Out of sight, out of mind

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Some might consider 8 cases of acute rheumatic fever (ARF) with 2 deaths in remote First Nations communities in northwestern Ontario hardly newsworthy. Given the challenges that face humanity and the carnage caused by the many threats to our health globally, it might hardly merit a second glance. But for Canadians, it is a canary in the coal mine—bellwether for problems and serious deficiencies in our health care system.

Rise of an old scourge

We know that, in general, our fellow citizens of aboriginal heritage suffer from rates of disease and burdens of ill health that are considerably greater than those of their neighbours. The case series published in this issue of *Canadian Family Physician* (**page 881**) describes the recrudescence of an old scourge, ARF.[1] Relegated largely to the history books in affluent countries, we currently have an alarmingly high rate in communities far flung across the Canadian shield.

The particulars of the cases are instructive. The nonsuppurative manifestations of streptococcal infection remind us of the great burden of infections and the consequences of late or missed diagnoses. Diagnosis and treatment of these infections requires excellent clinical, laboratory, and imaging services. Integration of public health and primary care ensures that the suffering of unfortunate victims is minimized. This did not happen in this case series. Two children died from complications of streptococcal infections.

It is not simply a question of ensuring adequate public health services for aboriginal communities. First Nations communities across this country are subject to a variety of challenges in housing; education; employment; domestic abuse; violence, particularly against women; drug use; and so on. Despite notable successes, the overall picture shows a widening gap between the health status of this marginalized population and the rest of Canadians.

No clear way forward

Federal policies to develop capacity and autonomy have been sparse, inadequate, and ineffective. The relationship between First Nations and our federal government has yet to result in strategies that improve the basic determinants of health for this vulnerable population.

When the layers of the onion are peeled back, ARF is a disease of poverty. Not just financial poverty, with its inadequate housing, overcrowding, poor sanitation, and suboptimal nutrition, but poverty in the thinking, concern, and commitment that permeates the relationship between the dominant society and its most vulnerable component. The quiddity of this relationship is fiduciary—putatively beneficial to both parties. The reality falls very short.

Most Canadians are unaware of the circumstances in which a great number of their aboriginal brothers and sisters live. Cloistered in ghettos in some of our larger cities or buried in the vast hinterland, they are not front of mind for the average Canadian. It is not that Canadians do not care but that they simply do not know enough to create the concern that will lead to much-needed action.

If the increased rate of ARF occurred in the affluent suburbs of Toronto, Ont, there would be a considerable mobilization of concern and resources. If the rates of suicide that have plagued reserve communities were mirrored in Ottawa, Ont, we would have declared a state of emergency and demanded that mental health services and strategies be commensurate with the size of the problem.

Troublesome reading

The recent report of the Auditor General of Canada makes for troublesome reading. In describing access to health services for remote First Nations communities, it lists a litany of serious deficiencies in Health Canada's capacity to deliver on its responsibilities.[2] Particularly remarkable in Health Canada's response is the absence of a concrete plan with timelines, actions, assignations, and the requisite additional budgets. Instead we see a weak-kneed acknowledgment of the problems with a series of blandishments and a commitment to, largely, continue with business as usual. The actual gap between what exists and what is needed is not acknowledged, measured, or addressed.

This is a signal failure of a federal department that has a mandate to improve and protect the health of all Canadians, with a particular responsibility to the original inhabitants of this wonderful part of the world. It has eerie echoes of the report of Canada's first Chief Medical Officer, Dr Peter H. Bryce, who, as early as 1907, pointed out the adverse effects on the health of children who attended residential schools.[3] The response at the time was to deny a budget to publish and circulate the findings and to, perversely, discontinue the collection of the data that supported such unwelcome criticism. We should not have had to wait for an independent body to

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inform us of this glaring gap in the performance of what is, arguably, the most important federal ministry. Health Canada should generate and articulate the standards of the programs for which it is accountable and it should ensure robust and transparent mechanisms to monitor their performance.

New approach needed

A just and civilized society is measured by how the weakest and most vulnerable are encouraged and assisted to reach their highest potential. We all benefit from this. This is not a patronizing, patriarchal, post-colonial, top-down process, but a partnership in which we realize that currently marginalized populations have gifts, a worldview, a culture, a heritage, and a spiritual capacity that enrich us all.

The recent conclusion of the Truth and Reconciliation Commission and its findings can help us enormously on this journey.[4] Viewed in combination with the report of the Royal Commission on Aboriginal Peoples, it gives a very clear picture of the history, the context, and the extent of the challenges that face all Canadians as we confront the legacy and reality of racism in this wonderful land.[5]

A practical departure in the delivery of health care to vulnerable aboriginal communities would be the development of a federal department of aboriginal health. It would report to Parliament through the Chief Public Health Officer for Canada, who would be charged with the responsibility for ensuring public health services and primary care services. It could facilitate a coordinated approach, allowing for the diversity of challenges and needs of this population, to improve the health of the First Nations and aboriginal peoples here. It would work in conjunction with the existing regional First Nations health authorities to undo the institutional racism that continues to permeate the various departments of the federal government.[6] The recent work and insightful publications of the National Collaborating Centre for Aboriginal Health[6] will assist in this process, as will its involvement in the wide, forthright, and inclusive approach that must replace current inadequate efforts.

This is a challenge. The failure to manage ARF properly underscores the inadequacy of the strategies and services aimed at improving health on reserves. The very publication of this case series[1] shows that there is local capacity to solve problems and a community of professionals who are keen to be involved. This is not enough. Current services are inadequate. This failure might not be as egregious as that of the residential school system, but it is a failure nonetheless. If it is not addressed, the health gap will widen. This is not the hope or the wish of those who labour at the coalface to deliver services. Neither is it the hope or wish of the policy makers who labour on behalf of our government, nor any Canadian who values the diversity that makes us the country that we have become. Yet this will be the outcome if we do not address this issue in a different, more comprehensive, and more unified fashion than we have to date.

Let us hope that we have the courage, humility, and wisdom to do so and that we support our current Chief Public Health Officer for Canada to have more effect than the sterling but, ultimately, futile efforts of his predecessor just over a century ago.

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None declared

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