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Indigenous Identity, Gender, and Self-Rated Health under Universal Healthcare in Canada

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Abstract. Canada's publicly funded universal healthcare system is intended to provide equitable access to medically necessary services regardless of ability to pay. However, universal coverage has not eliminated health differences between Indigenous and non-Indigenous populations. These disparities may be particularly important for Indigenous women, because Indigenous identity and gender intersect with social determinants of health. This study examines how Indigenous identity and gender were associated with self-rated physical and mental health among Canadian adults, and the extent to which selected social determinants were associated with these disparities. Secondary data came from the Canadian Community Health Survey Public Use Microdata Files for 2015–2016, 2017–2018, and 2019–2020. The 196,881 respondents aged 18 to 64 were split into Indigenous women, Indigenous men, non-Indigenous women, and non-Indigenous men. Fair/poor self-rated physical and mental health were analyzed using survey-weighted percentages, logistic regression, and linear regression. Indigenous women reported the highest prevalence of fair/poor physical and mental health; in 2019–2020, 22.0% reported fair/poor mental health versus 13.3% of Indigenous men and 10.3% of non-Indigenous women. After adjustment, Indigenous identity remained associated with higher odds of fair/poor physical (odds ratio = 1.62) and mental health (odds ratio = 1.31), while higher income and education were associated with lower odds. The Indigenous × female interaction for mental health was positive but imprecise on the odds scale and near null for physical health. Universal coverage alone does not eliminate Indigenous health inequities. Gender, Indigenous identity, and social conditions should be examined together to inform culturally safe, gender-responsive care.

Keywords: Indigenous health, gender, intersectionality, social determinants of health, self-rated health

1. Introduction

Canada is known for having a publicly funded healthcare system intended to provide eligible residents with reasonable access to medically necessary hospital and physician services without patient charges for insured services. The Canada Health Act establishes principles including public administration, comprehensiveness, universality, portability, and accessibility [1]. This structure reduces direct financial barriers to insured medical care but universal insurance should not be

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assumed to mean that every population experiences the same practical access or health outcomes. The distinction between coverage and equity is central to this investigation as access can be affected by whether a person has a regular healthcare provider, how far they must travel, whether services are culturally safe, whether they can obtain referrals, and whether they have experienced discrimination. Consequently, a population can have formal coverage while still experiencing barriers to timely or appropriate care.

2. Background

2.1. Indigenous health inequities in Canada

First Nations, Inuit, and Métis peoples continuously experience substantial health inequities compared with non-Indigenous populations. Statistics Canada describes these disparities as being deeply rooted in the legacy of colonial policies and reports continuing differences in health outcomes, healthcare access, and experiences of discrimination [2]. However, these differences should not be interpreted as inherent characteristics of Indigenous peoples. Instead, they should be understood within historical and contemporary social contexts specific to Canada. Colonial policies such as residential schools disrupted families, communities, languages, cultures, and traditional ways of life. The long-term effects of these policies can interact with present-day socioeconomic inequality, discrimination, geographic isolation, and barriers to healthcare.

Life expectancy demonstrates the cumulative nature of Indigenous health disparities. From 2016 to 2021, Statistics Canada estimated life expectancy at 74.0 years for First Nations people with Registered or Treaty Indian status, 80.5 years for Métis people, and 71.9 years for Inuit, compared with 85.0 years for the non-Indigenous population [2]. These differences cannot be attributed to a single healthcare access variable. Instead, they reflect the cumulative influence of socioeconomic conditions, disease, environment, healthcare access, and structural inequality.

2.2. The importance of focusing on Indigenous women

Gender adds an additional dimension to Indigenous health inequity. Indigenous women may experience barriers associated with Indigenous identity while also encountering gender-related inequalities. An intersectional perspective therefore questions whether the combination of Indigenous identity and female gender is associated with a health disadvantage beyond the independent effects of either characteristic. This distinction is important because an overall Indigenous/non-Indigenous comparison can conceal differences regarding gender within Indigenous populations. Indigenous women, Indigenous men, non-Indigenous women, and non-Indigenous men may experience different patterns of healthcare access and health outcomes.

2.3. Healthcare access, mental health, and cultural safety

The Public Health Agency of Canada identifies three broad barriers to healthcare for Indigenous women and gender-diverse people: living far from healthcare facilities and providers; difficulty affording healthcare-related services and transportation; and limited access to culturally safe and timely care [3]. These barriers are compounded by systemic racism, intergenerational trauma, mistrust, and gender inequality. In 2024, 32% of First Nations people living off reserve, 30% of Métis, and 29% of Inuit reported unmet healthcare needs, with commonly reported reasons including difficulty obtaining specialist referrals and healthcare services being too far away [4].

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Thus, the existence of a publicly funded healthcare system does not guarantee that a service is physically or culturally accessible.

Mental health is particularly important for understanding Indigenous women's health. In 2024, 47% of First Nations people living off reserve, 43% of Métis, and 35% of Inuit reported needing mental healthcare during the previous year, and among those who sought it, only 28%, 23%, and 22% respectively reported that their needs were fully met [4]. The present study therefore treats mental health as a primary outcome rather than focusing only on physical disease.

Healthcare access is not only a question of physical availability. Cultural safety concerns the patient's experience of care and includes respectful engagement, recognition of power imbalances, and an environment free from racism and discrimination [5], and a qualitative systematic review of 22 studies identified discriminatory attitudes and systemic challenges as main themes in Indigenous people's accounts of primary health care in Canada [6]. In 2024, 24% of First Nations people living off reserve, 18% of Métis, and 23% of Inuit experienced some form of unfair treatment, racism, or discrimination from a healthcare professional in the previous 12 months [4].

2.4. Social determinants of health and gender

Social determinants of health provide a framework for understanding how conditions outside the clinical setting influence health. Statistics Canada identifies income, education, employment, discrimination, and other social conditions as important determinants that shape health outcomes and access to care [7], and these variables were therefore incorporated into the present analysis. An intersectional approach further recognizes that these determinants may operate differently according to gender and Indigenous identity. The purpose of the present study is not to assume that Indigenous women are inherently less healthy, but to examine whether their observed health outcomes differ after accounting for measurable social and demographic factors.

2.5. Research gap and research question

Although previous research has documented Indigenous health disparities, fewer analyses directly examine whether Indigenous identity and gender interact in relation to self-rated health while simultaneously considering socioeconomic and healthcare-access variables. The present study addresses this gap using three national cycles of the Canadian Community Health Survey (CCHS) Public Use Microdata Files (PUMF).

Research question: *How do Indigenous identity and gender intersect to influence healthcare access and health outcomes for Indigenous women in Canada despite Canada's universal healthcare system?*

3. Methodology

3.1. Research design, data source, and sample

This investigation used a quantitative, observational, cross-sectional secondary data design based on Statistics Canada's Canadian Community Health Survey, which collects information about health status, healthcare utilization, and health determinants and produces population estimates for the Canadian population [8].

The study used the CCHS Public Use Microdata Files for 2015–2016, 2017–2018, and 2019–2020 [9]. The analytic sample was restricted to adults aged 18 to 64 years: the combined file

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contained 331,201 respondents across the three cycles, and excluding 24,133 respondents aged 12 to 17 and 110,187 respondents aged 65 and older left 196,881 respondents. The PUMFs report age in grouped categories and the 2019–2020 file combines all respondents aged 65 and older into a single category, therefore the upper limit of the sample was set at the 50 to 64 category. Focusing on working-age adults allowed household income and education to serve as comparable indicators of socioeconomic position.

The pooled sample contained 105,031 females (53.3%) and 91,850 males (46.7%); 70,857 respondents came from 2015–2016, 72,238 from 2017–2018, and 53,786 from 2019–2020, including 4,623, 4,897, and 2,564 Indigenous respondents respectively. A total of 160,149 respondents had complete data on every variable used in the multivariable models. Indigenous identity was missing for 26,623 respondents (13.5%) because they did not provide a valid answer; this proportion was much higher in 2015–2016 (17.6%) and 2017–2018 (17.4%) than in 2019–2020 (2.9%), which may reflect differences in questionnaire flow between cycles.

3.2. Survey weighting

The CCHS uses a probability sampling design, and Statistics Canada requires the sampling weight to be incorporated when producing population-level estimates [8]. The (WTS_M) sampling-weight variable was applied to all descriptive percentages and regression point estimates; descriptive percentages for each survey cycle used the cycle-specific weight, while the pooled percentages and the regression models used the weight rescaled so that it summed to the analytic sample size. A methodological caution is necessary: the PUMF does not contain the replicate weights needed for fully design-based variance estimation, so the resulting standard errors still treat the weighted sample as if it were a simple random sample and are likely to be too small. The regression results should consequently be treated as survey-weighted point estimates, and the confidence intervals and p-values should be interpreted cautiously.

3.3. Outcome and explanatory variables

Two primary outcomes were examined: self-rated physical health and self-rated mental health. Both responses were coded on a five-point scale. For the analysis, the adverse outcome was defined as fair or poor health, while good, very good, and excellent responses formed the comparison category. A third indicator, not having a regular healthcare provider, was examined descriptively as a measure of healthcare access. Self-rated health was selected because it captures a broad perception of health rather than a single diagnosed condition, and Statistics Canada uses perceived health as a population-health indicator [7].

The main explanatory variables were Indigenous identity (First Nations, Métis, or Inuk [Inuit] versus non-Indigenous) and female gender. Gender was measured with the binary sex at birth variable available in the survey. An Indigenous identity × female interaction term was also created; this interaction is the key statistical test of whether the association between Indigenous identity and health differs by gender. Selected social determinants and covariates included household income (five categories), household education (three categories), age group (18–34, 35–49, and 50–64 years), province or territory, access to a regular healthcare provider, and survey cycle. Income, education, and age group were entered as ordinal scores, which assumes equal spacing between adjacent categories. These variables were chosen because socioeconomic position, demographic characteristics, geography, and healthcare access can all influence health outcomes [7].

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3.4. Statistical analysis

Survey-weighted percentages were compared across four groups: Indigenous women, Indigenous men, non-Indigenous women, and non-Indigenous men, for three indicators: no regular healthcare provider, fair/poor self-rated physical health, and fair/poor self-rated mental health. Binary logistic regression was then used to model the odds of reporting fair/poor physical health and fair/poor mental health. The conceptual form of the model was: $\text{logit}(P(\text{adverse health})) = \beta_0 + \beta_1(\text{Indigenous}) + \beta_2(\text{Female}) + \beta_3(\text{Indigenous} \times \text{Female}) + \beta_4(\text{Income}) + \beta_5(\text{Education}) + \beta_6(\text{Age}) + \beta_7(\text{Province/Territory}) + \beta_8(\text{Regular Provider}) + \beta_9(\text{Survey Cycle})$. A linear probability model with the same predictors was also estimated so that associations could be read directly as percentage-point differences in the probability of reporting fair/poor health.

The interaction coefficient is central to the research question. An interaction odds ratio (OR) above 1 indicates that the association between Indigenous identity and the adverse outcome is greater among females than would be expected from the main effects alone, whereas an odds ratio near 1 indicates little additional multiplicative interaction. Finally, the fair/poor health indicator was regressed on the household income category (1 = less than $20,000 to 5 = $80,000 or more) using weighted least squares, separately within each of the four groups, and adjusted predicted probabilities of fair/poor health were calculated for each group from the fully adjusted linear probability model, holding all other covariates at their weighted means.

4. Results and analysis

4.1. Characteristics

The four groups were quite contrasting in their sociodemographic profiles. Indigenous respondents were younger: 44.6% of Indigenous men and 45.5% of Indigenous women were aged 18 to 34, compared with 36.7% of non-Indigenous men and 35.9% of non-Indigenous women. Only 45.1% of Indigenous women and 51.0% of Indigenous men lived in households with an income of $80,000 or more, compared with 59.5% of non-Indigenous women and 64.0% of non-Indigenous men, while 12.8% of Indigenous women lived in households with an income below $20,000 (4.5% of non-Indigenous men), and a post-secondary credential was the highest household education level for 71.9% of Indigenous women compared with 85.2% of non-Indigenous women. These differences in socioeconomic position motivate the adjustment for income, education, and age in the regression models.

4.2. Descriptive health and healthcare-access results

The descriptive results show a consistent pattern of unequal health outcomes, as seen in Table 1. Indigenous women reported the highest prevalence of fair/poor physical health and fair/poor mental health in all three survey cycles. Indigenous men had the highest proportion without a regular healthcare provider in every cycle, indicating that healthcare access alone does not fully explain the poorer health outcomes observed among Indigenous women.

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Table 1. Weighted percentage without a regular healthcare provider and reporting fair or poor self-rated physical and mental health, by Indigenous identity, gender, and survey cycle

Indicator and group	2015–2016	2017–2018	2019–2020
No regular healthcare provider			
Non-Indigenous men	22.7%	21.0%	21.3%
Non-Indigenous women	12.6%	11.0%	12.0%
Indigenous men	28.6%	27.5%	25.3%
Indigenous women	18.1%	17.5%	15.8%
Fair/poor self-rated physical health			
Non-Indigenous men	9.0%	9.2%	8.5%
Non-Indigenous women	9.3%	10.0%	9.2%
Indigenous men	14.2%	16.2%	14.8%
Indigenous women	18.0%	18.6%	17.2%
Fair/poor self-rated mental health			
Non-Indigenous men	6.2%	7.7%	8.9%
Non-Indigenous women	7.8%	9.9%	10.3%
Indigenous men	10.7%	11.0%	13.3%
Indigenous women	14.5%	15.4%	22.0%

In 2019–2020, 17.2% of Indigenous women reported fair/poor physical health compared with 14.8% of Indigenous men and 9.2% of non-Indigenous women. Mental health produced the largest and most rapidly widening disparity. In 2019–2020, 22.0% of Indigenous women reported fair/poor mental health, compared with 13.3% of Indigenous men and 10.3% of non-Indigenous women. The difference between Indigenous women and Indigenous men was 8.7 percentage points, while the difference between Indigenous women and non-Indigenous women was 11.7 percentage points.

The proportion of Indigenous women reporting fair/poor mental health increased by 7.5 percentage points, from 14.5% in 2015–2016 to 22.0% in 2019–2020, as seen in Figure 1. Because the final cycle overlaps with the beginning of the COVID-19 pandemic, this increase should not automatically be interpreted as a long-term trend or as being caused by the pandemic. In contrast, the percentage reporting fair/poor physical health changed little across cycles in any group.

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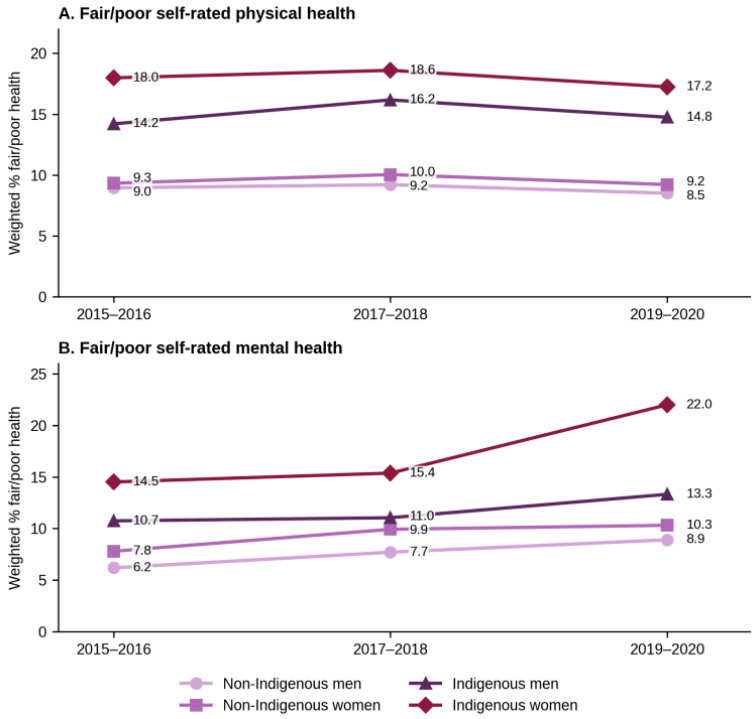


Figure 1. Fair or poor self-rated physical and mental health by Indigenous identity, gender, and survey cycle

4.3. Regression results

The survey-weighted logistic models provide a multivariable assessment of the same relationships (160,149 respondents with complete data). Because the PUMF does not include replicate weights for design-based variance estimation, the estimates in Table 2 are presented primarily as point estimates. Indigenous identity was associated with higher odds of fair/poor health for both outcomes after adjustment (physical health: OR = 1.62, 95% confidence interval (CI) [1.46, 1.79]; mental health: OR = 1.31, 95% CI [1.17, 1.46]). The Indigenous × female interaction was close to null for physical health (OR = 1.02, 95% CI [0.88, 1.17], p = .832) and above 1 for mental health (OR = 1.13, 95% CI [0.98, 1.31], p = .100). The mental-health interaction is therefore consistent with the descriptive finding that Indigenous women had a particularly large mental-health disparity, but its confidence interval includes 1, so the estimate is imprecise. In the unadjusted mental-health model the interaction was OR = 1.19, 95% CI [1.03, 1.37], p = .016.

Table 2. Adjusted odds ratios and linear probability model estimates for fair or poor self-rated physical and mental health

	Fair/poor physical health		Fair/poor mental health	
Predictor	OR [95% CI]	*B* [95% CI]	OR [95% CI]	*B* [95% CI]
Indigenous identity	1.62 [1.46, 1.79]	4.63 [3.68, 5.59]	1.31 [1.17, 1.46]	2.28 [1.32, 3.24]
Female	1.03 [0.99, 1.06]	0.14 [−0.13, 0.42]	1.20 [1.15, 1.24]	1.34 [1.06, 1.62]
Indigenous × female	1.02 [0.88, 1.17]	0.73 [−0.59, 2.04]	1.13 [0.98, 1.31]	2.48 [1.16, 3.81]
Age group (per category)	1.50 [1.47, 1.53]	3.08 [2.92, 3.25]	0.84 [0.82, 0.86]	−1.35 [−1.52, −1.19]
Household income (per category)	0.66 [0.65, 0.67]	−3.91 [−4.02, −3.79]	0.75 [0.74, 0.76]	−2.70 [−2.81, −2.58]

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Table 2. (continued)

Household education (per category)	0.69 [0.67, 0.72]	−4.47 [−4.78, −4.16]	0.78 [0.75, 0.81]	−2.37 [−2.68, −2.05]
Regular healthcare provider	1.47 [1.39, 1.55]	2.76 [2.39, 3.13]	1.18 [1.12, 1.24]	1.26 [0.89, 1.64]
Survey cycle: 2017–2018	1.09 [1.04, 1.14]	0.70 [0.35, 1.05]	1.31 [1.25, 1.37]	1.93 [1.58, 2.29]
Survey cycle: 2019–2020	1.05 [1.00, 1.10]	0.36 [0.03, 0.68]	1.53 [1.46, 1.60]	3.17 [2.84, 3.50]

Note: OR = odds ratio from the logistic model; *B* = percentage-point difference from the linear probability model. Models also adjust for province or territory.

Income and education had odds ratios below 1 in both models, indicating that higher categories of these variables were associated with lower odds of fair/poor health. Older age within the 18 to 64 range was associated with higher odds of fair/poor physical health (OR = 1.50 per category) but lower odds of fair/poor mental health (OR = 0.84). The regular-provider variable had an odds ratio above 1 in both models. This should not be interpreted as evidence that having a provider causes poor health; a plausible explanation is reverse directionality, as people with existing health needs may be more likely to have a regular provider.

The linear probability models express the same associations as percentage-point differences. After adjustment, Indigenous identity was associated with a 4.63-percentage-point (95% CI [3.68, 5.59], $p < .001$) higher probability of fair/poor physical health and a 2.28-percentage-point higher probability of fair/poor mental health. For mental health, the Indigenous × female interaction was 2.48 percentage points (95% CI [1.16, 3.81], $p < .001$), an additional difference beyond the sum of the Indigenous and female main effects. For physical health, the interaction was 0.73 percentage points (95% CI [−0.59, 2.04], $p = .277$). The logistic and linear probability results therefore agree on the main pattern but differ in how clearly they detect the mental health interaction: on the multiplicative (odds) scale the interaction interval includes 1, whereas on the additive (percentage-point) scale it excludes 0.

4.4. Income gradient and adjusted predicted probabilities

Linear regression models fitted separately within each group show a clear socioeconomic gradient, as seen in Table 3. In every group, each category increase in household income was associated with a lower percentage reporting fair/poor health. The slopes were steepest among Indigenous men, while the slope for Indigenous women was close to those of the non-Indigenous groups. Higher income did not close the gap between groups: in the highest income category ($80,000 or more), 10.8% of Indigenous women reported fair/poor physical health compared with 5.6% of non-Indigenous women, and 12.1% reported fair/poor mental health compared with 7.1%. Because these stratified models are unadjusted for other covariates, they describe socioeconomic gradients rather than independent effects.

Table 3. Linear regression of fair or poor self-rated health on household income category, by Indigenous identity and gender

		Slope for household income	
Group	*n*	Fair/poor physical health, *B* [95% CI]	Fair/poor mental health, *B* [95% CI]
Non-Indigenous men	69,296	−4.04 [−4.21, −3.87]	−2.62 [−2.78, −2.45]
Non-Indigenous women	79,951	−4.13 [−4.29, −3.98]	−2.81 [−2.97, −2.66]
Indigenous men	4,841	−6.92 [−7.61, −6.22]	−4.10 [−4.74, −3.47]

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Table 3. (continued)

Indigenous women	6,061	−4.36 [−4.98, −3.74]	−3.22 [−3.84, −2.61]

Adjusted predicted probabilities from the fully adjusted linear probability models, evaluated at the weighted means of all other covariates, were 8.5% for non-Indigenous men, 8.7% for non-Indigenous women, 13.1% for Indigenous men, and 14.0% for Indigenous women for fair/poor physical health. For mental health, the corresponding predicted probabilities were 7.9%, 9.2%, 10.2%, and 14.0%. After adjustment, Indigenous women therefore remained about 5 percentage points above non-Indigenous women for physical health and 4.8 percentage points above them for mental health, and their predicted probability of fair/poor mental health was 3.8 percentage points higher than that of Indigenous men, consistent with the positive interaction in Table 2.

5. Discussion

5.1. Social determinants and healthcare access as partial explanations

The income and education findings support the social determinants framework. Higher income and education categories were associated with lower odds of fair/poor health, and the stratified linear regression models showed a steep income gradient in every group. Indigenous respondents were also less likely to live in the highest income households and to hold a post-secondary credential, which is consistent with an unequal distribution of the resources that protect health. However, adjustment did not make the Indigenous association disappear. Even in the highest income category, Indigenous women reported fair/poor health more often than non-Indigenous women, and adjusted predicted probabilities remained higher for both Indigenous groups. This residual association should not be interpreted as evidence that Indigenous identity itself causes poorer health. Indigenous identity is embedded within historical and structural conditions that are only partially captured by the available variables; experiences of racism, cultural safety, housing, food security, geographic remoteness, historical trauma, and the availability of Indigenous-led services were not fully measured in this analysis.

The provider-access results also demonstrate why a single access indicator should not be treated as a complete measure of healthcare equity. Indigenous men had a higher percentage without a regular provider than Indigenous women, yet Indigenous women had worse self-rated health in the descriptive analysis. Statistics Canada's recent national findings [4] show that Indigenous people also experience unmet needs, long waits, travel requirements, difficulty obtaining specialist referrals, and concerns about culturally appropriate care.

5.2. Mental health shows the most pronounced intersectional pattern

The mental-health results are especially important because Indigenous women showed a much larger increase in fair/poor mental health over the three cycles than the other comparison groups, and the additional percentage-point difference for Indigenous women in the linear probability model points in the same direction. Statistics Canada [4] reported that Indigenous people had substantial unmet mental-health needs in 2024 and that Indigenous women were particularly likely to report needing mental healthcare. The present analysis cannot establish the mechanism behind the gender difference, and because the odds-scale interaction was imprecise, the evidence for an intersectional effect should be regarded as suggestive rather than conclusive. Nevertheless, the pattern is consistent

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with the broader evidence that mental health access and outcomes require attention to gender, Indigenous identity, and structural conditions simultaneously.

5.3. Implications for healthcare equity

The findings suggest that universal healthcare should be understood as a foundation for equity rather than a guarantee of equal health outcomes. Public insurance can remove direct charges for insured services, but it cannot by itself eliminate geographic barriers, socioeconomic inequality, racism, cultural unsafety, or historical trauma. For Indigenous women, healthcare policy should therefore include culturally safe and gender-responsive mental health services, improved access in rural and remote regions, stronger continuity of care, and approaches that recognize Indigenous knowledge and healing practices; large majorities of First Nations people living off reserve, Métis, and Inuit consider support for Indigenous traditional medicines, healing, and wellness practices important [4].

These recommendations should also be developed using a distinctions-based approach. First Nations, Inuit, and Métis peoples are not a homogeneous population, and health systems should account for their distinct histories, cultures, geographic circumstances, and priorities [5].

5.4. Limitations

1. The CCHS is cross-sectional, so the associations reported here cannot establish causation or temporal direction, and self-rated physical and mental health are subjective measures that should not be treated as equivalent to clinical diagnoses.

2. Gender was measured as binary sex at birth. The analysis therefore cannot describe gender-diverse or Two-Spirit people, who are specifically identified as affected by barriers to care [3].

3. The main analysis combines First Nations, Inuit, and Métis respondents into a single Indigenous category. This increases sample size but can conceal distinctions between populations with different histories, cultures, and healthcare contexts.

4. Complete-case analysis reduced the multivariable sample to 160,149 records. Indigenous identity was missing far more often in 2015–2016 and 2017–2018 than in 2019–2020, and if missingness is associated with Indigenous identity, socioeconomic status, or health, the resulting estimates may be biased.

5. The 2019–2020 cycle overlaps with the beginning of the COVID-19 pandemic. The increase in fair/poor mental health among Indigenous women therefore requires cautious interpretation.

6. Income, education, and age group were treated as ordinal scores, the linear probability model can produce predicted probabilities outside the 0-to-1 range, and the Public Use Microdata Files do not contain a complete replicate-weight design. Fully design-based standard errors and confidence intervals should be produced in a survey-analysis environment before making strong inferential claims.

5.5. Ethical considerations

This investigation uses anonymized secondary data and therefore did not involve direct recruitment, intervention, or collection of identifiable participant information. Nevertheless, Indigenous health research requires attention to data governance and interpretation. The First Nations principles of OCAP® (Ownership, Control, Access, and Possession) establish principles concerning how First Nations data and information should be collected, protected, used, and shared, and support First

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Nations data sovereignty [10]. OCAP® is specifically a First Nations framework and should not automatically be presented as a universal framework for Inuit and Métis data governance.

The paper also avoids deficit-based interpretations. Finding higher rates of fair/poor health among Indigenous respondents does not imply an inherent deficiency associated with Indigenous identity.

6. Conclusion

This study investigated how Indigenous identity and gender intersect to influence healthcare access and self-rated health outcomes among adults aged 18 to 64 within Canada's universal healthcare system. Across the three CCHS cycles, Indigenous respondents consistently reported poorer health than non-Indigenous respondents, while Indigenous women had the highest descriptive prevalence of fair/poor physical and mental health. Indigenous identity was associated with poorer physical and mental health in the multivariable models, but the Indigenous × female interaction was close to null for physical health and positive, though imprecise on the odds scale, for mental health. The findings therefore suggest that Indigenous identity and gender should not be analyzed as completely separate characteristics when investigating mental-health inequities.

Ultimately, universal healthcare coverage is necessary but not sufficient for health equity. Improving Indigenous women's health requires attention to socioeconomic conditions, geographic accessibility, culturally safe care, continuity of care, mental-health services, and the effects of systemic discrimination and colonial history. Future research should use distinctions-based analyses of First Nations, Inuit, and Métis populations, apply design-based variance estimation, and incorporate Indigenous-led approaches to research and data governance.

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