

6

Mitho-Pimatisiwin for the Elderly: The Strength of a Shared Caregiving Approach in Aboriginal Health

Bonita Beatty and Arnette Weber-Beeds

Introduction

Mitho-pimatisiwin is a northern Woodland Cree term that means “the good life,”¹ in reference to the overall quality of life or well-being that is culturally embedded in a northern way of life (Beatty 2006; Hart 2002; Cardinal and Hildebrandt 2000). It is a holistic world view that sees all things as interconnected, and in which health is seen as a balance of the physical, mental, emotional, and spiritual aspects of a person’s survival and well-being (PBCN 1995). It is in this context that this paper discusses the challenges of helping elderly First Nations transition into urban areas. More specifically, it examines what can be learned from current Aboriginal community practices to help foster mitho-pimatisiwin for the elderly, especially those in that vulnerable stage of transitioning between their home communities and urban areas.

This is addressed through the example of the Peter Ballantyne Cree Nation (PBCN) Health Services and its shared caregiving approach to elderly care services. It suggests that the way PBCN Health coordinates elderly care from the community health centres, in consultation with the elderly and their families, and then follows up with the urban-based health-care providers in hospitals and long-term-care homes, could help inform other health-care providers, policy-makers, and researchers as to how to better integrate their efforts and close some of the gaps in care for the elderly.

It should be noted that the terms “elderly” and “seniors” are used synonymously here to refer to those sixty-five years of age and older, rather than using the term “elder,” which can have a broader meaning. While some may refer to the elderly as those aged fifty-five years and older, in order to take into consideration the generally poor health status of Aboriginal peoples, (Assembly of First Nations 2007; Wilson et al. 2010), the focus here is on the older and often more vulnerable group.

It should also be noted that while the term “urban” implies permanent residency in a town or city, Aboriginal people, particularly the elderly, tend to move back and forth depending on need (Tjepkema et al. 2010). In fact, in Saskatchewan,

northern migration into cities for health reasons goes as far back as 1963. The more visible permanent Aboriginal residents of Saskatoon were “registered Indians and Métis” from northern Saskatchewan who remained in the city after their lengthy stays in the tuberculosis sanatorium (Dosman 1972). Consequently, the term “urban” is used here in a flexible fashion to refer not only to permanent residents, but also those in semi-permanent transition, considering that the latter often fall through the cracks of population profiles with their needs easily peripheralized by provincial and municipal public services.

The paper begins by discussing the broader challenges and issues in Aboriginal elderly health care, and then provides a description of the Peter Ballantyne Cree Nation Health Services study, along with a profile. It describes the organization’s approach to elderly health care, and its major strengths and challenges. This is followed by a discussion of some of the major themes that emerged from the findings, along with a conclusion.

Broader Challenges

The challenges facing elderly Aboriginal peoples in Canada are many, and can be largely attributed to poverty and to federalism, as jurisdictional divisions have fragmented what should be a seamless flow of health services to all Canadians. A recent report by the Organisation for Economic Co-operation and Development (OECD) hails Canada as one of the best places to live in terms of “quality of life” and people’s sense of well-being (CBC News Canada 2011), but there is no accounting for Aboriginal poverty. The Aboriginal elderly are, therefore, not only generally poor, but are aging in a seriously pressured health system consisting of an aging Canadian population with growing health needs (Romanow 2002; Stadynek 2002).

The Canadian standard is that all Canadian seniors should expect to be treated with dignity and respect, to support independence, respectful engagement, or participation; to be treated with fairness and compassion, and to have security of person, shelter, and faith (Turcotte and Schellenberg 2007). While these are reflected in the main elements of the Canadian health care system, which includes universal coverage, accessibility, portability among provinces and territories, comprehensiveness, and public, non-profit administration, the reality falls short (Health Canada 2011a). According to a recent report by the Canadian Institute for Health Information (2011), while age alone does not correlate with poor health status, there is a serious issue of seniors in poor health with multiple chronic conditions. Seniors in poor health are higher users of health-care resources and prescriptions drugs (Canadian Institute for Health Information 2011).

In the Canadian context, Aboriginal people,² especially the elderly, are particularly vulnerable (Wilson et al. 2010). A portrait of Canadian seniors suggests that seniors represented about 13.1 percent of the Canadian population (4.2 million people) in 2005, with Saskatchewan among those provinces with the highest senior

population at 14.8 percent (Turcotte and Schellenberg 2007). The percentage of the Canadian population as a whole that is Aboriginal is lower, at about 3 percent. In 2001, only 4 percent of the Aboriginal population was elderly (over sixty-five years of age), but this is expected to grow to 6.5 percent by 2017 (Turcotte and Schellenberg 2007).

Aboriginal elderly are significantly more likely than non-Aboriginal seniors to be in poor health—struggling with chronic diseases such as arthritis, diabetes, and respiratory, cardiac, and circulatory illnesses—and to have lower incomes. Unfortunately, these facts are borne out in significantly higher mortality rates and shorter life expectancies as well (Beatty and Berdahl 2011; Tjepkema et al. 2010). Health issues dominate the lives of the Aboriginal elderly, because of the direct influence they have on quality of life. As John Morin, PBCN senator and elder, put it, “if you have your health, you are a millionaire” (personal communication 2010).

While there are encouraging signs of increasing advocacy efforts to improve Aboriginal peoples’ health, they remain marginalized in the public debate on health care, and much still needs to be done to address the emergent and particular needs of the aging elderly (Assembly of First Nations 2007; Hampton 2007; Hotson, McDonald, and Martin 2004; Reading 2009; Wilson et al. 2010; Beatty and Berdahl 2011).

Issues in Aboriginal Elderly Health Care

The literature on Aboriginal elderly care portrays a growing population with complex and diverse health needs. The disparities that exist across the elderly population are generally attributed to broad health determinants, including socio-economic conditions, age, gender, ethnicity, marital status, geographical location, health-system capacity, and housing, among others (Special Senate Committee on Aging 2007; Downey 2003; Rosenberg et al. 2009; Chenier 1993; Krieg, Martz, and McCallum 2007; Wilson et al. 2010). The 2006 Census shows that the elderly population (sixty-five years of age or older) is increasing; an estimated 56,460 people, or 4.8 percent of Canada’s total Aboriginal population, are elderly (Rosenberg et al. 2009).

In Saskatchewan’s Aboriginal population, an estimated 5,230 of 141,890 people, or 3 percent, are elderly (sixty-five or older), and 7,110 of 141,890, or 5 percent, are nearing the retirement age of fifty-five to sixty-four years of age (Statistics Canada 2008).

Aboriginal people, including the elderly, are also moving to urban centres in greater numbers, and will likely to continue to do so in the future (Rosenberg et al. 2009). Aboriginal elderly are more likely than non-Aboriginal elderly to report poor health status and to develop more acute health-care needs (Rosenberg et al. 2009). Commonly identified chronic illnesses among members of the Aboriginal elderly population include disabilities, heart problems (Turcotte and Schellenberg 2007, 248–49); diabetes, hypertension,

cancer, arthritis, rheumatism, high blood pressure, and asthma, among others (O'Donnell and Tait 2003, 14; Public Health Agency of Canada 2003). There is broad consensus that root factors, such as social conditions and economic status, directly affect people's health (determinants of health), and should therefore be considered in any policy programs and interventions relating to Aboriginal elderly care (Public Health Agency of Canada 2010; Krieg, Martz, and McCallum 2007; Beatty and Berdahl 2011).

The PBCN Profile and Case Study

Although there is growing awareness of Aboriginal elderly care issues, there are still many gaps in the current literature, as it fails to properly address the effects and consequences of the weak, and often non-existent, links between isolated northern and urban health services. With the failure by governments to properly address and develop long-term-care homes in the northern communities and reserves, local health systems like PBCN Health have become increasingly stressed in their attempts to provide essential health-care and home-care services, and are often forced to refer elderly peoples to facilities in urban centres. The cost of this failure goes beyond services, because it affects the quality of life of the elderly and their families, with many facing potentially high-risk situations. That is why it is important to find out how Aboriginal communities are addressing these issues. The PBCN study is an example of an information source that could provide some ideas of how to bridge the northern-urban divide and help First Nation elderly better transition into urban health-care settings (Reading 2009).

The PBCN people are Woodland or Rocky Cree or Assin'skowitiniwak (meaning "people of the rocky area"). They largely reside in northeastern Saskatchewan, north of Reindeer Lake and due south to Sturgeon Landing, a vast area of about 51,800 square kilometres (20,000 square miles), consisting of lakes, swamps, trees, and the Canadian Shield (PBCN 2011). About 37,000 people (less than 4 percent of the provincial population) live in about forty-five different communities, consisting of reserves and municipalities (SaskAdapt 2011). It is a rapidly growing, young population that is 80 percent Aboriginal (over 60 percent are First Nation), compared to 13.3 percent of the province's population, and 3.3 percent of the population for the whole country (Northern Saskatchewan Regional Training 2010). Like other northern Aboriginal groups, PBCN is still struggling to cope with the myriad of changes brought about by the forces of colonialism and capitalism while trying to maintain their identity, language, land, and traditional "way of life," or "pimachesowin" (Cardinal and Hildebrandt 2000).

The PBCN is a multi-community band with most of its eight communities located in northeastern Saskatchewan (PBCN 2011a). The PBCN is one of the ten largest bands in Canada, with its 2009 population estimated at 8,928 members (PBCN 2011b). In 2007, its population was estimated at 8,344 members with 5,511 (66 percent) living on-reserve and 2,833 (34 percent) living off-reserve (Minister of Public Works 2008). What is less certain is how many individuals

are living permanently in the larger urban centres in the south and how many are elderly. One can get some idea by looking at where the majority of the urban population resides; for PBCN, most live in Prince Albert, and others in Saskatoon, Creighton, and La Ronge (Statistics Canada 2007). In 2006, it was reported that 13,570 Aboriginal people lived in Prince Albert, representing 34 percent of the city's population (Statistics Canada 2008a). The PBCN Health Survey suggests that about fifty elderly, on average, require respite, palliative, institutional, and/or specialized services largely offered in Prince Albert and Creighton, and would benefit from long-term care in the communities if it were available (PBCN Health Home and Continuing Care Program 2010). The *2003–04 PBCN Health Services Annual Report* suggests that there were seventy-seven elderly receiving PBCN home-care services. Forty were sixty-five years of age or older, and thirty-seven were seventy-five years of age or older (PBCN Health Services 2004).

Both First Nation and provincial health authorities provide health services in the region. PBCN Health provides comprehensive health services to four of its northern-based communities through the 1995 PBCN Federal Health Transfer Agreement. The other three PBCN communities were not part of the agreement because they did not have reserve status, and therefore receive services from provincial health authorities. PBCN Health currently provides some health support programs and services to those three communities—one of which is Prince Albert—but does not provide primary health services.

PBCN Health Services' central office is located in the PBCN urban reserve. It provides mostly financial and supervisory services to the four main health centres located in the north. As some of the PBCN communities are situated close to the Manitoba border, PBCN Health also works with the Norman Regional Health Authority in Manitoba. The primary connection to the provincial health authorities in the area is through the hospitals, and to an increasing degree, through the long-term-care facilities. The nearest hospitals to the northern PBCN communities are in La Ronge, Saskatchewan, and Flin Flon, Manitoba.

With the goals of achieving more local control (self-determination) and building healthy communities, the PBCN chief and council signed the Health Transfer Agreement in 1995. They then set up and mandated their own autonomous health agency, governed by a board of community representatives, to control, administer, and deliver health services to their communities. This was the beginning of PBCN Health, which can now be described as a maturing organization with over sixteen years of experience in the areas of health governance and administration (PBCN Health Services 1995). Elderly care is an emerging priority for the PBCN, as a growing number of elderly (an estimated fifty annually) require the higher levels of health care that are offered only in the urban centres.

Most PBCN elderly, like others, generally leave their home reserves because of limited home-care and palliative-care services to meet their more complex needs; inadequate housing; and the lack of other needed social support services (Hotson, McDonald, and Martin 2004). These are often the major push factors that drive

individuals into the cities. Although the data is limited, inferences from the PBCN study suggest that if they had access to good-quality home-care services or long-term-care facilities on-reserve, most Aboriginal elderly would stay or return to their home communities. Most wish to be in familiar surroundings at the end of their lives (Hotson, McDonald, and Martin 2004).

The Project

The PBCN Elderly Care Research Project was a small, two-year joint collaboration with PBCN Health Services that was funded by the Indigenous Peoples Health Research Centre. Its purpose was to explore the extent of the community elderly care services (for those aged sixty-five and up) in four of the PBCN communities serviced under the Health Transfer Agreement. The key research question was: “How can communities better facilitate the respect and dignity of elders (seniors) during chronic and/or end-of-life care?” Data was gathered through focus groups, primary documents, and interviews with health-care providers and the elderly in the PBCN region.

The elderly care services were based on the PBCN vision of health care, which is to “strengthen the individuals, families, and communities by using the holistic approach to health care by working in partnership with other community resources to address the physical, mental, spiritual, and social well-being of the people” (PBCN Health Services 1995). More specifically, the PBCN Home and Community Care Program, which remains the foundational program for elderly care in the communities, was intended to “enhance the persons’ self-determination, self-reliance, and well-being through family and community resources, thus enabling individuals to continue to live productive useful lives in their own homes” (PBCN Health Services 2010).

Methodology and Data Analysis

In exploring the PBCN elderly care services, the research project profiled the strengths and weaknesses of the PBCN community-based health programming, including its initiatives to help elderly who were forced to relocate to long-term-care facilities in urban centres for medical reasons. The required community- and university-protocol approvals were followed for behavioural research ethics; this included a board motion from the PBCN Health Services board. The data was collected through a total of nine focus group meetings (three in each community) with PBCN Health staff and other community agencies that provide a variety of elderly care programs and services. Through a second phase of the project that was later added, at least two elders from each of four communities were interviewed and asked their opinions (both in Cree and English, as needed) of PBCN elderly care services.

During the focus groups and the interviews with the elderly, a series of open-ended questions were posed. They asked participants to describe the health programs and services currently being provided for the elders in the community;

discuss any relative strengths and weaknesses; and provide some recommendations. The limitations of the research related to the small sample-size of the project itself. This limits the generalization of its findings, but the project's strength is that it highlights how the integration of the efforts of northern and urban health providers could occur to better streamline health services for the elderly in the towns and cities.

PBCN Elderly Care

One of the biggest fears of the elderly interviewed in the PBCN case is that they did not want to live out their days away from their families and communities. A good quality of life for them meant living at home or in their communities, and being able to access local health services for as long as possible. This appears to be a common sentiment among the elderly (Aboriginal Advisory Committee; Kuran 2002). In the PBCN case, the frailest elderly tended to end up in cities, either in respite- or institutional-care homes of sorts. These were people whose health was seriously compromised by debilitating illnesses such as strokes, or were otherwise physically and/or mentally limited, or both.

PBCN Health provides elderly care and support services through home and continuing care programs in both the reserve and off-reserve communities. The federal government, through the First Nations Inuit Health Branch, funds health services on-reserve, and in Saskatchewan, most are managed by First Nations through a variety of funding arrangements. Any home-care services offered off-reserve are covered by the provincial government and are managed by regional health authorities. However, coordination among these jurisdictions and among service providers has become a major problem (Beatty and Berdahl 2011; Rosenberg et al. 2009). Quality health care is a common concern because there is little continuity and coordination between service providers (on- and off-reserve) and with recipients. This creates many problems for elderly who are at risk for neglect if they do not have family or other supports.

There is generally a greater variety of essential elderly care services offered in the urban centres than on reserves and in the more northern Métis communities (Assembly of First Nations 2007; Krieg, Martz, and McCallum 2007). Standard services in urban areas include the provision of long-term and chronic-care facilities; palliative care; respite care; and home-support services like meal delivery, transportation, and other professional nursing and rehabilitative services. Unfortunately, these services are often overburdened, and many Aboriginal elderly with serious health problems are marginalized and unable to access them (Krieg, Martz, and McCallum 2007). Some studies suggest that services and programs in the towns and cities are underutilized by First Nations people because of cultural and other barriers (Hampton 2007; Saskatchewan Indian Institute of Technologies 2002). Another problem with accessing available urban programs and services is associated with multi-jurisdictional barriers, and who is responsible for paying for such programs (Special Senate Committee on Aging 2007).

The PBCN elderly care program in the northern transfer communities consists of a combination of home- and community-care nurse assessors (who provide home-nursing services and manage the home-care program in their respective communities), home-health aids, licensed practical nurses, and elderly support workers (who provide home living and social supports, as well as transportation). The director of home and community care is situated at the central office in Prince Albert, where she oversees and provides supervision, coordination, and training, as well as other support services to the home- and community-care programs.

The link between the community-based home-care services and the urban centres begins with the home-care nurse assessors, advocating for and working with the elderly and their families to arrange care with the hospitals and long-term-care facilities. This is done in conjunction with the home-care director. The elderly and their families are often ill-equipped to facilitate the process themselves, and need the help of trained professionals to navigate the health and long-term-care systems. The elderly and their families consider this a valuable strength of the system, because the consistency and organization of care provides them with a sense of security and the compassionate service they need. The director of home care arranges contracts with the various regional health authorities for home-care services in the non-transfer PBCN communities. There is also ongoing dialogue with the health authorities to facilitate services in the off-reserve areas. Ongoing communication and familiarity with other home-care programs helps them to establish the networks and working relationships that are so crucial to facilitating the care of the northern elderly in the urban areas.

PBCN Health Research Findings

The findings of the PBCN elderly care project identified some major strengths and weaknesses of the PBCN elderly care health services. These were useful for several reasons. First, the findings identified areas that were within the control of PBCN Health Services to improve, and it profiled the broader policy and jurisdiction issues that needed higher political and other action. However, second, and more pertinent to this paper, they highlighted the gaps in local PBCN health-care services and the striking lack of long-term-care facilities in the communities. As a result, the elderly were increasingly being forced into the cities, and into culturally foreign and institutionalized settings where they were essentially divorced from familiar contact with their family and community health systems.

The strengths identified in the PBCN health system included the development of a structured, stable home- and community-care program in 1999. Although there were no palliative-care programs in the communities, innovation and flexibility to meet the needs of clients in the end-of-life stage were illustrated in care plans. These were based upon the needs of individuals and the willingness of their families to provide the required care. In the ideal case-management scenarios, the elderly and their families were considered the team captains of

their own care. In some cases, this did not work out for reasons including issues accessing medical/health-care appointments, language barriers, lack of family support, transportation, social issues, and addictions.

The health programs encouraged involvement by the community and promoted traditional and cultural activities, including engaging the elderly with youth in organized activities such as storytelling. Regularly organized social outings for the elderly also helped reduce isolation and neglect, and kept the elderly more mobile while promoting good health. The multi-level programs offered in the health centres, including home care, helped promote independence and provided services that allowed the elderly to remain in the community, at home, for as long as possible. Although, the home-care programs were only funded for the provision of nursing or home-health-aide services on a Monday-to-Friday, regular-office-hours basis, adjustments were made to accommodate the needs of those requiring end-of-life care.

The presence of a cohort of skilled nurses and locally trained home-health aides in the home-care programs was considered essential for providing medical and other home-support services to the elderly. The networking of interagency committees also helped focus light on areas needing community-wide support, such as transportation, woodcutting, fuel assistance, social activities, and winter snow cleaning, among others. The enhancement of existing health programs allowed staff, like the elder coordinators, home-living assistants, holistic health workers, and casual home-helpers to provide practical help in the home, including translation services and provision of traditional foods. Overall, the establishment of more programs, services, and staffing, and the collaboration with other agencies and the community were seen as positive components of success. Good leadership, compassion, management, and dedicated staff were also identified as key elements.

Coordination between PBCN Health Services and the various health authorities was problematic, but these issues were increasingly being addressed through the home-care director and community home-care nurse assessors, who help the elderly and their family caregivers navigate through various health jurisdictions. The federal jurisdiction refers primarily to the First Nation Inuit Health Branch (FNIHB) policies that manage the non-insured health program benefits to cover such things as transportation. The Department of Indian and Northern Affairs (INAC)³ limited itself to a few programs, such as assisted living. The provincial jurisdictions involved three regional health authorities—one in an adjacent province, one in the northern region, and one in a larger urban centre. Some of the major issues in this area involved trying to work through differing program policies and rules on such matters as referring and placing the elderly who needed long-term care and respite services in appropriate facilities. The elderly really did not have much choice of where they could go, unless their families or friends were able to provide and pay for alternative arrangements.

The PBCN health providers responded to these challenges comprehensively and on an individual basis, where needed, through flexible case-management planning in the home- and community-care program. The home-care nurse assessors provided referrals and linkages to the services in the urban centres in collaboration with the key health providers and family caregivers. These were followed up and identified on a continuous basis for the elderly and their families. The elder coordinators in each of the communities were also valuable enhancements to the elderly services. They provided support services such as transportation; organized social events, among other activities, in the communities; and escorted the elderly in the urban centres to appointments when necessary and helped them get to wherever they needed to go. Another important enhancement was the family services coordinator, who was hired in the larger urban centre to assist the elderly through such services as visitations, translation work, coordination, and advocacy.

The challenges in the PBCN elderly care program highlighted the problems of trying to meet the increasing needs of the elderly, and their desire to stay at home in their communities during their end-of-life years. The lack of support from the federal government (INAC, FNIHB) for building long-term-care homes on-reserve often left the home- and community-care programs and workers stressed, as they tried to meet the varying and increasing needs in the communities (PBCN Health Services 2010). Other issues involved fragmented and insufficient funding; the lack of needed palliative, respite, and after-hour care services; and insufficient coordination to help the elderly access essential services in the cities.

The elderly who were interviewed commented on how grateful they were for the community-based health services, because they grew up in an era in which these services did not exist and life was “very tough.” But they also raised issues that they were struggling with, which included their lack of financial capacity, loss of autonomy, and lack of access to needed services. Their fixed pensions made it difficult to afford the high costs of power, fuel (propane), and food. The escorts they needed for medical trips out of the communities were also not covered.

Their common experiences in the urban institutional settings included the presence of communication barriers between the Cree-speaking elderly and non-Aboriginal health professionals in the long-term-care institutions; loneliness and feelings of isolation; lack of funding and coverage for certain programs and services (like respite care) caused by jurisdiction problems between governments; and issues accessing preferred facilities because of residency requirements between health regions and high costs. The chronic-care programs offered by PBCN often did not exist in the urban areas, and it was up to the individuals to seek care and manage their own chronic diseases as necessary. The difficulty of trying to navigate a complex health system, medical terminology, and associated medical costs were often perceived as overwhelming by the elderly, who felt compromised by multiple issues such as poor health, language barriers, transportation, and physical limitations.

Thematic Issues

Among the many issues in the broader Aboriginal elderly care literature, the dominant ones illustrated in the PBCN research findings, included the need for better coordination, improving poor socioeconomic conditions, and resolving the jurisdiction and access barriers for elderly care facilities, as well as accommodating language and culture needs.

Coordination

It was evident from the findings that the PBCN Health Services put much effort into developing a holistic network of community-based health services that could be linked to outside health systems through a variety of service agreements. For example, the home- and community-care programs were enhanced with other elderly support services and programs to assist the elderly and family caregivers. This shared approach was necessarily more comprehensive, although time-consuming, because PBCN strove to link services through coordination and advocacy among the various jurisdictions (PBCN Health Services 2010). It also aligned with the larger health reforms occurring across Canada that were promoting the primary health-care model, which went beyond the medical model by taking into account other causal health factors such as income, housing, and education (Health Canada 2011b; Reading 2009).

The major, overwhelming need that was identified was to build long-term-care facilities in the communities, so that the elderly would not have to move to the cities and experience the isolation that accompanies such a move (Assembly of First Nations 2007). Some elderly who had to move to the city found themselves lonely and fearful, and were not treated very well. The experiences of First Nations elderly in institutional facilities off-reserve have yet to be fully researched, but there is certainly cause for concern as the general population has become increasingly aware of elder abuse in institutions (Canadian Network for the Prevention of Elder Abuse 2010).

The demographics suggest that First Nations elderly will likely age faster and suffer from age-related degenerative diseases at a greater rate than the general elderly population; therefore, they will require culturally responsive long-term-care facilities, to meet both their medical and housing needs. Furthermore, Aboriginal elderly may experience greater cultural disruption, racism, multiple personal losses, poverty, and loss of their productive status, which can compound the general social and psychological stresses associated with aging (Assembly of First Nations 2007; Hampton 2007). Many elderly also carry the emotional scars of past institutional abuse, such as abuse in residential schools, thus making them more vulnerable. Finally, most Aboriginal elderly still wish to be active and prefer to speak their mother language, both of which are challenging in the current elderly care facilities (Turcotte and Schellenberg 2007; Kuran 2002; Wilson et al. 2010).

Poor Socio-economic Conditions

Elder care, whether on- or off-reserve, in northern regions, or in rural or urban areas, is a matter of increasing concern for everyone because of the generally poor socio-economic conditions in Aboriginal communities and among Aboriginal peoples (Assembly of First Nations 2007). Most Aboriginal elderly live in rural communities and on reserves in generally substandard, overcrowded houses, while the more-educated elderly (who attended residential schools) tend to live away from their communities (Turcotte and Schellenberg 2007). However, the push factors of illness and lack of facilities on the reserves inevitably force the less-educated Aboriginal elderly to move to urban areas, often without the financial and social supports they need. Regional health authorities and Aboriginal agencies will have to work together in a more integrated manner to resolve issues like residency requirements and waiting times, because the rules become particularly onerous for those Aboriginal elderly that have to cross the differing policy boundaries set by the various jurisdictions.

Jurisdiction (Funding) Problems

There is lack of government funding for elder-care services, such as elder-care homes on reserves (Assembly of First Nations 2007; National Aboriginal Health Organization 2002). Political jurisdiction and administrative or procedural blocks between federal, provincial, and regional authorities have to be resolved in a more integrated fashion to overcome these policy issues (Hotson, McDonald, and Martin 2004; Beatty and Berdahl 2011). Federal departments (FNIHB, INAC) argue that elder-care services are a provincial responsibility, but provincial authorities (SaskHealth, regional health authorities) maintain that there is no additional funding or special-care bed-designation policy for Aboriginal people that would allow them to get funding. As a result of these unresolved issues, the elderly, especially those without proper family supports, are placed in stressful situations that put their health at risk. To access publicly funded elder-care services, the elderly must leave their homes and communities and be placed in institutions, where they may have their medical needs cared for, but at the expense of their mental and cultural well-being, which in itself is a stressor that puts them at-risk.

Home care, nursing-home care, respite services, and pharmaceutical services are also funded under provincial health insurance plans; the elderly individual or family pays any cost the province does not cover (Stadnyk 2002). Variations across the provinces in terms of nursing-home-care costs have created health-care inequities for many seniors. This is especially stressful for Aboriginal elderly who do not have savings other than their senior's allowance to supplement higher nursing-home costs; in many cases, First Nations are not supported by any plan, due to unresolved payment coverage between provincial and federal non-insured health benefit programs. Issues related to hospital-to-hospital transfers, ambulance transport, and prescription drug costs for seniors over sixty-five, and poor or non-existent taxi services in some communities remain outstanding (PBCN Health Services 2010).

Language and Culture Gaps

Family is very important in the PBCN elderly care system, both as a guiding traditional ideology and as a source of practical support and advocacy for the elderly. Mutual sharing is considered a key cultural value and families are expected to take care of their elderly, but when that fails, the elderly are forced to depend upon community and health agencies (Kuran 2002). Some suggest that families and caregivers need better support and access to home and community care, including respite care. Caregivers need the formal structure to support them in managing care for their elderly family members (Canadian Healthcare Association 2009).

When the PBCN health-care system was first developed, much effort and resources were put into community development and public meetings; however, as it became busier and more institutionalized, the health system objectified the elderly into patient and client categories, which made some of the elderly feel overlooked. There were also concerns about solving personal differences between local community staff and the elderly, as some elderly perceived that others were being treated better than they themselves were. Other gaps in the PBCN case were related to the generational differences between workers and the elderly, and their differing expectations; language and advocacy barriers; policy and fiscal restrictions; high nursing turnover; and high staff workloads and absenteeism.

The generational, gender, and associated health differences amongst the elderly themselves need to be factored into their care (Krieg, Martz, and McCallum 2007). The health status of elderly people who are sixty to seventy years old and those who are seventy to eighty years old often differs, because they require different levels and types of health services. In one community, the elderly ranged in age from sixty to ninety-one (with the majority in their sixties), and their needs varied, increasing according to age. The needs of the younger elderly were less urgent and they were more likely to speak English, be better educated, and to effectively advocate for themselves with the health providers than the older group. The practice of grouping all elderly under chronic programming was sometimes perceived as marginalizing the more elderly and higher needs groups.

Language and culture gaps have frequently been identified as major problems and sources of confusion for the elderly who need to access services in urban centres (Downey 2003; Hotson, McDonald, and Martin 2004; Kuran 2002). The PBCN elderly identified problems communicating with the health professionals and needed to rely on others to advocate for them. Clearly, the regional health authorities must make more of an effort to provide cross-cultural training and to hire more Aboriginal liaison staff and medical social workers to help the elderly get better services and allow them some measure of dignity and autonomy (Downey 2003; Hotson, McDonald, and Martin 2004).

Conclusion

Overall, the findings suggest that the PBCN health providers and the elderly prefer culturally based elderly programming, and believe that having long-term-care facilities located in their own communities will improve elderly care. The objectives in the shared caregiving approach of PBCN and the maximization of resources through organized collective efforts are consistent with other literature (Reading 2009; Assembly of First Nations 2007). Clearly, health and family caregivers have to be supported so they can better help frail elders protect their sense of self and dignity, and assist them to make their own choices and have a better quality of life (Special Senate Committee on Aging 2007; Assembly of First Nations 2007). But the coordination and linkages that are evident in the PBCN case, notwithstanding the challenges, are not generally reflected in the urban Aboriginal elderly care experience and need to be improved. If the PBCN elderly did not have medical and social advocates from PBCN and their families, they would be likely be lost in the system and at risk of suffering unnecessary trauma, including homelessness. All health systems need to work together to coordinate their elderly care programs and policies in a more strategic and holistic manner so the Aboriginal elderly can “age well” in the place of their choice.

Endnotes

1. There is some variation of meaning, specific to place and region. Cree has five major dialects (y, th, n, l, r) specific to regions in Canada. For example: *mitho-pimatisiwin* (Woodlands); *mino-pimatisiwin* (Swampy); *miyo-pimatisiwin* (Plains).
2. The term “Aboriginal” is used here in a broad sense, since elderly care issues affect all Aboriginal elderly regardless of status.
3. Indian and Northern Affairs Canada (INAC) is used here, although the department’s new name is Aboriginal Affairs and Northern Development Canada.

References

- Aboriginal Advisory Committee. *Aboriginal Seniors Report*. Thunder Bay, Ontario. <flash.lakeheadu.ca/~mstones/Aboriginal%20Seniors%20Report.pdf> (accessed February 10, 2011).
- Assembly of First Nations. (2007). *Sustaining the Caregiving Cycle: First Nations People and Aging: A Report from the Assembly of First Nations to the Special Senate Committee on Aging*. Ottawa: Assembly of First Nations. <64.26.129.156/misc/SCC.pdf> (accessed April 11, 2011).
- Beatty, B. (2006). *Pimacesowin (to make your own way): First Nation Governance Through an Autonomous Non-Government Organization: The Experience of the Peter Ballantyne Cree Nation Health Services Inc. in Northern Saskatchewan*. Unpublished PhD thesis. Edmonton: University of Alberta. <iportal.usask.ca/index.php?sid=293682962&cat=217> (accessed May 12, 2011).
- Beatty, B., & Berdahl, L. (2011). Health Care and Aboriginal Seniors in Urban Canada: Helping a Neglected Class. *International Indigenous Policy Journal*, (2)1, Article 10. <http://ir.lib.uwo.ca/iipj/vol2/iss1/10> (accessed May 26, 2011).
- Canadian Healthcare Association. (2009). *Home Care in Canada: From the Margins to the Mainstream*. Ottawa: Canadian Healthcare Association. <www.cha.ca/.../Home_Care_in_Canada_From_the_Margins_to_the_Mainstream_web.pdf> (accessed February 10, 2011).
- Canadian Institute for Health Information. (2011). *Health Care in Canada, 2011: A Focus on Seniors and Aging*. <http://cvhl.ca/virtual-library/resources/health-care-canada-2011-focus-seniors-and-aging> (accessed May 26, 2011).
- Canadian Network for the Prevention of Elder Abuse. (2010). <www.cnpea.ca> (accessed January 2011).
- Cardinal, H., & Hildebrandt, W. (2000). *Treaty Elders of Saskatchewan: Our Dream is That Our Peoples Will One Day Be Clearly Recognized as Nations*. Calgary: University of Calgary Press.
- CBC News Canada. (2011). Canada Ranks High on “Better Life Index.” CBC News, May 24. <www.cbc.ca/news/canada/story/2011/05/24/oecd-better-life-index.html> (accessed November 3, 2011).
- Chenier, N. M. (1993). *The Health of the Canadian Elderly*. Ottawa: Government of Canada, Political and Social Affairs Division. <http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/bp351-e.htm#C.%20Gendertxt> (accessed May 30, 2011).
- Dosman, E. J. (1972). *Indians: the Urban Dilemma*. Toronto: McClelland and Stewart.
- Downey, B. (2003). Aboriginal Health Human Resources: “A Pillar for the Future.” Ottawa: National Aboriginal Health Organization. <www.naho.ca/documents/naho/english/pdf/pillar_for_future.pdf> (accessed May 30, 2011).
- Hampton, M. (2007). Improving End of Life Care for Aboriginal Families Project. Canadian Institutes of Health Research. <www.centre4activeliving.ca/publications/research_update/2007/mar07_vol14_1_spheru.pdf>
- Hart, M. A. (2002). *Seeking Mino-Pimatisiwin: An Aboriginal Approach to Helping*. Halifax: Fernwood Publishing.
- Health Canada. (2011a). *Canada Health Act*. <www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/indx-eng.php> (accessed November 28, 2011).
- . (2011b). *About Primary Health Care*. <www.hc-sc.gc.ca/hcs-sss/prim/about-apropos-eng.php> (accessed November 28, 2011).

- Hotson, K., McDonald, S., & Martin, B. (2004). Understanding Death and Dying in Select First Nation Communities in Northern Manitoba: Issues of Culture and Remote Service Delivery in Palliative Care. *International Journal of Circumpolar Health*, 63(1). <ijch.fi/issues/631/631_Hotson.pdf> (accessed February 8, 2011).
- Krieg, B., Martz, D. J. F., & McCallum, L. (2007). *Access to Health Services for Elderly Metis Women in Buffalo Narrows, Saskatchewan*. Winnipeg: Prairie Women's Health Centre of Excellence. <www.pwhce.ca/pdf/buffaloNarrowsAug07.pdf>
- Kuran, H. J. (2002). *The Barriers to Healthy Living and Movement for Frail Aboriginal Elders*. National Indian & Inuit Community Health Representatives Organization. <www.niichro.com/cfc/cfc_3.html> (accessed April 8, 2011).
- Minister of Public Works and Government Services Canada, Department of Indian Affairs and Northern Development. (2008). Registered Indian Population By Sex and Residence, 2007. <dsp-psd.pwgsc.gc.ca/collection_2009/ainc-inac/R31-3-2007E.pdf> (accessed October 19, 2011).
- National Aboriginal Health Organization. (2002). Discussion Paper of End-of-Life /Palliative Care for Aboriginal Peoples. <www.naho.ca/english/pdf/re_briefs2.pdf> (accessed January 27, 2011).
- Northern Saskatchewan Heritage Site. (2001). <www.kayas.ca/travelroutes.html> (accessed April 2, 2011).
- Northern Saskatchewan Regional Training Needs Assessment Report. (2009–10). <career.kcdc.ca/fore/pdf/2009/2009RegionReportfinalwithcover.pdf> (accessed January 27, 2011).
- O'Donnell, V., & Tait, H. (2003). *Aboriginal Peoples Survey, 2001, Initial Findings: Well-Being of the Non-reserve Aboriginal Population*. Statistics Canada, Cat. no. 89-589-XIE. Ottawa: Minister of Industry. <www.statcan.gc.ca/pub/89-589-x/89-589-x2003001-eng.pdf> (accessed January 12, 2011).
- PBCN (Peter Ballantyne Cree Nation). (2011). *History*. <www.peterballantyne.ca/history.html>
- . (2011a). *Communities*. <www.peterballantyne.ca/communities.html> (accessed September 20, 2011).
- . (2011b). *Administration*. <www.peterballantyne.ca/administration.html> (accessed October 19, 2011).
- PBCN Health Home and Continuing Care Program. (2010). *PBCN Health Home and Continuing Care Plan*. Prince Albert: PBCN Health Services.
- PBCN Health Services. (1995). *PBCN Community Health Plan*. Prince Albert: PBCN.
- . (2004). *PBCN Health Services Annual Report 2003–04*. Prince Albert: PBCN Health Services.
- . (2010). *Strengthening Ourselves to Help Others: 2009–10 Annual Report*. Prince Albert: PBCN.
- Public Health Agency of Canada. (2003). *Population Health Approach: What Makes Canadians Healthy or Unhealthy?* Ottawa: Public Health Agency of Canada. <www.phac-aspc.gc.ca/ph-sp/determinants/determinants-eng.php#income> (accessed January 10, 2011).
- . (2010). *What Determines Health?* Ottawa: Public Health Agency of Canada. <www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php> (accessed January 12, 2011).
- Reading, J. (2009). *The Crisis of Chronic Disease among Aboriginal Peoples: A Challenge for Public Health, Population Health and Social Policy*. Victoria: University of Victoria Centre for Aboriginal Health Research. <www.cahr.uvic.ca/docs/ChronicDisease%20Final.pdf> (accessed April 12, 2011).
- Romanow, R. J. (2002). *Building on Values: The Future of Health Care in Canada*. Final Report of the Commission on the Future of Health Care in Canada. Ottawa: Queen's Printer.
- Rosenberg, M. W., Wilson, K., Abonyi, S., Wiebe, A., Beach, K., & Lovelace, R. (2009). *Older Aboriginal Peoples in Canada—Demographics, Health Status, and Access to Health Care*. Social and Economic Dimensions of an Aging Population Research Papers. Hamilton: McMaster University. <http://econpapers.repec.org/paper/mcmstdapp/249.htm> (accessed April 8, 2011).
- SaskAdapt. (2011). *Aboriginal Communities: Climate Change and Adaptation*. <www.parc.ca/saskadapt/aboriginal-comm> (accessed November 3, 2011).
- Saskatchewan Indian Institute of Technologies. (2002). *Urban First Nations People Without Homes in Saskatchewan*. Saskatoon: Saskatchewan Indian Institute of Technologies.
- Special Senate Committee on Aging. (2007). *First Interim Report: Embracing the Challenge of Aging*. Ottawa. <www.parl.gc.ca/Content/SEN/Committee/391/agei/rep/repintfeb07-e.pdf> (accessed May 30, 2011).

Stadynk, R. (2002). *The Status of Canadian Nursing Home Care: Universality, Accessibility, and Comprehensiveness*. Halifax: Atlantic Centre of Excellence for Women's Health. <www.acewh.dal.ca/.../The%20Status%20of%20Canadian%20Nursing%20Home%20Care> (accessed September 16, 2009).

Statistics Canada. (2007). Mamawetan Churchill River Regional Health Authority, Saskatchewan (Code4711)—Table. Aboriginal Population Profile. 2006 Census. Statistics Canada, Catalogue no.92-594-XWE. Ottawa. <www12.statcan.census-recensement/2006/dp-pd/prof/92-594/index.cfm?Lang=E> (accessed September 20, 2011).

———. (2008). Population by age groups, sex, and Aboriginal identity groups, 2006 counts for Canada, provinces and territories—20% sample data—Table. *Aboriginal Peoples Highlight Tables*. Statistics Canada, Cat. no. 97-558-XWE2006002. Ottawa. .

———. (2008a). 2006 Aboriginal Population Profile for Prince Albert. <www.statcan.gc.ca/pub/89-638-x/201003/article/11078-78-eng.htm> (accessed November 29, 2011).

Tjepkema M., Wilkins, R., Senecal, S., Gulmond, E., & Penney, C. (2010). Mortality of Urban Aboriginal Adults in Canada, 1991–2001. *Chronic Diseases in Canada*, 31(1). <www.phac-aspc.gc.ca/publicat/cdic-mcbc/31-1/PDF/Vol31n1-eng.pdf> (accessed November 12, 2011).

Turcotte, M., & Schellenberg, G. (2007). *A Portrait of Seniors in Canada, 2006*. Statistics Canada, Catalogue no. 89-519-XIE. Ottawa: Minister of Industry. <www.statcan.gc.ca/pub/89-519-x/89-519-x2006001-eng.pdf> (accessed September 16, 2009).

Wilson, K., Rosenberg, M. W., Abonyi, S., & Lovelace, R. (2010). *Aging and Health: An Examination of Differences between Older Aboriginal and Non-Aboriginal People*. Social and Economic Dimensions of an Aging Population, Research Papers. McMaster University, SEDAP Paper No. 279. <<http://econpapers.repec.org/paper/mcmsedap/279.htm>> (accessed April 8, 2011).