

House of Commons Standing Committee on Health  
Dr. Marcia Anderson, President of the Indigenous Physicians Association of Canada  
October 28, 2009

I would like to begin by thanking the members of the Standing Committee on Health for the opportunity to stand on Algonquin territory and speak to you today about H1N1 influenza in First Nations communities. My name is Marcia Anderson, and I am Cree- Saulteaux from Manitoba, with clinical training in internal medicine and public health. I've been the president of the Indigenous Physicians Association of Canada for the past three years. As an organization of physicians who hold the vision of healthy and vibrant Indigenous nations, communities, families and individuals, we have been watching with interest as H1N1 influenza has circulated the globe. One of our key roles has been to support our member physicians who have served as clinicians at the front lines, advocated in their roles as researchers and public health professionals, or taken phone calls from family members who are concerned and confused about how to best protect themselves.

At this point, we are all aware of how H1N1 influenza disproportionately affected First Nations people in the first wave, which was particularly striking in Manitoba where 37% of all cases, and 60% of those admitted to the ICU with H1N1, were First Nations people. According to PHAC data, First Nations were also disproportionately represented among pregnant women who were infected with H1N1. This should not have surprised us, given that in past epidemics H1N1 has caused mortality rates 4-7 times higher in Indigenous people, and that each year First Nations people are hospitalized for seasonal influenza at 4-5 times the rate of the general population. Further, we now know from Australia's experience with

H1N1 that Aboriginal and Torres Strait Islander people were hospitalized and died from H1N1 at 10-15 times the rate of the general population. I remain concerned that we have not done enough to mitigate these expected patterns in the current wave of H1N1.

I consider it a success that Aboriginal ancestry has been considered a characteristic that makes people eligible for early treatment with antivirals and for priority group one vaccination in Manitoba. I find it concerning that the federal government has not clearly identified all First Nations people as higher risk or recognized them in priority groups based on the evidence that while the risk of severe H1N1 illness is lower for First Nations people in urban areas than it is for First Nations people in remote areas it is still higher than the general population, and the evidence from prior years and the current year with similar Indigenous populations. There has been a lack of targeted and focused communications on the risk of H1N1 illness for First Nations people that explains as best we can why First Nations people are at higher risk and how to best mitigate this risk. I cannot help but wonder if this had been recognized clearly as a risk factor, if more resources into identifying ways to and mitigating risk would have been made available.

First Nations leadership in Manitoba, to my understanding, have set up a command center to support First Nations communities in their H1N1 planning and response. I commend them for this, and would defer to them in terms of details about what financial support they need for this. I will say that it is my belief they should receive an equitable level of financial resources to support this new role. They have done an excellent job in representing and advocating for their

communities, filling gaps in communication pathways and identifying the logistic and operational realities that many in the provincial government were not familiar with. The provincial incident commander has the Chief Provincial Public Health Officer to provide expert public health knowledge and advice, the regional health authorities each have a Medical Officer of Health, and so I am wondering how we can equitably provide the same level of public health knowledge and advice to the First Nations incident command systems. In Manitoba there is a single federal Regional Medical Officer to serve 64 widespread communities, many of which are remote, and while I am sure she does the best she can, that is simply inadequate even at the best of times. Perhaps consideration should be given to providing adequate resources for the AMC to contract 1-2 public health professionals who can assist with finalizing the plans in the communities that have not finished them, and implementing them across the province as we are entering this second wave.

I will finish with two suggestions for addressing the risk of H1N1 in First Nations communities. First of all, an independent evaluation of the health care system response to the first wave of H1N1 in First Nations contexts that can identify the effectiveness of different elements of the response including adequacy of resourcing, communications, working relationships, and clinical care should be done. This is absolutely necessary to understand how to improve the health care system response, particularly in so much as we don't know if we as a system contributed to increasing the risk of severe illness, or mitigated that risk. I will note that on a CBC National interview with respect to the health system response to H1N1 in Aboriginal and Torres Strait Islander peoples, a senior Australian health

official stated that he didn't feel they should have done anything differently, that the gap was only 10x could be considered a successful outcome because if they had not done so well the gap would have been wider. I hope that none of us would consider such a significant inequity acceptable and evidence of a job well done.

Lastly, the elevated risk for respiratory infections including H1N1 is chronic and well known. Evidence shows that reasons for this include poverty, overcrowded and inadequate housing, higher rates of non-traditional tobacco use, and underlying medical conditions, which themselves are also due to underlying socioeconomic inequalities. We must see commitment to addressing these underlying social and structural inequities if we want to see a different outcome. I have heard Sir Michael Marmot, Chair of the WHO Commission on the Social Determinants of Health remind us that there is plenty of money to address underlying inequalities in social conditions, and we saw the clear evidence of this with responses to the economic crisis. He has stated that we have chosen to bail out banks and car manufacturers, and chosen not to ensure that all have access to shelter and a safe and potable water supply, for example. If we truly want to see the gaps in health close for First Nations communities, whether we are talking about H1N1 or seasonal influenza, or TB, or diabetes, or heart disease we must choose differently. We must have an explicit goal of health equity for Indigenous people in Canada, and we must ensure that every policy and program decision is evaluated for how it will impact the gap in health for First Nations, Inuit and Métis people.

Thank you.