare policy supporting the Indigenous population.[12] Currently, the Government of Canada has attempted to mitigate this absence by adopting practices in line with Indigenous culture, and build relationships with this population according to the Truth and Reconciliation Act.[13] This approach aims to address the determinants of health pertaining to the Indigenous population and is based on principles of social justice, human rights, equity and evidence-informed policy and practice.[13] Establishing relationships with cultural understanding and trust between healthcare providers and Indigenous peoples is one of the best ways to support the healing of the Indigenous population.[8]

Despite this governmental initiative, there is currently a substantial gap in the literature examining the healthcare experiences of this population in a primary care setting.[7] Given this gap in literature, coupled with the disparities in care that exist, the purpose of this scoping review is to investigate the quality of primary care that is received by the Indigenous population in Ontario.

METHODS

This scoping review uses the framework created by Arksey and O'Malley (2005) along with the modifications made to it by Levac et al. (2010) to guide the research process.[14,15] The Arksey and O'Malley paper outlined five distinct steps to perform a scoping review including: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, and (5) collating, summarizing and reporting the results.[14] The methodology and data extraction tables were also informed by the structure employed by Pham et al. (2014).[16]

Research Inquiry

A scoping review is defined as the process of mapping existing literature in a research area that has not yet been reviewed in-depth.[17] It can be used to accomplish goals such as summarizing the findings of research, identifying a gap in the research of a specific topic, and providing evidence to inform practice and policy making.[14] The research question that this scoping review aimed to answer was: what is the quality of primary care received by the Indigenous peoples in Ontario?

Article Selection

The search was performed in February 2020 using four electronic databases: CINAHL/EBSCO (nursing and allied health; 1981–present), MEDLINE/PubMed (biomedical sciences, 1946–present), ISI Web of Knowledge (multidisciplinary current awareness; 1998–present) and Embase (biomedical and pharmacological;1974-present).

The search was done using a variety of databases that cover multiple disciplines. Limits were not placed on the search. The terms used in the search query were relevant to the quality of primary care and Indigenous individuals in Ontario. The search string was developed through consultation with a librarian at McMaster University. The patient population was identified using the University of Alberta OVID/MEDLINE search terms for Indigenous peoples in Ontario, along with the official and comprehensive list of First Nation communities in Ontario provided by the Government of Canada.[18,19] The following search terms were used: "Athapaskan or Saulteaux or Wakashan or Cree or Aboriginal* or Indigenous* or Metis or Ojibway or Chippewa or Mississauga* or Mohawk or MunseeDelaware or Anishinaabe or Nipissing or Seneca or "six nations"". [18,19] The search strategy employed can be found through this study's supplementary information.

Citations

Citations were imported into the screening and data extraction tool, Covidence, in order to streamline this process between data reviewers. This software enabled the removal of duplicate citations and allowed researchers to efficiently upload search results from databases, screen abstracts and full-text, as well as collect data, resolve disagreements and export data into a spreadsheet.

Article Selection

Studies were eligible for inclusion if they were in English, examined humans, pertained to Indigenous peoples in Ontario and involved primary care. Studies were excluded if they were published in any language but English, pertained to Indigenous peoples outside of Ontario or involved non-primary care.

A total of 540 hits were imported into Covidence. After the title and abstract screening process, 32 hits remained. After further examining the full-text articles for relevance, researchers were left with seven hits. The authors reviewed each citation and discussed any inconsistencies. An outline of this process can be found in **Figure 1.**

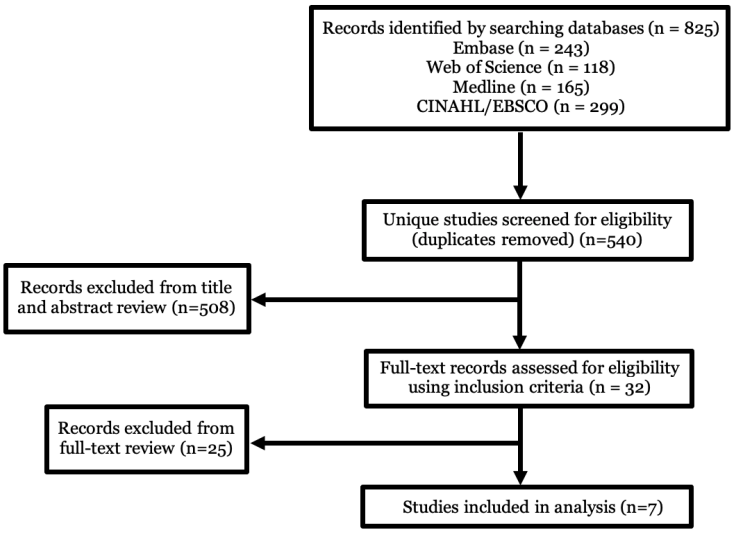

Figure 1. Flow diagram of study selection.

Data Organization

From a full-text review, selected articles were imported into a spreadsheet. Agreed upon and relevant categories, based on the Arksey and O'Malley (2005) scoping review protocol, were used to extract characteristics of each article. The characteristics of each study can be found through this study's supplementary information.

Data Analysis

Upon categorization of information in a spreadsheet, data was analyzed for common themes and ideas that arose among research articles. Similar ideas were grouped together to generate themes. The identification of themes was an organic process through which the authors presented novel ideas that would best define the patterns in the articles.

RESULTS

After the full-text screening process, a total of seven studies were identified that adequately fit the inclusion criteria. These studies ranged in type from scoping reviews to examining specific communities in Ontario using interviews and analysis of qualitative and quantitative data. Although all studies were conducted in Ontario, Canada, the specific locations within Ontario varied between studies. Three of the seven studies were conducted in specific communities such as Sioux Lookout, Kingfisher Lake, Wapakeka and Wunnimin Lake.[20-22] The remaining four studies were broadly conducted in communities across Ontario.[23-26] The date of publication of these studies also varies greatly. All studies were conducted after 2000, with the exception of a 1981 evaluation of a community.[20]

The literature was then analyzed to identify common themes which are outlined in **Table 1**. A total of six themes were identified; however, only four of these themes surfaced more than once. The most prominent themes, which were identified as physician and nursing shortage, strategies associated with improved quality of care, and inadequate preparation or training, each appeared in three of the seven studies. The remaining recurrent theme, management of mental health, appeared in two of the seven studies. The last two themes identified, the disparities in health service delivery station types, and ineffective primary care and impacts on hospitalizations, were each only present in one of the seven studies. A visual representation of this may be found in this study's supplementary information. **Table 1** identifies the specific themes found within each study.

Table 1. Quality of Care Related Themes Identified in Collected Literature.

Study	Theme
Ford-Gilboe, *Milbank Q*, 2018	Strategies associated with improved quality of care
Harfield, *Global Health*, 2018	Strategies associated with improved quality of care Inadequate preparation/training
Minore, *J Interprof Care*, 2004	Physician and nursing shortage Inadequate preparation/training Management of mental health
Minore, *Can J Nurs Res*, 2005	Physician and nursing shortage Inadequate preparation/training Management of mental health
Motta, *Point of Care*, 2015	Strategies associated with improved quality of care
Shah, *Am J Public Health*, 2003	Ineffective primary care and impacts on hospitalizations
Young, *Public Health Rep*, 1981	Physician and nursing shortage Disparities in health service delivery station types

Physician and Nursing Shortage

The studies conducted by Minore et al. in 2004 and 2005, in addition to the study by Young in 1981 all examined specific communities in Ontario that experienced a deficit in the number of healthcare professionals.[20-22] In the Minore et al. studies, the communities of Kingfisher Lake, Wapakeka and Wunnimin Lake were evaluated for the impacts of healthcare professional shortages and turnovers in regard to primary health outcomes.[21,22] Specifically, there was a distinct shortage in mental health nurses, resulting in serious detriments to patients' mental health status. [21,22] Further, the routine changes in nursing staff led to a constant introduction of nurses who were not educated regarding the cultural practices of Indigenous communities of northern Ontario and the realities of practicing in an isolated environment. [21,22] Namely, nurses experienced more isolation than they had anticipated, thus prompting them to leave the communities after a shorter period of time than usual. [22] These frequent staffing changes led to individuals being hesitant to utilize primary care services or continue the care they had started. [21,22] The short-term nature of the staffing translated to a lack of follow-up in the primary care received by the individuals of these communities. [21,22] As a result, patients abandoned treatment because they became obligated to retell their symptoms to unfamiliar nursing staff. [21,22]

Young's (1981) study found that the 25 Indigenous communities in Sioux Lookout in northwestern Ontario could be categorized as either having nursing stations or only having health stations.[20] Health stations are smaller than nursing stations and staffed by members of the community known as health aides, who have various training and experience. They help fill in the gaps by providing primary care services supplementary to visits by nurses and physicians.[20] Further, there is a significant physician shortage, as the nearest physician to these communities ranged from 40 to 750 kilometers away.[20] These shortages result in only half of those individuals that are sick actually using the available health services.[20]

Strategies Associated With Improved Quality of Care

The theme of strategies associated with improved quality of care was identified in the 2018 study by Ford-Gilboe et al., the 2018 study by Harfield et al. and a 2015 study conducted by Motta et al.[23-25] Ford-Gilboe et al. (2018) conducted interviews across Ontario to evaluate patient perceptions of the care they received in primary care settings.[23] These perceptions included their confidence in care providers and self-reported health outcomes.[23] The aim of this study was to determine if equity-oriented health care (EOHC) characterized by trauma and violence-informed, culturally safe, and contextually tailored care, would improve health outcomes including quality of life, chronic pain disability, Post-Traumatic Stress Disorder (PTSD) symptoms and depressive symptoms.[23] The authors found that providing EOHC, which seeks to reduce the consequences of structural inequalities (e.g. poverty, income, housing) on individual's access to services and the quality of care they receive, may improve patients' health outcomes over time.[23] EOHC may lead patients to have a greater level of confidence in their own ability to manage their health problems and have greater comfort and confidence in the primary care they receive.[23] Ultimately, this leads to improvements in depressive symptoms, PTSD symptoms and a higher quality of life.[23]

Harfield et al. (2018) investigated the characteristics that defined Indigenous primary care models.[24] The authors determined that a new primary health care service delivery model should integrate the numerous themes that were identified through the primary health care settings they investigated.[24] These themes include: accessible health services, community participation, continuous quality improvement, culturally appropriate and skilled workforce, flexible approaches to care, holistic health care, self-determination and empowerment.[24] The most significant factor that defines improved quality of care in Indigenous primary care service delivery models, is the role of culture.[24] Practices such as incorporating Indigenous artwork and signage, along with employing local Indigenous staff can help implement a culturally skilled workforce that takes into account values, customs and beliefs into practice.[24]

The study conducted by Motta et al. in 2015 examined the use of the Analytical and Clinical Excellence (ACE) program, an international Point of Care Testing (POCT) program for diabetes management for Indigenous peoples.[25] This program provided opportunities to improve the delivery of pathology services in rural and remote areas. Speed testing allowed clients to receive faster results, reduce their number of visits, reduce wait times and ultimately led to better management of diabetes.[25] In an Indigenous context, this program enabled culturally sensitive training for healthcare professionals and allowed for knowledge transfer to participating communities, providing them with the resources they need to

maintain the program long-term.[25] This study highlighted how POCT programs can play a role in better outcomes for Indigenous individuals.[25]

Inadequate Preparation or Training

This theme was identified in two papers written by Minore et al. in 2004 and 2005. [21,22] Both papers examined concerns regarding continuity of healthcare in three remote northern Indigenous communities. [21,22] These papers found that inadequate preparation among healthcare professionals including nurses recruited to northern Indigenous communities greatly affected the continuity of care.[21,22] The 2005 paper had a specific focus on nurses and identified a long time practitioner who mentioned that agency nurses who arrived did not have appropriate preparation, as they "had never been in the north, had never been trained to be in the north, had never been oriented on how to work in the north."[22] The lack of cultural awareness, due to systemic training errors and personal ignorance, plays a major role in acting as a barrier between nurses in these communities and their patients. It is reported that these nurses are often in cultural shock.[22] This lack of cultural awareness can result in nurses making social errors such as not avoiding eye contact with elderly patients, which can affect patient-provider relationships.[22] Additionally, a lack of knowledge to patient lifestyle factors can also cause poor treatment suggestions or misunderstandings.[22] One of the nurses interviewed in the study expressed that once, one of her colleagues was frustrated and proceeded to question her elderly diabetic patient, regarding why they had not bathed their infected foot as suggested. Unfortunately, this nurse did not realize that obtaining and heating water was an exhaustive process that would have been very difficult for the patient.[22]

Furthermore, the study conducted by Harfield et al. (2018) emphasized the importance of a culturally appropriate and skilled workforce.[24] The lack of these attributes can often contribute to poor health outcomes found in Indigenous populations when compared to non-Indigenous populations. Culturally appropriate service delivery is characterized by creating a welcoming and comforting space.[24] Further, having a workforce that is characterized by cultural respect, social justice and equality is vital to building trust with communities.[24] One of the best ways to ensure community beliefs and values are being prioritized in primary care delivery is through employing local Indigenous staff. This would also have several other benefits as these employees can serve as interpreters to translate local languages to non-Indigenous staff, and they can also mentor non-Indigenous staff members to ensure cultural competency.[24]

Management of Mental Health

This theme was identified in two papers written by Minore et al. in 2004 and 2005, that examined concerns regarding continuity of healthcare. [21,22] These papers outlined how it is possible to achieve appropriate care for oncology patients and those with diabetes, but disparities exist when looking at the management of mental health care for Indigenous populations. [21,22] In these three communities, once clients were stable, they were discharged back home where follow-up was inadequate to ensure the good health of these individuals. [21,22] These communities are prepared with crisis intervention strategies but do not have the framework in place for mental health maintenance and prevention services. Both papers also identified that Health Canada lacks a concrete Indigenous mental health policy. [21,22]

Disparities in Health Service Delivery Station Types

The 1981 paper written by Young identified this theme in the analysis of 25 Indigenous communities.[20] A disparity exists among the communities between access to either nursing stations, or health stations resulting in only half of the individuals who are sick being able to utilize these resources.[20] Furthermore, there is an imbalance between the gender and age range of the patients that use these primary care services.[20] For example, when evaluating the use of health services amongst those reported to be sick, highest users are under the age of five, over the age of 45, and female. Young adults had the lowest rates of health service use.[20] There is no uniform level of care provided at each station type, which impacts the health outcomes of individuals that visit one station type as opposed to another.[20] Health stations have less medical resources and types of professionals compared to nursing stations, resulting in a different type and extent of primary care.[20]

Ineffective Primary Care and Impacts on Hospitalizations

This theme was identified in a study by Shah et al. (2003).[26] This study examined the accessibility and quality of primary care for the Indigenous population in Ontario.[26] Researchers compared a group of Indigenous individuals with a non-Indigenous population, where both groups experienced the same level of geographic isolation and low socioeconomic status.[26] Upon examination of ambulatory care-sensitive (ACS) conditions and utilization of referral care-sensitive (RCS) procedures, it was found that

Indigenous individuals had higher ACS hospitalization rates and reduced RCS procedure utilization, indicating poor quality of primary care.[26] As timely and effective primary care for ACS conditions could potentially prevent and reduce hospitalizations, the increased hospitalization rate for ACS conditions amongst this population signifies disparities in care. The rate of utilization of RCS procedures can also indicate the quality of primary care, as high rates signify that a provider has been able to identify a care need in their client and an appropriate referral has been facilitated. The low RCS procedure utilization rates reported by Shah et al. (2003), however, signify a disparity in primary care delivery for this population.[26]

DISCUSSION

Through examining the seven studies included in this scoping review, the primary issue that was identified was a significant lack of literature with a comprehensive focus pertaining to the quality of primary care in the Indigenous population. Additionally, the time frame of these studies presents a major concern. The majority of literature can be considered outdated, as four of the seven studies were published more than 15 years ago. The studies therefore do not take into account the specific needs and concerns of the current Indigenous population.

Although a comprehensive search was performed through numerous databases, the stark reality is that only seven articles met the inclusion criteria of being conducted in Ontario, pertaining to Indigenous peoples, and being written in English. When taking into account that Ontario has the largest Indigenous population when compared to any other province or territory in Canada, and that this population has grown in the recent decade, this lack of literature becomes even more consequential.[27] Further, there exists a lack of systematic and scoping reviews that comprehensively investigate the quality of primary care in Indigenous communities all across Ontario. If improvements are to be made to the quality of Indigenous primary care and policy regulating this care, the current level of literature is inadequate to inform these decisions. These gaps in the literature must be overcome with thorough research and evaluation of the current quality of primary care for the Indigenous people in Ontario.

Of the themes that arose in this analysis, the most prominent themes included: inadequate preparation and training, physician and nursing shortage, strategies associated with improved quality of care and management of mental health.

Our findings revealed that a lack of culturally sensitive preparation and training of healthcare providers, creates a major barrier in the delivery of high quality primary care. This creates a disconnect in the patient-provider relationship and negatively impacts health outcomes. With healthcare providers being in cultural shock, they often make errors in communication which can pose significant challenges. [21,22]

The shortage of healthcare providers in areas with a high Indigenous population further contributes to gaps in care. This is an area of major concern, as it can lead to poor health outcomes and abandonment of treatment by patients.[21,22] For example, when patients become obligated to retell their health concerns to constantly rotating staff, they become discouraged and are hesitant to return to treatment.[21,22] Thus, even when patients' symptoms are addressed in the short-term, and follow up is needed by medical staff, it often does not occur.

In addition to identifying the significant challenges faced by the Indigenous population in Ontario, when it comes to primary health care, the studies identified in this scoping review also touch upon limited strategies that can be used to help overcome these disparities. For example, the literature has suggested that an EOHC model can predict positive health outcomes such as a decrease in depressive symptoms and can contribute to a greater level of confidence and comfort in care providers.[23] However, this model of care is not currently in place in Ontario. EOHC is crucial in the Indigenous population because it aims to reduce structural inequalities such as disparities in income and housing, which are prevalent in Indigenous communities.[23] Further, strategies such as implementing speed testing programs like ACE, which also consider the values, customs and beliefs of communities, can further help to improve health outcomes.[25]

It is also alarming that only two of the seven studies discussed mental health care, considering the scope of this issue in the Indigenous population in Ontario.[28] The studies reviewed in this article demonstrated how the management of mental health for Indigenous patients is poor compared to other diseases. [21,22] For example, Minore et al. (2004) note that the instance of suicide is so high that mental health care is centred around crisis response, as opposed to prevention and routine treatment.[21] Further, once patients become stabilized following a mental-health crisis, follow-up is inadequate, thus presenting the risk that the patient re-experiences the same mental health problem. This is of immediate concern given the magnitude of the

mental health challenges faced by the Indigenous population.[28] For example, statistics show that suicide amongst youth in the Indigenous population occurs five to six times more than non-Indigenous youth in Canada.[29]

Strengths and Limitations

A strength of this study was the use of the screening tool, Covidence, as it streamlined the process by which the authors screened and extracted data from the studies. There were no studies that were unaccounted for between the process of deeming studies eligible from title and abstract review, to screening the full-text, and then subsequently extracting data. Furthermore, the systematic approach that was utilized to extract data helped to ensure that the same information was extracted from each study and to ensure consistency between study authors. Each citation was reviewed by two independent reviewers who regularly met to resolve conflicts and discuss any inconsistencies.

Consultation with a librarian ensured that the search strategy was comprehensive and valid for the aim of this scoping review. However, it is possible that this review may not have identified all the existing literature on the quality of primary care for the Indigenous population in Ontario. Since grey literature was not included in the search, publications that fit under this category that pertained to quality of primary care in Indigenous communities in Ontario were not included. Another possible limitation of this study is the biased nature of the databases utilized in this scoping review. For example, although ISI Web of Knowledge is a multidisciplinary database, databases such as PubMed, CINAHL/EBSCO, and Embase are primarily biased towards health and sciences. Databases focused on humanities and social sciences would have helped provide a greater scope of literature.

Recommendations to Improve Quality of Primary Care

In regards to the shortage of healthcare professionals across Indigenous communities, the issue of frequent staff turnover can be addressed by implementing a program where the same group of healthcare providers rotate in and out of a community.[21,22] Through reduction of healthcare staff turnover, health outcomes, continuity of care and cost-effectiveness of care will be improved.[30] In order to do so, the prioritization of rural or remote based applicants and Indigenous health care workers must be employed.[30] Further, adequate infrastructure and funding of medical services is needed for work that is professionally satisfying, thus reducing the chances of staff turnover.[30] In order to promote staff retention, adequate personal and family support, professional development opportunities and alternative models of scheduling are necessary.[31] For example, creating a rotating cycle of working alternative months helps to maintain the same group of healthcare workers while providing staff with opportunities to return to their preferred environment.[31] This limits the number of unfamiliar faces that are introduced to a health care setting and helps to reduce the hesitation that individuals experience from re-explaining their health concerns to new healthcare staff each time they visit a primary care setting. [21,22]

System wide accommodations to collaborate with paraprofessional staff in the community can also help enhance patient care. As these staff members are well-versed in community values and beliefs, they can play a significant role in implementing long-term programs and improving patient outcomes.[21,22]

Furthermore, adequate training should be provided to all healthcare professionals who practice in Indigenous communities. This training should incorporate local customs, values, and beliefs into the model of care. [21,22] Training should be provided regardless of the length of the healthcare professionals' employment in an Indigenous community. Specifically, the role of elders and Indigenous governance in the care model should be respected to better engage with patients. EOHC would be a valuable tool to integrate into the current primary care system in order to reduce the effects of structural inequalities that may result in poor health outcomes.[23] Making EOHC a priority of healthcare providers would help to mitigate some of the effects of unequal housing, income and poverty that impacts the health of Indigenous populations in Ontario.[23]

Resources including the Indigenous Health Program of Alberta Health Services can be further explored to better understand how to create culturally competent, and sustainable partnerships between Indigenous peoples and stakeholders in the healthcare system.[32] Additionally, training such as the Cultural Safety Online Course provided by Island Health in British Columbia, can further improve cultural competency. This course encourages culturally safe and respectful care.[33]

Mental health is also an area where disparities in care exist for the Indigenous population. [21,22] As a result, a comprehensive mental health policy should be developed by Health Canada for this population to ensure adequate care. Speed testing through programs such as POCT have also shown great benefits and should be employed when working with Indigenous

patients to ensure efficiency of care.[25]

The overarching recommendation made by this scoping review is to conduct more in-depth research on the quality of primary care received by the Indigenous population in Ontario. To mitigate the substantial lack of literature on this subject, consistent and thorough data collection is crucial. In doing so, primary care can be tailored to meet the unique needs of each Indigenous community.

CONCLUSION

This scoping review involved performing a literature search to investigate the quality of primary care received by Indigenous individuals in Ontario. There was a need to identify the gaps in literature investigating the quality of primary care for Indigenous patients due to the current lack of conclusive and comprehensive evidence. There is a clear need for a significant transformation in the Indigenous primary care model in order to better meet the specific needs of these communities. This is crucial, as the Indigenous population in Ontario is the largest of any province or territory in Canada.[27] The implications of an inadequate health care model are significant. Action is urgently needed to ensure more research in this field along with the development of policies to improve the quality of primary care received by this population.

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ARTICLE INFORMATION

Senior Editor
Reza Khorvash

Reviewers and Section Editors
Kasia Tywonek, Naomi Suzuki

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Danial Aminaei

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