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Critical Social Determinants to Enhancing Health Equity: an Indigenous Perspective

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For everyone on this planet, the last 2 years felt "stolen". The COVID-19 pandemic occupied everyone's mind and vastly changed their daily activities. Because of it, we are isolated by being pulled further away from our beloved family and friends but also brought together as one big community to face the pandemic together. However, as Professor Davies of Western University said, "we are in the same storm, but not in the same boat," the health care available isn't the same for every Canadian. As someone who grew up in an Indigenous community and worked in a hospital with most indigenous patients from reserves up north, I'd like to discuss the 3 social determinants that should be modified to achieve health equity, especially for the indigenous population: geographic isolation, structural social inequalities, and wealth distribution issue. The discussion will be based on an indigenous perspective, as well as using my background knowledge as an epidemiology and biostatistics student.

As the owners of Canada, Indigenous people unfortunately no longer live on the land that belongs to them. 44% of First Nations and 73% of Inuit people live on reserves and Inuit Nunangat, both of which are difficult to access by transportation. (Statistics Canada 2020) Alongside the geographic isolation comes to the issue of lack of accessibility to healthcare. Reserves often have poor health care facilities Residents must travel great distances, both by driving and by airplanes, to obtain the health care they need. This lack of access to health care is

especially inconvenient when one is already ill. 1 in 10 First Nations reserve residents report they've had trouble accessing necessary health care (Statistics Canada 2020). The consequence of the absence of accessible healthcare for the reserve population is then enormously amplified by the pandemic, as the demand for urgent care skyrockets. As a worker on the frontline of COVID-19 as a health care aide, I've witnessed many indigenous individuals arriving at the emergency by air ambulances, many of them needing additional medical attention because their much-needed treatment was delayed by the inconvenience of transportation. To combat health care inequity due to the geographic isolation of reserves, multiple approaches must be taken. Most reserve residents cannot access health care promptly because their communities lack the standard health care infrastructure seen in urban and suburban areas. For them to gain better access to the care they need, more funds should be attributed to optimizing transportation between indigenous reserves and urban hospitals, such as air ambulances and highway construction. Lastly, more and better health care infrastructures such as hospitals and nursing homes should be established near reserves so the residents can access them at ease, just like us as urban residents.

Another critical social determinant is the perpetual structural inequity in Canadian society. Systematic racism, alongside social exclusion and repression, as well as generational trauma, are all indirect risk factors for the indigenous population's health. (Public Health Ontario 2020) Such risk factors have led to a higher prevalence of high blood pressure, diabetes, and cardiovascular disease in indigenous populations (Public Health Ontario 2020). These chronic diseases may then be associated with increased risk for acute infectious diseases COVID-19, since ill individuals are more prone to having compromised immunity, being unable to go to

hospitals and clinics when sick, and having lower income from missing work. The latter two social determinants are also discussed in this essay in terms of the lack of access to convenient health care on reserves and low-income's association with greater susceptibility to diseases. The root of the structural inequity in Canadian society traces back to colonization and residential school history, both of which resulted in generational traumas for the indigenous population. Furthermore, systematic racism put them at greater risk of poverty and chronic illnesses. A possible solution to this social determinant could be enforcing policies that eliminate systematic racism, such as setting racial quotas for workplaces and harshly punishing racist speech and actions. If the society's social structure was made more equitable for the indigenous population, they may be protected from risks that made them more susceptible to illnesses and have better access to the health care they need, thus promoting health care equity as well.

The last critical social determinant of health care inequity is the unequal wealth distribution (Davies and Sepulveda, 2021). Compared to the national proportion of 14% of Canadians living in a low-income household, 24% of indigenous people in urban areas live in low-income households (Anderson 2019). In Toronto, the low-income population has a much greater COVID-19 incidence (26%) compared to high-income population (16%) (Public Health Ontario 2020). A possible explanation could be low-income populations often live in unsuitable housing with crowdedness (Public Health Ontario 2020). The issue is especially concerning for older adults of indigenous families, since indigenous families tend to live in multigenerational households, resulting in their older adults being exposed to excess risk of COVID-19 because of crowdedness (Statistic Canada 2020). Moreover, low-income is often associated with poorer health conditions because individuals in worse financial situations are demanded to go to work

when ill. To eliminate wealth distribution from the equation of health care inequity, one may suggest a redistribution of wealth through taxes. However, Canada has a reputation for minimal income inequality as indicated by its Gini index, yet poverty is still present and almost hereditary over generations. A more contemporary approach is instead of redistributing wealth, the government should redistribute resources and opportunities in the hope that the low-income population will have improved housing and education, which are all important indicators of health. Furthermore, financial aid should be provided to low-income individuals that are ill, so they don't have to force themselves to go to minimum-wage work while bearing the risk of their illness worsening due to stress and having co-workers infected. With better living conditions, the low-income population will be less vulnerable to illnesses and have more freedom to pursue success and escape poverty.

In conclusion, geographic isolation, society's structural inequity, and wealth distribution are the three critical social determinants that should be subject to change to establish health equity, especially for indigenous people, who have been lacking the equity they deserve for too long in a country that is of their own land. I hope my opinions can bring insight to the readers on the necessity of health equity and potential solution to resolve the current inequity, not only just for Canada and indigenous people but for people of colour that are suffering inequity everywhere in any Western country.

Works Cited

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