NATIVE PEOPLE AND HEALTH CARE IN SASKATOON[1]

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INTRODUCTION

Native people in Canada are increasingly becoming urbanized.[2] It is likely that at least 30% of all Natives now reside in cities, and this proportion will continue to increase (cf. Canada 1980: 11-12). While the phenomenon of Native migration and adaptation to the city has been studied extensively by anthropologists and others (e.g., Nagler 1970; Brody 1971; Denton 1972; Dosman 1972; Stanbury 1975; McCaskill 1979; Clatworthy and Hull 1983), very little investigation has ever been undertaken into the patterns of health care utilization of urban Native people.

Despite this lack of research, there exists a variety of viewpoints both within and without the medical establishment that the health status of these people is lower than for non-Natives, and that their patterns of utilization of the health care system are "inappropriate." It is likely that researchers have been intimidated by the sheer complexity of the urban Native population. The result has been the development of a body of non-empirical, stereotypical and even racist viewpoints concerning the manner in which Native people utilize the health care system. Given this information vacuum, it is possible that the special circumstances of these individuals have often gone unnoticed, or their needs unmet, by primary and secondary health care institutions.

The objective of this paper is two-fold: to summarize the various viewpoints and research on urban Native health care utilization, and to describe a research project which was designed to provide sufficient baseline data on urban Native people to allow

for the development of better health care programs while simultaneously examining the accuracy of these various viewpoints.

HEALTH CARE AND URBAN NATIVE PEOPLE

The Constitution Act (1982) recognizes the existence of three groups of aboriginal people in Canada: Indians, Inuit and Metis.[3] Most of these aboriginal or Native people, some 70%, are still found in rural and remote areas, and in the case of the Indians, on federally-recognized reserves (Canada 1980: 12). But many Native people also live in the cities, and urban migration combined with natural population growth has given Native people a strong visible presence in many urban areas, especially those in western Canada. The movement to the cities has usually been undertaken to improve educational and employment opportunities, although the sad fact remains that many urban Native people do not fulfill their aspirations and remain relatively impoverished (Dosman 1972; Clatworthy and Hull 1983). The formation of Native ghettoes or Native concentrations in various parts of these cities, including but not limited to the inner city, have often resulted.

The health status of and delivery of health care services to urban Native people is a poorly researched area, and little attention has ever been paid to the extent to which they are adequately served (Shah and Farkas 1985). A number of recent studies, in Calgary, Edmonton and Vancouver, have added only minimally to our knowledge in this area (Calgary 1984; Alberta 1985; Mears et al. 1981), as has a study of off-reserve Native elderly in Saskatchewan (Senior Citizens' Provincial Council 1988). The findings of these studies have been somewhat contradictory, in some cases suggesting very little utilization of the urban health care system, while in others demonstrating fairly extensive utilization. In none of these has there been an attempt to compare Native utilization patterns with those of non-Natives in similar socio-economic circumstances, nor has there been an attempt to define "adequacy" or "appropriateness" in health care utilization.

The urban context is, without question, a different arena within which Native people operate, and a variety of viewpoints have been expressed to explain how Native people adapt in this milieu. While the health care system that characterizes Indian reserves and rural or remote Native communities usually involves only a single agency, delivering or arranging the delivery of all primary health care services, the city presents a variety of health care options which may be unfamiliar and even intimidating to the new migrant. However, familiarity with the city through long-term residency does not ensure improved accessibility to the health care system. The existence of racism among medical personnel, and perceptions of racism by Native people, may detract from the utilization of health services by the long-term resident. Native cultures may be so different from the non-Native cultures of the medical practitioners as to make communication within the clinical encounter virtually impossible (Hanson 1988). Similarly, western health care services may be culturally inappropriate, violating various Native norms and mores concerning acceptable modes of interpersonal contact and behaviour. For instance, norms concerning acceptable topics of discussion between the sexes may preclude a consultation between a Native female and a male physician, especially on obstetrical and gynecological matters. And even though most Native urban dwellers have some proficiency in the English language, communication problems still exist in the clinical setting when English only is used. Whatever the reason, it has been argued that urban Native people tend to avoid contact with the western medical system, often consulting the physician only after an illness has failed to resolve itself. Further, it has been argued that urban Native people are significantly less likely to have established a relationship with a particular physician, and are more likely to utilize emergency services at local hospitals for non-emergency medical treatment. It is often assumed that Native people both "underutilize" certain services and "overutilize" or "misuse" others, in a pattern which is not considered conducive to good health (Shah and Farkas 1985: 860; Mears et al. 1981: 45-46).

NATIVE HEALTH CARE IN SASKATOON

Saskatoon is a small Canadian prairie city of 170,000 people, located in central Saskatchewan. Native people number approximately 140,000 in the whole province (between 10% and 15% of the total provincial population), and the number in Saskatoon itself may range from 11,000 to 20,000 (or between 7% and 11% of the total city population) (Clatworthy and Hull 1983; Star-Phoenix 1986). Although the Native population is not located in any single area of the city, it has been estimated that they constitute at least 20% of the residential population in the west downtown core area (Clatworthy and Hull 1983: 17).

Relative to the rest of the city, the west downtown core area is not well-serviced by primary health care facilities. There exists only a few private physician's offices, one clinic, and a hospital. The area is characterized by its poverty, and the symptoms are everywhere evident: relatively high visible crime rate;[4] relatively high proportion of residential renters to owners; the existence of commercial operations catering to a population of lower socio-economic standing, such as hotel beverage rooms, pawn shops, store-front money-lenders, and discount stores; and the existence of a variety of social service agencies, such as the Salvation Army and the Friendship Inn. The relative poverty of the west core area is noticeable in contrast to the affluence of east core area.

In a recent study on programs for urban Indians, Anderson stated that "[Saskatchewan] Indian people who live in urban areas are not faced with a severe problem of access to institutionally based health care" (Anderson 1984: 288). Yet no research data was presented to support this assertion. It should be obvious that simply being surrounded by health care facilities represents an insufficient measure of accessibility. Indeed, it has been argued by others for many years that a problem does exist in the Native utilization of health services in this area. The Saskatoon Indian and Metis Friendship Centre's definition of the problem is typical of the view expressed by both health care practitioners and representatives of Native organizations:

> Economic, social and cultural problems pose barriers to good health practices and adequate medical care. Indians coming to Saskatoon from rural reserves face serious adjustment problems. It is difficult for them to use public transportation, keep scheduled appointments or follow directions in rapidly spoken English. Urban Native people do not normally develop a family physician contact, and when sickness strikes, tend to show up at the hospital Emergency Department. Care providers are usually unaware and uninformed about cultural differences and special Indian needs. Consequently, many services provided to Saskatoon Indians are not acceptable to them and therefore are not well utilized (SIMFC 1982: 4).

While socio-economic considerations are presented, generally this definition of the problem gives considerably greater weight to cultural considerations, and in so doing seems compatible with much of the existing literature and thought. To encapsulate this view, it is believed that Native people are culturally different from non-Natives, and that these cultural differences are at the root of what is assumed to be a Native "misuse" of urban health care services. However, it is clear that many ambiguities and conflicting views surround the question of Native utilization of these services. Comments made both in the literature and by physicians, nurses, health care administrators and representatives of Native organizations are all too frequently anecdotal in nature, based on clinical impressions and hearsay. The real questions remain unanswered: to what extent, and in what manner, do Native people utilize the health care system in Saskatoon; how different is this utilization from non-Natives of similar socio-economic circumstance; and can cultural variables really explain any differences?

THE WESTSIDE CLINIC - FRIENDSHIP INN RESEARCH PROJECT

Research aimed at answering these questions was undertaken at two sites in Saskatoon: the Westside Clinic and the Friendship Inn. The two facilities are located adjacent to each other in the west core area of the city.

The Westside Clinic was established in 1976 to provide primary health care to the underserviced Native and non-Native

people of the west core area. It is, in effect, a satellite of the larger Saskatoon Community Clinic established in the east core area in 1962. It is staffed by two physicians (sharing a two-thirds time position) seconded to the clinic from the main facility, who usually work solo on different days of the week, plus a clinic aide, a community nurse, a counsellor, and a receptionist. Westside Clinic staff estimate that about 80% of their patient base consists of Native people, and that the vast majority of all their patients are poor, including a number of homeless persons.

The Friendship Inn is a social service agency which provides, among other things, meals, recreation and companionship to disadvantaged urban dwellers. It operates as a drop-in facility, and attracts both Native and non-Native clientele. In the past the Inn has taken an active role in publicizing the plight of the urban poor in the city.

As one of the few medical facilities in the west core area, the Westside Clinic has been very concerned with the problems associated with delivering western-based health care to Native people. They have attempted to make the clinic as non-threatening as possible, by avoiding the overt use of medical symbols (such as white laboratory coats), providing coffee and a "living room" atmosphere in the waiting room, and even displaying patient's handicrafts in a showcase for sale purposes.

The staff at the Westside Clinic also have an active interest in the development of health care delivery programs targeted for Native people. In 1986, the author approached members of the clinic about the possibility of utilizing it as a base for a preliminary study of Native health care utilization patterns in Saskatoon. It was felt at the time that the clinic was the ideal base for such a study because of its location and its high Native patient load, and the fact that individuals arriving at the clinic would in many respects be prepared to discuss questions concerning their health and the health care system. The orientation was initially quite broad, since virtually no research had ever been done in Saskatoon concerning Native health care. However, it was essential that the study have practical

implications. After a number of meetings with Westside staff it was decided that the study should have as one of its main goals the production of data that would allow the staff to better deliver health care to its Native patients. Other key health care institutions and social agencies within the city were apprised of the research proposal, and the perspective of the director of the health program for the Saskatoon District Chiefs was sought in an effort to make the research likewise as responsible to the Native residents of the inner city area.

The director of the Friendship Inn was also approached regarding the research, and he expressed a great deal of interest and willingness to co-operate. While some of the Friendship Inn's patrons utilized the Westside Clinic, others did not, and little was known about the patterns of health care utilization by the patrons in general. The Inn was particularly important to the research in that it allowed for the development of comparative sub-populations of the urban disadvantaged population. For instance, it allowed for the interviewing of more non-Native poor, and ensured that a sufficient number of respondents would be interviewed who had not come within the influence of the Westside Clinic. Hence, we were able to obtain data on most segments of the targeted population in this area: those using the Westside, those using other facilities, Natives, non-Natives, males, females, and so on. The only population sub-group likely missed were the homeless: the research was undertaken intermittently from November 1987 to April 1988, and the number of homeless tends to increase in the warmer summer months.

Accountability is, of course, essential in all anthropological research, and crucial in clinically applied anthropological research if the ultimate goal, improved health status, is to be achieved. To this end, it was determined in the formulation of the research project that the first substantive report on the results would be made to the clinic itself. Through an examination of the preliminary findings, it was hoped that the clinic staff would help to elucidate the many unknowns that were likely to emerge, and provide the valuable "clinical" perspective which would be

important in the explication of the data in the final report by the anthropologist (cf. Barnett 1985: 60). This process was to be followed by reports to the Friendship Inn and other health and social service agencies. In this manner, the research results could have a relatively quick impact, avoiding the lengthy delays involved in the academic publication of research findings.

Since very little was known about the social, economic and demographic characteristics of Saskatoon's Native population, let alone their utilization of the urban health care system, it was decided that a quantitative technique would be the most suitable one to provide a broad data base within a reasonable time-frame. An interview schedule was developed and pre-tested at the main Community Clinic to avoid overlap with the Westside's patient base, and the subsequent refining resulted in an instrument comprised of 178 questions, both closed- and open-ended. Different sections of the instrument were designed to elicit information pertaining to basic sociological and demographic variables, utilization of health care facilities and services, the utilization of traditional Indian medicine, and the utilization of the Westside Clinic. Both Natives and non-Natives were interviewed to allow for comparisons. Interviews took place both in the clinic and in the Friendship Inn, and generally lasted from thirty to forty-five minutes each. Respondents were paid five dollars for their assistance.

Three different interviewers (including the author) were utilized over a six month period, and in all cases the interviewers were non-Native and unable to speak an Indian language. It was initially felt that Native interviewers would be important to the success of the research, and that Native respondents would be reluctant to speak openly with non-Natives about sensitive health and cultural matters. However, the 1983 Saskatoon study by Clatworthy and Hull (1983: 21) had found no difference in Native respondent's reactions to Native and non-Native interviewers, and our own pre-test supported their observations. When attempts to locate and fund suitable Native interviewers failed, it was decided to commence the research with non-Native interviewers. While

there were obviously limitations to this approach, we were nevertheless somewhat surprised at the positive reaction from the Native respondents. We had very few refusals, and there were only a couple of instances in which the respondent's inability to articulate in English hampered the data gathering. Overall, different Indian languages were spoken by the respondents in the survey, yet virtually all were competent in English, which emphasizes the bilingual and bicultural nature of these people. English is rapidly becoming the lingua franca of Indian peoples, even where they retain their aboriginal language. The success of the research is in direct contradiction of Dosman's (1972: 11) view, expressed in his monograph on Native poverty in Saskatoon, that "Indians are unanimous in their rejection of surveys, whether conducted by Whites or Indians."

The instrument was structured so as to allow for the evaluation of the accuracy of the self-reported utilization data. In particular, follow-up questions were utilized to obtain specific data on questions answered more generally. For instance, the question on the existence of a regular or family physician was followed by a question to name the specific physician. For the most part, between 95% and 99% of respondents providing general data were also able to follow up in this specific manner. Taken as a whole, then, we were able to assess the relative extent to which the instrument as a whole was being seriously addressed by the respondent.

One of the dilemma's which confront any urban social science researcher is the sheer numbers of potential respondents and their high degree of mobility. In the case of Saskatoon's Native population, only population approximates were available, and there existed no sampling frame from which to draw a random sample for interviewing purposes. Therefore, it was decided that an availability sample would be utilized at the two research locations, with the sampling frame consisting of individuals presenting themselves at the Westside Clinic or the Friendship Inn. All individuals agreeable to the research were then interviewed.

The clinic staff were included in the research process as much as possible given their other duties. The clinic aide, who had developed a strong rapport with the regular patients over the years, actually approached potential respondents first about the research. Upon receiving their agreement to be interviewed, they were brought by the receptionist to the interview area, a lounge located near the examining rooms. Most interviews took place after the patient had consulted the physician or nurse to avoid disturbing the smooth flow of the clinic. The two physicians also discussed the research from time to time with their patients, and facilitated the gathering of other related data in conjunction with the receptionist. It is clear that the success of the research was based on the relationship of trust that had developed between the clinic staff and the Native people of the area; through its co-sponsorship, the Westside Clinic ensured a study of sufficient quality to potentially provide significant data for their own programming needs, as well as for the needs of other organizations and institutions servicing the urban Native population.

SUMMARY OF RESULTS

By the completion of the data gathering phase, a total of 226 interviews had been achieved, 142 with Natives and 84 with non-Natives.

The research was received extraordinarily well by the respondents, both Native and non-Native. We were able to offer a small honorarium to respondents, and this was clearly a factor in achieving their cooperation. However, the quality of responses received from most respondents was far beyond the minimum that one might expect from reluctant individuals interested only in obtaining the honorarium. This was especially evident in sections of the interview which we had assumed would be "sensitive." For instance, of 106 respondents interviewed at the Westside who consulted with the physician or clinic aide, only five refused to describe the health problem that had brought them to the clinic, or gave a response that differed substantially from the physicians'

diagnosis. Native respondents were also willing to offer detailed information on their beliefs concerning traditional Indian medicine, including descriptions of actual healing procedures which they had undergone. The explanation for this tremendous receptivity lies in a number of areas: the utilization of the clinic as a research site, which predisposed individuals to discuss their health; the personal manner of the interviewers; the relaxed atmosphere of both the clinic and the Friendship Inn; the existence of a relationship of trust between clinic and Inn staff and respondents; and the likelihood that the researchers were viewed as part of the care-giving "team" within the clinic (cf. Barnett 1985: 60). The result was the accumulation of a solid body of quantitative and qualitative data on health care utilization.

While it is not possible to detail the specific results of the research in this paper (see Waldram and Layman 1989), a few comments can be made with respect to some of the assumptions and impressions expressed earlier by Natives and non-Natives alike regarding Native patterns of utilizing the urban health care system.

In general, the research demonstrated that Native residents had fairly extensive contact with the health care system, and that the differences between their utilization patterns and those of the poorer non-Natives were, in many ways, not extensive. Further, the data also suggested that cultural variables are considerably less important in understanding Native utilization patterns than many would expect, and that socio-economic variables seem to offer greater explanatory power. Surprising to some would be the finding that Native respondents frequently expressed attitudes and practices that would be considered more "appropriate" or conducive to good health in comparison to the non-Natives of similar socio-economic circumstance.

Overall, 79% of the Natives and 76% of the non-Natives interviewed indicated that they had a regular or family physician, and virtually all were able to name that individual. While we would expect that those interviewed at the Westside Clinic would demonstrate a greater tendency to have a family physician

(especially one from the clinic), the data for those interviewed at the Friendship Inn actually indicate that 82% of the Natives, in comparison to 73% of the non-Natives, had a regular physician. It is also surprising to note that more Natives (95%) than non-Natives (87%) believed that having a regular physician was important.

Native respondents also demonstrated a greater utilization of physicians than non-Natives. While 56% of the Natives indicated that they had seen their regular physician within the preceding month, only 44% of the non-Natives stated likewise; and while 90% of the Natives had seen their physician within the previous year, 83% of the non-Natives had done so.[5]

There was virtually no difference between Natives and non-Natives in having a regular dentist (both approximately 38%), but more Natives (43%) than non-Natives (38%) reported having seen a dentist in the preceding year. Similarly, more Natives (56%) than non-Natives (49%) reported having had an eye examination in the preceding two years.[6]

There were some other interesting differences. Natives did exhibit a ghettoization in their utilization patterns. For instance, Natives demonstrated the tendency to seek treatment at the Westside Clinic or at a local hospital almost to the exclusion of other city facilities, whereas non-Natives demonstrated a greater willingness or ability to use other city hospitals, medi-clinics and private physicians. The data suggested that convenience was more important for Native residents in the selection of a facility: they selected one that was close, likely to be open, and that would accept them with or without appointments. Non-Natives demonstrated a greater committment to facilities because of specific physicians or reputation. Natives expressed greater problems in communicating with non-Native physicians and nurses, greater drug illiteracy, and a greater reluctance to make appointments with physicians.

Both Natives and non-Natives utilized hospital emergency departments for primary health care needs, some of which could possibly have been handled by other non-emergency facilities.

Further, for both Natives and non-Natives approximately 39% of their visits were for treatment of injuries caused by accidents or violence, poisoning, or attempted suicide, which more so than anything else highlights the similarities between the two disadvantaged populations. However, Natives demonstrated a greater tendency to utilize other primary care facilities when they were available, resorting to the emergency department later in the evening or at night. For instance, whereas 46% of the Natives who visited an emergency department did so during the daytime, 55% of the non-Natives did likewise, exhibiting a greater tendency to use the emergency department when other facilities were likely available.

Individuals interviewed at the Westside Clinic were queried regarding the initial onset of symptoms for the conditions that brought them to the clinic on the day they were interviewed. The mean number of days which had lapsed from initial onset until presentation at the clinic was 3.8 for the Native respondents and 5.0 for the non-Natives.

CONCLUSION

Although the data summary presented in this paper has been necessarily brief, a picture nevertheless emerges in which Native urban dwellers are utilizing the health care system fairly extensively, in some cases more so than non-Natives who are similarly disadvantaged. Furthermore, the study demonstrates that, insofar as the Native and non-Native populations are socio-economically comparable, the Native individuals express a pattern of utilization which is more conducive to good health than their non-Native counterparts.[7]

The research also demonstrates very clearly the folly of subscribing to statements of health-seeking behaviours which are, at best, stereotypical, and at worst racist. While the differences between Native cultures and the Eurocanadian culture and its medical system are great, it cannot be assumed that these Native cultures are static and unable to adapt to changing circumstances. Indeed, most urban Native people in Canada today are either

bilingual and bicultural, or are unilingual and unicultural in Eurocanadian ways. For these individuals, understanding the urban health care system does not pose a serious obstacle. If they choose to utilize that system in a way that differs from what is considered "appropriate" by the medical establishment, this is more likely due to socio-economic considerations such as poverty and racism than to some inherent cultural traits that somehow prevent them from coming to understand that which is different. This is not to deny the importance of culture, nor is it to argue that attempts to make the health care system more culturally appropriate for Native people are misplaced. As the overall study shows (Waldram and Layman 1989), language differences in particular do result in serious clinical communication problems (cf. Kaufert et al. 1984).

I would also not argue that the general results of this study are applicable to other urban contexts. I would simply argue first, for the need to undertake empirical research to prevent the development of inaccurate stereotypes concerning Native health care behaviours, and second that we not make the error of assuming that Native people cannot adapt to the urban, predominantly non-Native, milieu, if they wish. And we must not confuse different patterns of utilization with inappropriate patterns, especially in the absence of an accepted definition of "appropriate utilization." After all, it is the health consumer who ultimately defines the nature of the health care system, and this study suggests that urban Native people are, like non-Natives, making informed choices about the health care options available to them.

NOTES

[1]The author wishes to acknowledge the assistance and co-operation of the staff of the Westside Clinic, including Drs. Stephen Helliar and Philip Loftus, Marg Cloak, Sheila Braidek, as well as the former director of the Friendship Inn, Lee Smith. Lisa Layman and Grace Leier assisted in the data gathering, and their efforts are appreciated. The research was funded by the University of Saskatchewan, through the Social Sciences and Humanities Research Council of Canada fund administered by the

President. The viewpoints expressed in this paper do not necessarily reflect those of any of the above, and I alone bear responsibility for errors in fact or interpretation.

[2]For the purposes of this paper, all status Indians, non-status Indians and Metis are referred to as "Native" people.

[3]The status of a fourth group, the non-status Indians, those individuals lacking federal recognition as "Indians," is still unclear.

[4]By "visible" crime I refer to such offenses as vagrancy, public intoxication, and assault. This can be contrasted with the "invisible" crimes of the more affluent urban residents, such as fraud, theft and impaired driving.

[5]While the data from the Canada Health Survey (Canada 1981: 163) is not directly comparable to these data, it is interesting to note that in the survey 76% of the respondents reported having seen a medical doctor (not necessarily their own) within the previous twelve months.

[6]Again, the Canada Health Survey data is not directly comparable, yet the survey shows that 50% of the respondents saw a dentist, and 21% saw an optometrist or optician, in the previous twelve months (Statistics Canada 1981: 163).

[7]This is not to say that the health status of Native people is better than that of non-Natives, for the study made no attempt to assess health. Indeed, the hypothesis that Native utilization of the health care system is greater than non-Natives due to greater ill health among the Native population cannot be discounted.

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