

FACTORS INFLUENCING ACCESS TO HEALTH CARE SERVICES IN LABRADOR

An Overview



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**A Report based on Masters Research and Thesis:
*Factors Influencing Access to Health Care Service in Labrador:
A Case Study of Two Distinct Regions*
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Introduction

In Labrador, you are physically isolated from service by geography... you can't change that. You have fly-in communities. You have no road access. You have weather... When I grew up in Labrador, there was very little access to anything... there's obviously been a great expansion of service, but the thing that changed is that we were just all from Labrador and now we are specific ethnic groups with our own health management... and what that does is it influences the access of anybody who physically lives in Labrador (community member interview, April 2011)

This quote introduces the complex realities that residents living in isolated Labrador face when accessing health care services. Labrador is made up of five distinct regions: Labrador West, Upper Lake Melville in central Labrador, the north coast, the south east coast and the Labrador straits and spans 51° to 60° latitude. There are great differences among communities within and between these regions of Labrador (Our Labrador, 2004). Some Labradorians live in non-isolated communities of over 7000 and others live in isolated communities of less than 200. In addition to geographic differences, communities are also culturally diverse. There are Innu, Nunatsiavut Inuit, Inuit-Metis and non-Aboriginal populations in Labrador. These geographic and cultural factors influence access to health care in Labrador.

Research Purpose and Objectives

This research explored the factors that create challenges accessing health care services and strategies for overcoming such challenges as reflected in the experiences of health care administrators, providers, and community members in two distinct regions of Labrador: the five northern isolated communities within Nunatsiavut, the land claims region of the Labrador Inuit, and Happy Valley Goose Bay, a multi-cultural community in the Upper Lake Melville region of Labrador.

The research question was:

1. What factors influence access to health care services in two geographically and culturally diverse regions of Labrador?

The study objectives were to:

1. identify factors that influence access to health care services in Happy Valley-Goose Bay and Nunatsiavut communities; and
2. determine strategies recommended by community members, health care providers and administrators in Happy Valley-Goose Bay and Nunatsiavut communities to improve access to health care services in Labrador.

Relevance

There is an identified need (Labrador Regional Council of the Rural Secretariat, 2009), but limited focus on the examination of factors that influence access to health care services in

Labrador. Health system development and health improvement requires effective policy decisions based on sound research evidence (World Health Organization [WHO], 2009). The Rural Secretariat identified a lack of knowledge regarding access to health care throughout Labrador as an impediment to developing effective policy initiatives to ensure the many diverse regions in Labrador have reasonable access to quality health care. The Rural Secretariat pursued a partnership with community health researchers at Memorial University to initiate a research project examining the barriers to accessing health care from a Labradorian perspective, wherein this research was born.

Research Scope

This research focuses on highlighting the experiences of community members in Happy Valley-Goose Bay and Nunatsiavut communities as a way of demonstrating the complexities surrounding access to health care in Labrador. The purpose of this research is not to assert that improving access to health care services will improve health status in Labrador, but to explore, create awareness, and to potentially inform policies surrounding the improvement of access to health care services between and among communities in Labrador.

Social Determinants of Health

Health status is determined by the interplay of physical, social and economic factors, known as the social determinants of health. The World Health Organization (WHO) defines the social determinants of health as,

the conditions in which people are born, grow, live, work and age... shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. (Commission on the Social Determinants of Health, 2008, p. 1)

The social determinants of health differ depending on the social, economic, political, cultural and physical climate within which they exist. According to the Public Health Agency of Canada (PHAC, 2011), health determinants include social support networks, social environments, physical environments, income and social status, employment and working conditions, education and literacy, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, culture, and gender. Each of these factors impacts health and is interconnected with the other social determinants.

Rural Considerations

Due to their heterogeneous nature, rural communities differ among themselves and from those of their urban counterparts in health and health care needs (Chenier, 2000; DesMeules and Pong, 2006). The Royal Commission on the Future of Health Care in Canada, led by Roy Romanow in 2002, found that the biggest concern of rural Canadians regarding the health care system was access to health care services. Rural regions face the most difficulties accessing health services in Canada (Hutten-Czapski, 2001), specifically, challenges related to geography, limited availability of services, lack of health care providers, and increased distance to services.

Less access to prevention, early detection, treatment, and support services in rural areas may further exacerbate these factors, making good health status even more difficult to achieve (Browne, 2009; DesMeules and Pong, 2006; Kirby, 2002; Romanow, 2002).

Aboriginal Considerations

Charlotte Loppie Reading and Fred Wien (2009) offer a critique of the social determinants of health framework in studying the health of Aboriginal people in Canada, contending that Health Canada's approach to the social determinants of health excludes the holistic approach to health of Aboriginal cultures that encompasses physical, spiritual, emotional, and mental components. Although not recognized by the PHAC, the historical effects of relations with Europeans was recognized as a fundamental social determinant of health among Aboriginal populations around the world at the WHO's International Symposium on the Social Determinants of Indigenous Health (CSDH, 2007). Increasing knowledge and awareness of the factors influencing access to health care services and how they interact can inform effective policy development and improve the availability and accessibility of health care services that fit the needs of diverse Labrador communities.

Labrador's People

Labrador is home to three Aboriginal groups, the Innu, the Inuit, and the Inuit-Metis, and non-Aboriginal multi-cultural Labradorians. In 2006, Innu, Inuit and Inuit-Metis comprised approximately 30% of Labrador's population, at 10,560 (Statistics Canada, 2008).

Innu

The Innu are a First Nations¹. First Nations are Status and Non-Status "Indian" people in Canada. There are currently 615 First Nation communities in Canada representing more than 50 cultural groups and languages (Indian and Northern Affairs Canada [INAC], 2008). First Nations are recognized under the *Indian Act* and are eligible for federal coverage for social and health programs (INAC, 2008). The Labrador Innu, however, were not recognized under the *Indian Act* until 2000 (INAC, 2008).

Archaeological evidence has found the Innu people have inhabited Labrador for over 7,000 years. The Innu name for their homeland is Nitassinan. Traditionally a nomadic people, the Innu of Labrador traveled the interior of Labrador and Quebec in the winter to hunt caribou, and spent summer months on the coast to fish (Matthews, 1998). At the time of this research, there were approximately 2200 Innu of two Innu First Nations in Labrador: the Mushuau Innu, located in Natuashish Innu First Nation on the north coast of Labrador and the Sheshatshiu Innu, located on the Sheshatshiu Innu First Nation in central Labrador. These communities were recognized as reserve lands in 2003 and 2006 respectively (Higgins, 2008a). The language of the Labrador Innu is Innu-aimun, and it is still practiced as a first language in Sheshatshiu and Natuashish, though the communities have different dialects (Matthews, 1998).

¹ First Nation has been adopted by some Indian communities to replace the term Indian band. A band is defined as a body of Indians for whose collective use and benefit lands have been set apart or money is held by the Crown, or declared to be a band for the purposes of the *Indian Act*. Many Indian bands started to replace the word band in their name with First Nation in the 1980s (INAC, 2005).

Inuit

Inuit² are the Aboriginal people of Arctic and Sub-Arctic Canada. There are currently 53 Inuit communities, classified by region, tribe, and culture in Canada (CIHI, 2004). Four regions in Canada have settled Inuit land claims: Nunatsiavut (Labrador), Nunavik (Quebec), Nunavut and the Inuvialut Settlement Region of the Northwest Territories. At the time of interviews, there were approximately 2500 Inuit living in five coastal communities in Nunatsiavut on the north coast of Labrador: Rigolet, Postville, Makkovik, Hopedale, and Nain, and approximately 2000 living in the Upper Lake Melville region (Government of Newfoundland and Labrador, 2002), accounting for 84% of the population in the region (Statistics Canada, 2008).

Inuit are the direct descendents of the prehistoric Thule people who hunted from Alaska across the circumpolar regions of Canada and Greenland. The Thule people are thought to have first moved to Labrador as a result of a decrease in access to European metal following the collapse of the Norse colonies in Greenland (Rankin, 2009). Although there is no agreed upon date of the Thule expansion into Labrador, two possible dates have arisen from archaeological evidence in the region. Evidence dating between AD1296-1466 suggests Thule occupation in Nunaingok, on the northern tip of Labrador (Rankin, 2009) and other archaeological evidence in Ikkusik on Rose Island in Saglek Bay dates in the probable range of AD 1475-1674 (Rankin, 2009). Thule/Inuit southern expansion in Labrador has been debated for several decades, though it is generally accepted that the Thule arrived in northern Labrador and expanded south to Hebron, and perhaps Okak or Nain prior to contact with Europeans. Occupation of more southerly areas, such as Hamilton Inlet and farther south is generally accepted as being post-European contact (Rankin, 2009). European presence in southern Labrador increased in the 16th century, which prompted further southward movement of some communities. Excavations in Red Bay in southern Labrador that uncovered Thule material, for example, indicate that Thule contact with Europeans commonly occurred in the 16th century. Evidence also suggests further southern expansion of winter settlements at Okak, Nain, Hopedale, and finally Hamilton Inlet into the 17th century (Rankin, 2009). This evidence suggests that Inuit had limited, perhaps seasonal, contact with Europeans, who settled further south where the climate was more hospitable and the landscape more desirable.

The Labrador Inuit Association was formed in 1973 to promote Inuit culture, improve health and well-being, protect constitutional and human rights and advance Inuit claims to land and to self-government (Nunatsiavut Government, 2011). The Inuit submitted its land claim to the provincial and federal governments in 1977. It was settled in 2005 and the Nunatsiavut Government was formed, making it the first Inuit region to reclaim self-government in Atlantic Canada (Nunatsiavut Government, 2009). The Nunatsiavut Government is a regional Inuit government within the Province of Newfoundland and Labrador. Nunatsiavut, which means 'our beautiful land' in Inuttitut, is the homeland of Labrador Inuit.

The Nunatsiavut Government was designed to operate at both the regional (departmental) level and the community level. The departmental level government is located in Happy Valley-Goose

² Inuit are the Aboriginal people of Arctic Canada. Inuit live primarily in Nunavut, the Northwest Territories and northern parts of Labrador and Quebec. They have traditionally lived above the tree line in the area bordered by the Mackenzie Delta in the west, the Labrador coast in the east, the southern point of Hudson Bay in the south, and the High Arctic islands in the north. Inuit are not covered by the Indian Act. However, in 1939 the Supreme Court interpreted the federal government's power to make laws affecting "Indians, and Lands reserved for the Indians" as extending to Inuit (INAC, 2005).

Bay. The community level of Nunatsiavut Government is comprised of five Inuit Community Governments representing the Inuit communities of Nain, Hopedale, Postville, Makkovik and Rigolet. Currently there are also two Inuit Community Corporations within the Nunatsiavut Government: the NunaKatiget Inuit Community Corporation serving beneficiaries residing in Happy Valley-Goose Bay and Mud Lake; and the Sivunivut Inuit Community Corporation serving beneficiaries residing in North West River and Sheshatshiu. A final constituency, the Canada constituency, enables Labrador Inuit living outside of Labrador to be represented by an elected member in the Nunatsiavut Assembly.

The Nunatsiavut Government has many of the responsibilities and rights of other governments, such as planning for sustainable economic development, protecting and preserving Labrador Inuit Culture and traditions, and implementing social programs on behalf of beneficiaries of the Labrador Inuit Land Claims Agreement. There are seven departments, each reflecting the unique principles of the Labrador Inuit Constitution. The departments are: Nunatsiavut Secretariat; Nunatsiavut Affairs; Finance and Human Resources; Health and Social Development; Education and Economic Development; Lands and Natural Resources; and Culture, Recreation and Tourism.

Inuit-Metis³

Formerly the Labrador Metis Nation, the NunatuKavut Community Council (NCC) was formed in 1998 to represent people of European and Inuit descent not recognized by the Labrador Inuit Association. The NCC is an affiliate of the Congress of Aboriginal Peoples, the national Aboriginal representative body. The NCC assert Aboriginal rights in Labrador, but are not recognized under the Indian Act (INAC, 2010). In 2010, the NCC formally submitted new documentation in support of its land claim to the federal and provincial governments in a report entitled “Unveiling NunatuKavut”. The NCC represents approximately 6,000 members. At the time of this research, resident membership was primarily concentrated in Upper Lake Melville and the southeast coast of Labrador (Government of Newfoundland and Labrador, 2002; NCC, 2012). Because NCC members in Labrador are not recognized under the Indian Act, they do not receive federal health and social services coverage available to both the Nunatsiavut Inuit and the Sheshatshiu and Mushuau Innu.

Non-Aboriginal

The remainder of the population of Labrador is non-Aboriginal, living in diverse communities dispersed over the large geographic expanse. Europeans began settling Labrador in the 16th century to engage in the transatlantic cod fishery and whaling. Jurisdiction over the area was passed between France and Britain (British colony of Newfoundland) for the following three centuries. As a result, most inhabitants in Labrador have English, French, or Irish ancestry. The commercial fur trading company, Hudson Bay Company was established in 1831 and interacted mainly with the Innu in central Labrador (Higgins, 2008b). Moravian, and later Roman Catholic, mission stations were established throughout Labrador in the 18th and 19th centuries.

During the early days of settlement, communities in Newfoundland and Labrador were established based on proximity to resources: shelter, fresh water, access to the fishery, or access to fur trading sites in Labrador (Butt, 1998). Communities in the Straits and on the south

³ The NunatuKavut Community Council (NCC) refer to its members as Southern Inuit. However, at the time of this research the NCC referred to its membership as Inuit-Metis, and therefore, this term is used through out this thesis.

coast were settled in the 17th and 18th centuries. A military base was created in Happy Valley-Goose Bay in Central Labrador in the early 1940s and mining towns centered around emerging mining activity in Labrador City and Wabush in the 1960s. These events increased the number of non-Aboriginal people living throughout all regions in Labrador. Today, multi-cultural, non-Aboriginal populations are the majority population in the mining communities of Labrador City, Wabush and Churchill Falls, and in Happy Valley-Goose Bay.

Labrador's Health Context

The Labrador-Grenfell Health Region comprises the area north of Bartlett's Harbour on the northern peninsula of Newfoundland and all of Labrador, and mirrors the national pattern of inequity between rural and urban regions on a smaller scale (Statistics Canada, 2012b). In Labrador, for example, 71% of people reported having contact with a medical doctor in the last 12 months versus 81% in the entire province, and only 55% of Labradorians reported having a regular family doctor compared to 88% in the entire province (Statistics Canada, 2012b).

In terms of health care resources, Happy Valley-Goose Bay houses the main hospital in the region (the Labrador Health Centre) and the regional and provincial medical evacuation planes. Labrador's health care services, physicians, and secondary care services are also centralized in Happy Valley-Goose Bay. All Nunatsiavut communities are fly-in communities, isolated from other communities in the region. All Nunatsiavut communities (Rigolet, Postville, Makkovik, Hopedale, and Nain) have community clinics with primary care provided by nurses and community health nurses and 24-hour observation capabilities.

Labrador has higher rates of daily smoking and alcohol consumption than the provincial average, and lower fruit and vegetable consumption (Statistics Canada, 2012b). In Labrador, the long-term unemployment rate is 16% compared to an 11% provincial average (Statistics Canada, 2012b). According to Statistics Canada (2012b), 79% of Labradorians surveyed between 25 to 29 years graduated high school, compared to 86% in the province as a whole. Labrador has double the number of injuries causing hospitalization per 100,000 people compared to provincial numbers, higher suicide rates, at 28 per 100,000 people in Labrador, compared to 8 per 100,000 people in the entire province (Statistics Canada, 2012b). Infant mortality is higher and life expectancy is lower by 2 years. Percentage of deaths due to circulatory disease and cancer are higher in Labrador than the province. Mental illness hospitalization rates in Labrador are 821 per 100,000 people, compared to 391 per 100,000 people in the entire province (Statistics Canada, 2012b).

Although there is no demonstrated connection between improving access to health services and improving health status, access to health care is still a concern of rural Canadians (Browne, 2009; Romanow, 2002). There is common belief that inequities in access to health services in rural regions are a part of a system of social inequities between different communities. Examining the factors that determine health can highlight root causes of complex social inequities and are helpful in determining priority areas for improvement of social realities and community well-being.

Methodology

Collective Case Study Approach

The collective case study methodology is the utilization of diverse data sources to holistically explore a phenomenon. Collective case studies allow for in-depth investigation into a particular case through the exploration of various dimensions of social phenomena surrounding that case (Gillham, 2000; Lincoln and Guba, 1985; Feagin, Orum and Sjoberg, 1991). Case studies allow the qualitative researcher to capture and offer rich descriptions of the complexities of interactions between individuals and their social and physical context (Yin, 1994), and are also useful when limited research is available on an issue (Brophy, 2008; Polit and Beck, 2008). Case studies can unearth preliminary information about phenomena that have not been rigorously researched. I chose the case study approach to explore concerns regarding access to health care services because research investigating access to health care in Labrador was in its exploratory stage and because I will be using data from a variety of perspectives from two regions in Labrador.

Data Collection

My data collection methods of one-to-one and focus group interviews with health care administrators and providers and community members practicing and living in Happy Valley-Goose Bay and Nunatsiavut communities are consistent with the study's methodological framework. The purpose of interviews was to explore Labradorians' personal experiences accessing health care services through semi-structured open-ended dialogue.

Purposeful sampling, defined by Polit and Beck (2008) as a selection method based on personal judgment about which participants would be most informative, was used to recruit health care providers and administrators for one-to-one interviews. Labrador Grenfell Health and Nunatsiavut Government's Department of Health and Social Development provide health care services in Happy Valley-Goose Bay and Nunatsiavut communities. Participants in both organizations were selected based on experience, role, and knowledge regarding health care delivery. The only criteria for inclusion of participants in community member interviews was that participants were members of the selected communities and had experience accessing health care in the region within the previous year.

Data Analysis

My approach to analysis of interview transcripts was based on an approach used and refined by Natasha Mauthner and Andrea Doucet (1998) called the voice-centered relational method, which consists of four readings of interview transcripts, case studies and group work. Mauthner and Doucet's voice-centered relational method represents their attempt to translate a relational ontology into concrete methodological steps of data analysis by exploring participant transcripts in terms of relationships to themselves, to people around them, and to the broader social, structural, and cultural contexts within which they exist. After all transcripts were analyzed, I organized passages into similar thematic categories, which allowed me to generate clear names for themes sub-themes that became the identified factors influencing access to health care in

Labrador and the strategies to overcome the challenges created by them.

Ethics

Ethics approval was sought after the initial research proposal was developed in conjunction with the Labrador Aboriginal Health Research Committee. Ethics approval was obtained through the Interdisciplinary Committee on Ethics in Human Research ethics board at Memorial University in August 2010, Labrador-Grenfell Regional Health Authority and the Nunatsiavut Government in November 2010. The agreements addressed the ethical protections that apply in gaining individual informed consent, specify commitments regarding collective community participation, decision making and consent, set out the purpose of the research, and detailed mutual responsibilities in project design, data collection, management, analysis and interpretation, production of reports and dissemination of results (Section 9C, Article 9.11, TCPS; CIHR, NSERC, SSHRC, 2009).

Findings

Major Challenges Accessing Health Care in Labrador

Participants identified major factors that created challenges accessing health care services in Labrador, which I categorized into four overarching themes:

1. *Physical Environment:*

1. Distance to Service
2. Weather
3. Geography

2. *Political and Socio-cultural Environment:*

4. Cultural Landscape
5. Jurisdictional Differences
6. Cultural Safety

3. *Gender:*

7. Maternal Care
8. Family Needs
9. Seasonal Employment

4. *Continuity and Comprehensiveness of Care:*

10. Provider Shortages
11. Fit Between Community Needs and Services

Physical Environment

The relationship between health and place has been investigated in the literature (Bender, Clune, and Guruge, 2007; Wilson, 2003). Amy Bender and colleagues (2007) contend, “when a

geographic location is assigned meaning, it becomes a place” (p. 21). The authors argue that place matters both as geographic location and also as experience, and geography includes social, cultural, historical, political, economic, and physical features that together create context. This context creates different life experiences that influence patient and health care provider relationships because individuals generally view health from very different places and perspectives (Bender, Clune, and Guruge, 2007). Kathleen Wilson (2003) investigated the relationship of Aboriginal people with the land and highlighted the complex link between spiritual and social aspects of place, land and health. Although there is evidence suggesting physical context attributes to health outcomes, the effect of these factors on ability to access health care services is less clear (Litaker, Koroukian, Siran, and Love, 2005). However, information on how place effects access to health care is necessary for effective health planning in rural areas (Hodgins and Wuest, 2007). In Labrador, the context of place influences the experiences of Labradorians living and accessing health care in diverse cultural and geographic communities.

Physical environment interacts with income to determine access to health care in rural areas. Financial burdens, for example, are intensified in situations where individuals have to travel from their home. This creates challenges for rural residents of Canada, because they are more likely to be in poorer socio-economic conditions and have lower education levels than their urban counterparts (DesMeules and Pong, 2006). Though provincial, territorial and federal governments may partially subsidize transportation costs for necessary health care services, many rural Canadian residents are left to cover high costs of travel, child-care at home, accommodation, and food out-of-pocket (Chenier, 2000; DesMeules and Pong, 2006). Travel outside of the home community during a medical crisis can create emotional burden on individuals and families, and further exacerbate poor health outcomes (Sutherns, McPhedran, and Haworth-Brockman, 2004). Distance to health care services has been identified as a critical variable for studying health care utilization of people living in rural areas (Arcury et al., 2005), and is a central factor in rural residents’ ability to access adequate and timely health services (CIHI, 2006). A large proportion of rural communities in Labrador face the added challenges of travel that go hand in hand with living in isolated regions.

Distance to Services

Residents of Labrador must travel long distances to access health care within and outside of the region. “If a patient in Nain has to seek a service that cannot be provided locally, it’s a long way to travel for them... Access to care outside Nain is time consuming and costly.” Great hardships resulted for families left behind and for patients who were isolated from their communities while away.

Weather

In Labrador, weather usually creates the most challenges for air travel twice a year, during “freeze up” in December/January, and “break up”, March/April, when ice starts to break up and move through the Labrador Strait and winter storms, high winds, and fog are common. Participants stated that weather not only posed a threat to accessing emergency medical attention, but to specialist services in Happy Valley-Goose Bay or outside the region.

Geography

The geographic location of communities in Labrador affects how residents access health care

services. Because Nunatsiavut communities are isolated and fly-in only, geography creates challenges accessing health care when weather makes air travel impossible. In Nain, for example, mountainous regions around the community create difficulty taking off and landing, especially during high winds and low visibility.

Socio-Cultural and Political Environment

Although all Labradorians access the same health care system, the ways in which they do so is influenced significantly by their cultural heritage. According to participants, some policies work on a region-wide scale or in communities of the same culture, but most health policies need to be adapted to the distinct health needs and unique characteristics of specific communities. For example, despite significant differences in cultural practices, histories, lifestyles and social contexts of Nunatsiavut Inuit and Labrador Innu, some Nunatsiavut administrators reported that policies handed down from the federal government often lump together these two culturally distinct groups. Participants reported great differences among each of the five Nunatsiavut communities and discussed the importance of adapting health care policies and programs to each community depending on its needs.

Cultural Landscape

Rural populations do not share a homogeneous culture. Canadian rural communities, for example, are located in agricultural regions, close to urban centers, in coastal regions and the most remote regions of the north. These different manifestations of rurality can influence cultural traditions (Ryan-Nicholls, 2004). As previously mentioned, place has a significant impact on health behaviors (Bender, Clune, and Guruge, 2007). Despite marked differences between them, however, rural communities share many common features. Strasser (2003) writes that rural residents share feelings of loyalty to their home communities, relationships are viewed as personal and durable and rural inhabitants embody self-sufficiency, self-reliance and independence.

Rural Aboriginal people have health cultures that differ from the health culture of their non-Aboriginal Canadian rural counterparts. The unique histories and cultures of Aboriginal people emphasize the importance of integrated approaches to problems that affect communities and reinforce the necessity of holistic approaches to life. Exploring the underlying reasons for health access inequities is paramount to improving the quality of health services in Aboriginal populations through appropriate policies and programs (First Nations and Inuit Health Branch, 2009). Access to culturally relevant care has been a major issue for all Aboriginal groups in Canada (Loppie Reading and Wien, 2009; Romanow, 2002). This includes adequate access to interpretation services, cultural and regional understandings within the health care system of unique cultures and needs within communities (First Nations Regional Longitudinal Health Survey, 2005).

Jurisdictional Differences

Political divisions arising between different cultural groups in Labrador has resulted in jurisdictional differences in health care coverage for residents of Labrador. There are four political organizations representing Labradorians that add complexity to accessing health care services in Labrador: the Government of Newfoundland and Labrador representing all people in Labrador, and the three Aboriginal political organizations: Nunatsiavut Government

representing the Inuit, Innu Nation representing the Innu, and the NunatuKavut Community Council representing the Inuit-Metis. Aboriginal cultural and political populations cross geographical boundaries in Labrador so individuals identify with their larger cultural community as well as their geographical community. Some Aboriginal groups in Labrador have established self-government (Nunatsiavut Inuit), others are negotiating comprehensive land claims (Innu Nation), while others are waiting on the Federal Government to make a decision on whether their land claim will be accepted for negotiation (NunatuKavut).

Jurisdictional differences in health care coverage were identified as the most significant factor creating inequity in access to health care coverage in Labrador. It was reported that external health benefits, available to some communities and not available to others, further segregate the different Aboriginal communities and non-Aboriginal communities in the Labrador health care system. According to participants, Labradorians limited to MCP coverage faced the most significant financial barriers to accessing provincially insured and uninsured health care services created by jurisdictional differences. There was a common sentiment among community members that financial inequities in access to health care existed between different cultural communities of Labrador that left many people financially drained, mentally stressed, and in some cases, led them to disregard their health because it was too expensive to leave the region to gain access to required services.

Cultural Safety

The concept of cultural safety is used “to express an approach to health care that recognizes contemporary conditions of Aboriginal people which result from their post-contact history” (Brascoupé and Waters, 2009, p. 7). Cultural safety developed in nursing practice in New Zealand in 1999 to provide more inclusive and respectful health care delivery for Maori people. The concept asserts that to provide quality care for people from diverse cultures, the care is best provided within the cultural values and norms of the patient (Brascoupé and Waters, 2009). Participants addressed cultural challenges with health policies, programs, services, and providers in Labrador and centers in Newfoundland and other provinces.

Participants attributed a lack of cultural safety in the health care system to several factors. The first was inadequate cultural competence of health care professionals. Labrador Grenfell Health provides cultural orientation to new physicians practicing in Labrador. Although orientation is meant to introduce physicians to the Labrador wilderness and the different Aboriginal cultural traditions, several participants expressed concern that cultural orientation programs for new physicians lacked Inuit representation or further promoted stereotypes of Aboriginal cultures, instead of directing attention to cultural and social context. Second, lack of cultural safety in the health care system was attributed to high turn-over rates and long working hours of health care professionals in Labrador. Third, there was concern that cultural education programs were restricted to physicians. Fourth, participants identified a lack of support provided to Labrador residents in referral centers outside of St. John’s.

Non-Aboriginal Labradorians also felt their rural culture was disregarded in the health care system outside of Labrador. Participants were concerned that cultural supports available to Inuit and First Nations people were not available to non-Aboriginal or Inuit-Metis residents of Labrador, although they come from distinct communities as well. Without navigational and cultural supports in new urban centers, participants said they felt scared, abandoned, confused and disregarded in the health care system outside of Labrador. Participants felt that mental

health supports and counseling that recognized the social, historical, and cultural community context for Inuit were lacking in Nunatsiavut communities and would be more effective were they run by community members aware of such factors. In addition, several participants noted a lack of cultural competence at drug and alcohol rehabilitation centers, which are only available outside of Labrador.

Structural Barriers

McGibbon and Etowa (2009) argue that all forms of oppression, such as racism, sexism, and ageism, are structural, meaning they are embedded in social institutions such as the health care system. Several community members perceived there were structural barriers, notably institutional racism, in the health care system in Labrador and offered several specific examples of its occurrence. Residents of Nunatsiavut voiced their concern about institutional racism toward Inuit, especially elders. Traditionally, Inuit elders are highly respected members of communities. According to one participant, experiences of institutional racism had left elders from Nunatsiavut communities over-stressed and distraught when accessing health care outside of their communities, producing risks to their already vulnerable health. Inuit participants described first hand experiences with institutional racism in the health care system outside of Labrador. One participant attributed his removal from an alcohol rehabilitation program to racism engrained in western policies that did not fit with Inuit ways of healing and rehabilitation. These stories demonstrate the importance of improving cultural competence among practitioners providing care to Aboriginal residents of Labrador.

Gender

Physical environment and gender are intricately linked in determining access to health services in rural areas. (Leipert and George, 2008; Leipert and Reutter, 2005). Labrador is no different. Women face added emotional stressors in traveling away from rural communities because they are typically responsible for maintaining the home, caring for children and monitoring the emotional climate of the family (Sutherns, McPhedran, and Haworth-Brockman, 2004; Kornelsen and Grzybowski, 2010). However, there is limited research on the effects of geography on women's health (Leipert and Reutter, 2005). Kornelsen, Grzybowski, and Iglesias (2006) investigated the sustainability of maternal care in rural areas of the country. They documented most pregnant women who live in communities that women from rural areas that provide some level of maternal care services have better birth outcomes than women without access to local services (Kornelsen, Grzybowski, and Iglesias, 2006). Gender was one of the most referenced themes relevant to accessing health care in Labrador.

Maternal Care

In Labrador, pregnant women of isolated communities are required to leave their homes to give birth in Happy Valley-Goose Bay at the Labrador Health Centre. Women travel twice throughout pregnancy for ultrasounds and are required to remain in Happy Valley-Goose Bay for three weeks (four if the woman is from Nain) before and a week after delivery. Administrators and health care providers in the region were firm in the belief that women had to come to Happy Valley-Goose Bay to deliver babies, since the resources to aid in emergency situations during childbirth were unavailable in isolated communities. At the time of interviews, if women chose to remain in their communities, they were required to sign a form that transferred all

responsibility of the health of woman and baby to the woman. Participants said although most women choose the baby's father to accompany them, the choice caused stress for the pregnant woman as mothers generally desire to be present. In Nunavut, it has been found that forcing Inuit women to leave home can disjoint the family unit and put undue pressure on the pregnant woman (Purdon, 2008). In Labrador, some nurses provide strong pre and post-natal care, but midwives are not found in every community. Although maternal care decisions need to be made based on safety or resources and financial constraints, Labradorians felt it was equally important these decisions be made with an appreciation of cultural and community sustainability. The availability of suitable maternal care has been linked to the sustainability of communities. Miewald et al. (2011) found that continuity of larger system supports throughout pregnancy, such as pre and post-natal care, important to the health of mother and baby, is lacking in communities where women have to travel away from home to give birth.

Family Needs

Interviews with Labrador women revealed they were generally the primary caregivers of the family. Although it is stressful for families left behind when women are away seeking care for themselves or accompanying a sick loved one, participants said women bore the brunt of the stress. At the time of interviews, deep-rooted gendered family care-giving responsibilities were differentially impacting women of Labrador. Stress was two-fold for employed Labrador women leaving their communities for health care services, because they were still expected to fulfill their traditional role as primary caregiver. This finding is not unique to Labrador. Women employed outside the home in rural Nova Scotia reported being overwhelmed by feelings that family care-giving was their fundamental role and they were increasingly burdened by dependent family members with declining health (Harold and Jackson, 2011).

Seasonal Employment and Hunting/Trapping Patterns

In coastal communities, many Labradorians, mainly men, work seasonally. In Nunatsiavut communities, it was common for men to spend extended periods of time throughout the year hunting and trapping on the land. These months of work were reported as critical for families relying on seasonal employment and/or hunting and trapping. This factor appeared more prominently in interviews with residents outside of Happy Valley-Goose Bay. Participants said there was a drop off in the rate of men accessing health care services while they are working seasonally. Seasonal workers' disconnected from personal health circumstances while working because their families relied on Employment Insurance during the off-season. Participants noticed similar patterns in the rates of men traveling out of Nunatsiavut communities during peak hunting and trapping times. In families that rely on country foods as part of their subsistence, men were said to prioritize between their personal health and providing food for their families. According to these participants, if a health care issue could be postponed, it would not be addressed until after the hunting/trapping season.

Continuity and Comprehensiveness of Health Care Services

Continuity of care implies there is consistency and predictability in the way patients' access and receive health care services. Comprehensiveness of care implies a physician's ability to respond to the variety of health care needs during a patient's lifetime. According to this perspective, true continuity and comprehensiveness of care requires access to human resources other than physicians, such as nurses, dieticians, social workers, and other health care professionals (CFPC,

2007). At the time of interviews, continuity and comprehensiveness of health care did not exist in Labrador.

Provider Shortages

As reported in Statistics Canada's community health profiles (2011), 65% of Labradorians do not have a family doctor, compared to 12% of the province as a whole. Most Labradorians felt they were unable to access physician care in a timely manner and reported seeing a different physician each time they went to the hospital. Participants attributed this to high turnover rates of physicians. Due to such high turnover rates, some participants felt physicians were unaware of personal health histories of patients, so could not advocate for them in the health care system. Some participants said they felt personally responsible for themselves when it came to seeking appropriate care.

Access to specialist care. At the time of interviews, there were no specialists practicing in Happy Valley-Goose Bay. For community members who required ongoing specialist services for chronic conditions, the lack of specialty services was challenging. As mentioned already, weather is a significant factor in whether or not a resident is able to travel by air to the specialist appointment. Many individuals with chronic conditions decided to move to larger urban centers to save on costs associated with frequent travel to and from Labrador to access specialized care.

Wait times. In Labrador, wait times are prolonged due to weather or other geographic factors that impede travel to referral centers. According to participants residents of Happy Valley-Goose Bay could schedule an appointment no less than a month in advance with a general practitioner at the hospital. At the time of interviews, participants reported that having a family doctor did not mean faster access, which left some Labradorians fearing for their health. Participants reported that a consequence of long wait times to see general practitioners meant that the emergency department in Happy Valley-Goose Bay was used for non-emergent health care problems, such as medication refills, because residents had no other choice if they could not wait a month to see a physician.

Recruitment and retention challenges. Labrador, like many northern, rural regions of Canada, faces challenges recruiting and retaining health care professionals (Curran, Bornstein, Jong and Fleet, 2004). Participants in the present study recognized symptoms of burn out in health care professionals, especially nurses, in Nunatsiavut communities and attributed it to a lack of community support networks and long working hours in high stress environments without professional support. Due to high turn over rates, Nunatsiavut community members reported being left without continuity in health care professionals. One of the most often discussed issues associated with retaining health care professionals was the lack of opportunities in the region for spouses and children. One participant felt recruiters need to think holistically about families in order to retain health care professionals. At the time of interviews, another challenge was recruiting health care professionals with the broad set of skills necessary for providing care in isolated communities, not typical of new graduates. According to participants, more experienced nurses nearing the end of their careers were typically the ones that stayed in the communities for longer periods because they had the skills to deal with the broad range of issues.

Fit Between Community Needs and Services

Participants felt services available in communities did not fit the needs of the community.

According to one participant, it is not only access to health care services, equipment and providers that is needed in Labrador communities, but health promotion activities that fit specific community needs and culture. The need for access to appropriate mental health and addictions services in Labrador was one of the most significantly discussed issues when it came to fit between community needs and services. At the time of interviews, Labrador Grenfell Health was recruiting a psychiatrist, but due to the absence of this specialist care, social work counselors were filling the role for mental health care services in the region. Although residents described mental health counseling services in Happy Valley-Goose Bay as lacking, the community was the primary referral center for Labradorians with mental health and addictions needs. At the time of interviews, the province and Labrador Grenfell Health were recruiting mental health and addictions counselors in all communities in Nunatsiavut.

Inappropriate models of care for isolated northern communities. According to participants, models of health care in Labrador were inappropriate for isolated, northern communities. Participants believed they should be able to access a broader scope of care in their communities without having to seek referrals from physicians. In Labrador participants said that physicians were not offering health promotion, self-care and counseling because there is no compensation for these services. The Newfoundland and Labrador health care system compensates general practitioners based on a fee structure, within which consultations are coded and compensation is allotted for different tasks. Participants felt Labradorians faced added challenges seeking referrals because most did not have family doctors and had to travel or wait upwards of 6 weeks to receive a referral. Participants felt if primary care models were introduced to isolated communities in Labrador, residents would not have to travel outside of their communities as frequently for referrals from physicians to access other modalities of health care. The primary care model is based on a holistic approach that takes into account the cultural, physical and social environment and treats mental and emotional as well as physical well-being. This is in line with Inuit ideologies and culture of health. Primary care models also emphasize the importance of continuity and comprehensiveness of health care (CFPC, 2007).

Dissatisfaction with physician care. Community members identified a lack of rapport with physicians caused by high turnover rates, heavy workloads, and limited access to family doctors, which left them dissatisfied with physician care. Several participants voiced their reluctance to be treated by over-worked physicians and how it has led them to avoid dealing with his health. Nunatsiavut participants discussed residents' reservation to access mental health care providers because of their lack of knowledge on the social, cultural and historical realities that impact Labradorians' mental wellness specifically. Peiris, Brown, and Cass (2008) write that when care providers promote trust, reciprocity, effective communication, and shared decision-making with Aboriginal patients, they can promote respectful relationships with patients, which can encourage positive health outcomes.

Major Strategies to Overcome Challenges to Accessing Health Care in Labrador

Participants identified seven strategies to help overcome challenges accessing health care in Labrador: Tele-health, bringing services to communities, the scheduled evacuation system (Schedevac), the medical evacuation system (Medevac), the MTAP, recruitment and retention strategies, and tools for navigating the health care system.

Strategies that help overcome challenges accessing health care in Labrador

	Physical environment	Socio-cultural and political environment	Gender	Continuity and Comprehensiveness of Care
Tele-health	X	X	X	X
Bringing services to communities	X	X	X	X
Recruitment/retention	X	X		X
MTAP	X	X		X
Patient Navigation tools		X		
Medevac	X			X
Schedevac	X			

Tele-Health

Participants identified Tele-health as the most cost-effective and efficient tool to overcome the barriers to accessing health care in Labrador created by physical, socio-cultural and political environment, gender, and ensure continuity and comprehensiveness of care. Tele-health allows residents to access health care in their home community and an opportunity for Nunatsiavut residents to attend appointments accompanied by family or a friend if they are in need of cultural, translational or emotional support. Participants said it could improve access to pre and post-natal care services and decrease stress on mother and baby in isolated communities in Labrador, and allow men hunting and trapping to access care without leaving their communities. Participants concerned with the lack of counseling services in Nunatsiavut communities felt Tele-health was one way to improve access to counseling services. According to participants, improving Tele-health infrastructure would create large cost-savings to Nunatsiavut Government and improve access to health care for residents of remote and northern communities in Labrador. Labrador Grenfell Health and Nunatsiavut launched a Tele-Psychiatry pilot project to address the mental health needs in Nunatsiavut communities in 2003. The project connected Nain residents at risk of suicide to a psychiatrist in St. John's for mental health assessment. Seventy-one patients were able to remain in their community for assessment. A study conducted after the project concluded found the use of Tele-health for psychiatric assessment saved the provincial government \$140,088 and patients and health care providers were satisfied with the service (Jong, 2004).

Bringing Services to Communities

Another identified strategy to overcome challenges accessing health care in Labrador was to physically bring services to communities. Participants believed there were several benefits associated with bringing services to isolated communities, rather than bringing residents to services outside of Labrador. If more services were available in communities, Nunatsiavut Government would undergo enormous cost savings associated with covering associated travel costs for all Nunatsiavut residents. Participants noted that visiting health care providers are able to learn about how social, cultural and historical context of communities effect health behaviors

of residents and how to deliver culturally consistent health knowledge, clinic nurses gain confidence in referring and diagnosing patients, and clinic staff broaden their skill set of specific health conditions. Increasing the number of physicians and specialists that visit Nunatsiavut communities can help residents overcome challenges accessing health care associated with gender in similar ways as Tele-health. Participants felt that being able to access some health care services in the community would allow greater access to care for pregnant women and men working harvesting seasonally. In addition, the employment of services and health care professionals that filled a community need would mean community members could access appropriate services.

Recruitment and Retention Strategies

Improving recruitment and retention strategies was also identified as a strategy to help overcome challenges associated with the physical environment, socio-cultural and political environment, and continuity and comprehensiveness of care. In Labrador at the time of interviews, these strategies included: offering orientation programs, recruiting and building capacity within communities, training professionals in specific areas of practice, addressing family and spousal issues, overseas recruitment, and incentives. One administrator said rural Canadian medical students are twice as likely to return to a rural area to practice, but most of them stay in urban areas once they have been trained in that environment. This administrator felt it essential to train medical staff in the location they will practice. Memorial University's NorFam allows medical residents of the general practice stream from across Canada to train in Labrador and enhance skills in rural and northern medicine. At the time of interviews, the program was seen as very successful in Labrador.

Retention and recruitment can help residents overcome barriers to health care created by the physical environment by employing more health care professionals and making services available in Labrador so that residents do not have to travel long distances. Recruitment and retention of health care professionals from within communities in Labrador was identified as a strategy to overcome challenges accessing culturally competent health care providers. Recruitment and retention of health care professionals from Labrador to return and work in Labrador communities was identified a sustainable solution to challenges associated with continuity and comprehensiveness of care, including high turn-over rates. In addition, recruiting Labradorians means a better fit between community needs and services, as residents of these communities have experienced similar social, cultural and historical factors.

Education initiatives were identified as sustainable ways to recruit and retain health care professionals from Labrador. At the time of interviews, orientation programs were offered to students in the NorFam program to help introduce them to the geographical and cultural landscapes in Labrador. There is also a cross Canada recruitment program for foreign physicians, called the Clinical Skills Assessment Test (CSAT) program, which recruits foreign trained doctors. Nunatsiavut Government partnered with the Faculty of Nursing at Memorial University to offer the Integrated Nursing Access Program (a post-secondary program for Inuit nurses) in response to challenges recruiting and retaining nurses in Nunatsiavut communities. The provincial government and Labrador Grenfell Health at the time of interviews also provided financial incentive for new health care professionals to live and work in Labrador.

Medical Transportation Assistance Program (MTAP)

The MTAP was identified as a strategy that could be improved to help Labradorians overcome

challenges accessing health care associated with the physical environment and socio-cultural and political environment by allowing residents limited to MCP coverage to access the same financial coverage as Labradorians covered under other jurisdictions received. Labradorians identified several problems with the program that needed to be remedied before MTAP became a viable strategy for accessing health care in Labrador. Community members suggested the provincial government provide upfront coverage rather than reimbursement through MTAP. In the 2011 Government of Newfoundland and Labrador Budget, it was announced that the government will be enhancing MTAP by providing the prepayment of 50% of the costs of airfare for rural residents of the province. At the time of this research, however, the implementation of this policy was yet to materialize. Even with the implementation of this policy, residents still face challenges producing the other 50% of travel costs associated with airfare, accommodation, and food.

Patient Navigation Tools

Patient navigation tools were identified as useful strategies to help Labradorians overcome barriers to health care access created by the socio-cultural and political environment. Although there is not a standard definition for patient navigation, a barrier-focused definition developed by Dohan and Schrag (2004) after an extensive literature review denotes patient navigation as the provision of particular services or set of services to patients that specifically address barriers to care. For the purposes of this research, a navigation tool refers to systemic, technological and human resources that help residents navigate the health care system. According to a non-Aboriginal Happy Valley-Goose Bay resident, the lack of navigation support in Labrador was especially hard for vulnerable sections of society who were under informed or had low literacy. Participants identified the Aboriginal Patient Navigator Program in St. John's as an effective navigation tool. Two Aboriginal Patient Navigators, employed by Eastern Health, provide navigation assistance in the health care system, hospital, the city, and finding accommodations, meals and social support services for Aboriginal individuals accessing health care in St. John's. According to Nunatsiavut participants, these navigators are a useful resource for Inuit residents who are aware of the program. However, participants identified a lack of awareness of the program in Nunatsiavut communities that created a barrier to accessing the health care service.

Schedevac

The Schedevac system was said to help overcome challenges accessing health care associated with the physical environment, by providing scheduled air over long distances from isolated communities three days a week, and continuity and comprehensiveness of care, by allowing residents to access a broader scope of services in referral centers. According to participants, the Schedevac system was running effectively given limited resources. Labrador Grenfell Health subsidized the majority of the flight cost, so residents were required to pay \$40 for travel to health care services in Happy Valley-Goose Bay. Administrators believed it offset expensive travel costs of flying in Labrador. At the time of interviews, Nunatsiavut and Innu Nation members did not have to cover the \$40 portion of the Schedevac as it was covered by non-insured health benefits. Participants believed this helped Inuit patients overcome financial barriers associated with air travel. Another way Schedevac had improved access to health care in Labrador is through accommodating for seasonal changes in daylight hours and weather. During the winter, the Schedevac traveled to the northernmost communities first. It was suggested that all Labradorians living in isolated communities receive travel coverage for flights to the main hospital in Happy Valley-Goose Bay.

Medevac

The Medevac system was identified as a strategy to help overcome challenges associated with the physical environment. Medevac was reported to be working well as the primary mode of emergency evacuation in Labrador's isolated communities given limited resources, unpredictable weather conditions and staff shortages. Several back-up supports from other systems were available in case the primary emergency evacuation plane was unable to travel, which helped the system work efficiently: the Schedevac plane could transform into a second Medevac; also, a physician could communicate with clinic staff through Tele-health in emergency situations. One identified problem in providing timely medical evacuation is the scheduling system for nurses on Medevac flights. At the time of interviews, nurses were volunteering and self-scheduling to go on Medevac flights on their days off. With nursing shortages, it was difficult to find staff if no one was scheduled for the flight.

Recommendations

Recommendations associated with Physical Environment

Recommendation 1. That the provincial government provide financial incentive for physicians and specialists to provide Tele-health consultations and follow-up appointments in Labrador.

Video-conferencing by physicians and specialists in the region was seen as a cost-effective solution to overcome challenges created by the physical environment. Although administrators and providers saw many benefits to Tele-health use and it has been proven to provide cost-savings to government and to have high consumer satisfaction in northern Inuit communities in Labrador (Jong, 2004), physicians and specialists did not receive incentive to use the Tele-health system at the time of interviews. Addressing this issue can stand to improve access to physician and specialist related health care for individuals in isolated communities in Labrador, decrease wait times for Labradorians, and create cost savings for government and patients.

Recommendation 2. That the provincial government improve infrastructure in the region to expand Tele-health use by health care providers and broaden the scope of services available to residents of Labrador.

Increasing bandwidth in the region will allow Tele-health to serve as a viable solution to improving access to otherwise time consuming and expensive travel to specialist health care services for residents of isolated communities in Labrador.

Recommendation 3. That the provincial government provide incentives for specialists and other health care providers to bring clinics to northern and remote communities.

Visiting specialists in isolated communities allow rural inhabitants to access a broader range of health care services and allow them to remain in their home community to access specialist care (Drew, Cashman, Savageau, and Stenger, 2006). Currently, the provincial government does not provide incentives for specialists in the province of Newfoundland and Labrador and elsewhere to travel to Labrador. If more specialists held clinics in remote communities of northern Labrador, cost-savings would result for Nunatsiavut Government in associated with travel-costs for Inuit residents attending medically necessary specialist appointments outside of the region and for residents limited to MCP who were reported to receive insufficient travel funding through the MTAP.

Recommendation 4. That Labrador Grenfell Health work with nurses to ensure there is adequate staffing on the Medevac flights to the coast, thereby avoiding delays in emergency evacuation.

Assigning nurses to emergency evacuation shifts, so that a Medevac team is ready for departure when emergencies arise in isolated communities will ensure more efficient departure and treatment for residents waiting for swift evacuation due to health emergency situations.

Recommendation 5. That the provincial government implement its commitment to prepaying 50% of travel costs through MTAP as soon as possible.

Residents who are limited to MCP face significant out-of-pocket costs associated with long distance travel to access needed health care services. Participants noted that many low-income residents of Labrador limited to MTAP for travel coverage could not afford the upfront costs necessary to travel outside of Labrador. Covering 50% of airfare still leaves Labradorians with significant out-of-pocket costs for accessing health care services.

Recommendation 6. That the provincial government provide cash advances to Labradorians through MTAP based on the interaction of a resident's income, health care costs, and health care needs.

Provincial programs that intend to improve access to health care for rural residents have been found to be generic in nature and to not address the needs of the rural poor (Pong, 2007). In Labrador, the MTAP does not account for differences in income, health care costs, or specific health care needs, rather it requires Labradorians limited to MCP for health care coverage to pay upfront costs of travel, regardless of circumstance. Labradorians have a range of incomes and health care needs and therefore, face varying out-of-pocket costs. Out-of-pocket costs are dependent on health condition, number of trips out of Labrador per year, referral center, type of health care service, follow-up services and equipment for residents returning to Labrador. Therefore, a one-size-fits-all policy is not appropriate in Labrador. Distribution of financial assistance through MTAP should take into account the above factors in order to equitably distribute resources and improve access to health care outside of Labrador.

Recommendation 7. That the provincial government provide financial assistance to escorts for Labrador youth up to the age of 16, and for residents who require an escort to perform basic living tasks while seeking health care outside of Labrador.

At the time of interviews, parents and caretakers who needed to accompany children and other family members and friends out of Labrador to aid with daily functioning and tasks were personally responsible for funding their own travel, a great burden and significant barrier to accessing timely medical care for many residents. Participants noted jurisdictional differences between communities in Labrador, so that Inuit and Innu patients received financial coverage for the accompaniment of a caretaker if needed. However, certain populations, most notably, low-income, non-Aboriginal and Inuit-Metis residents limited to MCP coverage did not receive comparable funding and faced financial hardship coming up with the up-front costs of travel for two people.

Recommendation 8. That the provincial government provide financial assistance associated with the costs of return airfare for those individuals evacuated by air ambulance out of Labrador.

Residents evacuated by emergency air ambulance out of Labrador reported being unprepared

to cover the costs of airfare to return home to Labrador. Many of these residents were left stranded without financial assistance from the province for costs associated with accommodation or food to stay in the referral centre or travel to return home.

Recommendation 9. That the provincial government provide assistance to Labradorians requiring medical follow-up care and equipment on return to Labrador.

As an isolated region, Labradorians face heightened challenges accessing medical equipment and follow-up care due to such things as provider shortages and limited availability of services. Individuals limited to MCP coverage did not receive any supports for follow-up care or equipment. However, the factors that create challenges accessing health care services in Labrador for residents limited to MCP coverage should be considered.

Recommendations associated with the Socio-cultural and Political Environment

See recommendations 1-3, 5, 6.

Recommendation 10. That Labrador Grenfell Health, Nunatsiavut Government and the College of the North Atlantic collaborate to implement short-term technical programs to recruit and train health care aides from Nunatsiavut.

Participants raised concern that certain modalities of care, especially rehabilitation services were not offered on Nunatsiavut communities, and community members were required to travel for these services. Nunatsiavut participants felt that having more health care professionals from Nunatsiavut would improve access to needed health care services that were delivered by professionals who shared similar social, historical, and cultural roots as patients. This was especially pertinent to women who felt there was a severe lack of pre- and post-natal care available in their communities.

Recommendation 11. That Labrador Grenfell Health create a working group of Inuit, Innu, and Inuit-Metis Aboriginal and non-Aboriginal representatives from across Labrador to create and provide a mandatory cultural orientation program to all health care professionals that encompasses the historical, social, and cultural contexts that different communities face in the region.

Participants reported that orientation programs for new working professionals in Labrador were inadequate and served to perpetuate stereotypes of Aboriginal communities. There was concern that cultural orientation was not offered to all health care professionals, but limited to physicians, so cultural competence among health care professionals was lacking in Labrador.

Recommendation 12. That Labrador Grenfell Health, partner with Labrador Aboriginal organizations to re-establish an alcohol and drug treatment and rehabilitation center for Aboriginal adults grounded in traditional cultural healing practices.

Inuit residents reported drug and alcohol rehabilitation and counseling services in Labrador and outside the region to be inadequate in addressing the complex needs of Inuit in Labrador tied to a historical and social realities and traditional healing practices. Programs in the region that encompass traditional healing and cultural practices of Labrador's Aboriginal populations will ensure residents will have better access to more effective and that programs are compatible with the many diverse cultures in the region.

Recommendation 13. That Labrador Grenfell Health provide navigational support and

connections for residents traveling outside of Labrador to access health care. Regional health authorities should create patient navigator positions to provide navigational support for all rural residents of the province.

Participants highlighted the lack of navigation support for non-Aboriginal Labradorians accessing health care in referral centers outside of Labrador. Participants suggested that patient navigators in referral centers should be available to help all residents of rural communities, regardless of cultural affiliation.

Recommendation 14. That Labrador Grenfell Health in collaboration with the Labrador Friendship Centre create an interactive website that enables residents and health care providers of Labrador to share experiences and advice on accessing health care within and outside Labrador.

As documented in Chapter 6, participants felt there should be a community-run on-line navigational tool that enabled Labrador residents to communicate with each other, offer support and encouragement, and provide advice on specific health care services available in and outside of Labrador.

Recommendations associated with Gender

See recommendations 1-3.

Recommendation 15. That Labrador Grenfell Health and Nunatsiavut Government implement ultra-sound applications on video-conferencing units in Nunatsiavut communities.

Traditionally, births in Inuit culture were a collective process of family units. In Labrador, women are required to leave their community three times during pregnancy which disrupts the family unit. Inuit participants felt strongly about being able to access maternal care at home. If these capabilities were present, pregnant mothers would not have to leave their communities twice during pregnancy to have routine ultra-sounds in Happy Valley-Goose Bay, thus decreasing stress to mother and baby and costs to Nunatsiavut Government.

Recommendation 16. That Nunatsiavut Government partner with community clinics to offer traditional Inuit midwifery training workshops with elders and midwives in communities for public health nurses and interested residents of Nunatsiavut communities.

One way to initiate midwifery knowledge sharing is to record experiences and stories of elder Inuit women who are experienced in the traditional midwifery practices. This initiative has taken place in Inuit communities in Nunavut and could be used as a practical example that guides the development of a similar initiative in Labrador.

Recommendation 17. That Labrador Grenfell Health, Nunatsiavut Government's Department of Health and Social Development and Memorial University's Labrador Institute collaborate/partner to investigate the effects of seasonal work and hunting/trapping patterns on health care utilization in Labrador.

There is paucity in available literature looking at the influence on health care utilization during peak hunting/trapping seasons and periods of seasonal employment for men of Labrador. Research into this issue could stand to inform health care delivery and provision policies in Labrador.

Recommendations associated with Continuity and Comprehensiveness of Care

Recommendations 1-3, 10-16

Recommendation 18. That Labrador Grenfell Health employ a coordinator to compile issues faced by families of new health care professionals in Labrador and provide support in their achievement of optimum well-being in Labrador communities.

Opportunities for spouses and families were seen as a central factor determining retention of health care professionals in Labrador. Considering the high turn-over rates of most health care professionals in the region, it is recommended that this coordinator work with all health care professionals as similar issues were identified from both the nursing, social work, and physician perspective in this study. This coordinator could liaise between community organizations and Labrador Grenfell Health and work on the development of community initiatives to help retain health care professionals in Labrador communities. This would improve continuity of care as residents would be able to access the same health care professionals and comprehensiveness of care as a broader scope of services would be available in isolated communities in Labrador.

Recommendation 19. That Nunatsiavut Government's Department of Health and Social Development, the College of the North Atlantic in Happy Valley-Goose Bay and the special advisor for Aboriginal affairs at Memorial University support and encourage more initiatives for Aboriginal and non-Aboriginal Labradorian students to pursue careers in medicine, nursing, social work and other health care professions.

At the time of interviews, Memorial University held two seats for Aboriginal students in their medicine program. The Integrated Nursing Access Program was also identified as a strategy to encourage Inuit nurses to pursue careers in nursing. The Inuit Bachelor of Social Work program has also been successful with 18 Inuit students scheduled to graduate in May 2013. Initiatives for Labradorian students to pursue health care careers could stand to improve continuity and comprehensiveness of care in the region.

Recommendation 20. That Labrador Grenfell Health dedicate two physicians to the emergency department after 5 PM to ensure residents can access timely medical care.

Participants identified challenges accessing emergency care after working hours because there was only one emergency physician working after 5PM in the emergency department, responsible for all patients in the Upper Lake Melville region and in isolated and south coast communities in Labrador.

Recommendation 21. That Labrador Grenfell Health and Nunatsiavut Government work together to identify specific community needs in Labradorian communities and strategies to recruit specialists to conduct consultations and clinics with residents via Tele-health that fit the needs of the communities.

Participants discussed the need for services that suit the specific needs of different communities in the region. Participants discussed how the Nunatsiavut Government's Department of Health and Social Development is cognizant of the differences between communities when implementing health care policies and programs in Nunatsiavut. Recruiting services through Tele-health is a cost-effective solution to improving the fit between needs and services in communities related to continuity and comprehensiveness of health care.

Conclusion

My findings suggest that access to health care services in Labrador can be improved if the diverse cultural, social, political, physical, gender, and systemic realities of Labradorians are appreciated, and strategies are adapted to address the identified needs of rural residents living in the diverse communities of Labrador. The recommendations address inequities in health care access for Labradorians and provide suggestions for improvement at both the regional level through community organizations, health authorities, training institutes, universities and the Nunatsiavut Government and the provincial level through the Government of Newfoundland and Labrador. The recommendations can be used to inform the development and implementation of health policies and programming in the area of health care delivery and provision in Labrador and other rural and northern regions of Canada.

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