Meeting the Health Care Needs of Elderly Métis Women in Buffalo Narrows, Saskatchewan

Brigette Krieg, MSW, PhD(c), Prairie Women’s Health Centre of Excellence, University of Regina

Diane Martz, PhD, Prairie Women’s Health Centre of Excellence and Saskatchewan Population Health & Evaluation Research Unit, University of Saskatchewan.

ABSTRACT

There is limited data, including health data, specific to the Métis population in Canada. As a result, the health issues and concerns of Métis communities—in particular Métis women—have largely been ignored in health research and in program and policy development. To address this dearth of information, a community-based research committee made up of Métis women initiated the Buffalo Narrows Métis Women’s Health Research Project. The goals of the project were to investigate the health care needs of elderly women and their caregivers in a northern and remote Saskatchewan Métis community. The project looked at barriers to health care service access in terms of accessibility, affordability, availability, acceptability and accommodation. Results showed that elderly Métis women experienced multiple, interconnected barriers to accessing health care services, making it difficult to isolate one variable as being more important than another. However, the Métis women interviewed did identify a number of recommendations to help in meeting the complex service needs of elderly women in the community. If implemented, these recommendations would help to ease the pressure put on extended family members who act as informal caregivers to elderly residents as well as giving elderly patients more independence and improving elderly women’s access to primary health care services.

KEYWORDS

Métis women’s health, elderly women’s health, remote communities, access to health services, Saskatchewan, Participatory Action Research (PAR)

INTRODUCTION

The Buffalo Narrows Métis Women’s Health Research Project was created after women from four northern Saskatchewan communities met to discuss important health care issues in their respective regions. At this meeting, the Métis Women’s Research Committee of Buffalo Narrows decided to partner with the Prairie Women’s Health Centre of Excellence (PWHCE) to carry out a research project focused on identifying the services required to meet the health care needs of elderly women in Buffalo Narrows—a remote Métis community in northern Saskatchewan.

Although Métis people account for more than 26 per cent of Aboriginal people in Canada, “there are few specific data, including health data, on the Métis population” (Canadian Institute for Health Information, 2004, p. 78) and less than one per cent of health research on Aboriginal...
populations has focused on Métis people (Young, 2003). Current literature on the health care needs of elderly Métis women residing in northern and remote locations is even more limited. This lack of information persists despite acknowledgement of the unique health needs and barriers to health care services in Canada’s rural and remote Métis communities (Romanow, 2002).

In this article, the issue of access to health care services is explored within the context of Pechansky and Thomas’ (1981) approach, which assesses the “fit” between client needs and health services in terms of accessibility, affordability, availability, acceptability and accommodation. Further, by looking at the specific needs of women, the research project documented here aimed to raise the issue of gender as an important factor to consider in the development and implementation of policies related to care of the elderly.

BACKGROUND & LITERATURE

Section 35 of the 1982 Constitution Act recognizes three distinct groups of Aboriginal Peoples in Canada: First Nations, Inuit and Métis. Membership in the Métis Nation is currently based on three criteria: mixed Aboriginal ancestry from either maternal or paternal ties, self-declaration as Métis and community acceptance (Métis National Council, 2006). Despite being recognized as a distinct Aboriginal group, Métis people are at a disadvantage when it comes to the provision of health care because they do not receive the same health benefits afforded First Nations and Inuit populations, such as those covered by Non-Insured Health Benefits (NIHB) program administered by Health Canada’s First Nations and Inuit Health Branch (Métis Centre, 2004). The NIHB program funds extended benefit claims for eligible First Nations and Inuit populations. For example, funding is provided on a needs basis for health services that are not usually covered by provincial and territorial health care plans, including prescription drugs, eye and dental care, and counselling (Health Canada, 2007).

Health care provision in Canada is a provincial/territorial responsibility reliant on federally transferred funds. Health services, therefore, differ across the provinces and territories, and health resources are not always equitably distributed between and within communities (Métis Centre, 2004). In communities with both First Nations and Métis residents, for example, Métis women are at a disadvantage because they have limited coverage for services such as medical transportation, support for maternal care and crisis counselling.

Although Buffalo Narrows is known primarily as a Métis community, residents also identify as Cree, Dene and Caucasian (Keewatin Yattthé Regional Health Authority, 2006). In 2006, Buffalo Narrows had an estimated population of 1,080 people, with 515 men and 565 women (Statistics Canada, 2006). The community has a very young population; in 2006 only five to six per cent of the people living in Buffalo Narrows were over the age of 65, 60 per cent of whom were women (Statistics Canada, 2006). While Statistics Canada reports that approximately 18 per cent of the Canadian population over the age of 15 provides care for an elderly person, in the community of Buffalo Narrows this figure is at 28.5 per cent. Overall, 60 per cent of the people providing informal care in Buffalo Narrows are women (Statistics Canada, 2001). Older women are both providers and recipients of care, while younger women are most often caregivers.

Services currently available to elderly Métis women living in Buffalo Narrows include a mixture of both health care services offered out of community and community-based programs. The majority of the community-based services are run out of the local home care office, which offers supportive living programs—such as Meals on Wheels and homemaking—that enable elderly residents to continue to live independently. A nursing staff is also available to address health issues such as diabetes. The local Friendship Centre facilitates community activities and gatherings, and organizes local transportation for the elderly women (Keewatin Yattthé Regional Health Authority, 2006). All of these programs offer respite for family members, who often provide informal care for their parents.

Although extensive services are offered to the residents of Buffalo Narrows, there are many services that residents can only access by referral from a visiting physician, who only comes to the community on scheduled dates. Residents needing appointments for eye or dental care must travel between two to six hours, depending on the location of their specialist, to larger urban centres. In addition, Buffalo Narrows does not currently have a senior’s home, which means that seniors who need more comprehensive care must leave the community.

Aboriginal women living in remote and northern communities experience additional forms of marginalization based on their geographic isolation. Those living in remote areas often have limited access to social and health services (Benoit, Carroll & Chaudhry, 2002; Bourassa, McKay McNabb & Hampton, 2004; Leipert & Reutter 2005a, 2005b). This has been linked to a higher occurrence of chronic illness, disability, poverty, and victimization.
Remote and northern Aboriginal communities, for example, can always rely on informal support networks. In many services based on the assumption that Aboriginal seniors face. Buchignani and Armstrong-Esther (1999) caution against the downscaling of assisted living programs or home care using such assertions to support the discontinuation or placement on Elders in Aboriginal cultures. However, community support networks and because of the importance of Elders in Aboriginal cultures. Still, there are many gaps in the provision of formal health care services for this demographic, especially for elderly residents living in remote areas. These gaps are largely a result of successive funding cuts, which have contributed to, among other evils, the closure of local health service offices, problems recruiting and retaining health care professionals, and lack of awareness on the part of health care providers and patients about available resources in remote communities (Magilvy & Congdon, 2000). Buchignani and Armstrong-Esther (1999) assert that current health and social policies have failed to meet the service needs and demands of Aboriginal seniors and that, if not rectified, this could become a major social issue in the near future. To begin to address this issue, it is important to understand the specific health needs and barriers to service that Aboriginal seniors face.

Magilvy and Congdon (2000) suggest that Aboriginal seniors are generally at an advantage when it comes to receiving care, due to their generally large family and community support networks and because of the importance placed on Elders in Aboriginal cultures. However, Buchignani and Armstrong-Esther (1999) caution against using such assertions to support the discontinuation or downscaling of assisted living programs or home care services based on the assumption that Aboriginal seniors can always rely on informal support networks. In many remote and northern Aboriginal communities, for example, poverty and low employment rates mean that adult children must often work outside the home or move to urban centers in search of employment, leaving elderly parents without informal health care and social support (Magilvy & Congdon, 2000).

Formal health care services are increasingly organized and delivered from a small number of centralized locations, rather than being based in each community. This may reduce the quality of formal care received by elderly Aboriginal women living in remote areas, because health care providers from outside the community do not have the same intimate understanding of the women's personal living situations (Morgan, Semchuk, Stewart & D'Arcy, 2002). As a result, many elderly residents are reliant on family members to provide informal care. Crosato and Leipert (2006) further note that Aboriginal women who provide informal care for elderly family members face many challenges, including “limited access to adequate and appropriate health care services, culturally incongruent health care, geographical distance from regionalized centers and health services, transportation challenges and social/geographical isolation” (Crosato & Leipert, 2006, p. 1).

**METHODOLOGY**

The Buffalo Narrows Métis Women’s Health Research Project was led by a research committee made up of Métis women from the community of Buffalo Narrows, who worked in partnership with the Prairie Women’s Health Centre of Excellence (PWHCE). The research committee was comprised of elderly Métis women who lived in the community, extended family members who provided informal care to elderly residents, and local service providers. Together with the PWHCE, the research committee adopted the Ethical Guidelines for Aboriginal Women’s Health Research (Saskatoon Aboriginal Women’s Health Research Committee, 2004) to ensure that the research would provide benefits to the community, and submitted a research proposal and ethics application to the PWHCE Advisory Committee for approval. Members of the committee assisted in developing the research project’s interview guidelines, advised on the methods used to recruit participants, and ensured that the appropriate protocols were used in interactions with community members. Once the research was completed, the committee members received the findings for review and indicated that they were satisfied with the final report.

A Participatory Action Research (PAR) framework...
underpinned the research methodology, and qualitative methods were used to gather data. A female resident of Buffalo Narrows was hired as a community researcher and received training in research ethics, interview skills and qualitative data analysis from the Aboriginal research coordinator contracted to conduct the project. She conducted and transcribed semi-structured interviews in Cree, Dene, Michif, and English. This was based on the fact that women from Buffalo Narrows had expressed a desire for the research to be carried out in a way that reflected Métis cultures and values; they wanted to discuss their health issues in their own languages and for the interviews to be conducted by a local Métis woman. Overall, this community-based approach was meant to empower the participants to work together towards a vision of accessible, high quality health care that would meet the needs of elderly Métis women and Métis caregivers in Buffalo Narrows.

Twelve women were interviewed, including six elderly Métis women who were users of formal and informal health services, three younger Métis women who provided informal care to family members and three younger Métis women who were health service providers. During each interview the participant was asked to describe the types and quality of health and social services available to them and the additional services they felt they needed. They were also asked to identify barriers limiting their access to services and to suggest ways that those barriers might be overcome. Interviews were tape recorded and transcribed to ensure the accuracy of the information shared during the interviews. The transcribed interviews were analyzed using Atlas-ti, a computer program designed to label and organize recurrent themes in qualitative data.

RESULTS

Thematic analysis of the interviews presented a thorough picture of the existing services available to elderly women living in rural communities and identified service needs that could influence government policy around health services for elderly women in rural or remote areas. The elderly women and their caregivers identified several shortcomings in the current health care services offered to the senior Métis population in Buffalo Narrows. Quotations from the interviews are used to describe the home care and long-term care service needs of elderly women living in the particular demographic, social, cultural, and economic context of northern Métis communities.

Current barriers to accessing health services

The five dimensions of access outlined by Pechansky and Thomas (1981) provide a useful framework to examine potential barriers to accessing health care services. Applying this framework to the information shared by the interview participants, we were able to assess the “fit” between client needs and health services based on an analysis of the five dimensions of access: availability, accessibility, affordability, acceptability, and accommodation. Each of these five dimensions is presented below and described within the context of rural health care delivery.

**AVAILABILITY:** Availability refers to the relationship between the quantity and diversity of services provided and user needs (Pechansky & Thomas, 1981). For residents of Buffalo Narrows this pertains to both services provided within the community and those accessed in larger city centers through referrals. While some health services were available in the community, barriers still existed to make some of these local services inaccessible to elderly Métis women. In remote communities, available health care delivery is often compromised by irregular visits or minimal staffing of medical personnel (Newbold, 1998; McCann, Ryan & McKenna, 2005; Morgan et al, 2002) and difficulties in recruiting and retaining qualified medical staff (Minore, Boone, Katt, Kinch & Birch, 2004). This can lead to delayed diagnoses, which can prolong treatment and recovery for patients.

Participants in our study identified numerous barriers to the availability of services in Buffalo Narrows, which were related to the isolated location of the community, the lack of many required services, and the inability of existing services to meet the needs of the local population. Women noted that there was no pharmacy, dentist, optometrist, or long-term care facility in the community. One participant spoke about why it would be good to have a long-term care facility in Buffalo Narrows:

Oh yeah, it would be great to have something like that [a long-term care facility] here, because she [participant’s mother] is right at home . . . . She knows everyone here and it’s not hard on her emotionally, you know . . . . People will come to visit her, she’s closer to home. (personal communication, March 2006)

Further, women felt that the existing services available in Buffalo Narrows were in such great demand that service providers were unable to dedicate sufficient time to their clients. One young woman commented on how this meant
that service providers could only provide elderly women with the minimal services needed by them to maintain their independence:

There’s a lot of things she [participant’s mother] could get help with that they don’t have here, because with home care we only have two workers and they have to go all through the whole community, because there’s not enough physical therapists. There is only one, so she can’t get her therapy. (personal communication, March 2006)

ACCESSIBILITY: Accessibility refers to both the physical location of services, as well as patient mobility (Pechansky & Thomas, 1981). In rural or remote areas, problems travelling to and from a community due to poor roads or weather conditions can lead to postponed appointments and delays in visits from medical professionals. Accessibility is also compromised when medical visits are not coordinated with community activities or when they are scheduled during a time when residents are out of the community (Minore et al, 2004).

Transportation was identified as a major challenge because elderly residents often had to travel great distances to receive the health services they needed. Some of the participants were fortunate to have social support networks, or extended family living nearby, to help them with transportation to and from social activities and appointments both in their home community and in other communities. One woman recognized the difficult position that she would be in if she could not rely on her family to assist her with transportation, stating “For you to go to the hospital or go to the city, you can’t go by taxi or ambulance. Your kids have to take you, right? . . . . . If you didn’t have kids, who would take you? Nobody!” (personal communication, March 2006).

AFFORDABILITY: Affordability refers to the ability of individuals to pay for the direct and indirect costs of health services, including medications, independent living appliances and transportation to specialist appointments (Pechansky & Thomas, 1981). In another study, Aboriginal seniors reported being ill-prepared for independent living because they did not have the financial resources to meet their basic needs (Buchignani & Armstrong-Esther, 1999). Indeed, Aboriginal people living in rural areas often experience more poverty and have minimal health care coverage, which, in turn, limits their access to health services, especially for older women living on small pensions (Leipert & Reutter, 2005b; Morgan et al, 2002).

Elderly Métis women living in Buffalo Narrows had to pay for home care services, such as homemaking and meal delivery. In addition, the cost of prescriptions and ambulance services were not covered by the women’s health plans and thus became out-of-pocket expenses. The women were also expected to cover the costs of travel to access medical services not available in the community. This put financial stress on the elderly women and their family members, who at times accompanied them. One of the participants commented:

She [participant’s mother] doesn’t have the money, I don’t have the money, if [the hospital] was in our community we wouldn’t have to travel. That’s the big issue, that’s the biggest issue of all. Because when she has an emergency, or if she has a check up, we got to take her the day before, we got to get a room, we got to get her to the hospital. See, that’s already three days of travel. When she’s done her check up in Saskatoon, we have to spend a night again because it’s too late to come home. (personal communication, March 2006)

The elderly women spoke of the challenges of living on a fixed income and the insufficient amounts provided through pension allotments (i.e., Old Age Security). Even without added medical expenses, they talked about how the pension amounts afforded to them monthly were often not enough to cover their basic needs and expenses. As stated by one participant:

And they [health care personnel] think you are getting such a big cheque at the end of the month but you’re not . . . . Most of these people don’t even have enough to last till the 15th of the month. Even the one’s that don’t smoke, that don’t drink, they still have to eat. (personal communication, March 2006)

Being able to rely on family members to help pay for unexpected medical needs was therefore critical for many of the elderly women interviewed. The women who did not have extended family members to rely on for assistance were at a disadvantage, as they had to pay an escort from the community to take them to their appointments in other communities.

ACCEPTABILITY: Acceptability refers to the compatibility of attitudes and beliefs between health care providers and users (Pechansky & Thomas, 1981). Although exact numbers are not known, many health care providers
in rural, northern Métis communities are not Aboriginal. Therefore there is often a mismatch of values or approaches relating to health and well-being between clients and providers. Western approaches to health, for example, do not incorporate more holistic understandings of spiritual, emotional, physical, and mental well-being. They also tend not to take into account the unique value systems of Métis women around collective identity and communal support (Bartlett, 2005). The failure of health care providers to promote all areas of well-being when working with Aboriginal clients may lead to feelings of isolation or act as a deterrent for Aboriginal patients to access services (Bartlett 2005; Dickson, 2000).

The women who participated in this study identified social isolation as a main area of concern relating to the acceptability of health care provision. Health care services provided to elderly Métis women often targeted diagnosable health concerns without addressing social and emotional factors of illness and well-being. Many of the elderly women interviewed felt isolated and recommended health care services that increased opportunity for social interaction. One woman talked about her desire to have “gatherings at other ladies’ houses to just have coffee and visit each other . . . It gets quite lonesome being home alone and nobody to talk with” (personal communication, March, 2006).

Language barriers emerged as a major issue for the participants, who talked about the need for health care workers who could speak the local languages. Elderly residents in the community relied on family members for translation, to ensure that their needs and symptoms were clearly expressed to medical personnel, as well as to make sure they understood the diagnoses. This was commented on by one of the younger women interviewed:

Well, for myself, it is okay because I can speak English, but I imagine someone that only speaks Cree would have a hard time trying to get their message out to the doctors or . . . to understand what the doctors are trying to tell them. (personal communication, March 2006)

ACCOMMODATION: Accommodation refers to how appropriate service provision is for clients, in terms of things like hours of operation, wait times and office policies and protocols (Pechansky & Thomas, 1981). Urban models of health service delivery increasingly determine the provision of health services in rural areas, yet these models do not address the diverse needs of remote and northern communities nor do they address the specific health care needs of women and aging populations living in these areas (Leipert & Reutter, 2005b). For instance, program funding for home care in remote communities is often short term and irregular, emergency and other services are limited, health centres are understaffed, and health care providers are only available during restricted times (Morgan et al 2002; Minore et al, 2004).

The participants commented on the limited number of home care personnel in Buffalo Narrows and how this meant office hours and appointment times were not very flexible. One woman talked about the challenges this created in terms of having her personal needs accommodated: “She [the home care worker] also said they are short of workers, so they only have two workers that go around and do the cleaning” (personal communication, March 2006).

The participants felt that with additional supports they would be better able to live independently and be less reliant on their families to help them with transportation, household chores and social activities. Additional support personnel would be beneficial to escort them to appointments outside of the community. They could also act as mediators between clients and medical personnel by addressing language barriers and ensuring clear and accurate communication.

DISCUSSION

The Métis women whose voices are profiled in this article call for more formal, affordable and comprehensive health services for elderly women living in remote northern communities. Currently, gaps in formal and informal service provision limit or deny elderly residents from having many of their health-related needs met. The Métis women from Buffalo Narrows offered suggestions about how the complex service needs of elderly clients could be better addressed. This in turn could help to ease the burdens placed on extended family members who provide informal care to Elders and would also give elderly residents more independence. Their recommendations are summarized below.

Recommendations: Improving Health Care Services for Elderly Métis Women

The women interviewed felt that home care programming should be better funded to support elderly Métis residents in a more comprehensive and affordable way. They recommended, for instance, that costs for services such as meal delivery and home maintenance should be eliminated for elderly Métis residents. They also suggested that home
care providers should become more involved in developing and implementing services that would meet the unique needs of each community. In addition, the women called for extended home care services to include services like overnight care.

Overall, the women talked about the need for more home visits and broader community support for the elderly residents of Buffalo Narrows as a way to address these women’s feelings of loneliness and isolation. One major concern of elderly residents related to the lack of available social resources, regardless of existing social supports. They suggested a variety of possible activities that could help in this regard, including visits from school children, craft-making gatherings, exercise programs (i.e., walking and swimming programs), and grocery delivery for seniors. Other suggestions included having a gathering place where Elders could socialize and having access to Cree language library books to help them keep up with how the world is changing. Finally, the women felt that the community should have a free medical van service that would assist elderly women in emergency situations or with getting them to and from medical appointments, picking up prescriptions and groceries, and other transportation needs.

The participants felt that with these additional supports they would be better able to live independently and be less reliant on their families to help them with transportation, household chores and social activities. Personal assistants are needed for those who do not have family members to escort them to appointments outside of the community. Women thought that this person could also act as a mediator between clients and medical personnel by addressing language barriers and ensuring clear and accurate communication. They further suggested that elderly clients would benefit from help with activities such as banking, making a will, cutting the grass, and snow removal. Elderly women also need access to affordable medical equipment that would allow them to live safely and independently.

CONCLUSION

Aboriginal populations continue to experience higher rates of poverty and face different social and health concerns, as compared to the Canadian population as a whole. Aboriginal seniors often experience much poorer health than non-Aboriginal elderly people with similar physical, emotional and medical needs. These issues are further compounded by the broader challenges faced by Aboriginal Elders living in remote and northern communities, including limited financial resources, poorer housing conditions, fewer household conveniences, and restricted mobility. As the elderly Aboriginal population continues to grow, these issues are likely to become more problematic.

When discussing health service provision for northern Métis communities, it is evident that there are multiple barriers to accessing health care for residents in these areas. Barriers to access—including service availability, transportation, limited financial means, language issues and geographic isolation—have led to Aboriginal seniors’ increased dependence on informal caregivers to fill the gaps in available health care services. The dimensions of access outlined by Pechansky and Thomas (1981) are helpful in developing a good understanding of the many intersecting axes of client needs and service provision. It is essential that future research conducted into the multiple barriers and needs experienced by elderly Métis women is mindful of Pechansky and Thomas’ (1981) five dimensions of access while taking into consideration the health and social issues unique to senior Métis women.

REFERENCES


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