Access, Equity, Coordination: A Position Statement on Health Authority Engagement with AHMA Members

Aboriginal Housing Management Association

Introduction

Safe and appropriate housing is a core social determinant of health, yet housing instability remains a widespread issue across British Columbia (BC). Indigenous peoples remain disproportionately impacted by housing precarity and continue to be overrepresented among those experiencing homelessness. At the same time, Indigenous people face persistent barriers to accessing health care, including a lack of cultural safety and discriminatory practices that undermine trust and timely care.

Recognizing the critical intersection between housing and health, AHMA undertook a province-wide survey between March and May of 2025 to more accurately understand how its members interact with BC's five regional Health Authorities (HAs) (Fraser Health, Interior Health, Island Health, Northern Health, and Vancouver Coastal Health). The goal of the survey was to identify patterns in engagement, service gaps, barriers to access, and opportunities for improved collaboration between Indigenous housing providers and the health system. A total of 24 organizations responded to the survey, representing about 50% of AHMA's membership.

This position statement draws on survey findings to outline urgent systemic issues and advocate for change. It calls on HAs to establish formal, reciprocal, and culturally safe partnerships with Indigenous housing providers; embed cultural safety in all interactions; and improve access to mental health and substance use services, primary care, and supports for Elders.

Background and Survey Findings

Indigenous housing providers across BC face systemic barriers when engaging with regional HAs, resulting in inconsistent and often inadequate access to health care for their tenants. The findings from AHMA's province-wide survey of Indigenous housing providers identified three interconnected challenges: lack of access to care, inequitable treatment within the health system, and weak coordination between housing providers and HAs.

Access to care, as experienced across the province, emerged as the most pressing issue. Survey respondents reported insufficient medical staffing, long wait times, and funding constraints that prevented timely and effective service delivery. Despite ongoing efforts to advance equity within the healthcare system, individual experiences of racism and discrimination continue to serve as a prominent barrier and compound the lack of access to care. The landmark *In-Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care* documented thousands of similar experiences and found that "67 per cent of Indigenous respondents […] had experienced discrimination from BC health care staff in the past based on ancestry or origin, compared to just five per cent of non-Indigenous respondents." [1]

Racism operates at interpersonal, institutional, and structural levels, often blocking timely and culturally safe access to health and housing services. In health settings, discriminatory attitudes and practices erode trust, delay help-seeking, and lead to under-assessment and poor follow-up, ultimately worsening health and housing outcomes for Indigenous peoples.

In AHMA's survey, racism was reported most prominently in the Vancouver Coastal Health jurisdiction. These findings align with the *In-Plain Sight* [1] report, where Vancouver Coastal and Northern regions are noted as areas where Non-Indigenous and Non-Racialized (NINR) respondents were more likely to have witnessed racism or discrimination directed at Indigenous patients.

Significant service gaps further limit tenants' ability to access culturally safe and timely care. Mental health and addiction support was the most frequently identified gap, followed by primary care, assisted living and home support for elders, access to dedicated Indigenous liaisons, and culturally safe medical supports.

Survey respondents also reported making referrals to regional HAs. The most common reasons for these referrals were mental health issues, followed by substance use issues and chronic illness. These referral trends mirror the findings of the *2023 Point-in-Time Count* [2] for the province, which identified the same primary health concerns among people experiencing homelessness, 40% of whom self-identified as Indigenous. Regarding incoming referrals, from HAs to AHMA members, these are most often related to women fleeing violence and supportive housing.

Organizations also reported that they primarily rely on informal channels and personal contacts to identify the appropriate departments for referrals. Established agreements are rarely used, indicating a lack of structured pathways for service navigation. Similarly, efforts to form connections with HAs are largely one-sided; organizations are taking the lead in outreach, while proactive engagement from HAs remains rare. This imbalance not only strains organizational capacity but also perpetuates inequities in care, leaving tenants, many of whom already face multiple barriers, without the timely, culturally safe health services needed to support housing stability and well-being.

This is echoed partially by the *Supporting Partnerships between Health and Homelessness* [3] study, which, after conducting interviews and case studies among persons with lived experience of homelessness, describes that effective communication and coordination between healthcare and housing or shelter providers is essential to assist this group of people in navigating the hospital-to-shelter/housing transition.

Analysis

Taken together, the survey findings indicate a structural problem with three interrelated dimensions: access, equity, and coordination. Access to care is undermined by insufficient medical staffing and funding, and by persistent service gaps, most notably in mental health and addictions, primary care, and supports that allow Elders to remain housed. Equity concerns, especially racism and culturally unsafe care, magnify those access barriers and undermine trust in the health systems that tenants must rely on. Further, coordination between housing providers and HAs is insufficient. While referrals from housing to health are frequent, navigation depends on informal relationships rather than clear pathways or agreements.

The implications for tenants are direct and harmful. When culturally safe services, primary care, or addiction support are hard to reach, care becomes crisis-driven, where symptoms worsen in place and the first reachable doorway becomes the ER or police. Weak discharge planning and limited post-hospital supports increase the risk of re-entry into emergency or short-term housing, increasing the risk of tenants returning with unmet care needs that spiral in the unit [3].

There are also material consequences for providers. In the absence of formal referral routes and designated contacts, Indigenous housing organizations shoulder disproportionate administrative and advocacy burdens, including finding the right department, arranging follow-up, documenting incidents, and attempting to coordinate discharges. Access often depends on personal connections; this reliance on informal, person-dependent ties makes access uneven across communities and vulnerable to staff turnover.

For HAs, the current state is inefficient and costly [3]. Fragmented pathways lead to avoidable crises, repeat emergency visits, and missed opportunities for early intervention. Excluding housing providers from routine care planning, especially at discharge, means the system fails to leverage partners who are closest to tenants and best positioned to support continuity of care. Health authorities should include housing providers in discharge coordination and provide timely post-discharge information, especially for supportive and seniors housing.

The survey also underscores that cultural safety is not a one-off training issue; without accountability and Indigenous-informed practices, trust erodes and engagement drops.

The strategic implication is clear: improving outcomes requires structured, reciprocal, and culturally safe partnerships (co-designed with Indigenous providers and tenants) between HAs and Indigenous housing providers. Formal referral and discharge protocols, dedicated Indigenous liaison/navigation roles, and transparent service information would replace ad hoc workarounds with predictable access. Strengthening and delivering mental health, addictions, primary care, and Elder supports in ways that are culturally safe and connected to housing would improve health outcomes and stabilize tenancies.

AHMA’s Position

AHMA asserts that Indigenous housing providers are essential health equity partners. Housing is often where health supports are accessed and coordinated, yet current engagement with HAs is inconsistent, culturally unsafe, and heavily dependent on informal relationships. This produces fragmented care for tenants and places a disproportionate coordination burden on Indigenous organizations.

System change is required. HAs must establish formal, reciprocal, and culturally safe partnerships with Indigenous housing providers, considering that housing is one of the most important determinants of health. At a minimum, this includes clear two-way referral pathways, shared discharge-planning processes that consistently involve housing providers, designated Indigenous liaison/navigation roles, transparent information about available services, and health supports within housing.

Cultural safety is not a one-time training; it is an ongoing practice with accountability. AHMA’s position is that racism and discrimination in health care must be named, prevented, and acted on through respectful communication, consistent follow-up, and mechanisms to escalate and resolve concerns. Tenants must be able to access services that are culturally safe and low-barrier, where cultural healing and daily supports are integrated within housing.

Improving access also requires community-connected services where the gaps are greatest, including mental health and addictions supports (including detox, treatment, and post-treatment options), primary care, and supports for Elders. These services should be delivered in ways that connect directly to Indigenous housing and reflect community priorities, without the risk of losing housing or stability when accessing them.

Calls To Action for Health Authorities

1. Ensure that existing senior Indigenous leadership within each health authority (e.g., VP of Indigenous Health or Indigenous Partnerships) works directly with Indigenous housing providers to implement ongoing cultural safety initiatives. This should include clear accountability mechanisms and escalation processes when racism is encountered.
2. Designate Indigenous liaisons to AHMA members to reduce reliance on informal relationships.
3. Co-develop two-way referral and discharge pathways with Indigenous housing providers.
4. Provide clear, current program maps and points of contact so providers and tenants can navigate the system without inconvenience.
5. Improve Senior support, with more access to Assisted Living and coordinated home supports.
6. Deliver on current provincial priorities by establishing predictable, housing-connected access to mental health, substance use, and primary care.

References

1. Turpel-Lafond, M. E. (2020). In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care.
2. Homelessness Services Association of BC, Caspersen, J., D'Souza, S., & Lupick, D. (2024). 2023 Report on Homeless Counts in B.C. https://www.bchousing.org/research-centre/housing-data/homeless-counts
3. Canham, S. L., Bosma, H., Mauboules, C., Custodio, K., Good, C., Lupick, D., Seetharaman, K., & Humphries, J. (2019). Supporting Partnerships between Health and Homelessness. Vancouver, BC: Simon Fraser University, Gerontology Research Centre.