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Health and Health Care: Manitoba's First Nations

MANITOBA CENTRE FOR HEALTH POLICY

Summary by RJ Currie, based on the report *The health and health care use of Registered First Nations people living in Manitoba: a population-based study* by Patricia Martens, Ruth Bond, Laurel Jebamani, Charles Burchill, Noralou Roos, Shelley Derksen, Marcella Beaulieu, Doreen Sanderson and the Health Information and Research Committee of Assembly of Manitoba Chiefs, Marilyn Tanner-Spence, Audrey Leader, Brenda Elias, John O'Neil, Carmen Steinbach, Leonard MacWilliam, Randy Walld, and Natalia Dik.

If you are not a First Nations person living in Manitoba, imagine for a moment that you are. Your life expectancy just became eight years shorter than it is for other Manitobans. And the likelihood that you will die at a young age has more than doubled—tripled if you are female. The chances that you will have diabetes have more than quadrupled and the chances you will need amputation as a result of diabetes have increased sixteen times.

Startling, isn't it? These are but some of the surprising, at times paradoxical, findings in this latest report by MCHP. It provides information based on the entire First Nations population of the province, using all other Manitobans as a comparison group.

With funding and support from Manitoba Health, MCHP worked collaboratively with the Health Information and Research Committee of the Assembly of Manitoba Chiefs to provide information that might help in the planning processes of First Nations Tribal Councils, Regional Health Authorities (RHAs), as well as the provincial and federal governments.

There are seven Tribal Councils in Manitoba and two groupings we call Independent North and South which include both independent and unaffiliated communities. These nine Tribal Council areas in order are: Keewatin, Island Lake, Interlake Reserves, Independent First Nations North, Independent First Nations South, Swampy Cree, West Region, Southeast Resource Development and Dakota Ojibway.

There are 12 RHAs in Manitoba. Listed in order they are: South Eastman, Central, Brandon, South Westman, Winnipeg, Interlake, Marquette, North Eastman, Parkland, Burntwood, Nor-Man, and Churchill. Each is responsible for the planning, integration and monitoring of health care services in their region.

Now when we say that the Tribal Councils and RHAs are listed "in order," we mean in order of their *health status,* with the last few in each list having the poorest health status compared to the others.

MCHP's *Population Information System*—or POPULIS—makes it possible to compare the health status of people of different geographical areas, be it a Tribal Council or an RHA. It can also track the residents' use of health care services (such as hospitals and physicians) and how that relates (or doesn't) to residents' health. Most importantly, POPULIS does this regardless of where the use occurred. This population-based approach gives us a more complete picture of health care use, rather than just the care provided by "in-area" doctors or facilities.

Another advantage of POPULIS is that its rates are age/sex-adjusted. What this means is regardless of the population make-up of the various regions—proportionately more men? more women? more young? more old?—POPULIS makes essentially an "all things being equal" comparison. So a Tribal Coucil with, say, a smaller proportion of elderly residents could have a crude (unadjusted) rate below the provincial rate, but an age-adjusted rate that is above it.

For this report, we worked with SVS (Status Verification System) files to ensure that our Registered First Nations (RFN)

grouping included all persons having band membership with a Manitoba First Nations community. This does not include band members living outside of Manitoba nor those who have out-of-province band affiliation but are living in Manitoba.

What this report does not provide is a detailed explanation of the differences in various rates. We believe that much of this interpretation should come from the Tribal Councils and RHAs themselves, based on their understanding of local circumstances.

A focus on health

So what makes us say that people in one area have better health status than people in another area? Well, three things mainly, the first of which is PMR—Premature Mortality Rate or death before age 75. PMR is a widely used measure of health because populations with higher rates also report more sickness and more symptoms of illness. The health status ranking for Tribal Councils and RHAs mentioned earlier is based on this important measure.

There are two other global measures that help give a more complete health picture. One of them is life expectancy: where people live longer, it follows that their health is better.

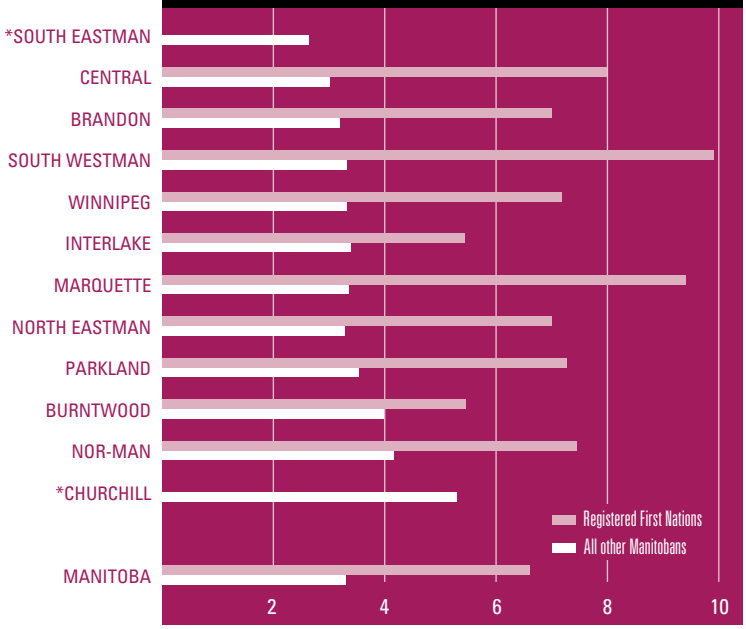
The other key measure of health status is PYLL—Potential Years of Life Lost. PYLL tells us not only the rate at which people die before age 75, but whether they are dying at a younger or older age. So a high PYLL means more deaths at a young age.

Health status

- The RFN population in Manitoba has twice the PMR compared with all other Manitobans—6.6 vs. 3.3 premature deaths per thousand (Fig. 1). Some of the southern RHAs that have the healthiest overall populations, at the same time have Registered First Nations populations with the poorest health status. Although all Tribal Councils have relatively high PMR (Fig. 2), there's a range: from a high of 9.3 per 1000 (Dakota Ojibway in the south) to a low of 4.8 per 1000 (Keewatin in the north).

- Life expectancy of Registered First Nations people (both male and female) is about eight years less than it is for all other Manitobans. Within Tribal Council areas there is also a big difference in life expectancy—lowest in some southern Tribal Council areas, highest in some Northern.

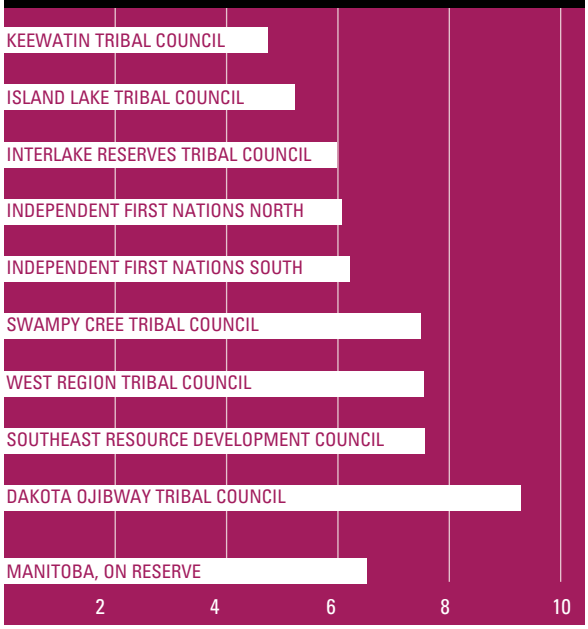
1. Premature Mortality Rates: Registered First Nations vs. All Other Manitobans, 1995-99



Age/sex adjusted deaths per 1000 ages 0-74

*RFN rate not shown due to small numbers

2. Premature Mortality Rates by Tribal Council, 1995-99



Age/sex adjusted deaths per 1000 ages 0-74

- RFN people are far more likely to die young. Their PYLL is much higher than it is for other Manitobans—two and a half times higher for males and three times higher for females.

- Treatment for diabetes is over four times as high for RFN people compared to all other Manitobans (18.9% vs. 4.5%). Amputation related to diabetes complications is sixteen times higher for the RFN population (3.1 vs. 0.19 per thousand for ages 20 through 79), and is especially high in Dakota Ojibway Tribal Council (6.2 per thousand).

- Hospitalization rates due to injury are over three times higher for RFN compared to all other Manitobans (30 vs. 8 per thousand). The highest rates are in the northern Tribal Councils of Keewatin and Island Lakes.

Preventive care

- Registered First Nations children have far lower immunization rates than all other Manitoba children at both one year—62% vs. 89%—and two years of age—45% vs. 77%. (RFN estimates may be a little lower than they actually are due to underreporting into the provincial immunization system.)

- Breastfeeding rates at hospital discharge are considerably lower for RFN children compared with all other Manitobans (57.1% vs. 80.5%).

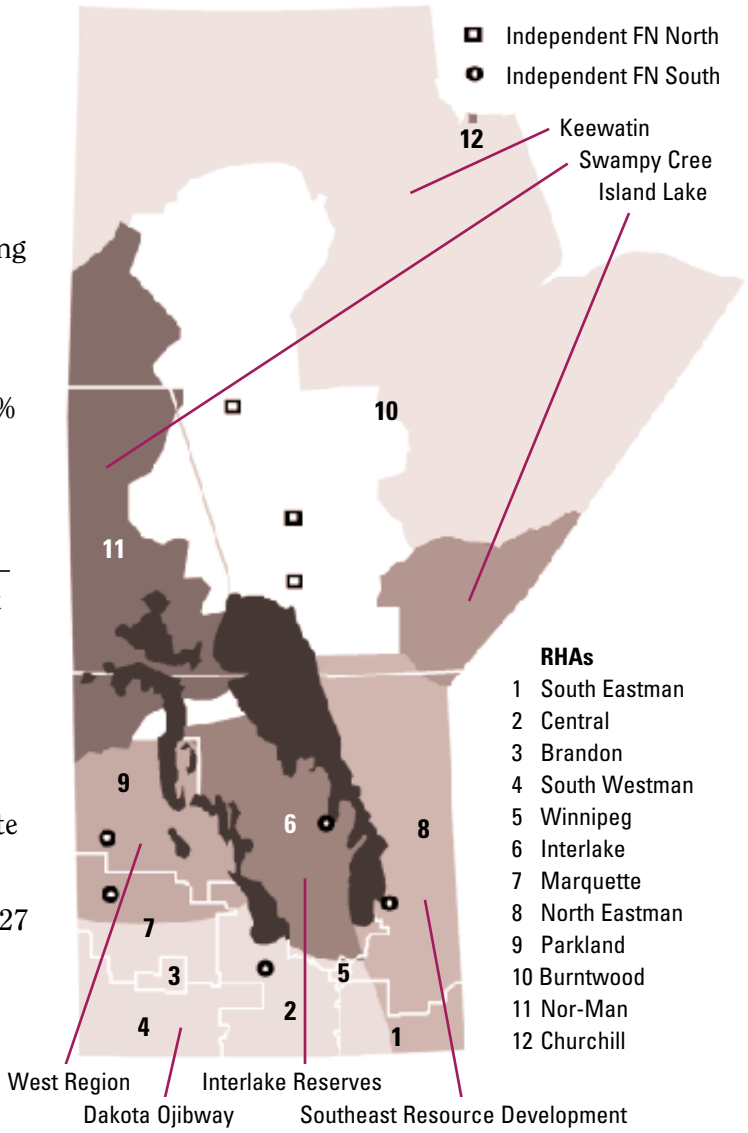
Health care use

- Hospitalization rates are double for RFN people compared to all other Manitobans—348 vs. 156 per thousand per year. In most RHAs, Registered First Nations residents have the highest rates of both hospitalization and total days of care.

- RFN persons average more contact with physicians than do other Manitobans—5.8 visits per year compared to 4.7. But the rate at which they are referred to a specialist (taking into account the first, or referral, visit only) is almost the same at 0.29 vs. 0.27 visits per person per year. Churchill RHA has the highest RFN referral rate in Manitoba at 0.5 visits per year. Comparing only Tribal Councils, referral rates are highest for Island Lake and Independent First Nations South, lowest for Dakota Ojibway.

- In Winnipeg and Brandon (where 90% of the specialists are located) RFN people have fewer contacts per person with specialists (first visit and follow-up treatment by a specialist) than do other residents—Winnipeg: 1.60 vs. 1.71; Brandon: 0.82 vs. 0.98—despite their overall poorer health. This is in contrast to RHAs such as Nor-Man, Burntwood, Parkland, Marquette and South Westman, where a higher specialist contact rate compared to other RHA residents may reflect a more needs-based delivery of care.

Tribal Council Areas with RHAs Outlined



Where do we go from here?

As stated earlier, MCHP has not focussed on offering a detailed explanation of our findings (though to aid decision-makers' understanding of the information, the report offers some sample interpretations and possible questions). As such, our report doesn't provide answers. But it does highlight many important observations that raise a lot of questions.

Overall, the story of the health of Manitoba's Registered First Nations people is not a good one. They can expect to live a startling eight years less than other Manitobans. And the rate at which they die young is especially troubling. They are also three times more likely to be hospitalized for injury. Of particular concern is diabetes; the RFN treatment rate for this illness is more than four times higher than it is for other Manitobans.

Not only are *rates* of diabetes a concern, so too is the *burden of illness* (impact on the health care system) that diabetes represents across RHAs—even in some RHAs where the RFN diabetes rates are lower. For example, RFN people in Burntwood have a lower rate of diabetes than those in Central. But Burntwood also has more than four times the RFN population. So while the burden of diabetes in Central is large at around 450 cases, it is even larger in Burntwood—about 1600 cases—despite Burntwood having a lower rate.

Kneejerk questions arising from these alarming data might be: Are more hospitals needed? More doctors? But as is the story in other reports on population health, neither appears to be the answer here.

Take for example the Tribal Councils of Keewatin and Island Lakes. They have the highest life expectancy for males and females respectively. Yet they are in two of the northernmost areas where health care services are the least available.

Compare them to two southern Tribal Councils—Dakota Ojibway and Southeast Resource Development. Their potential years of life lost is the highest in the province for males and females respectively. This, despite being in two of the healthiest RHAs, in close proximity to Brandon and/or Winnipeg, where the majority of physicians and major hospitals are found.

Consider also that RFN people make high use of health care services. They average one more visit per year to a physician than other Manitobans. They also average twice the hospitalization rate and 1.7 times the total days in hospital. So the system appears to be responding to the needs of those in poorer health, which is good news. The bad news is that poorer health is not likely due to a lack of health care services; more health care doesn't appear to be the answer.

That being said, the rate at which RFN people are referred to a specialist—which is on a par with other Manitobans—is surprisingly low given their much poorer health. So are more specialists needed? You might think so when you look at Dakota Ojibway Tribal Council, where health status is poorest and specialist consults are lowest. Then again, it is also close to Winnipeg and Brandon, where 90% of the specialists are located. Meanwhile, more isolated northern areas such as Churchill RHA and Island Lake Tribal Council have high consult rates despite few if any regional specialists. So is this a question of more specialists, or is it a question of improving the referral system?

If health care alone can't create good health, what can? Perhaps stakeholders and policymakers in the various Tribal Councils and RHAs might feel prevention is the answer. Maybe finding ways to increase immunization and breastfeeding, and decreasing injury is a logical place to start. They may also want to learn from each other: Why is life expectancy higher in one Tribal Council? Why are amputation rates lower in another? What are they doing differently?

There are many such questions that need to be answered for the health of Manitoba's First Nations people to improve, to be on a par with the rest of Manitobans. This report is not a blueprint to that end. It's more of a map pinpointing possible places to start.

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