Congress of Aboriginal Peoples

Social Determinants of Indigenous Health

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1. Executive Summary

This report describes three levels of social determinants of health (SDOH) and their influence on the health of CAP's constituency. Social determinants of health are socio-economic conditions and factors that influence health outcomes. For Indigenous peoples in Canada, social determinants of health cause overwhelmingly negative effects on physical, mental, and community well-being.[1] As the world wrestles with the effects of the COVID-19 pandemic, it is crucial to consider the health needs of CAP's constituency.

In 2011, the life expectancy for Indigenous peoples at age one was from 4.5 to 11.2 years shorter than for non-Indigenous peoples.[2] Despite the fast pace of medical advances and modern health care delivery in Canada, Indigenous people suffer disproportionately from preventable and treatable illnesses and conditions.

The key findings of this report are as follows.

- There are three main levels of SDOH: systemic, structural, and individual. For CAP's constituency, the systemic-level factor that informs and determines all others is colonialism.[3]
- Each level of factors has unique negative impacts on the health of Indigenous peoples. These impacts are well-documented in academic research and Statistics Canada publications.[4]
- To address health inequality in Canada, it is crucial to understand how the systemic factor of colonialism is related to the others. Health reforms that do not consider the specific needs of Indigenous peoples are not as effective as those that do.[5]

[1] Sarah Nelson, "CHALLENGING HIDDEN ASSUMPTIONS: Colonial Norms as Determinants of Aboriginal Mental Health," 2012, 16.
[2] Statistics Canada Government of Canada, "Life Expectancy of First Nations, Métis and Inuit Household Populations in Canada," December 18, 2019, https://www150.statcan.gc.ca/n1/pub/82-003-x/2019012/article/00001-eng.htm.
[3] Charlotte Reading and Fred Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health," 2009, 36.
[4] Statistics Canada Government of Canada, "Health Indicators, by Aboriginal Identity, Four-Year Period Estimates," May 10, 2018, https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310045701; Mohammad Hajizadeh et al., "Socioeconomic Inequalities in Health among Indigenous Peoples Living Off-Reserve in Canada: Trends and Determinants," *Health Policy* 122, no. 8 (August 2018): 854–65, https://doi.org/10.1016/j.healthpol.2018.06.011.
[5] Reading and Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health."

- Racism and discrimination within institutions like the child welfare, criminal justice, and health care systems cause and exacerbate physical and mental illnesses in Indigenous peoples.[6]

This March 2020 CAP report, "Social Determinants of Indigenous Health," will inform the organization's ongoing advocacy work to improve the health of off-reserve Indigenous peoples. It represents both qualitative and quantitative research on social determinants of health for our constituency and concludes with recommendations for CAP's work going forward. For more information on the relationships between health, housing, child welfare, criminal justice, the environment, international relations, or language and culture, please see the other March 2020 CAP policy research reports.

[6] Stephen Cudmore, "Indigenous Overrepresentation in the Justice System" (Congress of Aboriginal Peoples, March 2020).

2. Fact Sheet: Social Determinants of Indigenous Health

- In Canada, the systemic social determinant of health that underlies and informs all others is colonialism. The federal government and settler society have forcefully imposed socio-economic inequalities, intergenerational trauma, and systems of discrimination on the Indigenous peoples of this continent since colonies were first established and continue to do so today.[7]
- The Residential Schools of the mid 1800s to 1996 are one example of colonialism's impact on health. Survivors of the Residential Schools have higher rates of mental and physical health problems than Indigenous adults that did not attend.[8] Intergenerational trauma as a result of these programs also directly causes adverse health outcomes.[9]
- In 2011, the life expectancy for Indigenous peoples at age one was from 4.5 to 11.2 years shorter than for non-Indigenous people.[10]
- Indigenous peoples are disproportionately affected by food insecurity in Canada, partly due to historical separation from resources like hunting and gathering patterns. 20.7% of Indigenous households experienced food insecurity from 2007 to 2010 compared to 6.8% of non-Indigenous households.[11]
- There is a growing gap between the education attained by Indigenous children and non-Indigenous children. Appropriate education has been empirically tied to improved health outcomes.[12]
- Indigenous peoples do not have regular access to doctors at the same rates as non-Indigenous peoples (67.4% of Indigenous people report a regular doctor, compared to 85.1% of non-Indigenous people).[13] This is caused by inadequate health care delivery systems as well as racist beliefs held by health care providers.[14]
- Unemployment, poverty, and housing need among Indigenous peoples are growing. From 2001 to 2012, the extent of absolute income-related inequalities in health increased by 42% for off-reserve Indigenous people in Canada.[15]

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[7] Paul J. Kim, "Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System," *Health Equity* 3, no. 1 (January 1, 2019): 378–81, https://doi.org/10.1089/heq.2019.0041.,

[8] Amy Bombay, Kimberly Matheson, and Hymie Anisman, "The Intergenerational Effects of Indian Residential Schools: Implications for the Concept of Historical Trauma," *Transcultural Psychiatry* 51, no. 3 (June 2014): 323, https://doi.org/10.1177/1363461513503380.

[9] Bombay, Matheson, and Anisman, "The Intergenerational Effects of Indian Residential Schools."

[10] Government of Canada, "Life Expectancy of First Nations, Métis and Inuit Household Populations in Canada."

[11] Government of Canada, "Health Indicators, by Aboriginal Identity, Four-Year Period Estimates."

[12] Reading and Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health."

[13] Government of Canada, "Health Indicators, by Aboriginal Identity, Four-Year Period Estimates."

[14] Environics Institute, *Urban Aboriginal Peoples Study: Main Report.* (Toronto, Ont.: Environics Institute, 2011), http://www.deslibris.ca/ID/228457; Ashley Goodman et al., "'They Treated Me like Crap and I Know It Was Because I Was Native': The Healthcare Experiences of Aboriginal Peoples Living in Vancouver's Inner City," *Social Science & Medicine* 178 (April 2017): 87–94, https://doi.org/10.1016/j.socscimed.2017.01.053.

[15] Hajizadeh et al., "Socioeconomic Inequalities in Health among Indigenous Peoples Living Off-Reserve in Canada"; Jesse Thistle, "Definition of Indigenous Homelessness in Canada," Canadian Observatory on Homelessness, 2017, https://www.homelesshub.ca/sites/default/files/attachments/COHIndigenousHomelessnessDefinition.pdf; Reading and Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health."

3. Introduction

Almost 20 years ago, the World Health Organization (WHO) began using social factors to explain health inequalities. In a 2003 report, WHO suggested that socio-economic conditions like employment, social exclusion, and transportation had direct impacts on health.[16] Likewise, Indigenous peoples across Turtle Island have always understood the relationships between physical health and other aspects of life, such as environment, mental well-being, safety, education, and culture.[17] In 2018, the CAP Political Accord emphasized a commitment to "research plans and policies in a post-Daniels context to help determine needs and program and service gaps, and improve access to existing programs and services for Non-Status and other off-reserve Indigenous peoples in such areas as housing, education, [and] health."[18] As CAP continues to advocate for policies that address the health of its constituency on a federal level, it is important to understand what exactly social determinants of health are.

Social determinants of health (SDOH) are factors that influence a wide range of health conditions. Their impacts can compound on one another, so that they both influence health outcomes and produce new health issues.[19] For example, living with a low income can make treatment for an illness inaccessible, which impacts an individual's ability to find employment and raise their income.[20] Broadly, SDOH can be categorized into three main levels. These levels

[16] Richard Wilkinson and Michael Marmot, eds., *The Solid Facts: Social Determinants of Health*, 2nd ed (Copenhagen: WHO Regional Office for Europe, 2003).
[17] Jacqueline M Quinless, "Indigenous Well-Being in Canada: Measuring Wellness in the Context of Knowledge Networks, Interconnectedness, and Social Change," *The Global Studies Journal*, 2015, 14.
[18] Cite political accord
[19] Reading and Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health," 2.
[20] Nelson, "CHALLENGING HIDDEN ASSUMPTIONS: Colonial Norms as Determinants of Aboriginal Mental Health," 10.

can be conceptualized as a tree (see Figure 1).

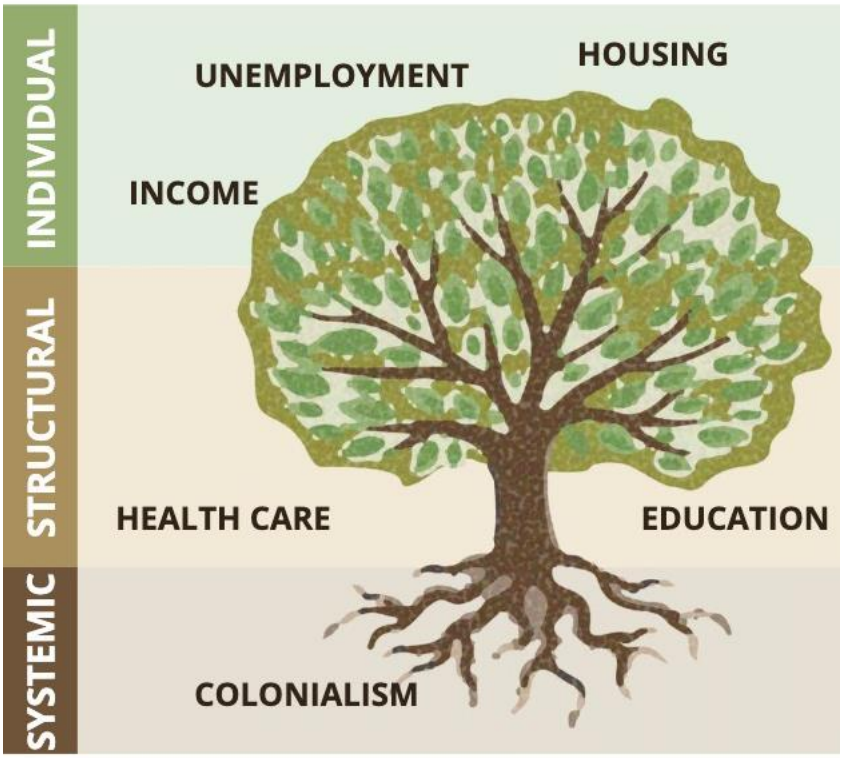

Figure 1. Social determinants of health as a tree, produced by Ashley Grenstone and Maeanna Merrill

At the root of the tree, informing and feeding all other SDOH, are the systemic factors. These overarching systems and institutions can be political, social, or economic. When discussing SDOH for Indigenous people in Canada, the main systemic factor of concern is colonialism.[21]

The trunk of the tree represents structural factors. These SDOH are health care systems, infrastructure of communities, and available resources. They cannot be separated from the systemic factors, as the roots of a tree provide fundamental support for the trunk.[22]

Finally, the leaves and branches of the tree represent individual-level factors. These SDOH are the factors that are most obviously linked to health, like physical environments, socio-economic conditions, and health behaviours like drug use or exercise habits. The systemic and

[21] Nelson, "CHALLENGING HIDDEN ASSUMPTIONS: Colonial Norms as Determinants of Aboriginal Mental Health.", 10
[22] Nelson, 10.

structural factors affect and shape the individual-level factors in the same way that the roots and trunk of a tree feed and support the leaves.[23]

As CAP advocates for policies and programs that address SDOH, it is crucial to remember the relationships between each of the three levels of the tree. For example, CAP may choose to support a program that addresses diet in off-reserve non-status Indigenous youth. Diet is a health behaviour and an individual-level SDOH. However, a program that simply focuses on diet without exploring structural and systemic SDOH will only address the leaves of the tree. This hypothetical program must also acknowledge the role of food systems, a structural SDOH in diet. It is possible that the target population for this program does not have access to healthy and affordable food options, which may cause a poor diet. In addition, the program must consider the role of colonialism, a systemic SDOH. It is probable that one cause of the limited access to healthy food in this population is historical and modern-day colonial separation from lands that provide both economic resources and the ability to hunt and harvest. In order to have the greatest effect, CAP must consider each of the three levels of the tree of SDOH when evaluating and creating health policy.

4. Social Determinants of Health

As CAP is the national representative organization for off-reserve status and non-status Indian, Métis and Southern Inuit Indigenous Peoples, it is important to discuss how SDOH create health inequities between our constituents and the non-Indigenous peoples in Canada. The peoples of CAP's constituency are by no means homogenous, and SDOH have varying effects in different communities, but it is possible to identify some broad trends in health inequities across Canada.

Systemic Factors

In Canada, the systemic social determinant of health that underlies and informs all others is colonialism. The federal government and settler society have forcefully imposed socio-economic inequalities, intergenerational trauma, and systems of discrimination on the Indigenous peoples of this continent since colonies were first established, and continue to do so today.[24] In

[23] Nelson, 10.
[24] Kim, "Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System.",

addition to being the basis of other levels of SDOH, colonialism itself has direct impacts on Indigenous health.[25] In this section, we will focus on colonialism's direct impacts on health. In later sections on structural and individual-level factors, we will unpack the ways in which colonialism is at the root of other SDOH.

Through colonial programs like the Residential Schools, the Canadian government imposed health issues on Indigenous people across the country. Individuals with direct contact with these institutions suffered physical and mental abuse at the hands of the state, decreasing their overall health. Even now, survivors of the Residential Schools have higher rates of mental and physical health problems than Indigenous adults that did not attend.[26] In addition to causing harm to survivors, these institutions created intergenerational trauma, defined as historical stressors and trauma that began in the past and that contribute to decreased well-being in the modern-day, in the families of survivors. [27] For example, an individual's attendance at an Indian Residential Day School is explicitly tied to the health outcomes of their family. In a 2014 study of off-reserve Aboriginal people, it was found that the more generations of a family that attended Residential School, the poorer the overall psychological well-being of the following generations.[28] In this way, historical colonialism created modern health inequities in modern-day Canada.

Colonialism in its present form also creates health inequities. This is done in part through the child welfare and criminal justice institutions, which "are grounded in colonial objectives and assimilationist policies that separate families and remove Indigenous people from their land and culture."[29] Like the colonial programs of the past, modern day institutionalization of Indigenous peoples severs individuals and families from the capacity to establish stable and healthy lives.

The child welfare system institutionalizes Indigenous peoples at a young age. Today, it is estimated that over half of the children in the Canadian child welfare system are Indigenous, despite accounting for only 7.7% of the child population.[30] There are more Indigenous children

[25] Reading and Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health," 23.
[26] Bombay, Matheson, and Anisman, "The Intergenerational Effects of Indian Residential Schools," 323.
[27] Bombay, Matheson, and Anisman, 321.
[28] Bombay, Matheson, and Anisman, 331.
[29] Megan Sinclair and Shelagh Roxburgh, "Justice" (Congress of Aboriginal Peoples, April 2020).
[30] Ontario Human Rights Commission, "Interrupted Childhoods: Over-Representation of Indigenous and Black Children in Ontario Child Welfare," Ontario Human Rights Commission, February 2018, http://Indigenous.ohrc.on.ca/en/interrupted-childhoods.

in care now than there were at the height of the use of Residential Schools.[31] This inequity is caused by the racist and colonial ideas that inform much of modern child welfare policy, including the paternalistic belief that removing children from their homes protects them from the perceived deviance of Indigeneity.[32] As a result of modern child welfare policy, Indigenous children suffer adverse health outcomes. Removal from homes causes trauma and increases the chances a child will be exposed to negative outcomes. While in care, children are vulnerable to sexual violence and exploitation. These conditions place Indigenous children at higher risk of long lasting mental and physical health problems.[33] In addition, involvement in the child welfare system is the single greatest predictor of future incarceration.[34] Therefore, institutionalized Indigenous children are placed in danger of even more health issues in what is known as the "child-welfare-to-prison-pipeline."[35] For more information, please consult the April 2020 CAP publication "Child Welfare."

The criminal justice institution of Canada also acts as a modern colonial systemic SDOH. Through all levels of the system, Indigenous peoples are subject to discrimination: they are more likely to be denied bail and more than twice as likely as non-Indigenous Canadians to be incarcerated.[36] Likewise, Indigenous children are statistically more likely to be involved in the criminal justice system than they are to graduate from high school.[37] Mental health is intrinsically tied to this systemic inequality. Indigenous people often end up in conflict with the justice system as a result of untreated mental health problems including addictions and trauma.[38] These untreated mental health problems are often caused by other colonial systems, like involvement in the child welfare system or intergenerational trauma. While incarcerated, prisoners experience new trauma and lack resources and treatment for addictions and mental health problems.[39] Thus, the criminal justice system erodes the mental and physical health of communities it proports to

[31] Ontario Human Rights Commission.
[32] Sinclair and Roxburgh, "Justice."
[33] Megan Sinclair and Shelagh Roxburgh, "Child Welfare" (Congress of Aboriginal Peoples, April 2020).
[34] Cudmore, "Indigenous Overrepresentation in the Justice System."
[35] Sinclair and Roxburgh, "Justice."
[36] Sinclair and Roxburgh.
[37] Sinclair and Roxburgh.
[38] Cudmore, "Indigenous Overrepresentation in the Justice System."
[39] Cudmore.

protect. For more information, please consult the March 2020 CAP publication "Indigenous Overrepresentation in the Justice System."

Structural Factors

Structural factors are SDOH like health care systems, infrastructure of communities, and available resources, including education and broad environmental conditions. Like systemic factors, these SDOH inform and shape individual-level SDOH.[40] Structural SDOH influence health conditions and create health issues on a medium scale.

Food systems and access to appropriate and healthy food are often cited as an important SDOH.[41] In 2011, more than 12% of Canadian households experienced food insecurity. Food insecurity, defined by Statistics Canada as being unable to afford necessary food at some point in the 12 months before the survey,[42] can cause health issues like malnutrition, obesity, or a compromised immune system.[43] Indigenous peoples are disproportionately affected by food insecurity in Canada. According to the Canadian Community Health Survey, food insecurity was more prevalent for Indigenous people than non-Indigenous people from 2007 to 2011 (see Figure 2). Food insecurity, like all structural SDOH, has roots in colonialism. Robust and affordable food options are difficult to access for many Indigenous people due to historical separation from hunting, gathering, and mobility patterns.[44] Likewise, colonial programs like the Residential Schools left lasting impacts on families, so that off-reserve Indigenous children whose parents attended Residential Schools are more likely to grow up with food insecurity than those who did not.[45]

[40] Nelson, "CHALLENGING HIDDEN ASSUMPTIONS: Colonial Norms as Determinants of Aboriginal Mental Health."
[41] Kim, "Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System"; Durdana Islam and Fikret Berkes, "Indigenous Peoples' Fisheries and Food Security: A Case from Northern Canada," *Food Security* 8, no. 4 (August 2016): 815–26, https://doi.org/10.1007/s12571-016-0594-6.
[42] Statistics Canada Government of Canada, "Food Insecurity in Canada," March 25, 2015, https://www150.statcan.gc.ca/n1/pub/82-624-x/2015001/article/14138-eng.htm.
[43] Government of Canada.
[44] Jesse Thistle, "Definition of Indigenous Homelessness in Canada," Canadian Observatory on Homelessness, 2017, https://Indigenous.homelesshub.ca/sites/default/files/attachments/COHIndigenousHomelessnessDefinition.pdf.
[45] Bombay, Matheson, and Anisman, "The Intergenerational Effects of Indian Residential Schools," 325.

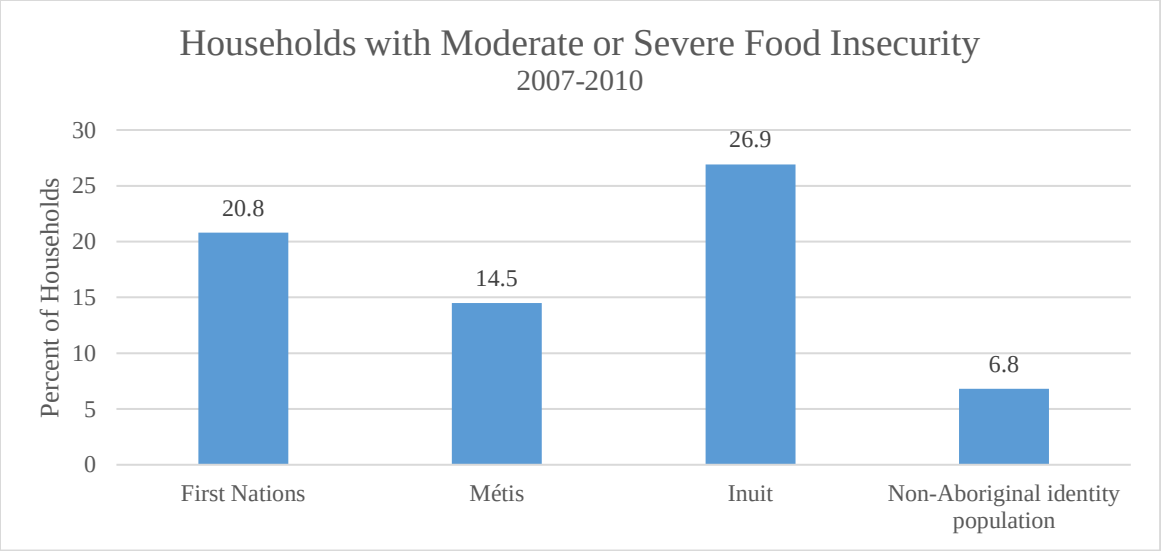

Figure 2. Food insecurity among Aboriginal identity populations, 2007-2010. Data from: Statistics Canada. Table 13-10-0457-01 Health indicators, by Aboriginal identity, four-year period estimates.

Educational systems and access to schooling are also empirically tied to health outcomes.[46] School can improve health in three main ways: education about health, physical education in schools, and education itself as a contributor to wellbeing.[47] As children learn about physical and mental health in school, they are better prepared to live healthy lifestyles. Therefore, an absence of appropriate education can have negative health benefits. According to the Office of the Child and Youth Advocate of Alberta, 2SLGBTQQIA+ youth are negatively affected by a lack of sexual health education in schools.[48] Likewise, access to physical education classes can improve the physical health of children.[49] Finally, there is an established link between education itself and health outcomes in life. Studies have shown that the process of learning and thinking can improve health outcomes.[50] In addition, education has an important relationship with employment and income, which are individual-level SDOH that directly impact health.[51]

[46] Reading and Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health," 19.
[47] Robert A. Hahn and Benedict I. Truman, "Education Improves Public Health and Promotes Health Equity," *International Journal of Health Services : Planning, Administration, Evaluation* 45, no. 4 (2015): 2, https://doi.org/10.1177/0020731415585986.
[48] Office of the Child and Youth Advocate Alberta, "Speaking OUT: A Special Report on LGBTQ2S+ Young People in the Child Welfare and Youth Justice Systems," November 2017, https://www.ocya.alberta.ca/wp-content/uploads/2014/08/SpRpt_2017November_Speaking-OUT.pdf.
[49] Hahn and Truman, "Education Improves Public Health and Promotes Health Equity."
[50] Hahn and Truman, 5.
[51] Reading and Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health."

Conversely, a lack of appropriate schooling or education that is used to harm children can worsen health tremendously. In Canada, historical federal efforts to educate Indigenous children were based in assimilationist colonial policies. At Residential Schools from the mid 1800s to 1996, education was used as a tool to "kill the Indian in the child," prepping children for manual labour rather than focusing on literacy and numeracy.[52] Programs and employees at federally-funded Residential Schools abused children for over a century, threatening their identities and well-being, but they also fostered a pervasive distrust of public educational systems in many Indigenous families. Many survivors of the Residential Schools and their families see schools as sites of abuse and trauma rather than growth and safety.[53] In addition, the experience of many Indigenous children in the education system today is characterized by deeply rooted racism and colonialism, preventing them from accessing the benefits of education afforded to white children.[54] School programs fail to introduce and build Indigenous identity, as most urban Indigenous people do not learn about Indigenous history and culture in elementary and high school.[55] Education systems on reserves also suffer from the colonial system, receiving 30% less funding than off-reserve school districts.[56] Education has been used as a tool of colonialism since the first Residential School and continues to threaten the health of Indigenous children today because "white privilege is written into the school landscape."[57]

Finally, health care systems themselves act as a structural SDOH that create health inequalities and health issues. According to the Canada Health Act, every person has the right to timely and appropriate health care.[58] However, that is not the case for many Indigenous peoples in Canada (see Figure 3).

[52] Geography Open Textbook Collective, "Case Study 1: The Indian Residential School System," in *British Columbia in a Global Context* (BCcampus, 2014), https://opentextbc.ca/geography/chapter/4-4-case-study/.
[53] Chinta Puxley, "Indigenous Parents More Fearful, Distrusting of Education System: Study | CBC News," CBC, August 17, 2016, https://www.cbc.ca/news/indigenous/indigenous-parents-more-fearful-of-education-system-1.3724785.
[54] Cathy Van Ingen and Joannie Halas, "Claiming Space: Aboriginal Students within School Landscapes," *Children's Geographies* 4, no. 3 (December 2006): 379–98, https://doi.org/10.1080/14733280601005856.
[55] Environics Institute, *Urban Aboriginal Peoples Study*, 117.
[56] Christopher Dart, "Bee Nation: First Nations Schools Are Chronically Underfunded," August 3, 2019, https://www.cbc.ca/cbcdocspov/m_features/first-nations-schools-are-chronically-underfunded.
[57] Van Ingen and Halas, "Claiming Space."
[58] "Canada Health Act," 1985, https://laws-lois.justice.gc.ca/PDF/C-6.pdf.

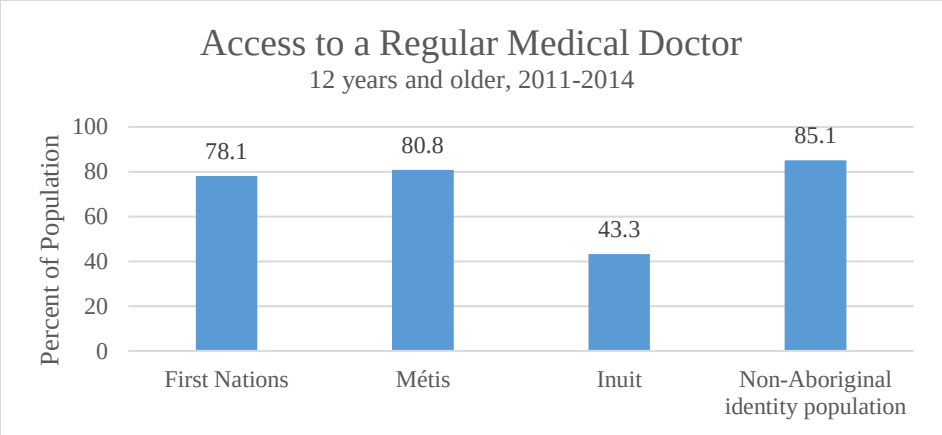

Figure 3. Access to a regular medical doctor among Aboriginal identity populations, 2007-2010. Data from: Statistics Canada. Table 13-10-0457-01 Health indicators, by Aboriginal identity, four-year period estimates.

The Canada Health Act states that health care provision and organization is primarily a provincial responsibility.[59] However, the 2016 *Daniels Decision* and the *Indian Act* place fiduciary responsibility for Indigenous peoples on the federal government.[60] This unique jurisdictional situation can create barriers for Indigenous peoples when attempting to navigate the already confusing system of health care. There is a lack of accountability for Indigenous health as the federal government negotiates with provincial governments on health care delivery. In a 2008 survey, when asked about negative experiences with services like health care, 29% of urban Indigenous respondents had problems with processing, paperwork, and fees.[61]

Moreover, Indigenous peoples face substantial barriers like discrimination and racism when attempting to access health care systems. These barriers are rooted in the systemic SDOH of colonialism, as discrimination is an important tool of colonial rule.[62] When Indigenous patients are finally able to navigate through the aforementioned jurisdictional complexities to meet with health care providers, they report discrimination based on race, socio-economic condition, and substance use. Urban Indigenous people report that non-Indigenous people hold a wide range of stereotypes, believing that Indigenous people lack intelligence, work ethic, and

[59] "Canada Health Act."
[60] Congress of Aboriginal Peoples, "Daniels Legal Case," accessed March 23, 2020, http://www.abo-peoples.org/project/the-time-is-now/.
[61] Environics Institute, *Urban Aboriginal Peoples Study*, 84.
[62] Nelson, "CHALLENGING HIDDEN ASSUMPTIONS: Colonial Norms as Determinants of Aboriginal Mental Health."

employment.[63] These stereotypes impact service delivery as providers view routine requests and obligations through a racist lens, believing patients to be scamming them for pain medication or to be acting in a dishonest way.[64]

In sum, structural factors interplay with systemic factors to create health inequalities for Indigenous peoples. Though there is no uniform solution to inequity, just as there is no uniform population of Indigenous people, it is important to understand some common themes in structural factors of SDOH.

Individual-level Factors

Finally, the leaves of the tree of SDOH will be addressed. Individual-level factors, like unemployment, housing, and income, are socio-economic conditions that have direct impacts on health. They are factors that shape an individual's daily life and that are supported by structural and systemic SDOH. The relationship between individual-level factors is also important, as they can inform and exacerbate one another. For example, living with a low income can cause health problems, but it can also make safe and appropriate housing inaccessible, which causes additional health problems.

Unemployment is widely regarded as one of the most significant individual-level SDOH.[65] It is directly related to physical and mental illness in the general population[66] and is significantly tied to other SDOH like education, income, and housing. In a quantitative study of data from the Aboriginal Peoples Surveys of 2001, 2006, and 2012, Hajizadeh, Bombay, and Asada demonstrated the strength of the link between unemployment and socio-economic driven health inequity.[67] Using a decomposition analysis, Hajizadeh et al isolated the effect of unemployment from the effects of variables like location, age, occupation, and educational attainment on the health of off-reserve Indigenous peoples in Canada. They showed that unemployment itself is responsible for 23.88% of all socio-economic based health inequality for

[63] Environics Institute, *Urban Aboriginal Peoples Study*, 74.
[64] Goodman et al., "'They Treated Me like Crap and I Know It Was Because I Was Native,'" 90.
[65] Hajizadeh et al., "Socioeconomic Inequalities in Health among Indigenous Peoples Living Off-Reserve in Canada."
[66] Kim, "Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System."
[67] Hajizadeh et al., "Socioeconomic Inequalities in Health among Indigenous Peoples Living Off-Reserve in Canada."

off-reserve Indigenous peoples.[68] This is consistent with other qualitative research,[69] and demonstrates the power of unemployment on health issues.

Housing is another significant individual-level SDOH. The quality of a physical structure can impact the health of a household through exposure to conditions like mold or overcrowding. Many physical structures inhabited by Indigenous families are in poor condition, according to Canada Home and Mortgage Corporation. In 2016, 18% of off-reserve Indigenous households were in core housing need, compared to 12% of non-Indigenous households. Core housing need refers to households that are below one or more of three housing standards (adequacy, suitability, and affordability) and that would need to spend 30% or more of their before-tax income to access other housing in the same community that meets all three standards.[70] In addition, overcrowding disproportionately affects Indigenous households, causing families to live in unsafe or unsanitary conditions. These poor housing conditions can have many detrimental health effects. For example, in the period of 2011 to 2014, the rate of Métis individuals aged 12 and older with asthma was 80% higher than the rate of non-Indigenous individuals.[71] Asthma can be caused by poor physical home conditions as well as exacerbated by them.[72] In addition, overcrowding in homes can contribute to stressors that generate or exacerbate health problems, like family violence and strain.[73]

Indigenous homelessness, which refers to more than just a lack of physical shelter, can also have extreme health impacts.[74] For more information on Indigenous homelessness, as well as the relationship between colonialism and housing need, please see the CAP report of March 2020, "Indigenous Homelessness and Housing Need."

The final individual-level SDOH discussed here is income. In the same quantitative analysis as mentioned above, Hajizadeh et al demonstrated that income inequality accounts for

[68] Hajizadeh et al.
[69] Reading and Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health."
[70] Amran Wali, "SOCIO ECONOMIC ANALYSIS: Housing Needs and Conditions – The Housing Conditions of Off-Reserve Aboriginal Households," March 2019, 28.
[71] Government of Canada, "Health Indicators, by Aboriginal Identity, Four-Year Period Estimates."
[72] Reading and Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health."
[73] Reading and Wien.
[74] Thistle, "Definition of Indigenous Homelessness in Canada."

29.41% of all socio-economic health inequality in off-reserve Indigenous peoples.[75] Income levels for off-reserve Indigenous peoples are lower than income levels for non-Indigenous peoples (see Figure 4), which has serious consequences for health. Poverty, which is directly informed by income, is associated with obesity and diabetes as well as social exclusion and increased crime levels. This is thought to be because poverty creates a lack of control over one's circumstances, causing anxiety and other psychosocial stress.[76] The negative effects of income inequality on health are only growing. From 2001 to 2012, the relative income-related inequality in health for off-reserve Indigenous men increased 7.6% and 35.4% for women.[77]

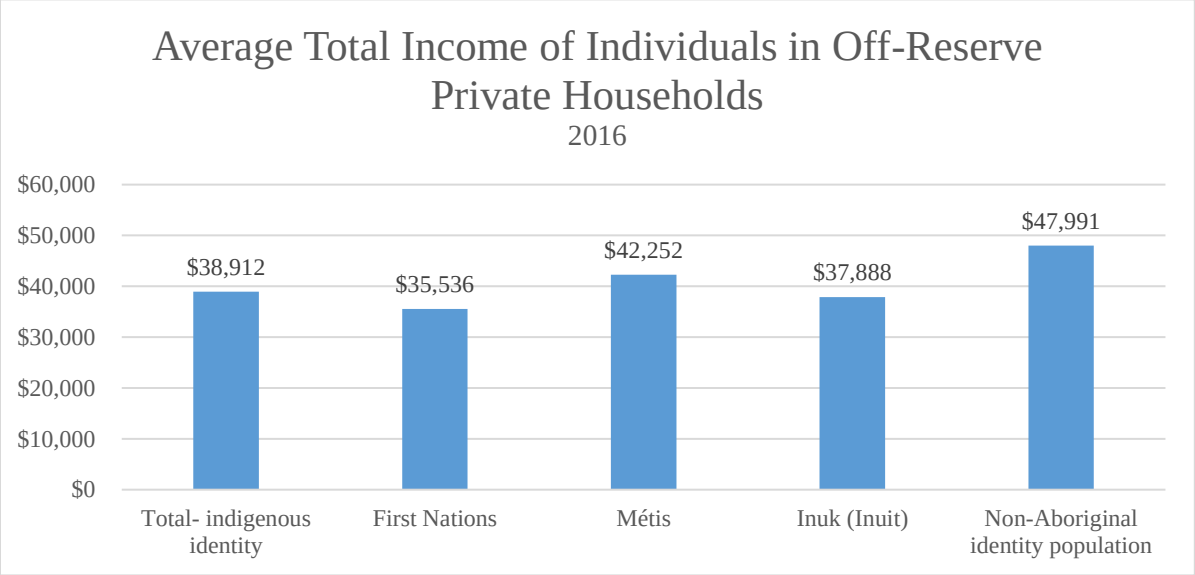

Figure 4. Average total income of individuals in off-reserve private households. Data from: Statistics Canada. *Aboriginal Population Profile*. 2016 Census. Statistics Canada Catalogue no. 98-510-X2016001.

Each of the individual-level factors discussed above must be understood in the context of our colonial society. The act of colonization forcefully separated Indigenous peoples across Canada from their livelihoods by seizing lands and destroying hunting, mobility, and gathering patterns.[78] Likewise, the cultural genocide of policies like the Residential Schools and the Sixties

[75] Hajizadeh et al., "Socioeconomic Inequalities in Health among Indigenous Peoples Living Off-Reserve in Canada."
[76] Reading and Wien, "Health Inequalities and Social Determinants of Aboriginal Peoples' Health."
[77] Hajizadeh et al., "Socioeconomic Inequalities in Health among Indigenous Peoples Living Off-Reserve in Canada," 854.
[78] Thistle, "Definition of Indigenous Homelessness in Canada."

Scoop caused substantial harm to generations of Indigenous peoples. Today, Indigenous peoples suffer from colonial policies within institutions like the child welfare and criminal justice systems as well as regular discrimination and racism. Therefore, individual-level factors are not personal failings, but rather the outcome of historical and modern-day colonialism. They must be framed in the history and reality of genocide and oppression, rather than in a neo-liberal sense of personal responsibility for one's conditions. To heal the individual-level factors of social determinants of health, or the leaves of the tree, we must heal the trunk and roots of the tree first.

5. Recommendations

The healing of the SDOH tree is a monumental task. It will require the collaboration of many different actors, as well as a fundamental shift the narrative around health inequity in Canada. To truly address all SDOH, action must be taken on all three levels.

Systemic Healing

At the root of all other SDOH, colonialism is responsible for Indigenous health inequity in Canada. The decolonization of all systems, spaces, and institutions is not only necessary, it is long overdue.

1. To heal the system, the federal government must accept responsibility for colonialism's impact on Indigenous health.[79] The government must acknowledge that negative health outcomes are a direct result of Canadian policies and that recognizing and implementing the full rights of Indigenous peoples is demanded under international, constitutional, and treaty law.[80,81] In the words of the Truth and Reconciliation Commission Call to Action number 18, "we call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of

[79] Kim, "Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System."
[80] Truth and Reconciliation Commission of Canada, "Truth and Reconciliation Commission of Canada: Calls to Action," 2015, http://nctr.ca/assets/reports/Calls_to_Action_English2.pdf.
[81] United Nations, "United Nations Declaration on the Rights of Indigenous Peoples," 2007, https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf.

previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people."[82]

Structural Healing

Time and time again, the government has shown its reluctance to take the necessary steps towards decolonization. In the meantime, CAP can advocate for changes on the structural level to advance the health of its constituency.

1. Advocate for health policy based on research that recognizes and addresses the underestimation of health inequities caused by specific and fixable data quality challenges. There are three main problems with the quality of national data on Indigenous health and well-being:
    a. National data sets like the Aboriginal Peoples Survey, the Census, and the National Housing Survey are not sufficient to identify the health needs of Indigenous peoples.[83] This is mainly due to the absence of robust, disaggregated estimates of health indicators for sub-populations like off-reserve or non-status Indigenous peoples. Most national data sets only provide information on a large scale, which makes it impossible to evaluate the health needs of distinct areas.[84] For example, it is common sense that a rural Indigenous community in Saskatchewan has different health care needs than the urban Indigenous population of Toronto, but due to the jurisdictional complexities of health care delivery and the absence of detailed health information systems, it is difficult to accurately represent the difference between the communities with quantitative data. One possible solution to this lack of information is the inclusion of self-identification of Indigenous identity upon receiving health care. In some jurisdictions in Canada and the United States, including the option to self-identify

[82] Truth and Reconciliation Commission of Canada, "Truth and Reconciliation Commission of Canada: Calls to Action."
[83] Janet Smylie and Michelle Firestone, "Back to the Basics: Identifying and Addressing Underlying Challenges in Achieving High Quality and Relevant Health Statistics for Indigenous Populations in Canada," *Statistical Journal of the IAOS* 31, no. 1 (2015): 67–87, https://doi.org/10.3233/SJI-150864.
[84] Smylie and Firestone.

has improved data quality immensely.[85] CAP may choose to advocate for increased self-identification options within health care delivery systems.

b. Research based on national data sets often excludes Indigenous leadership and Indigenous voices in planning and administration. This exclusion often contributes to findings that inform policy that does not directly improve the health of our constituency.[86] According to the UNIDRIP, Indigenous people have a right to governance and management of their own health and social data.[87] Therefore, it is crucial that research about Indigenous peoples includes Indigenous voices and management. In the words of many CAP constituents and leaders, "nothing about us without us." Research about Indigenous peoples must include clear partnerships and sharing agreements. According to a 2011 Councils of Ministers of Education workshop on pan-Canadian Indigenous data, Indigenous people must be key actors in research.[88] CAP should be elevating other Indigenous voices within academic and private sector research projects.

c. National data sets, which frame the scope and direction of health policy, vastly underestimate the true depth of health inequity for Indigenous peoples.[89] To estimate Indigenous health indicators, many research projects rely on registries of status Indians held by bands. This effectively excludes all other Indigenous peoples, who make up the majority of the Indigenous population in Canada. In addition, research based on band registries lumps all other Indigenous people in with the comparison population. Therefore, if non-status Indigenous people are disproportionately affected by some health issue, the results of the research will underestimate the true inequality for both the status Indians and all other Indigenous people.[90] Other research projects rely on geographic proxies to identify Indigenous populations. By choosing an area with a high percentage of Indigenous people according to the census and measuring the total health of that

[85] Smylie and Firestone.
[86] Smylie and Firestone.
[87] United Nations, "United Nations Declaration on the Rights of Indigenous Peoples."
[88] Council of Ministers of Education, Canada, "CMEC Technical Workshop on Pan-Canadian Aboriginal Data," March 2011.
[89] Marcia J. Anderson and Janet K Smylie, "Health Systems Performance Measurement Systems in Canada: How Well Do They Perform in First Nations, Inuit, and Métis Contexts?," *Pimatisiwin* 7, no. 1 (2009): 99–115.
[90] Smylie and Firestone, "Back to the Basics," 80.

area, researchers fundamentally underestimate the health inequity of that area because they are unable to separate out non-Indigenous individuals.[91] Finally, national data sets rely on survey respondents having permanent addresses. This underestimates health inequities by failing to account for mobile and homeless individuals, who often experience negative health issues.[92]

CAP has already committed to supporting alternative research methods that address these data quality challenges by Dr. Janet Smylie and her colleagues. In the 2019 Annual General Assembly, the following resolution was passed: "Therefore, be it resolved that the Congress of Aboriginal Peoples accept and endorse Dr. Janet Smylie's data as significant and accurate and will support this data through media outreach." CAP must respond to this resolution with a stronger relationship with Dr. Smylie as well as increased advocacy for Indigenous voices in health research.

2. Advocate for policies and programs that address the growing education gap between Indigenous and non-Indigenous children. Schools must be sites of safety, growth, and identity building for all, and the fact that Indigenous children do not receive the same benefits as other children is unacceptable. Educational systems must be reformed so as to mitigate the damage of colonial policies like Residential Schools and chronic underfunding.
3. Demand that health policy and health care delivery are transformed so as to provide accessible and culturally appropriate care to Indigenous peoples.
    a. CAP must advocate for health policy that reforms access to health care. Off-reserve Indigenous peoples face significant barriers when attempting to receive care, including jurisdictional complexities, discrimination, and insufficient coverage for medication and treatment. These barriers are surmountable but must be addressed directly.[93]
    b. The federal government must implement anti-racism and cultural humility training and practice for all health care providers.[94] Indigenous peoples should not

[91] Smylie and Firestone, "Back to the Basics."
[92] Anderson and Smylie, "Health Systems Performance Measurement Systems in Canada."
[93] Truth and Reconciliation Commission of Canada, "Truth and Reconciliation Commission of Canada: Calls to Action."
[94] Nelson, "CHALLENGING HIDDEN ASSUMPTIONS: Colonial Norms as Determinants of Aboriginal Mental Health."

face additional hardship when accessing health care due to the discriminatory or uneducated beliefs of their health care providers. Providers must be trained on the social determinants of health that impact Indigenous peoples as well as anti-racism practices.[95]

4. Demand that all health research and policy include Indigenous knowledges and Indigenous voices. Indigenous understandings of SDOH can be used to both assess and improve individual and community health, as traditional knowledge provides a more wholistic view of well-being than other forms of science.[96]

Improve Outcomes for Individuals

While advocating for change on the systemic and structural levels, it is crucial that CAP also be mindful of opportunities to improve the health outcomes for individuals within our constituency. The socio-economic inequalities between Indigenous peoples and other Canadians are substantial. To fully advocate for the health of our constituency, CAP must support policies and programs that seek to improve socio-economic conditions like unemployment, housing need and homelessness, and poverty.

6. Data Usage

This report was informed by open sourced quantitative data provided by Statistics Canada. Data sets such as "Table 13-10-0457-01 Health indicators, by Aboriginal identity, four-year period estimates" helped to establish background information on the socio-economic conditions for the populations of interest. Data sets were downloaded as comma separated values and inputted into Microsoft Excel. Then, using the tools offered in the program, pivot tables, charts, and tables were generated. These visualizations helped researchers to understand the data and to develop new research questions and hypotheses. In addition, data manipulation helped researchers to isolate specific sub-populations like women, off-reserve Indigenous peoples, and socio-economic statuses. The documentation on the data collected by surveys like the Aboriginal Peoples Surveys and the 2016 Census were also useful, as they allowed CAP to interpret findings

[95] Kim, "Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System."
[96] Quinless, "Indigenous Well-Being in Canada: Measuring Wellness in the Context of Knowledge Networks, Interconnectedness, and Social Change."

of other researchers. The documentation was consulted to establish the scope of various variables used in other studies.

CAP also benefited from semi-custom data tabulations through an agreement with Statistics Canada as one of the five National Indigenous Organizations recognized by the Government of Canada. This was made possible by cooperation with "The Centre for Indigenous Statistics and Partnerships, Social, Health and Labour Statistics Field." Quintessential Research Group prepared the data tabulations for CAP's review through a consultation agreement to produce a report on social determinants of health. This report helped to inform the researchers at CAP on both the background of the subjects and the specifics of Indigenous SDOH.

7. Conclusion

Indigenous peoples across Canada suffer from health issues that are grounded in socio-economic inequality. This is unacceptable. Canada prides itself on its robust health care system and public health policies but continues to allow disproportionate burdens of disease and sickness to fall on its Indigenous peoples. In fact, many health issues of our constituency are the direct result of Canadian federal policies and programs. Without directed, sweeping, and culturally appropriate action, the health of Indigenous peoples will continue to suffer under the federal government's watch.

As social determinants of health continue to gain momentum as key health factors, it is important that CAP's advocacy work is informed by a strong understanding of colonialism's ongoing impact on our constituency's health. In this report, individual-, structural-, and systemic-levels of social determinants of health have been discussed as well as shown to be deeply rooted in colonial society. To properly address these levels and their negative effects, our policy making, research, and engagement with government all must support the active process of decolonization.

8. Appendices

Appendix A: Works Cited

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Appendix B: Annotated Bibliography

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- This article reviews the systems in Canada that collect information about health care delivery and shows how they are inadequate to inform accurate community health interventions or planning. It finds that health system performance measurement infrastructure is much better for non-Indigenous Canadians than Indigenous peoples. This contributes to overall health inequities in a serious way.

Bombay, Amy, Kimberly Matheson, and Hymie Anisman. "The Intergenerational Effects of Indian Residential Schools: Implications for the Concept of Historical Trauma." Transcultural Psychiatry 51, no. 3 (June 2014): 320–38. https://doi.org/10.1177/1363461513503380.

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- This report is one of CAP's 2020 internally developed pieces on key policy issues.

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- This report describes the key findings from the Urban Aboriginal Peoples Study. This study provides invaluable data that can support CAP's work in advocacy for urban Indigenous peoples. It touches on culture, identity, experiences with non-Aboriginal people, political voice, justice, happiness, and non-Aboriginal perspectives.

Goodman, Ashley, Kim Fleming, Nicole Markwick, Tracey Morrison, Louise Lagimodiere, and Thomas Kerr. "'They Treated Me like Crap and I Know It Was Because I Was Native': The Healthcare Experiences of Aboriginal Peoples Living in Vancouver's Inner City." Social Science & Medicine 178 (April 2017): 87–94. https://doi.org/10.1016/j.socscimed.2017.01.053.

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- This article advocates for improving education as a way to improve public health and to address health inequity. The authors review empirical studies to show how education is related to health and to support their points. It is not focused on health in Canada, but is applicable to our constituency, nonetheless.

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that having a low income is having a more and more detrimental effect on the health of Indigenous peoples as time goes on.

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- This article advocates for the need for health cares to be educated about the SDOH unique to Indigenous patients, including the impact of colonialism and residential schools.

Nelson, Sarah. "CHALLENGING HIDDEN ASSUMPTIONS: Colonial Norms as Determinants of Aboriginal Mental Health," 2012, 16.

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- This is a 2020 CAP publication on the relationship between the child welfare system and violence committed against Indigenous girls and women. It is part of a wider project to educate the public on the systemic causes of the huge number of missing and murdered Indigenous women and girls.

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- This is a 2020 CAP publication on the relationship between the justice system and violence committed against Indigenous girls and women. It is part of a wider project to educate the public on the systemic causes of the huge number of missing and murdered Indigenous women and girls.

Smylie, Janet, and Michelle Firestone. "Back to the Basics: Identifying and Addressing Underlying Challenges in Achieving High Quality and Relevant Health Statistics for Indigenous Populations in Canada." Statistical Journal of the IAOS 31, no. 1 (2015): 67–87. https://doi.org/10.3233/SJI-150864.

- This journal article shows how specific Indigenous data quality challenges contribute to a significant underestimate of health inequities in Canada. It also shows how these data quality challenges are completely fixable, but they continue to go unaddressed. This problem creates a tremendous barrier for evidence-based health interventions in Indigenous communities. It demonstrates the failure of health data from national data sets like the census down to local hospital records to adequately capture and address health inequities for Indigenous populations. It also provides suggestions to improve Indigenous data gathering and management.

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