

**Métis National Council  
Canada – Aboriginal Peoples Roundtable**

**Health – Position Paper**

THE HISTORY OF MÉTIS HEALTH

There has been a longstanding misconception that by the end of the 1800s, most Métis communities in Canada had been destroyed or assimilated into the mainstream non-Aboriginal populace. Despite the various battles, the unjust hanging of Louis Riel and persecution of other Métis leaders, the fraudulent scrip land grant system, and exclusion from government policies and programs, the Métis Nation and its communities have survived. However, this survival is not without consequences such as higher rates of unemployment, lower levels of educational attainment, inadequate housing and poorer health status in comparison to the non-Aboriginal population.

The historical roots of poorer health status among the Métis lies in the marginalization of Métis people. Originally, the Métis acted as economic mediators in the fur trade, however, as the fur trade declined their value and participation in the economy decreased. The impact resulted in the Métis being isolated from both the native and non-native worlds, which has had devastating impacts on the health and well being of the Métis people.

Another and ongoing impact on the health of the Métis was the legacy of colonialism. It began in 1857 with the passing of the *Gradual Civilization Act*, which would “encourage the gradual civilization of Indian tribes” which included the Métis. The effects of colonization on the Métis have had severe and long-standing impacts on the health status of the Métis. To begin, the colonization and

Census Canada indicated in 2001 that there were 292,310 Métis who live primarily in the western provinces of British Columbia (44,265), Alberta (66,055), Saskatchewan (43,695), Manitoba (56,795) and the province of Ontario (48,345).

attempted assimilation of the Métis into the non-Aboriginal population resulted in a loss of dignity and self-esteem among the Métis people. This combined with a loss of control and authority over sectors has resulted in a variety of disorders that can only be broken through empowerment and actualization of our governance structures.

In terms of accessing health care, the Métis have been excluded to a certain degree from both the Aboriginal and non-Aboriginal health systems. First Nations and Inuit people access some of their programming through the First Nations and Inuit Health Branch of Health Canada. This branch of Health Canada does not have a mandate to work with the Métis. The Métis have accessed the majority of their health services through the provincial governments. As such, the Métis Nation does not have access to comparable or consistent programming within the Nation as different provinces offer different programs and services. In addition, the majority of health programming

accessed, be it provincial or federal, is pan-Aboriginal and not designed to meet the unique needs or realities of Métis people. The result is non-responsive and poorly developed programs that fail to improve the health status of Métis people.

In efforts to make known their position on health, the MNC in its submission to the Royal Commission on Aboriginal Peoples (RCAP) demonstrated through statistics that Métis

<b>Report on the Royal Commission on Aboriginal People</b>		
<b>Item</b>	<b>Métis</b>	<b>Non-Aboriginal</b>
Life Expectancy at Birth	70.4 years (M) 76.9 (F)	74.6 (M) 80.9 (F)
Family Violence	39%	
Alcohol Abuse	58.8%	
Drug Abuse	43.2%	
Unemployment Rate	14.5% (1981) 21.3% (1991)	7.2% (1981) 9.9% (1991)
Income under \$2,000	22.9%	14.4%
Less than Grade 9	19.1%	11.8%
University Degree	3.3%	12.2%

health problems relating to arthritis, bronchitis, and asthma were actually higher than that of Aboriginal peoples in general. The MNC based its health discussion on a health determinants approach and noted factors such as poverty, housing, literacy and remoteness as all contributing to the lower health status of the Métis. It was also noted that for many Métis residents, unless they are on social assistance or are evacuated for medical emergencies, they have to pay personally for all medical transportation costs and in situations of remoteness, this can be quite costly. The MNC summarized that the main reason for the denial of basic health services to Métis people was due to the failure of provincial and federal governments to sort out their jurisdictional and fiscal responsibilities to the Métis.

RCAP in turn was committed to renewing partnerships, strengthening Aboriginal governance, developing a new fiscal relationship and supporting strong communities, people and economies. In terms of renewing partnerships, RCAP suggested that Federal-Provincial-Territorial-Aboriginal partnership and coordination move beyond debate and disagreement over jurisdictions and responsibilities. In addition, Aboriginal people must participate fully in the design and delivery of programs affecting their lives and communities. For the Métis, this was welcome news especially in the area of health from which the Nation has always been excluded.

## CURRENT STATUS

### The Demographics

In terms of demographics, the Aboriginal population is the fastest growing in Canada from 3.8% of the total population in 1996 to 4.4% in 2001. In addition, the Aboriginal birthrate is 1.5 times that of the non-Aboriginal birthrate. Unfortunately, demographic and health data on Métis people is difficult to find. What data, is available, fails to provide a real and comprehensive picture of Métis people in Canada. In addition, the data also fails to demonstrate the diversity that exists between Métis sub-populations within the Métis Nation. There are distinctive social and economic differences between remote northern Métis communities and those Métis residing in urban centres such as Winnipeg and Regina. What brings our people together is their unique relationship to the land and our subsequent historical relationships that we continue to have with the various levels of government.

Health disparities between Métis people and the non-Aboriginal population exist because of variety of economic, social and political inequities. Socio-economic determinants such as infrastructure, employment, housing, education and the environment need to be addressed if substantial improvements in health status are to be realized. It is important to note that many of these inequities are entrenched in the history of relations between the Métis people and various levels of government. Relocation of Métis children to institutions, inadequate services in Métis communities, jurisdictional wrangling between the various governments and attitudes have resulted in many of the ills our people face to this day. In addition to the types of inequities mentioned above, Métis women experience additional barriers such as individual and systemic discrimination on the basis of gender.

### The Métis Nation Health Committee

The Métis Nation's Health Committee currently manages the health of the Métis Nation. The Committee includes the MNC's Director of Health, National Health Coordinator and two representatives (one technical and one political) from each of the five Governing Members. The Governing Members include the Métis Nation of Ontario, the Manitoba Métis Federation, the Métis Nation – Saskatchewan, the Métis Nation of Alberta and the Métis Provincial Council of British Columbia. The Committee reports to the Minister of Health who is appointed by the MNC President to the Métis Nation Cabinet. The Minister acts as an advisor, advocate and representative of the Métis Nation in relation to his/her area of responsibility.

The Métis Nation's Health Committee is committed to improving the health status of Métis people to a level comparable to the non-Aboriginal population in Canada. It does this through individual and group efforts. Each Governing Member has its own unique partnerships and relationships with both the federal and provincial governments. For instance, Saskatchewan, in partnership with the Royal

91% of Métis offenders were identified as having high substance abuse needs at admission to federal custody (Motiuk & Nafekh, 2000).

Canadian Mounted Police, has prevention programming beginning at the grade 4 level, as part of its Métis Addictions Counsel of Saskatchewan Inc. (MACSI). No other

Governing Member has implemented a similar program to date. This is not because they have not tried or are not interested – it is due in part to varying capacities among the Governing Members and more important, varying interest among external partners.

The Métis Nation’s Health Committee is trying to build capacity internally but with limited resources at the national level this is no easy task. One of the key components of capacity building is information sharing among the Governing Members. When the Committee meets they share best practices and lessons learned in terms of accessing health funding and services.

### The Métis National Council – Health Section

The MNC’s health section that is managed by the Director of Health acts as a liaison between the federal government and the Governing Members. To date, the MNC, through federal support, has participated in consultations on Early Childhood Development, the Aboriginal Diabetes Initiative, Healthy Living, the Aboriginal Health Reporting Framework and HIV/AIDS. In terms of the latter, the first ever Métis-specific health document, entitled, *HIV/AIDS: The Basic Facts for Métis Communities*, was produced and distributed throughout the Métis Homeland. The report was so well received that a second printing was ordered immediately and the supply still did not meet the demand. This booklet exemplifies the Métis people’s appetite for Métis-specific health information.

HIV/AIDS cases contracted by Aboriginal people has risen from 1% in 1990 to 7.2% in 2001.

## KEY ISSUES

### Jurisdictional Wrangling

Even though illness and disease do not discriminate between the three Constitutionally recognized peoples, Canada’s current health policies and programs do when it comes to Métis access. The result of this jurisdictional wrangling between the federal and provincial governments, is that even though Métis people represent close to 26% of the Aboriginal population in Canada (2001 Census), they receive minimal to no access to Aboriginal health programming provided by the federal and provincial governments. Most of the provinces within the Métis homeland have based their argument on Section 91(24) in that Métis health services are a federal responsibility. Conversely, the federal government has been reluctant to offer any programs to the Métis specifically in fear of setting a precedent that would only give the provinces more reason not to provide or increase services.

The current system of accessing pan-Aboriginal programming on an ad hoc basis is not satisfactory and is having a negative impact on the health and well-being of Métis people. The Métis Nation is committed to obtaining Métis-specific health programs and

services designed by and for Métis people to meet their unique needs and realities. The Métis Nation believes that the best means to do this is through increased Métis participation in health policy and program development.

### A Nation-to-Nation Approach

RCAP, as mentioned above, supports strengthening Aboriginal governance. The Métis have long argued that the best way to ensure their Nation's needs are met is through increased authority over programs and services and recognition of the governing capacity of the Métis Nation. Many First Nations and Inuit are currently receiving transfer agreements for health services and programming from the federal government. No such transfers or devolution of authority for health programs exist for the Métis. The Métis Nation's Health Committee is exploring options for transferring authority of certain health programming to the Governing Members and/or to the community level. The Health Committee's position is that the flow of health funding needs to be through a direct bilateral relationship with the federal government and not via the current system where funding flows from the federal government to the provincial government and eventually to the Métis people via pan-Aboriginal envelopes. It is obvious that the current system is not working for Métis people. The Métis Nation needs to have input and control over health policy and programs in order to improve the health status of its people and eliminate the gaps inherent in the current system.

### A Holistic Approach to Health

RCAP spoke of a circle of well being which includes self-government, economic self-reliance, healing and a partnership of mutual respect. This circle of well-being is based on a number of factors; access to clean water, adequate housing, higher levels of educational attainment, participation in the economy, and access to health, social and cultural supports. The Métis need equitable access to Métis-specific health services and programming that meets our unique needs and realities if the circle of wellness is to be respected.

### Funding

RCAP noted that the government will attempt to create multi-year funding arrangements for Métis by introducing multi-year funding arrangements to harmonize federal fiscal reporting requirements while maintaining accountability. This would mean more stable and predictable flow of revenues for the Métis to facilitate program and financial planning. The Métis Nation supports the notion of multi-year funding arrangements but in the area of health, this situation has yet to be realized. Currently, the majority of health dollars the Métis Nation accesses is obtained through the competitive Request for Proposal process. This current process adds to inconsistency between the Governing Members as certain Members have different levels of capacity to compete in the RFP process. The Health Committee is trying to control this situation by sharing RFP information among the Governing Members but this still fails to address the issue of competing for dollars.

One particular funding model that has worked for the Métis Nation is the Aboriginal Human Resources Development Strategy (AHRDS) model. What makes this model work is that it is based on a bilateral relationship between the federal government and its Métis partners. This devolution model was implemented without jurisdictional wrangling or positioning with provinces and was supported by the existing *Inherent Right Policy* with respect to the Métis. To date, the AHRDS has made a real difference in to our people and has facilitated the inclusion of Métis and other Aboriginal peoples into the Canadian Labor Market. It is the Métis Nation's position that a similar version of this model be applied to other areas such as health. Similar in that the current version needs to devote more resources to capacity building, review its current accountability framework, be implemented through nation-to-nation agreements, allow for Métis input into strategic directions and policy decisions, etc. These are just a few of the Métis Nation's recommendations on AHRDS, of which the Nation would be more than willing to discuss further with its potential stakeholders, especially in the area of health.

## Research

The lack of Métis-specific health data is evident. It is but one piece of a large challenge for the Métis Nation – a lack of data in general. The Métis Nation is committed to working with its partners to access data in such initiatives as the Aboriginal Health Reporting Framework. The majority of the data available resides at the provincial level, however, issues such as identifiers, privacy, etc. hamper the extraction of this data. Like the federal government, the Métis Nation is interested in developing an evidence-based approach to decision-making. However, unlike the federal government, the Métis Nation lacks the capacity and resources to make progress in this area. At this point, the Métis currently access the majority of their data through the Aboriginal Peoples Survey. As stated above, the Nation would be more than interested to engage in any and all discussions in relation to obtaining Métis-specific data in a variety of sectors. The MMF has partnered with the Centre for Aboriginal Health Research of the University of Manitoba to produce an analysis of the latest APS information on Metis health conditions. However, this study is not yet complete and much more research work must be done to find effect solutions to the health-related issues that it will identify.

## MOVING FORWARD

### The Métis National Council's Action Plan for Health

First presented at the Council of Federation Meeting in Niagara-on-the-Lake on July 28<sup>th</sup>, 2004 and again at the Special Meeting with First Ministers and Aboriginal leaders held on September 13<sup>th</sup>, 2004, the Health Action Plan (see Appendix A) outlines the Métis Nation's key areas of focus in health. The Plan is a living document that over time and with community consultation will develop into a comprehensive Action Plan to improve the health status of Métis people. Current key areas of focus include building on best practices in Métis health care, health career development for Métis people, new

models to address jurisdictional issues and increased Métis participation in health policy.

### Aboriginal Health Blueprint

President Clément Chartier, with five delegates from the MNC, attended the Special Meeting with Aboriginal leaders on September 13<sup>th</sup>, 2004. Overall, the MNC was pleased with everyone's commitment to develop an action plan that would improve health services for all Aboriginal peoples and adopt specific measures to close the gap in health status between Aboriginal and non-Aboriginal peoples in Canada. In addition, governments committed to recognizing and respecting the unique and specific needs of all Aboriginal peoples regardless of age and gender. The Government of Canada committed to three areas of investment: an Aboriginal Health Transition Fund, an Aboriginal Health Human Resources Initiative and investments in health promotion and disease prevention.

What remains to be determined is how the above Blueprint will be implemented. Federal-Provincial-Territorial Ministers responsible for Health and Aboriginal Affairs were tasked to work with Aboriginal leadership to develop a blueprint and to report back in one year's time to First Ministers. The Métis Nation is looking forward to this work but feels that such activity cannot be done in isolation from other initiatives currently underway such as the existing Federal-Provincial-Territorial-Aboriginal process, the Canada-Aboriginal Peoples Sector-Specific Health Roundtable, etc. As stated above, the Métis Nation currently accesses a number of ad hoc health programs and services. One of the biggest challenges is the lack of consistency and coordination within the Nation. Any new initiatives cannot be developed in isolation and must take into account existing processes in order to avoid duplication and fill gaps.

*Nota Bene: This position paper is preliminary only and the Métis position in relation to health matters will be elaborated further during the health discussions of the Canada-Aboriginal Peoples Roundtable process.*