



Social Determinants of Métis Health

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Introduction

Social determinants of health (SDOH or less commonly SDH) is a concept embraced by many Métis researchers because it mirrors common Métis beliefs about health. (Métis Centre, 2008a) Historically, the Métis view of health has been primarily holistic. In the words of Métis Elder Tom McCallum, “we see each other as being related to everything.” (Métis Centre, 2008b, p17) This perspective is similar to what many believe today.

Similarly, the social determinants of health perspective views health as greater than just physical health, and often determined or impacted by other types of influences, such as social, political and economic. These determinants are the ‘causes of the causes.’ The causes of the causes can be complicated and difficult to uncover. There are many variations of the following story, frequently used to demonstrate the complexity of health determinants (Raphael, 2006). This version is a fictional story created from stories gathered at the Kelly Lake Métis Settlements (Métis Centre, 2007). While the stories of Métis across Canada are very different, this may help to illustrate the impact of the ‘causes of causes:’

“Why is Lisa in the hospital?

Because she fainted in her elementary school and the paramedics were called.

But why did she faint?

Because she was exhausted and hungry.

But why was she exhausted?

Because she has a two-hour bus ride to and from school.

Why does she have such a long ride?

Because she has to go to school in another province.

But why does she go to school so far away?

Because she lives in northern British Columbia and the county closed the community’s school.

OK, but why is she so hungry?

Because there is not enough food to eat in her home.

Why isn’t there enough food?

Because her family does not have as much money as it needs.

But why don’t they have enough money?

Because Jessica’s father was just laid off and can’t find another job.

Why can’t he find another job?

Because there are not many jobs where they live. He will probably have to travel far from his family to provide for them.

But then, why doesn’t the whole family move somewhere else?

Because they grew up there. Their community is there. It is their traditional territory.

But why can’t they leave?

Because they are afraid of losing their traditional way of life: hunting, trapping, gathering medicines and speaking their language.

Oh! If they can hunt, why don’t they have food to eat?

Because there was a natural resource boom during the past decade, which meant Jessica's father found paid employment for a while, but it also meant the new roads and machinery changed the land. The developers had no respect for the Métis way of life and now the wildlife, the water and the plants are all polluted.

But why didn't Jessica's community stop the developers?

Because they had no say in the matter. They had no control over their land.

But if it's their land, why didn't they have a right to be consulted?

Because many Métis do not have the same rights and recognition as many First Nations and Inuit.

Why not?...

History: The Rise of the Social Determinants

Originally the determinants of health consisted of a very standard set, including such vital statistics as infant mortality rates and life expectancy (Etches et al, 2006), and the prevalence of disease. In the past, the use of only these (and similar) determinants was reflective of a more bio-medical approach (or epidemiological perspective) that supported the idea of health as only including physical health. Within this perspective, good health is seen as only the absence disease. Now nearly all health professionals and researchers accept a broader idea of health that involves inter-connected health determinants such as societal and environmental impacts. (Raphael, 2006) Some authors have indicated this broad idea of health determinants dates back centuries and even millennia. For example, the Chinese have written about the many influences on health for over millennia. (Etches et al, 2006) More recent thinkers include Rudolph Virchow and Frederick Engels who, in the nineteenth century, looked to economic, political and social forces as capable of influencing health and well-being. (Raphael, 2005) The work of Marx, Engels and Durkhiem, particularly their population-level analyses, were also very influential in moving this broad idea of health forward. These ideas have been passed on within the tradition of historical materialism, outlining how modes of production impact politics, economics and society, thus impacting health. In essence, a discussion of the causes of health, or the determinants of health, is very often a discussion of the structural determinants of health (Raphael, 2005).

Similarly, in the 1960s and early 1970s, a move away from Gross Domestic Product (GDP) as the sole determinant of the well-being of a nation or population furthered the movement of broad, or social, determinants of health. During this time, the broad concept of health and its causes was moved forward, as much of the global focus turned from emphasizing economic determinants to searching for social determinants that affect or determine health. Prior to this time, measures like GDP were prioritized in determining how a population was doing (Beavon et al, 2007). Researchers began to realize, however, that a high GDP does not necessarily translate into a high standard of living for the population (Beavon et al, 2007). It was within this climate—this broader understanding of the determinants of health—that several key documents were written and several key initiatives began.

Researchers began searching for an understanding of why different socio-economic groups had different levels of health. This search led to the creation of the term ‘social determinants of health.’ The social determinants of health (SDOH) approach is now commonly accepted. Researchers and policy analysts alike acknowledge that forces greater than medical and behavioral factors impact health (Raphael, 2006).

Within the SDOH framework, an individual does not have control over the primary influencers of his or her health. For example, the ‘traditional’ tips for good health may include the following:

- Don’t smoke.
- Keep physically active.
- Eat a balanced and healthy diet.

In contrast, a similar list for the SDOH approach would include:

- Don’t be poor.
- Don’t have poor parents.
- Own a car.
- Don’t live next to a polluted area or a busy road.
- Don’t have a low-paid and stressful job.

(Raphael, 2006)

Over the past two decades, there has been a surge of interest in the social determinants of health, particularly in North America and other English-speaking countries. It has become clear that any adequate discussion of health determinants must bear witness to the social determinants of health (Raphael, 2005).

There is substantial evidence supporting the use of a SDOH approach. For example, a study by Statistics Canada looked at predictors of life expectancy and the existence of fair or poor health among residents across Canada. It was found that while behavioural factors like obesity were weak predictors of health, socio-demographics factors (being Aboriginal, of a visible minority, unemployed, etc.), were stronger predictors. For example, obesity predicted 10 per cent of self-reports of poor or fair health, while socio-demographic factors predicted 25 per cent (Raphael, 2005).

The social determinants of health approach is widely used and prioritized in a variety of venues around the world. For example, in March 2005, the World Health Organization (WHO) launched the WHO Commission on Social Determinants of Health to address health inequities within and between countries. The Commission has contributors from all geographic regions of the world, including Canada. In Canada, a group was created to support the Commission called the Canadian Reference Group (Public Health Agency of Canada, 2006).

Social Determinants of Health in Canada

Canada has a comprehensive history in the work of health determinants¹, particularly in the population health field. In 1981, Canada's then Minister of National Health and Welfare Mark Lalonde, wrote a paper entitled *A New Perspective on the Health of Canadians*, which revitalized the idea that there are many underlying causes of ill health and mortality completely outside of the health care system. Lalonde recognized that the health care system is only one of the many ways to maintain and improve the health of Canadians (1981).

In 1986, Jake Epp, then Minister of Health and Welfare, presented a proposed health promotion framework for Canada at the First International Conference of Health Promotion in Ottawa. The principles of health promotion were very similar to the ideas of population health. Both are committed to reducing inequities in order to improve health. The Minister's framework also emphasized prevention and the necessity to increase people's "capacity to cope" (not only with mental and physical health illnesses and conditions, but also with daily stresses). Three "mechanisms intrinsic to health promotion" are self-care (decisions and practices a person takes to preserve his or her health), mutual aid (how we help each other cope), and healthy environments (including making surroundings and conditions conducive to health) (Epps, 1986).

In Canada, there have been many other health determinant frameworks embracing the social determinants of health. In 1986, the Ottawa Charter for Health Promotion called the determinants or "prerequisites for health" peace, shelter, education, food, income, and so on. In 1996, Tarlov looked at inequality in housing, education, etc., and its relation to disease-related processes. The Canadian Institute of Advanced Research identified determinants of health, which includes many social determinants. (Etches et al, 2006). More recently, Dr. Dennis Raphael of York University synthesized these, and other works, in order to compile 11 key social determinants of health. These include: Aboriginal status, early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion, and unemployment and employment security (2004).

Currently, Canada's major federal health bodies, Health Canada and its agency, the Public Health Agency of Canada, include information on population or social determinants of health on their websites. The Health Canada (2007) website includes information on the population health approach, and the Public Health Agency of Canada (PHAC) lists 11 determinants of health: income and social status; social support networks; education; employment and working conditions; social environments; geography; physical environments; healthy child development; health services; gender; and culture (2003).

¹ Raphael notes that while Canada has made significant contributions to the SDOH field in the form of writing reports, it has not been as successful in implementing a SDOH approach in practice (2006).

First Ministers' Meeting

In 2000, the First Ministers' Communiqué on Health inadvertently led to the eventual development of Aboriginal-specific health determinants (Health Canada, 2006).

At that time, they prioritized the development of a comprehensive health determinants framework, to be consistent across federal, provincial and territorial jurisdictions. This common set of health determinants, The Comparable Health Indicators, is used to report on the status of the population (Health Canada, 2006).

In 2002, all 14 jurisdictions across Canada released reports on an agreed-upon set of 67 health determinants (Health Canada, 2006).

In 2003, the First Ministers' Accord on Health Care Renewal amended this set of determinants into a set of 70 determinants. Published in 2004, *Healthy Canadians – A Federal Report on Comparable Health Indicators* reports on 18 of the 70 determinants. These 18 determinants were selected by federal, provincial and territorial governments for inclusion in the report (Health Canada, 2006).

By 2006, the list still included a set of 70 determinants for data collection (Canadian Institute for Health Information, 2006).

Though the Comparable Health Indicators are relevant for the general population in Canada, it was recognized that some determinants are not relevant or culturally appropriate for Aboriginal populations. Additionally, data for all determinants are not available for all Aboriginal populations in Canada. In 2003, the First Ministers agreed that a framework was needed for Aboriginal Peoples. This led to the beginning of work on the Aboriginal Health Reporting Framework (AHRF), with input and collaboration Canada's Aboriginal Peoples (Métis National Council, 2006).

Indigenous-Specific Health Determinants

There is a growing body of literature that advocates using and promoting indigenous frameworks to conduct research with Aboriginal and indigenous communities. Because health is not often a straight-forward individualistic idea for most Indigenous Peoples, the best way to understand the health of Indigenous Peoples is through their eyes and within their parameters and frameworks. For many indigenous populations, health is a communal concept, which has clear implications for understanding determinants of health. For instance, spirituality, relation to the land, and identity are often connected within ideas of overall health, meaning all would have to be incorporated into a framework for determinants of health (Nettleton, 2007).

The need for indigenous-specific determinants has been echoed by many, including the United Nations Permanent Forum on Indigenous Issues, that saw it was a priority to ensure determinants are developed in accordance with the perceptions and aspirations of

Indigenous Peoples. The Forum further identified the need for such culturally-specific determinants to be developed jointly with Indigenous Peoples (Beavon et al, 2007).

Canada's Aboriginal People

A social determinants of health understanding of health determinants is a common approach to indigenous health. At the WHO Commission on Social Determinants of Health, many Aboriginal organizations, researchers and experts stressed the importance of “adopting a social determinants lens to understanding and addressing health inequalities that exist for Aboriginal peoples and communities” (NCCAH, 2007).

Although differences exist between Aboriginal groups in Canada, there are also commonalities in recognized factors of health, including self-determinants, colonization and poverty. Other commonalities in perceptions of health and well-being include the belief that good health includes both positive elements (energy, spiritual strength, etc.) and the absence of negative elements, as well as holistic frameworks. Often, the well-being of Aboriginal people is seen as connected to the well-being of community, society and the world (NCCAH, 2007).

Canada recognized the need for Aboriginal-specific health determinants through the experience of the First Ministers meeting and the creation of the Comparable Health Indicators (CHI). From this set of determinants for the general population in Canada (CHI) came an initiative for Aboriginal people to be a part of, or create, a specific health determinants framework relevant to Aboriginal issues, needs and beliefs. This initiative resulted in the Aboriginal Health Reporting Framework, which was essentially completed by 2005. Although the framework may be not equally applicable to First Nations, Inuit and Métis populations *in all manners*, it is a reasonable first step. A report by the Métis National Council (MNC) said the Framework was a useful foundation for MNC activities, particularly in relation to the Aboriginal Health Blueprint Initiative² (2006).

Lessons for Métis Social Determinants of Well-being

Literature Review

In order to further explore the idea of a best fit for Métis, an intensive literature scan was conducted. This scan revealed several key points and recommendations that are worth keeping in mind when developing a collection, or framework, of determinants of health. Many of the same recommendations were reiterated by different key players. Those recommendations that were deemed relevant to Métis, meaning they fell within the

² Canada's *Blueprint on Aboriginal Health* (as cited in NCCAH, 2007) outlines a population health approach incorporating social determinants of health that addresses determinants like housing; education; food security; violence against Aboriginal women, children and elders, and the environment.

context of Métis life in Canada and fit within Métis priorities, have been grouped into a simplified visual representation (Figure 3.0).



Figure 1.0

The literature scan revealed several key principles or beliefs to be embraced throughout the work of developing a framework of determinants. Those of particular relevance to Métis are as follows: holistic, intertwined and fluid determinants, well-being driven, and culturally/contextually relevant (Figure 1.0).

Holistic means using an approach that is not individualistic. Health and well-being can include that of the individual, family, community, neighbourhood, and nation, across many demographics: Elder, adult, youth, child and infant. Any adequate Métis health determinants framework must account for all dimensions.

Intertwined refers to the interplay between all variables. None are static and none can stand alone.

Fluid explains the malleability of determinants or indicators. They must be able to change to adequately reflect the reality for Métis. For example, typical variables of education will prove inadequate for Métis if such variables do not also include informal education and lifelong learning.

Well-Being driven is a principle often heard within indigenous literature, and heard very often from Métis. Too often research is deficits-driven, ignoring both the progress made and the many successes.

Culturally and contextually relevant is a common sense principle. Any determinants used must be deemed relevant to Métis and be in keeping with the needs and priorities of Métis.

These overarching principles must form the thought behind a Métis health determinants framework. They are the combined lessons learned from the thorough literature search. They are also highly relevant within the Métis population.

The central components found in the literature scan include: self-determination, colonization, spirituality, land, and culture and tradition. These themes or components are very meaningful to Métis and can be used to form the basis of a Métis health determinants framework (Figure 2.0).

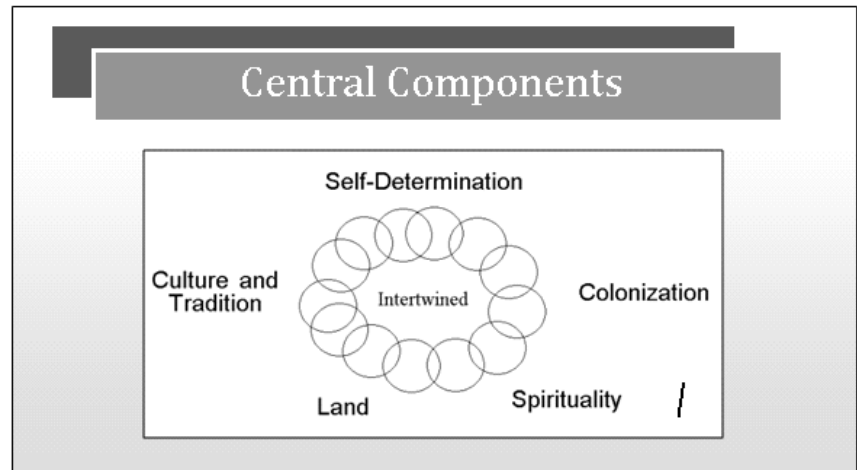


Figure 2.0

Self-determination is an ever-increasingly common health determinant for the world's Indigenous Peoples, as is the impact of **colonization**. Both have had, and continue to have, a tremendous potential in affecting the well-being and health of Métis in Canada. There is a considerable body of work mounting on the impact of self-determination on the health of Indigenous Peoples, and there is a wealth of information speaking volumes to the negative impact of colonization, or attempted genocide, on Canada's Aboriginal People. These are clear determinants of health.

Spirituality, while a very difficult and heterogeneous matter for Métis, is still highly relevant to health and well-being. Often it is by the population's definition of well-being that spirituality gains precedence. Spirituality is an important part of life for Métis, as it is with most indigenous populations. As Métis are highly diverse, and since spirituality is highly personal, this may be a difficult determinant to adequately capture. Not only does this concern vastly different forms of spirituality, say Cree versus Roman Catholic, but also individual differences within religions.

It would be difficult to underestimate the importance of **land** to many Indigenous Peoples, with Métis as no exception. While land may be a complicated issue for Métis, since many do not have a legal land base, it is still a very important consideration. Even though many Métis live in urban centres, nearly all feel a deep connection to the land, one that may be interpreted as a relationship of stewardship over ownership. Such importance to the population cannot be overlooked when examining well-being.

Culture and tradition are similar to spirituality in that they are highly personal components with no uniform definition. Culture and tradition are fluid concepts and often change over the lifespan. It is not an easy theme to capture within health determinants, however, it is a necessary determinant for health. Essentially, this is asking the near impossible questions, “what does it mean to be Métis?” and “how do you act out what it means to be Métis?”

Obviously this graphic cannot capture all of the lessons learned from the literature scan, but it does adequately summarize the key messages that are relevant to Métis determinants. The same messages were iterated repeatedly by researchers and by indigenous populations. These arise from their recommendations.

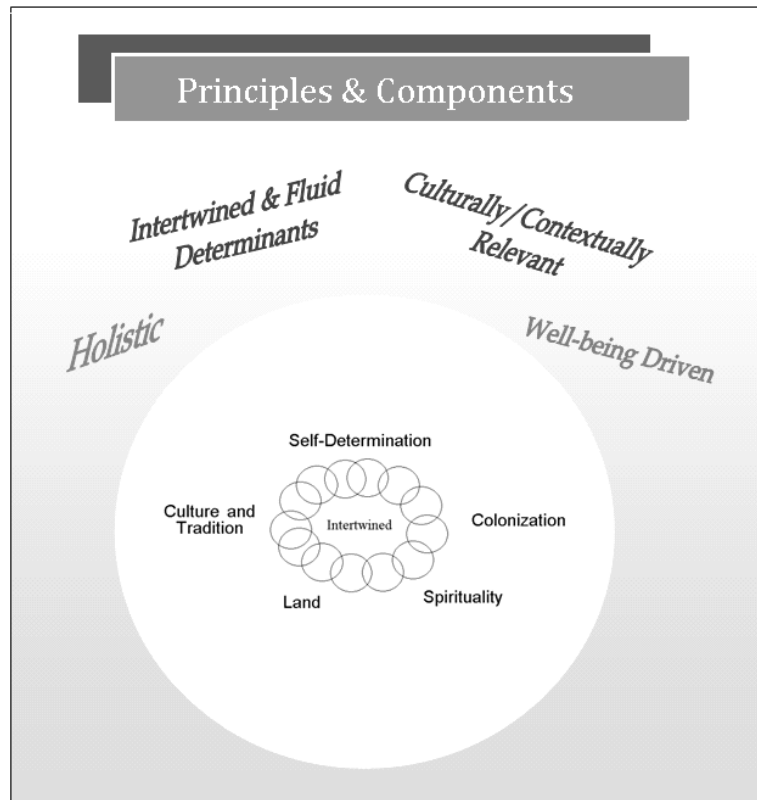


Figure 3.0

The central components of ‘Lessons Learned’ are very strong and important themes for indigenous populations, and are in line with the priorities and needs of Métis. These components, along with the overarching principles, can begin to frame a thorough health determinants framework for Métis research.

Métis Priorities

In 2007, the Métis Centre of the National Aboriginal Health Organization (NAHO) coordinated and hosted a think tank, *Métis Health: Culture, Identity, History*, that brought together Métis from across Canada. Through the voices of the participants, we were able to identify a number of priorities for Métis. Major themes or priorities identified throughout the think tank included:

- The impacts of colonialism and dispossession on Métis health and identity.
- The importance of emphasizing the strength of Métis communities and the healing that has occurred.

- Education as a means for improving Métis health.
- The necessity for Métis-specific data, research and programming.
- Concerns over the potential loss of historic Métis knowledge.
- How a lack of Métis rights has impacted the well-being of Métis.

These priorities are similar to the principles and central components identified in the literature scan. In coupling these priorities with the lessons learned from the literature scan, it is possible to create a collection of Métis determinants of health.

A Métis Social Determinants of Well-being

Understanding how Métis think of health or well-being is important on various levels. It means we can more effectively target programs and services to Métis. It also means we can provide a more complete portrait of how Métis currently are and how we've progressed.

Of course not all Métis experience the same realities, and not all view health and well-being in the same way. Given the diversity within the Métis population, some of which may be related to geography, it is not possible to create a framework of well-being or health that will be relevant and meaningful to every Métis. That said, it is possible to use the lessons learned from the literature scan and the identified Métis priorities to begin to understand what determinants will be important within concepts of Métis well-being.

According to the voices of Métis within the think tank, the main determinants of Métis well-being can be best summarized on a continuum of past to future. Such a continuum fits with the lessons learned from the literature scan. It is both interesting and undeniable that the Métis

priorities identified demonstrate how crucial it is to include historical determinants in Métis portraits of health. This continuum iterates the importance of understanding the shared history of Métis, in order to understand both the present condition and the future.

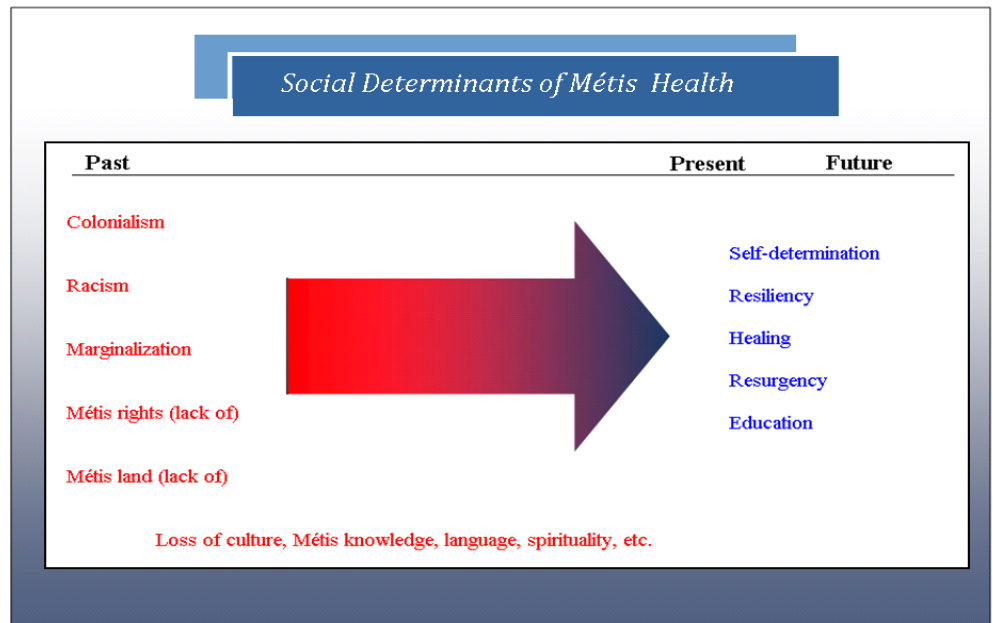


Figure 4.0

This continuum demonstrates that the ‘social’ determinants of Métis health are not only social, but are primarily and more specifically political and historical. As opposed to being a framework, this continuum—and indeed this paper—is a first step towards a Métis framework of health. As mentioned previously, the vast diversity within the population requires that any framework or template needs intensive consultation with Métis across Canada. Without such consultation and feedback, a framework of health would not adequately reflect the stories of all Métis. This paper provides the tools for Métis to tell their own stories and to create their own frameworks.

The difference between indicator frameworks is really in the tools you apply to the data and how you organize it. It's really in the story you tell. It's in the knowledge translation process. Data is simply one tool for telling this story. At a certain point, you need to accept that current data sets cannot tell the entire story. The story can be filled in by people with knowledge of context, as well as, by other sources and types of knowledge.

– Patricia J. Martens PhD, Director, Manitoba Centre for Health Policy; CIHR/PHAC Applied Public Health Chair; Associate Professor, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.

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