THE TREATY RIGHT TO HEALTH AND THE LEGACY OF THE INDIAN HEALTH POLICY (1979):

Contemporary Legislative and Policy Considerations

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EXECUTIVE SUMMARY

This document provides a succinct overview of the health-related legal and policy frameworks that frame and limit the potential for self-determination and self-government of First Nations people. This review is informed by recent developments such as the report of the Truth and Reconciliation Commission and the associated Calls for Actions,[1] and the United Declarations on the Rights of Indigenous Peoples Act passed by Canada on June 21st 2021.[2] The objective of this review is to support the development of a First Nations distinction-based health legislation.

This document is based on,

- A review of the Treaties, legal analyses of the Treaty Right to Health, and jurisprudence;
- A careful review of federal, provincial and territorial legislation of relevance to First Nations' health;
- A review of relevant reports making recommendations on how to best address inequities experienced by First Nations; and
- Empirical analyses on the performance of the system as created by legislation and federal policy, on addressing First Nation health inequities.

This analysis shows that to date, the federal government has opted to leave it to the courts to define Indigenous and Treaty Rights. The courts, through Dreaver (1935)[3] and Wuskwi Sipihk (1999),[4] have ruled that a Treaty Right to Health, not restricted to Treaty 6, exists and should be understood in contemporary terms. Despite this, federal policies related to health services provided on-reserve, have been positioned outside of Aboriginal and Treaty Rights discussions.

To date, federal obligations have been defined as complementary to the provinces, leading to continued confusion over federal-provincial obligations, jurisdictional gaps, and inequities. Pathways to implement UNDRIP, the TRC Calls to Actions and Joyce's Principle have yet to be created. Moving forward include two broad categories of considerations: the framing of the legislative instrument, and its content.

To have the impact required, a federal First Nations health legislation will need to create a framework to incentivize the provinces/territories, professional orders and health organizations to adopt rights-based and equity-informed practices to counter systemic and interpersonal racism, address jurisdictional barriers and wrangling, increase the number of First Nations health professionals, and respectfully integrate and protect First Nation medicine and healing practices. The Canada Health Act

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[1] Truth and Reconciliation Commission of Canada. (2015). *Truth and Reconciliation Commission of Canada: Calls to Action*. Ottawa: Truth and Reconciliation Commission of Canada. http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

[2] United Nations Declaration on the Rights of Indigenous Peoples Act S.C. 2021 c. 14 (2021). https://laws-lois.justice.gc.ca/PDF/U-2.2.pdf

[3] Dreaver et al. v. the King, 5 C.N.L.C Ex Ct. 92 (unreported), 15186 Stat. (1935). http://nosho.usask.ca/islandora/object/Mistawasis:75

[4] Canada. (1999). *Wuskwi Sipihk Cree Nation v. Canada (Minister of National Health and Welfare) Between The Wuskwi Sipihk Cree Nation, The Mathias Colomb Cree Nation, The Opaskwayak Cree Nation, The Sapotewayek Cree Nation, The Mosakahiken Cree Nation, The Grand Rapids First Nation, and The Chemawawin Cree Nation, plaintiffs, and Her Majesty the Queen in right of Canada, as represented by the Minister of National Health and Welfare, defendant [1999] F.C.J. No. 82 Court File No. T-383-98 Federal Court of Canada - Trial Division Winnipeg, Manitoba Hargrave, Prothonotary January 21, 1999*. http://jerchlaw.com/wp-content/uploads/2017/08/wuskwi.pdf

1984 (CHA) can act as a template, in that it provides a set of principles, and incentivizes the provinces and territories to join in its implementation. Like the CHA, the federal distinctions-based First Nations health legislation could incentivize the provinces and territories to commit to abiding by the legislation. In terms of content, possible overarching principles the Assembly of First Nations may advocate for include:

- A definition of First Nations' Treaty Right to Health;
- The portability of Indigenous rights;
- A commitment to addressing systemic racism; and
- Specific provisions for professional organizations, universities and colleges, health systems to address anti-Indigenous racism.

Beyond principles, a distinction-based First Nation health legislation could,

- list federal obligations, based on jurisprudence;
- entrench tripartite agreements in each province and territory as mechanisms to address jurisdictional obligations and gaps;
- include an explicit recognition of the on-reserve healthcare system as Canada's 14th healthcare system; and
- draw from the United Declaration on the Rights of Indigenous Peoples Act,[5] the Truth and Reconciliation's Call to Action[6] and Joyce's Principle[7] to define rights and obligations to be recognized and acted on by the federal and provincial/territorial governments, professional orders, medical and nursing schools, and health organizations.

Beyond health and health care, attention to First Nation determinants of health is required, including cultural continuity, environmental stewardship, community infrastructure and assets, educational systems, justice, employment and income, and food security.[8] Addressing these determinants will improve individual, family and community's health and reduce reliance on health and social services.

[5] UNDRIP Act (2021), op. cit.

[6] Truth and Reconciliation Commission of Canada. (2015), op. cit.

[7] Conseil des Atikamekw de Manawan. (2020). *Principe de Joyce: Le Conseil des Atikamekw de Manawan annonce l'ouverture d'une consultation publique en preparation d'un dépôt à L'Assemblée Nationale du « Principe De Joyce»*. Manawan, Québec: C. d. A. d. Manawan. https://www.atikamekwsipi.com/public/images/wbr/uploads/telechargement/Doc_Principe-de-Joyce.pdf

[8] Loppie, S., Reading, C., & de Leeuw, S. (2014). *Social Determinants of Health: Aboriginal Experiences with Racism and its Impacts*. Prince George BC: National Collaborating Centre for Aboriginal Health. https://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/131/2014_07_09_FS_2426_RacismPart2_ExperiencesImpacts_EN_Web.pdf

Greenwood, M., de Leeuw, S., Lindsay, N. M., & Reading, C. (2015). *Determinants of Indigenous Peoples' Health in Canada: beyond the social*. Toronto: Canadian Scholars' Press.

1. INTRODUCTION

The purpose of this document is to provide a concise review of the health-related legislative and policy frameworks that frame and constrain First Nations' opportunities for self-determination and self-government. This review is informed by jurisprudence, recent developments such as the report of the Truth and Reconciliation Commission and the associated Calls for Actions,[9] and the United Declaration on the Rights of Indigenous Peoples Act adopted by Canada on June 21st 2021.[10] Table 1 below summarizes key milestones reviewed. The objective of this review is to support the development of a First Nations distinction-based health legislation.

The document is divided into three broad sections. Section one discusses the existing legislative framework that informs access to health services for First Nations. Second two discusses how the existing legislative framework has been applied to date. A final section summarizes key points and offers considerations for the creation of a First Nations distinction-based legislation.

I feel that it is important to introduce myself to provide context. My ancestry is French from Quebec. I grew up in Quebec in northern remote communities (where access to care was complex) as a French speaker, with no contact with Indigenous people, beyond superficial encounters. I began working with Indigenous communities during my Master Degree (McGill University, Medical Anthropology, 1989-93) when the government of Mr Parizeau announced James Bay II. At that time, McGill University was approached by Cree and Inuit communities to help with social impact assessments to support potential court action. This is the moment, at 27 years old that I realized I knew nothing about this country and its relationship with Indigenous peoples. I chose to focus on Nunavik. I moved to the NWT in 1992 (Rankin Inlet) to work with an Inuit Health Board to continue my learning.

I heard about the Health Transfer Policy during my Masters and kept paced as much as I could with its progress. When I moved to Saskatchewan in 1994, I looked for opportunities to learn more about the policy. I worked for Peter Ballantyne Cree Nation and the Prince Albert Grand Council in their health departments as a proposal writer, community development manager and evaluator until 2000 when I left to undertake a PhD. During this time, I also taught with First Nation Elder Vicky Wilson in university settings. Since my PhD, all research I undertake is in partnership with Indigenous organizations (the First Nations Health and social Secretariat of Manitoba and the Manitoba Inuit Association are primary partners at this point). I continue to work with colleagues across circumpolar countries, and in Australia and New Zealand. I still uphold an obligation to team-teach with an Elder, Gramma Geraldine Shingoose for the past 6 years, as a condition for me to teach on Indigenous issues.[11] Gramma Shingoose is a well known Elder, who has been interviewed by the BBC, the New York Times and is guiding the Swedish Government towards the development of their own Truth and Reconciliation Commission, in support of rebalancing their relationship with Sāmi. I am grateful for Gramma's friendship and guidance.

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[9] Truth and Reconciliation Commission of Canada. (2015), op. cit.

[10] United Nations Declaration on the Rights of Indigenous Peoples Act S.C. 2021 c. 14 (2021). https://laws-lois.justice.gc.ca/PDF/U-2.2.pdf https://laws-lois.justice.gc.ca/PDF/U-2.2.pdf.

[11] Shebahkeget, O. (2022). Residential school survivor from Manitoba speaks to Sweden's truth commission about her experiences. *CBC News*. Retrieved from https://www.cbc.ca/news/canada/manitoba/gramma-shingoose-sweden-truth-commission-1.6628685

Table 1, Summary of historical milestones cited in this report		
Year	**Policy/Legislative Instrument**	**Significance**
1867	British North American Act	Defined health as a provincial jurisdiction and Indian affairs as a federal jurisdiction
1876	Indian Act	Gave the government sweeping powers with regards to First Nations identity, political structures, governance, cultural practices and education. These powers restricted Indigenous freedoms and allowed officials to determine Indigenous rights and benefits based on "good moral character.
1935	*Dreaver et al v. the King*	A Treaty Right to Health, not restricted to Treaty 6, exists and should be understood in contemporary terms.
1966	*R. v. Johnston*	A Treaty Right to Health exists and should be understood in contemporary terms. This interpretation was rejected on appeal.
1970	*R. v. Swimmer*	A Treaty Right to Health exists and should be understood in contemporary terms. This interpretation was rejected on appeal.
1982	Constitutional Act 1982	Affirms but does not define Aboriginal and Treaty Rights
1983	Nowegijick v. The Queen	Ruled that Treaties provisions should be liberally construed, and doubtful expressions resolved in favour of the Indians.
1984	Canada Health Act	Provides for the federal transfer of funding to the provinces and territories, in exchange for provincial and territorial adherence to Medicare's key principles
1985	Indian Act 1985	Articles 2 and 73 (1) limit the autonomy of First Nations, by investing decisive authority in the Minister and the Governor in Council.
1989	Health Transfer Policy	Supports the administrative transfer of existing on-reserve health services funded by the federal government to First Nations
1990	R. v. Sparrow	Defines the scope of what constitutes an Aboriginal right and defines to what degree the Canadian government can reasonably infringe upon, or limit such right
1996	R. v. Van der Peet	Sets parameters for the courts to determine what constitutes a valid Aboriginal right.
1999	Wuskwi Sipihk	Confirms the earlier decision in *Dreaver* was correct, and that contemporary context could require "a full range of contemporary medical services"
2007	UNDRIP	The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) is adopted by the General Assembly on Thursday, 13 September 2007, by a majority of 144 states in favour, 4 votes against (Australia, Canada, New Zealand and the United States).
2010	UNDRIP	November 12, 2010 – The Government of Canada today formally endorsed the United Nations Declaration on the Rights of Indigenous Peoples in a manner fully consistent with Canada's Constitution and laws.
2015	Truth and Reconciliation Commission of Canada	The Truth and Reconciliation Commission (TRC) provided those directly or indirectly affected by the legacy of the Indian Residential Schools system with an opportunity to share their stories and experiences, and resulted in 94 "calls to action" (or recommendations) to further reconciliation between Canadians and Indigenous Peoples.
2020	Joyce's Principle	The death of Joyce Echaquan, a member of the Atikamekw community of Manawan, occurs in abject circumstances on September 28, 2020, at the Joliette Hospital Center in Lanaudière, Quebec. Her death resulted in the creation of Joyce's principle, which aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health. Joyce's Principle requires the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health.
2021	United Declaration on the Rights of Indigenous Peoples Act	The *United Nations Declaration on the Rights of Indigenous Peoples Act* received Royal Assent in June 2021.

2. THE LEGISLATIVE FRAMEWORK

The proposed First Nations distinction-based health legislation will become part of the legislative frameworks that defines federal obligations to First Nations in regards to health and access to health care. Existing components of this legislative framework include,

- the Canada Constitution 1982,
- jurisprudence on Aboriginal and Treaty Rights,
- currently federal understanding of the Treaty Right to Health,
- the Indian Act 1985, and
- the Canada Health Act 1984.

Given the federal commitment to implement the Calls for Action of the Truth and Reconciliation Commission, and the United Nations Declaration on the Rights of Indigenous Peoples, the legislative framework in place should provide a framework to guide implementation. This section reviews these components, and discuss areas of divergence and gaps.

2.1 The Constitutional Act 1982

Aboriginal rights are collective rights of distinctive Indigenous societies, flowing from their status as the original peoples of Canada.[12] Slattery distinguishes between generic and specific rights. Generic rights are held by all Aboriginal peoples across Canada, and include:

- Rights to the land (Aboriginal title);
- Rights to subsistence resources and activities;
- The right to self-determination and self-government;
- The right to practice one's own culture and customs including language and religion. Sometimes referred to as the right of "cultural integrity;" and
- The right to enter into treaties.

In contrast, specific rights are rights that are held by an individual Aboriginal group. These rights may be recognized in treaties, or have been defined as a result of a court case.[13]

The Constitutional Act 1982 affirms Aboriginal and Treaty Rights: as a result, the Crown no longer has the ability to unilaterally extinguish Aboriginal and treaty rights. As the federal government stipulates that specific Aboriginal rights are to be defined in the courts on a case-by-case basis,[14] jurisprudence continues to define what the federal government will consider a right. For examples, the 1990 R v Sparrow[15] decision defines the scope of what constitutes an Aboriginal right and defines to what degree the Canadian government can reasonably infringe upon, or limit such right. The 1996 R. v. Van der Peet[16] decision sets parameters for the courts to determine what constitutes a valid Aboriginal

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[12] Crown-Indigenous Relations and Northern Affairs Canada. (2023). *Treaties and agreements*. Ottawa: Crown-Indigenous Relations and Northern Affairs Canada. https://www.rcaanc-cirnac.gc.ca/eng/1100100028574/1529354437231

[13] Slattery, B. (2007). A Taxonomy of Aboriginal Rights. In H. Foster, H. Raven, & J. Webber (Eds.), *In Let Right Be Done: Aboriginal title, the Calder Case, and the Future of Indigenous Right* (pp. 111-128). Vancouver: UBC Press.

[14] Ibid.

[15] R. v. Sparrow, 1 S.C.R. 1075, [1990] 3 C.N.L.R. 160 Stat. (1990).

[16] R. v. Van der Peet, 2 S.C.R. 507, [1996] 4 C.N.L.R.146 Stat. (1996). https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1407/index.do

right. The Van der Peet test only recognizes as valid Aboriginal rights that were practiced prior to European contact.[17]

Speaking specifically to healthcare, the British North American Act 1867 defined Indigenous issues a matter of federal jurisdiction, whereas health care was defined as a provincial jurisdiction. This division of responsibility was repeated in the Constitutional Act 1982, resulting in on-going jurisdictional confusion and gaps.[18] The federal government has held a long-standing assumption that federal funded, on-reserve health services would eventually devolve to the provinces, territories,[19] and Indigenous authorities.[20] The latter was assumed to imply greater integration into provincial systems, and perhaps an eventual wholesale transfer of oversight to the provinces. In that context, clarifying the federal government's responsibilities would have been seen as irrelevant. As a result, jurisdictional confusion continues to create barriers to access to care, and contributes to inequities.[21]

The inherent and treaty rights of Aboriginal peoples are protected by section 35(1) of the Canadian constitution, and although the jurisprudence has been clear that these rights arise not from the Constitution itself but from Indigenous peoples' prior occupation of the land in organized societies, in practice Canada still treats them as rights subject to the normative superiority of Canadian law.[22]

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[17] Hanson, E. (2009). Aboriginal Rights: What are Aboriginal rights? *Indigenousfoundations.aarts.ubc.ca*. https://indigenousfoundations.arts.ubc.ca/aboriginal_rights/

[18] Booz•Allen & Hamilton Canada Ltd. (1969). *Study of health services for Canadian Indians*. Ottawa: Booz•Allen & Hamilton Canada Ltd. https://archive.org/details/HCStudyOfHealthServicesForCanadianIndians1969/page/n189/mode/2up

The Jordan's Principle Working Group. (2015). *Without denial, delay, or disruption: Ensuring First Nations children's access to equitable services through Jordan's Principle*. Ottawa: Assembly of First Nations. https://www.afn.ca/uploads/files/jordans_principle-report.pdf

Lavoie, J. G., & Dwyer, J. (2015). Implementing Indigenous community control in health care: lessons from Canada. *Aust Health Rev, 40*(4), 453-458. doi:10.1071/AH14101. http://www.ncbi.nlm.nih.gov/pubmed/26553422

[19] Booz•Allen & Hamilton Canada Ltd. (1969), op. cit.

Lavoie, J. G., O'Neil, J. D., Sanderson, L., Elias, B., Mignone, J., Bartlett, J., Forget, E., Burton, R., Schmeichel, C., & MacNeil, D. (2005). *The Evaluation of the First Nations and Inuit Health Transfer Policy*. Winnipeg: Manitoba First Nations Centre for Aboriginal Health Research. https://www.academia.edu/283509/The_Evaluation_of_the_First_Nations_and_Inuit_Health_Transfer_Policy

[20] Ibid.

[21] Lavoie, J. G., Kaufert, J. M., Browne, A. J., Mah, S., & O'Neil, J. D. (2015). Negotiating barriers, navigating the maze: First Nation peoples' experience of medical relocation. *Canadian Public Administration, 58*(2), 295–314. https://onlinelibrary.wiley.com/doi/epdf/10.1111/capa.12111

Katz, A., Avery Kinew, K., Star, L., Taylor, C., Koseva, I., Lavoie, J. G., Burchill, C., Urquia, M., Basham, A., Rajotte, L., Ramayanam, V., Jarmasz, J., & Burchill, J. (2019). *The Health Status of and Access to Healthcare by Registered First Nation Peoples in Manitoba*. Winnipeg. http://mchp-appserv.cpe.umanitoba.ca/reference//FN_Report_web.pdf

Lavoie, J. G., Kornelsen, D., Boyer, Y., & Wylie, L. (2016). Lost in Maps: Regionalization and Indigenous Health Services. *HealthcarePapers, 16*(1), 63-73. doi:10.12927/hcpap.2016.24773.

[22] McKerracher, K. (2023). Relational legal pluralism and Indigenous legal orders in Canada. *Global Constitutionalism, 12*(1), 133-153. doi:10.1017/S2045381722000193. https://www.cambridge.org/core/services/aop-cambridge-core/content/view/784B3EC65FF4C32314E36D2A92481992/S2045381722000193a.pdf/relational-legal-pluralism-and-indigenous-legal-orders-in-canada.pdf

2.2 First Nations and the Treaty Right to Health

First Nations have continually argued that all Treaty negotiations which led to the so-called numbered Treaties (1891 to 1906), called for a Right to Health.[23] Boyer concurs,

> *According to the Supreme Court of Canada, treaties entrench a legal relationship between the Crown and Indian nations with the intent to create obligations. These obligations are derived from the intent and context of the treaty negotiations. The controlling premise of treaties is that the parties are bound by those rules to which they have consented. Treaty obligations and rights result from formal negotiations and explicit consent. Treaties were recorded in the English language and being a non-Indigenous language, the Supreme Court has held that treaty rights made to the Indian nations by the sovereign's agent were often not included in the English written treaties (R. v. Badger, 1996). This is important as many First Nations have historical oral accounts of the terms of the treaties.* [24]

While a right to health care is explicitly included in the text of Treaty 6,[25] Boyer,[26] Craft[27] and Lavoie[28] have collated evidence of similar promises in the negotiations of all other Treaties. These Treaty rights then are recognized and affirmed in section 35 of the Constitution Act, 1982.[29]

Jurisprudence has progressed a definition of Treaty rights. According to prominent Indigenous legal scholars,[30] *Dreaver et al v. the King* (1935),[31] *R. v. Johnston* (1966)[32] and (*R. v. Swimmer,* 1970)[33] set a precedent on federal obligation to the Treaty Right to Health, ruling that Treaty provisions meant that all medicines, drugs and medical supplies should be provided free of charge. Both *Johnston* and

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[23] Craft, A., & Lebihan, A. (2021). *The treaty right to health: A sacred obligation*. Prince George: National Collaborating Centre for Indigenous Health. https://www.nccih.ca/Publications/Lists/Publications/Attachments/10361/Treaty-Right-to-Health_EN_Web_2021-02-02.pdf

[24] Boyer, Y., & Spence, S. (2015). Identifying and Advancing the Treaty Rights to Health… Signed from 1871 and 1906 in Manitoba. *Revue Française d'Études Américaines, 144*(3e trimestre), 95-108. doi:10.3917/rfea.144.0095. file:///C:/Users/lavoiej/Downloads/RFEA_144_0095.pdf

[25] Canada. (1876). *Copy of Treaty No. 6 between Her Majesty the Queen and the Plain and Wood Cree Indians and other Tribes of Indians at Fort Carlton, Fort Pitt and Battle River with Adhesions, Roger Duhamel, F.R.S.C., 1964* (Cat. No.: R33-0664, IAND Publication No. QS-0574-000-EE-A-1). Ottawa: Q. s. P. a. C. o. Stationary. http://www.trcm.ca/wp-content/uploads/PDFsTreaties/Treaty%206%20Text%20and%20Adhesions.pdf

[26] Boyer, Y., & Spence, S. (2015), op. cit.

[27] Craft, A., & Lebihan, A. (2021), op. cit.

[28] Lavoie, J. G., Gervais, L., Toner, J., Bergeron, O., & Thomas, G. (2013). *Aboriginal Health Policies in Canada: The Policy Synthesis Project*. Prince George, BC: N. C. C. f. A. Health. http://www.nccah-ccnsa.ca/docs/Looking%20for%20Aboriginal%20Health%20in%20Legislation%20and%20Policies%20-%20June%202011.pdf

[29] Canada. (1982). *The Constitution Act, 1982*. http://laws.justice.gc.ca/en/const/annex_e.html#II

[30] Boyer, Y. (2014). *Moving Aboriginal health forward: discarding Canada's legal barriers*. Saskatoon, SK: Purich Publishing Ltd, Craft, A., & Lebihan, A. (2021). *The treaty right to health: A sacred obligation*. Prince George: National Collaborating Centre for Indigenous Health. https://www.nccih.ca/Publications/Lists/Publications/Attachments/10361/Treaty-Right-to-Health_EN_Web_2021-02-02.pdf

[31] Dreaver et al. v. the King (1935), op. cit.

[32] Regina v. Johnston, 56 D.L.R. (2d) 749 Saskatchewan Court of Appeal, Culliton C.J.S., Woods, Brownridge, Maguire and Hall JJ.A., 17 March 1966, Saskatchewan Court of Appeal (1966).

[33] R. v. Swimmer, 17 D.L.R., , 1 W.W.R. 756, Pub. L. No. (1970) 6 C.N.L.C. 621, 3 C.C.C. (2D) 92 Stat. (1970).

Swimmer were however reversed on appeal, the Court taking a restrictive approach, contrary to the court decision in *Dreaver*.

In the 1999 *Wuskwi Sipihk Cree Nation v. Canada* (signatory of Treaty 4), Federal Court and the Saskatchewan Queen's bench took a more liberal and contemporary approach confirming the earlier decision in *Dreaver* was correct, and that contemporary context could require "a full range of contemporary medical services".[34] In this case, the federal court referred to *Nowegijick v The Queen*[35] as the authority for Treaties being "liberally construed and doubtful expressions resolved in favour of the Indians".[36] The court referred to *Sparrow*[37] as an authority for interpreting rights in a flexible manner "in order to permit the evolution," as opposed to adopting a rigid perspective by defining rights as they would have been understood at the time the Treaty was signed.

To summarize, the current state of the law indicates that the Treaty 6 right to health means that *all* medicines, drugs or medical supplies are to be supplied free of charge to "Treaty Indians," as was originally decided in the 1935 *Dreaver* case[38] and reaffirmed by the 1999 Wuskwi Sipihk Cree Nation v. Canada case.[39] It is noteworthy that Wuskwi Sipihk Cree Nation is signatory of Treaty 4, suggesting that First Nations beyond Treaty 6 hold a Treaty Right to free healthcare. These decisions have yet to impact federal policy.

2.3 The Indian Act 1985[40]

To date, federal policies continue to uphold that access to health care for First Nations is a matter of federal policy, not a Treaty Right.[41] This position is entrenched in the Indian Act 1985, shown in Box 2. Articles 2 and 73 (1) of the Indian Act limit the autonomy of First Nations, by investing decisive authority in the Minister and the Governor in Council. The Indian Act 1985 seems misaligned with the Constitutional Act 1982, UNDRIP and the TRC.

Box 2, Health-specific Indian Act 1985 Provisions

25.- *The guarantee in this Charter of certain rights and (2) The Minister may authorize the use of lands in a reserve for the purpose of…Indian health projects…;*

(73, 1) The Governor in Council may make regulations…(g) to provide medical treatment and health services for Indians;

81 (1) The council of a band may make by-laws not inconsistent with this Act or with any regulation made by the Governor in Council or the Minister, for any or all of the following purposes, namely, (a) to provide for the health of residents on the reserve and to prevent the spreading of contagious and infectious diseases.

[34] Canada. (1999). *Wuskwi Sipihk Cree Nation v. Canada*, op. cit.

[35] Nowegijick v. The Queen, 15833 (1983). https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2462/index.do

[36] Canada. (1999). *Wuskwi Sipihk Cree Nation v. Canada*, op. cit.

[37] R. v. Sparrow, 1 S.C.R. 1075, [1990] 3 C.N.L.R. 160 Stat. (1990).

[38] Dreaver et al. v. the King (1935), op. cit.

[39] Canada. (1999). *Wuskwi Sipihk Cree Nation v. Canada,* op.cit.

[40] Indian Act, R.S. 1985, c. I-5, (1985). http://laws.justice.gc.ca/en/I-5/

[41] Boyer, Y. (2004). *Discussion Paper Series on Aboriginal Health, Legal issues: No. 3, The International Right to Health for Indigenous Peoples in Canada*. Ottawa: N. L. C. National Aboriginal Health Organization, University of Saskatchewan. https://senatorboyer.ca/wp-content/uploads/2020/09/NAHO-paper-No.-3-INTERNATIONAL.pdf,

2.4 The Canada Health Act 1984[42]

The Canada Health Act (CHA) 1984 provides for the federal transfer of funding to the provinces and territories, in exchange for provincial and territorial adherence to Medicare's key principles of universality; comprehensiveness; portability; accessibility; and public administration. The Act is silent on its relationship to the Indigenous health care system – what some have described as Canada's 14th health care system.[43] To date, these have been no efforts by the federal government to hold provincial and territorial governments accountable for the persisting health inequities First Nations experience.

Interpersonal and structural racism is a significant contributor to pronounced and widespread health inequities affecting Indigenous peoples in Canada.[44] Recent events surrounding the tragic death of Ms. Joyce Echaquan in Quebec[45] have renewed attention to the devastating harms of Indigenous-specific racism. In the wake of Ms. Echaquan's death and widespread public outrage, Ottawa hosted a series of meetings in 2020–2021 for federal, provincial, and territorial governments; First Nations, Inuit and Métis political and service delivery organizations; and health system partners; to discuss racism in healthcare. These meetings led to the action plan, shown in Box 3.

Notable limitations have been noted to this plan. To begin, the focus on physician is a good start, however all types and levels of healthcare staff, including physicians, nurses, social workers, security guards, healthcare aides, intake workers, and triage staff, among others, can (often unintentionally) become caught up in perpetuating systemic racism.[46] In addition, the support to the

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Boyer, Y. (2014). *Moving Aboriginal health forward: discarding Canada's legal barriers*. Saskatoon, SK: Purich Publishing Ltd.

[42] Canada Health Act, R.S.C., 1985, c. C-6, Government of Canada (1984). https://laws-lois.justice.gc.ca/eng/acts/c-6/fulltext.html

[43] Lavoie, J. G. (2018). Medicare and the Care of First Nations, Métis and Inuit. *Journal of Health Economics, Policy and Law, 13*(3-4), 280-298. doi:10.1017/S1744133117000391.

[44] Selected examples of empirical studies include:

Browne, A. J., Lavoie, J. G., Logan McCallum, M. J., & Big Canoe, C. (2022). Addressing anti-Indigenous racism in Canadian health systems: Multi-tiered approaches are required. *Canadian Journal of Public Health, 113*, 222-226. doi:doi.org/10.17269/s41997-021-00598-1.

Kétéskwēw Dion Stout, M., Wieman, C., Bourque Bearskin, L., Palmer, B. C., Brown, L., Brown, M., & Marsden, N. (2021). Gum yan asing Kaangas giidaay han hll guudang gas ga. I Will Never Again Feel That I Am Less Than: Indigenous Health Care Providers' Perspectives on Ending Racism in Health Care. *International Journal of Indigenous Health, 16*(1), 13-20. doi:10.32799/ijih.v16i1.36021. https://doi.org/10.32799/ijih.v16i1.36021

Hassen, N., Lofters, A., Michael, S., Mall, A., Pinto, A. D., & Rackal, J. (2021). Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review. *International journal of environmental research and public health, 18*(6), 2993. doi:10.3390/ijerph18062993. https://doi.org/10.3390/ijerph18062993

Phillips-Beck, W., Eni, R., Lavoie, J. G., Avery Kinew, K., Kyoon Achan, G., & Katz, A. (2020). Confronting Racism within the Canadian Healthcare System: Systemic Exclusion of First Nations from Quality and Consistent Care. *International Journal of Environmental Research and Public Health, 17*(8343), 1-20. https://www.mdpi.com/1660-4601/17/22/8343/pdf

[45] Bureau du Coroner du Québec. (2021). *Rapport d'enquête, Loi sur la reecherche des causes et des circonstances des décès, pour la protection de la vie humaine, concernant le décès de Joyce Echaquan, 2020-00275*. Québec: Bureau du Coroner du Québec. https://www.cbc.ca/news/canada/montreal/joyce-echaquan-systemic-racism-quebec-government-1.6196038

[46] Browne, et al. (2022), op. cit.

Atikamekw community is laudable, yet resting the responsibility to address interpersonal and systemic racism onto a single community can only progress this national issue so far.

Scholars have suggested that embedding anti-Indigenous racism as part of the Canada Health Act is a more robust approach: such a provision would alert provincial and territorial healthcare institutions and organizations to operationalize plans for accountability, and consider how accountability measures can be built in as organizational aspirations.[47] This proposition intersects directly with the recently released report from the Quebec coroner's inquiry into the death of Ms. Joyce Echaquan, which identified, as the top recommendation, for provinces to acknowledge that systemic racism exists and "make the commitment to contribute to its elimination."[48] The community of Manawan, the home of Ms Echaquan, created Joyce's Principle, shown in Box 4.[49] Implementing Joyce's principle requires federal and provincial governments, teaching institutions, professional organizations, and health and social service organizations to work with Indigenous organizations, and,

- address systemic racism,
- resolve underfunding and jurisdictional conflicts,
- hold professionals and health and social service organizations accountable, and
- educate the next generation of health and social service professionals to end systemic and interpersonal racism.

Box 3, Federal action plan to address racism in the healthcare system

• Launching engagements to support the co-development of distinctions-based (First Nations, Inuit, and Métis) Indigenous health legislation.

• $2 million to the First Nations governing authorities of Manawan Atikamekw Council and Atikamekw Nation Tribal Council in Quebec for training and education on the right to equitable access to social and health services, as stated in Joyce's Principle.

• $4 million for the creation of a National Consortium on Indigenous Medical Education led by the Indigenous Physicians Association of Canada, tasked to provide leadership and implement Indigenous-led projects to reform and update the education of physicians.

Box 4, Joyce's Principle

Joyce's Principle aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health.

Joyce's Principle requires the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health.

[47] Johansen, C., Nakagawa, B., Hacker, C., & Oetter, H. (2021). Racism in health care: An apology to Indigenous people and a pledge to be anti-racist. British Columbia College of Nurses & Midwives, College of Dental Surgeons of British Columbia, College of Pharmacists of British Columbia, & College of Physicians and Surgeons of British Columbia. Retrieved from https://www.bccnm.ca/BCCNM/Announcements/Pages/Announcement.aspx?AnnouncementID=267

University of Manitoba Rady Faculty of Health Sciences. (2020). *Rady Faculty of Health Sciences Policy: Disruption of all Forms of Racism*. Winnipeg: University of Manitoba Rady Faculty of Health Sciences. http://umanitoba.ca/faculties/health_sciences/media/Disruption-of-all-Forms-of-Racism_Policy-approved-August-25-2020.pdf

[48] Bureau du Coroner du Québec. (2021), op. cit.

[49] Conseil des Atikamekw de Manawan. (2020), op. cit.

As the legislative framework currently stands, Joyce's Principle depends on the goodwill of governments, teaching institutions and professional organizations.

2.5 The Truth and Reconciliation Commission

The Truth and Reconciliation Commission (TRC) provided those directly or indirectly affected by the legacy of the Indian Residential Schools system with an opportunity to share their stories and experiences. In December 2015, the TRC released its entire 6-volume final report, encouraging all Canadians to read the summary or the final report to learn more about the terrible history of Indian Residential Schools and its sad legacy. Health-relevant calls for action are listed in Box 5, below. These lay out responsibilities for governments and institutions,

> *to recognize healthcare rights of Indigenous people of Canada, to identify and close gaps in health equity by identifying and addressing these groups' unique health needs, to recognize the value of Indigenous perceptions of health and knowledge of traditional healing and practice, to increase the number of Indigenous healthcare professionals, and to incorporate education and training in the health professions that ensure cultural competency (including knowledge of Indigenous health issues, history, formal Aboriginal rights, and Indigenous teachings and practices).*[50]

The TRC calls on all health care stakeholders to work towards the implementation of the calls to action.

Reconciliation plans have been emerging from post-secondary settings,[51] professional organizations[52] and health systems.[53] The scope of these plans, and the extend to which Indigenous peoples are engaged in shaping them, remain to be analyzed. No oversight mechanism has emerged.

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[50] McNally, M., & Martin, D. (2017). First Nations, Inuit and Metis health: Considerations for Canadian health leaders in the wake of the Truth and Reconciliation Commission of Canada report. *Healthc Manage Forum, 30*(2), 117-122. doi:10.1177/0840470416680445. https://www.ncbi.nlm.nih.gov/pubmed/28929885

[51] Castleden, H., Darrach, M., & Lin, J. (2022). Public health moves to innocence and evasion? Graduate training programs' engagement in truth and reconciliation for Indigenous health. *Can J Public Health, 113*(2), 211-221. doi:10.17269/s41997-021-00576-7. https://www.ncbi.nlm.nih.gov/pubmed/34783999

Lane, A., & Petrovic, K. (2018). Educating Aboriginal Nursing Students: Responding to the Truth and Reconciliation Report. *Int J Nurs Educ Scholarsh, 15*(1). doi:10.1515/ijnes-2017-0064. https://www.ncbi.nlm.nih.gov/pubmed/29306922

[52] Anderson, M. (2018). An Indigenous physician's response to the settler physician perspective on Indigenous health, truth, and reconciliation. *Can Med Educ J, 9*(4), e142-e143. https://www.ncbi.nlm.nih.gov/pubmed/30498555

Gasparelli, K., Crowley, H., Fricke, M., McKenzie, B., Oosman, S., & Nixon, S. A. (2016). Mobilizing Reconciliation: Implications of the Truth and Reconciliation Commission Report for Physiotherapy in Canada. *Physiother Can, 68*(3), 211-215. doi:10.3138/ptc.68.3.GEE. https://www.ncbi.nlm.nih.gov/pubmed/27909369

Jaworsky, D. (2018). A settler physician perspective on Indigenous health, truth, and reconciliation. *Can Med Educ J, 9*(3), e101-e106. https://www.ncbi.nlm.nih.gov/pubmed/30140353

Smith, P. (2018). Commentary: A settler physician perspective on Indigenous health, truth, and reconciliation. Ibid*., 9*(3), e107-e108. https://www.ncbi.nlm.nih.gov/pubmed/30140354

[53] Kelly, L. P., & Chakanyuka, C. (2021). Truth before reconciliation, antiracism before cultural safety. *Contemp Nurse, 57*(5), 379-386. doi:10.1080/10376178.2021.1991415. https://www.ncbi.nlm.nih.gov/pubmed/34623223

McGibbon, E. (2019). Truth and reconciliation: Healthcare organizational leadership. *Healthc Manage Forum, 32*(1), 20-24. doi:10.1177/0840470418803379. https://www.ncbi.nlm.nih.gov/pubmed/30514125

Box 5, Truth and Reconciliation's Health-specific Calls to Action

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 previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:

- *i. Increase the number of Aboriginal professionals working in the health-care field.*
- *ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.*
- *iii. Provide cultural competency training for all healthcare professionals.*

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

2.6 The United Nations' Declaration on the Rights of Indigenous Peoples Act (UNDRIP)

The *United Nations Declaration on the Rights of Indigenous Peoples Act* received Royal Assent in June 2022, and immediately came into force.[54] The Act unconditionally commits to the implementation of UNDRIP[55] as a minimum standard. UNDRIP is a broad reaching document referencing Indigenous rights

McNally, M., & Martin, D. (2017), op. cit.

Williams, K., Potestio, M. L., Austen-Wiebe, V., Population, P., & Indigenous Health Strategic Clinical, N. (2019). Indigenous Health: Applying Truth and Reconciliation in Alberta Health Services. *Cmaj, 191*(Suppl), S44-S46. doi:10.1503/cmaj.190585. https://www.ncbi.nlm.nih.gov/pubmed/31801766

[54] UNDRIP (2021), op. cit.

[55] United Nations. (2007). *United Nations Declaration on the Rights of Indigenous Peoples*. Geneva: United Nations. https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html

in social, spiritual, legal, educational, and economic dimensions. Health-specific provisions are shown in Box 6. Implementing UNDRIP will require the "braiding" of Indigenous and western legal traditions.

The Act also reiterates the federal government's commitment to protect Aboriginal and Treaty Rights as recognized and affirmed by section 35 of the Constitution Act 1982.[56] It also commits to the adoption of an action plan, as shown in Box 7.[57]

There is evidence that this plan is being implemented in British Columbia.[58] Evidence from other jurisdictions could not be located.

Box 6, Health related commitments under UNDRIP

Article 23	*Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.*
Article 24	*1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.*
	2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Box 7, UNDRIP implementation action plan

6 (2) (a) measures to (i) address injustices, combat prejudice and eliminate all forms of violence, racism and discrimination, including systemic racism and discrimination, against Indigenous peoples and Indigenous elders, youth, children, women, men, persons with disabilities and gender diverse persons and two-spirit persons, and
(ii) promote mutual respect and understanding as well as good relations, including through human rights education;

6 (2) (b) measures related to monitoring, oversight, recourse or remedy or other accountability measures with respect to the implementation of the Declaration; and

6 (3) measures related to monitoring the implementation, reviewing and amending the Action Plan.

[56] Canada (1982), op. cit.

[57] UNDRIP (2021), op. cit.

[58] https://www2.gov.bc.ca/gov/content/governments/indigenous-people/new-relationship/united-nations-declaration-on-the-rights-of-indigenous-peoples/implementation

3. HOW THE LEGISLATIVE FRAMEWORK HAS BEEN APPLIED TO DATE

Current jurisprudence on the Treaty Right to Health includes access to all treatment and medication free of charge. While the federal government has decided to rely on the courts to define Aboriginal rights, court rulings have been repeatedly ignored. A recent case in point is the series of Canadian Human Rights Tribunal rulings between 2007 and 2022 were continuously ignored, causing delays in implementing Jordan's Principle.[59]

Policy options extended to First Nations have been shaped by historical decisions, and more recently, informed by the legislative framework in place. The UNDRIP Act and the TRC Calls for Actions add to this policy framework, but fail to provide clear pathways to expand the space given to First Nations self-government and self-determination.

The following section illustrates the disconnects that exist between the legislative and policy frameworks, using the 1979 Indian Health Policy and the Health Transfer Policy as exemplars.

3.1 The Indian Health Policy 1979

The emergence of the Health Transfer Policy is linked to a series of events that reshaped relations between First Nations and the nation-state. A possible first is the 1966 Hawthorn Report,[60] the first comprehensive survey of on-reserve social and economic conditions. The report, commissioned by the liberal government, emphasised the dismal living conditions on Indian reserves, and recommended a shift from caretaking and management to economic development.

It is unclear to what extent the Hawthorn report, as opposed to ideology, actually informed subsequent developments.[61] The Trudeau's liberal government was elected in 1968, having fought a campaign couched in liberal ideology under the slogan *The Just Society,* advocating for equality and human rights on an individual basis. The Trudeau government's position on Indian affairs was articulated in what became known as the 1969 *White Paper* calling for the repeal of the Indian Act; the dismantling of the Department of Indian Affairs; the elimination of the Indian reserve system, and the

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[59] First Nations Caring Society. (2016). *Information Sheet Canadian Human Rights Tribunal Decisions on First Nations Child Welfare and Jordan's Principle Case Reference CHRT 1340/7008*. Ottawa. https://fncaringsociety.com/sites/default/files/Info%20sheet%20Oct%2031.pdf

Lett, D. (2008). Jordan's Principle remains in limbo. *Canadian Medical Association Journal, 179*(12), 1256.

Sinha, V., & Wong, S. (2015). Ensuring First Nations children's access to equitable services through Jordan's Principle: The time to act is now. *Paediatrics and Child Health, 20*(2), 62-64.

The Jordan's Principle Working Group. (2015), op. sit.

Sinha, V., Sangster, M., Gerlach, A. J., Bennett, M., Lavoie, J. G., Lach, L. L., Balfour, M., & Folster, S. (2022). *The Implementation of Jordan's Principle in Manitoba: Final Report*. Winnipeg. https://manitobachiefs.com/wp-content/uploads/22-01-28-The-Implementation-of-Jordans-Principle-in-Manitoba-Final-Report.pdf

[60] Hawthorn, H. (1966). *A Survey of the Contemporary Indians of Canada Economic, Political, Educational Needs and Policies Part 1 (The Hawthorn Report)*. Ottawa: I. A. Branch. http://www.ainc-inac.gc.ca/pr/pub/srvy/sci_e.html

[61] Weaver, S. M. (1981). *Making the Canadian Indian Policy: The hidden agenda, 1968-1970*. Toronto: University of Toronto Press.

inclusion of First Nation peoples in the fabric of Canadian society on an individual basis.[62] This proposal was met with a political mobilisation of First Nations, eventually leading to the formation of the National Indian Brotherhood (now and hereafter the Assembly of First Nations, or AFN) and the withdrawal of White Paper.[63] The Indian Chiefs of Alberta tabled a counter proposal in June 1970: the position paper *Citizen Plus* (also known as the *Red Paper*) proposed to retain legal Indian status; preserve Indian culture through status, rights, lands and traditions; accept legislative responsibility for Indians; support the development of all tribes; modernize the treaties and recognize that land title belongs to Indian people held in trust by Crown.[64]

In 1969, the firm Booz Allen and Hamilton was tasked to study the health and health care needs of Indians in the 'middle north', and to make recommendations. The impetus was probably the federal adoption of the federal Medical Care Act 1966[65] which entrenched a federal obligation for Canada to contribute financially to provinces choosing to provide access to insured services on a non-profit basis.[66] The Act was silent on provision of care to "Indians".

The middle north was a term given by Booz Allen and Hamilton to the northern regions of each province, the historical territory of many Indigenous communities, and of much younger and at times short-lived non-Indigenous communities fueled by resource extraction economies (i.e. mining and logging). The impetus to study the middle north was likely in recognition that provincial health services tended to be located in larger urban and southern centres, leaving much of the middle north with poorer access to emerging provincial services.[67] This focus on the middle north, however, aligned well with a longer-term agenda of offloading obligations onto the provinces, in that the final report recommended that services extend by the federal government *complement* those offered by the provinces: the report did not define federal obligations.

In the report, the reserves were seen as temporary. This was captured by the following quote in which, speaking to the need for new health facilities on-reserve, the consultants recommended,

> *[N]ew [health] facilities should be mobile. It is hoped that, in time, economic development will take place in the Middle North. With the resulting influx of population and increased economic vitality, [provincially-funded] resources for health care would be established, making permanent Indian facilities obsolete. In cases where economic development does not take place, it would be hoped that Indians would move to more economically viable areas and they should be encouraged to do so. If permanent facilities were constructed, their existence might discourage bands from relocating. If the band does relocate subsequent to the construction of a permanent facility, that facility would no longer be suitable.* [68]

This quote captures the ideology of the time, echoing the White Paper, promoting the need to "normalize" First Nations' presence in Canada through assimilation into the social fabric of Canadian society, where access to care is through the provinces. This plan ignored First Nations' aspiration for

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[62] Canada. (1969). *Statement of the Government of Canada in Indian Policy*. Ottawa: Indian Affairs and Northern Development. https://publications.gc.ca/collections/collection_2014/aadnc-aandc/R32-2469-eng.pdf

[63] Weaver, S. M. (1981), op. cit.

[64] Ibid.

[65] The Canadian Medical Association. (1966). The Medical Care Act - Bill C-227. *News & Views on the Economics of Medicine, 19*(142), 1-2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1936851/pdf/canmedaj01191-0054.pdf

[66] Lavoie (2018), op. cit.

[67] Booz•Allen & Hamilton Canada Ltd. (1969), op. cit.

[68] Ibid.

self-determination and failed to consider how prevailing racist perspectives might undermine any possibility of First Nations' integration, should individual First Nations opt for greater integration into the Canadian social fabric. Assumptions of a *just society* were not supported by evidence.[69] In addition, the Booz Allen and Hamilton report noted that federal-provincial jurisdictional debates over the responsibility to fund, subsidize or provide services on-reserve resulted in barriers to access care.[70]

The mobilisation of the nineteen-sixties, and the formation of the AFN, acted as a catalyst and led to numerous debates over *the Indian problem* between the federal government and First Nations. In November 1974, at a federal-provincial health ministers' conference, the Minister of National Health and Welfare tabled a *Policy of the Federal Government concerning Indian Health Services*, reiterating that it recognized no statutory or treaty obligations to provide health services to Indians. The federal government nevertheless committed to ensure access to services where provincial services are lacking, and financial support to indigent Indians to access provincial services *when the assistance (was) not otherwise provided*, thereby establishing itself as the payer of last resort, obligated only to complement access to provincial services. [71]

The subsequent 1975 *Indian Relationships Paper*,[72] which was created with First Nations engagement, outlined a policy framework for enhancing First Nations' control over on-reserve health programs and services. A starting point was the creation of two new roles to be added to the on-reserve health care team: the Community Health Representative (CHR) Program and the Native Alcohol and Drug Addiction Program (NNADAP). As a result, 75 percent of First Nations began managing these new roles, through contribution agreements.

In late 1978, the Medical Services Branch issued the *Policy Directive on the provision of uninsured benefits to Indians,*[73] now called the Non-Insured Health Benefit program (NIHB). The directive reflected an apparent belief of widespread abuse in the area of drugs, glasses, dental care and medical transportation. To address escalating costs, the directive proposed to cover only indigent Indians. In response, strong in the belief that NIHB was a Treaty right, First Nations marched on Parliament Hill and a group mounted a toll gate at the international border near Cornwall, Ontario, to draw attention to their opposition. In January 1979, the Minister of National Health and Welfare agreed to suspend the implementation of the Directive for 6 months only.[74] It was never reinstated.

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[69] Lux, M. K. (2010). Care for the 'racially careless': Indian hospitals in the Canadian West, 1920-1950s. *Canadian Historical Review, 91*(3), 407-434. doi:10.3138/chr.91.3.407. https://www.utpjournals.press/doi/abs/10.3138/chr.91.3.407

Lux, M. K. (2016). *Separate Beds: a history of Indian hospitals in Canada, 1920s -1980s*. Toronto: University of Toronto Press.

[70] Booz•Allen & Hamilton Canada Ltd. (1969), op. cit.

[71] Department of National Health & Welfare. (1974). *Policy of the Federal Government concerning Indian Health Services*. Ottawa

[72] Castile, G. P. (2006). *Taking Charge: Native American Self-Determination and Federal Indian Policy, 1975-1993*. Tucson: The University of Arizona Press.

[73] National Health and Welfare Canada. (1978). *Policy directive for the provision of uninsured medical and dental benefits to status Indians and Inuit*. Ottawa: National Health and Welfare Canada

[74] Young, T. K. (1984). Indian health services in Canada: a sociohistorical perspective. *Social Science & Medicine, 18*(3), 257-264.

This protest might have also been the catalyst for the 1979 *Indian Health Policy*, which recognised three pillars: community development, the traditional relationship of the First Nations to the Federal Government, and the Canadian health system.[75] It is most likely in preparation for the tabling of the policy that the same year, Justice Thomas Berger was commissioned to define a process designed to effectively engage First Nations and Inuit in the on-going consultation process anticipated to support this policy. He proposed that $800,000 be utilized to fund the AFN and provincial First Nation organizations, and that another $150,000 be housed at the AFN for the formation of a *National Commission of Inquiry on Indian Health*.[76]

Three months after the tabling on the *Indian Health Policy*, the *Indian Health Discussion Paper* was issued, outlining a possible process to transfer of existing health services to First Nation communities.[77] By May 1981, Monique Bégin, then Minister of National Health and Welfare, tabled a document exploring the possibility and complexities of transferring existing services to First Nations.[78] By 1982, the *Community Health Demonstration Program* was in place to support First Nations to experiment with different models of community based service delivery.[79]

The *Health Transfer Policy* was announced by Minister Jake Epp in 1986, presumably in answer to pressure by demonstration projects for assurance of continued funding. A national consultative conference was held with the AFN in November 1987 to explore concerns.[80] The conference yielded 94 recommendations to Health Canada, spanning issues of Aboriginal and Treaty Rights, jurisdiction, transfer process and negotiations, funding and facilities, personnel, and north of 60-specific issues. These recommendations were documented, along with federal government's response,[81] and additional comments from the *National Indian and Inuit Community Health Representative Organisation* (NIICHRO)[82] and the *Indian and Inuit Nurses of Canada*.[83] These documents speak to a long list of administrative concerns.

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[75] Crombie, T. H. D. (1979). *Statement on Indian Health Policy*. Ottawa: National Health and Welfare. https://publications.gc.ca/collections/collection_2018/sc-hc/H14-296-1979.pdf

[76] Berger, J. T. R. (1980). *Report of the Advisory Commission on Indian and Inuit Health Consultation*. Ottawa: National Health and Welfare. https://publications.gc.ca/collections/collection_2018/sc-hc/H34-322-1980-fra.pdf

[77] National Health and Welfare. (1979). *Indian Health Discussion Paper*. Ottawa: National Health and Welfare

[78] Bégin, T. H. M. (1981). *Discussion paper: Transfer of Health Services to Indian Communities.* Ottawa: National Health and Welfare

[79] Garro, L. C., Roulette, J., & Whitmore, R. G. (1986). Community control of health care delivery: The Sandy Bay experience. *Canadian Journal of Public Health, 77*(July/August), 281-284.

[80] Assembly of First Nations. (1987). *Special Report: The National Indian Health Transfer Conference*. Ottawa: Assembly of First Nations

[81] Assembly of First Nations. (1989). *Assembly of First Nations comments on M.S.B. response to the Recommendations made at the AFN National Indian Health Transfer Conference in November of 1987*. Ottawa: Assembly of First Nations

[82] National Indian and Inuit Community Health Representatives Organization. (1989). *NIICHRO's comments on NH&W's reponse to the recommendations obtained at the AFN National Indian Health Transfer Conference*

[83] Indian and Inuit Nurses of Canada. (1989). *Comments on MSB Response on Recommendations made at the Transfer Conference in Montreal, November 1987*. Ottawa: Indian and Inuit Nurses of Canada

3.2 The Health Transfer Policy 1986

It is difficult to estimate to what extent the *National Indian Health Transfer Conference* helped shape the subsequent submission to the Treasury Board, required for Health Canada to secure the permission to enter into funding agreements with First Nations. The transfer process was already well underway, with 279 Indian communities located in Saskatchewan, Manitoba, British Columbia and Quebec engaged in pre-transfer activities as early as 1988.[84] The first transfer was completed in Montreal Lake Saskatchewan in 1988, apparently in anticipation of the Treasury Board's approval: the agreement was delayed because of the lack of tools necessary to enact a transfer.[85] Health Canada's submission to Treasury was eventually approved,[86] and Regional Directors advised of the transfer initiative's approval in June 1989.[87] It is important to note that the Health Transfer Policy was positioned by the federal government outside of any discussions of a Treaty Right to Health, with the following provision appearing in Transfer Agreements:

> *Nothing in this Agreement shall: (a) be construed to diminish, derogate from, or prejudice any treaty or aboriginal rights of the Recipient; (b) prejudice whatsoever any applications, negotiations or settlements with respect to land claims or land entitlements between Canada and the Recipient; (c) prejudice whatsoever the implementation of the inherent right to self-government nor prejudice in any way negotiations with respect to self-government involving the Recipient.*[88]

The *Health Transfer Policy* has provided a somewhat flexible framework with regards to governance: individual First Nations might pursue the transfer of community-based positions (termed 1st level transfer). Or First Nations might pursue transfer under the umbrella of a Tribal Council (regional consortium of First Nations, with voluntary membership) or other organizational cluster of communities. If a regional model is pursued, regional positions previously held by Health Canada (termed 2nd level transfer, nutritionists and environmental health officers for examples) may be transferred in addition to community-based positions. In some cases, 3rd level transferred, i.e. the transfer of the Medical Officer of Health and nursing supervisory positions, have also been transferred.[89]

Positions listed in the transfer agreement originally included all community-based and some regional positions. Transfer agreements with the Meadow Lake Tribal Council (SK), Peter Ballantyne Cree Nation (SK), Lac LaRonge Indian Band (SK), the Prince Albert Grand Council (SK) and Berens River First

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[84] Health and Welfare Canada. (1989). The transfer of health services to Indian control. *Saskatchewan Indian Federated Journal, 4*(1), 7-11-17-15.

[85] Bird, L., & Moore, M. (1991). The William Charles Health Centre of Montreal Lake Band: a case study of transfer. *Arctic medical research, Supplement 50 (1-4)*, 47-49.

[86] National Health and Welfare, & Treasury Board of Canada. (1989). *Memorandum of Understanding between the Minister of National Health and Welfare and the Treasury Board concerning the Transfer of Health Services to Indian Control*. Ottawa: National Health and Welfare

[87] Nicholson, J. (1989). Memorandum from the Assistant Deputy Minister, Medical Services Branch, Health Canada, to Regional Directors (pp. 7). Ottawa: Health Canada, Medical Services Branch,

[88] Lavoie et al. (2005), op. cit.

[89] Merasty, R. (2001, June 21, 2001). NITHA, Health Canada Sign Demonstration Project for third level health services, The project is the first of its kind in Canada. *PAGC Tribune*.

Health Canada (FNIHB). (2001). *Transfer policy for 2nd and 3rd level services*. Ottawa: Health Canada First Nations and Inuit Health Branch

Health Canada Medical Services Branch. (1991). *Critical Mass Policy*. Ottawa: Health Canada Medical Services Branch

Nations (MB) included primary care nurses. The transfer of primary care nurses was apparently halted thereafter because of concerns from the Public Service Commission which threatened a national strike if primary care nurses were to continue to be transferred to First Nation authorities. Thus, across most of Canada, First Nation-employed staff and federal staff work to provide a complement of primary care services to community members. In my experience, where primary care nurses have been transferred, team-based work is more readily evident. Where primary care nurses remain federal employees, divergent directives, employment benefits, employer's culture, create challenges for the implementation of an integrated approach.

Some First Nations have opted to integrate health under the political umbrella of Chief and Council. In these cases, a Health Committee is generally appointed by Chief and Council to advise on health programs. Others, especially the larger First Nations, may have opted to set up an arm length corporation, to ensure some insulation from potential financial liabilities that may be incurred by Chief and Council through economic development activities. In such cases, Chief and Council may either appoint the Health Board, or the Health Board may be elected directly by the membership. In cases where a regional structure is set up,[90] the regional Health Board may work with local Health Committees. Since the Health Board remains liable for all decisions, Health Committees usually retain an advisory role.

Historically, the majority of health service provided on-reserve was from nurses.[91] This nursing-focused model evolved out of necessity: economies of scale often meant that communities were too small to make the presence of a physician economical; and recruitment and retention issues were compounded for physicians. Health Canada began a CHR program in 1974 to support the primarily non-Indigenous nurses working on reserve. The CHRs were to assure a linguistic and cultural liaison with the community, thus supporting the nurses in the delivery of clinical and public health services. They were not and still are not considered health professionals. In the early years, the role of the CHR expanded and contracted at the whims of the nurse in charge, spanning the direct delivery of midwifery services to strictly clerical and translation roles. They received little formal training, other than what nurses were prepare to deliver on-the-job. Informal discussions with senior CHRs over the past 10 years nevertheless point out that in the early years of the program, CHRs were likely to perform tasks that are no longer allowed under the health professions' scope of practice legislation and regulations. The current role is more likely to be that of translation, health promotion, contact tracing for infectious diseases and collaborating with nurses in immunization or prenatal clinics. Although there have been talks that the CHRs program was a step towards training Indigenous nurses, this has proven difficult to implement, and has not been facilitated by the federal government.

3.3 Continued role of the federal government in a post-transfer environment

With the implementation of the Health Transfer Policy, the role of federal government began to shift away from direct service provision. The residual role of the branch has been discussed repeatedly over

[90] As in the cases of multi-community First Nations or when transfers are undertaken under the umbrella of a Tribal Council.

[91] The extended scope of practice means that nurses working on reserve can prescribe a limited number of drugs, perform basis interventions such as sutures, etc. The scope of practice is determined in collaboration with the provincial nursing licensing body, and protected by legislation. Provincial variations have been noted.

the past decades. The 1986 *Sub-Committee on the Transfer of Health Services to Indian Control* initially identified four broad areas:

- Obligations arising from the traditional relationship between First Nations and the federal government, including the continued accountability for prudent management of federal resources appropriated by Parliament for health programs and their achievements, and the assurance of the protection of the health and safety of communities.
- Responsibilities to continue to provide certain health services as a matter of policy: including the provision of direct services to First Nations who do not wish to take on health program responsibilities, the continued provision of non-insured health services, and maintaining a capacity to assist at the request of a community with a major unforeseen or emergency health situations.
- Continuing program responsibilities arising from considerations related to economies of scale: including responsibilities related to education and training currently provided by the federal government as a matter of policy, which would not lend themselves readily to decentralization and transfers because of financial and administrative practicality.
- Responsibilities for health-related developmental assistance to communities, including program support, training, etc.

In 1996, Health Canada released a discussion paper to explore the potential for outsourcing as many responsibilities as possible, in light of a decision from the Departmental Executive Committee to *move out of the direct service delivery business*.[92]

The most recent exercise proposes four residual areas for the federal government: a. managing the accountability relationship with First Nation communities; b. monitoring and evaluation of health plans; c. capacity-building in First Nation communities; and d. provision of *Public Goods*, ie. the development of "goods" or tools such as standards related to all aspects of the design and delivery of community health services; production and dissemination of experiences, good practices and lessons learned in health services delivery and administration; and advocacy related to major community health issues. [93]

In addition, I would argue that there is yet a role to be played to ensure that provincial reforms do not open gaps in services for on-reserve First Nations. Provincial health systems are planned and reformed independently from the federal-First Nation systems, creating opportunities for cost shifting between both governments or for gaps in service to emerge, leaving First Nations in a substandard or no care situation.[94] By virtue of being a *federal jurisdiction*, First Nations have historically had a marginal role, if any role at all, in provincial health care reforms, although there is evidence that this is starting to

[92] Health Canada. (1996). *Refocussed role of Medical Services Branch, Draft*: Health Canada

[93] Schacter, M. (2001). *From means to ends: defining a new role for the First Nation & Inuit Health Branch in a post-transfer world*. Ottawa: Institute on Governance

[94] Lemchuk-Favel, L. (1999). Financing a First Nations and Inuit integrated health system: a discussion document (pp. 78). Ottawa. (Reprinted from: Not in File)

shift, notably in British Columbia[95] and Manitoba.[96] The federal government may also have a role in monitoring federal-provincial and First Nations to First Nations funding inequities,[97] and the performance of the provinces and territories in addressing systemic and interpersonal racism.[98]

3.4 Contemporary Context

While tweaks have been done to the *Health Transfer Policy* following the release of the 2005 evaluation,[99] the framework of the Policy has remained, and continues to be used albeit with slightly different terminology.[100] A recent analysis shows that communities and Tribal Councils which operate under the *Health Transfer Policy*, have in fact limited opportunities to exercise control over the delivery of health services, and the authority they hold is over a limited number of programs.[101]

Beyond the *Health Transfer Policy*'s framework, tripartite models have also emerged. Some are the product of land claim agreements: the *Cree Board of Health and Social Services of James Bay* (CBHSSJB), and the *Nunavik Regional Board of Health and Social Services* (NRBHSS),[102] as well as the

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[95] Gallagher, J., Mendez, J. K., & Kehoe, T. (2015). The First Nations Health Authority: a transformation in healthcare for BC First Nations. *Healthcare Management Forum, 28*(6), 255-261. http://journals.sagepub.com/doi/abs/10.1177/0840470415600131?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed

O'Neil, J. D., Gallagher, J., Wylie, L., Bingham, B., Lavoie, J. G., Alcock, D., & Johnson, H. (2016). Transforming First Nations' health governance in British Columbia. *International Journal of Health Governance, 21*(4), 229-244. doi:DOI 10.1108/IJHG-08-2016-0042. http://www.emeraldinsight.com/doi/pdfplus/10.1108/IJHG-08-2016-0042

[96] Lavoie, J. G., Phillips-Beck, W., Clark, W., Star, L., & Dutton, R. (2020). Mapping Manitoba health policy response to the outbreak. In A. Rounce & K. Levasseur (Eds.), *Manitoba in Lockdown: Public Policy Conversations about COVID-19* (pp. 9-25). Winnipeg: University of Manitoba Press.

Clark, W., Lavoie, J. G., Nickel, N., & Dutton, R. (2020). Manitoba Inuit Association's rapid response to ensuring an Inuit identifier in COVID-19 testing within Manitoba testing processes. *American Indian Culture and Research Journal, 44*(3), 5-14. doi:https://doi.org/10.17953/aicrj.44.3.clark_etal. https://meridian.allenpress.com/aicrj/article-abstract/44/3/5/467369/Manitoba-Inuit-Association-s-Rapid-Response-to?redirectedFrom=fulltext

[97] Lavoie, J. G., Forget, E., & O'Neil, J. D. (2007). Why equity in financing First Nation on-reserve health services matters: Findings from the 2005 National Evaluation of the Health Transfer Policy. *Healthcare policy, 2*(4), 79-98. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585472/pdf/policy-02-79.pdf

[98] Truth and Reconciliation Commission of Canada. (2015), op.cit.

[99] Amalgamation of separate programs, increased budgetary line flexibility, some consolidation of reporting requirements, etc.

Lavoie et al. (2005), op. cit.

[100] The terms non-transferred, integrated and transferred became set, transitional, flexible and flexible transfer. Both sets of terms reflected a gradient in terms of flexibility and autonomy. Health Canada (FNIHB). (2008). *Contribution Funding Framework and Agreement Modification*. Ottawa: Health Canada (FNIHB)

[101] Marchildon (2021), op. cit.

[102] Bearskin, S., & Dumont, C. (1991, 1991). *The Cree Board of Health and Social Services of James Bay: the First Twelve Years - 1978-1990.* Paper presented at the 8th International Congress on Circumpolar Health, Whitehorse, Yukon, Canada. (1974). *The James Bay and Northern Quebec Agreement (JBNQA)*. Ottawa: Indian and Northern Affairs Canada. https://www.rcaanc-cirnac.gc.ca/eng/1407867973532/1542984538197

NWT Tłı̨chǫ Government.[103] Some are tripartite agreements designed to improve access to care, for example, the Saskatchewan-based *Athabasca Health Authority* (AHA).[104] Others resulted from the transfers of First Nations' hospitals to First Nations' control: the Saskatchewan Fort Qu'Appelle Tribal Council and Associated First Nations' All Nations' Healing Hospital and the Norway House Cree Nation Health Centre of Excellence.[105]

The most noticeable model that emerged is the creation of the British Columbia *First Nation Health Authority* (FNHA) in 2013, funded and empowered by the federal government to shoulder federal responsibilities previously managed by the regional federal office. The FNHA is led and governed by the *First Nations Health Council*, in partnership with BC First Nations, the *Provincial Health Services Authority*, and the Regional Health Authorities across the province. First Nation communities fully participate in health care planning and delivery of on-reserve health services.[106]

In the Atlantic provinces, discussions suggest some interests in the creation of an Atlantic-wide or province-wide First Nations Health Authority.[107] In Manitoba, the report Wahbung articulates a vision of an integrated, province-wide First Nations-led health care system.[108] Discussions have been side-tracked by the COVID-19 pandemic, although in the Manitoba context, concerns have been expressed that although First Nations in British Columbia had been supported in creating a model of province-wide transfer fitting their needs, other provincial an d territorial First Nation organizations (PTOs) were now expected to simply adopt this model, this despite different contexts, history, relationships, etc.

Province-wide models increase the leverage First Nations may exercise over federal and provincial policy, and service delivery. In the context of the BC FNHA, the leverage exercised by FNHA by virtue of its size, has resulted in greater integration of provincial and First Nations health services, and improvements in access to respectful and responsive care, through transformations at the structural,

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[103] Canada, Government of the Northwest Territories, & The Tłı̨chǫ. (2003). *Land Claims and Self-Government Agreement among the Tlı̂chô and the Government of the Northwest Territories and the Government of Canada*. Ottawa: Canada. https://www.tlicho.ca/sites/default/files/documents/government/T%C5%82%C4%B1%CC%A8cho%CC%A8%20Agreement%20-%20English.pdf

[104] Saskatchewan. (2007). Athabasca Health Authority. *Athabasca Health Authority*. Retrieved from http://www.health.gov.sk.ca/athabasca-health-authority

[105] Marchildon (2021), op. cit.

[106] Gallagher (2015), op. cit.

O'Neil (2016), op. cit.

[107] Atlantic First Nations Health Partnership. (2020). *First Nations Control Models: Exploring the Devolution of Health Program Funding in Atlantic Canada*. Halifax. https://www.apcfnc.ca/wp-content/uploads/2020/07/FN_Health_Control_Models_FINAL.pdf

[108] The Asembly of Manitoba Chiefs. (2019). *Wahbung Our Tomorrows Imagined: Vision for the Next 50 Years*. Winnipeg. https://reospartners.com/wp-content/uploads/2019/12/Wahbung-Our-Tomorrows-Imagined_FINAL.pdf

systemic and individual levels.[109] Analyses listing challenges and limitations have yet to be published. The Atlantic First Nations Health Partnership [110] noted the following pros and cons with such model:

Table 2, Atlantic First Nations Health Partnership perspective on province-wide approaches to self-determination over health services

Some PROs:	*Some CONs:*
• *Moves accountability for health spending from the federal government to the communities.* • *Creates the opportunity to shift funding from administration to program delivery.* • *Could enable shift from siloed approach to culturally appropriate, holistic funding strategies.* • *Improved opportunities to work across communities for programming efficiencies.*	• *FNHA Board of Directors politically liable for spending choices in a high need, resource strained environment.* • *Gaining consensus among all FN communities on health funding decisions may be challenging*

There are limitations to First Nations authorities shouldering the responsibility for regulatory and accountability functions previously enforced by the federal government, in under-resourced system.

3.5 Self-government and health north of the 60th parallel

Self-government agreements have been signed in the Northwest Territories and Nunavut, however these did not include local control over health services. Nunavut won't be discussed further as it does not include First Nation communities.

Some Yukon First Nations and the Northwest Territories are managing community-based health programs. The Health Transfer Policy was implemented differently north of 60.[111] Arrangements have been either under an *integrated agreement*[112] or through a collection of grants for the management of discrete programs. Recent discussions suggest that some First Nation authorities might want to expand their control over health and other services in the future.[113]

3.6 The obvious gaps

To date, provincial healthcare systems seem to alternatively be unaware of, adverse to, or apathetic towards traditional health knowledge and healing practices upon which some Indigenous

[109] Greenwood, M. (2019). Modelling change and cultural safety: A case study in northern British Columbia health system transformation. *Healthc Manage Forum, 32*(1), 11-14. doi:10.1177/0840470418807948. https://www.ncbi.nlm.nih.gov/pubmed/30514119

[110] Atlantic First Nations Health Partnership. (2020), op. cit.

[111] Lavoie wt. al. (2013), op. cit.

[112] See footnote 102 for a description.

[113] Marchildon, G. P., Lavoie, J. G., & Harrold, H. J. (2021). Typology of Indigenous health system governance in Canada. *Canadian Public Administration-Administration Publique Du Canada, 64*(4), 561-586. doi:10.1111/capa.12441. <Go to ISI>://WOS:000716485500001

peoples rely to achieve and maintain their health and wellbeing.[114] While efforts have been made by the federal government to engage First Nations (the AFN, PTOs) in the development of new programs, the services funded, and regulatory and accountability frameworks, give little space for the creation of localized, adapted, holistic, culturally-informed approaches to support individuals, families and community wellbeing.[115] Integrated models have emerged in a few communities.[116] In many other communities, both systems co-exist in parallel, with little interactions, and mutual distrust.

Barriers to the integration of traditional and Western care are related to,

- The hegemonic mindset prevalent in medicine, where traditional healing modalities are side-stepped, ignored or trivialized in favour of biomedically-informed services;
- The limited space and support communities have received to date to rediscover and recover traditional practices and modalities, and develop integrated models of care. This point is linked to the momentum of on-reserve health services provided, which are a result of underfunding and understaffing, swallows all energies.
- Limited funding to support patients and families wanting to access traditional healing. Accessing required care may involve travel across jurisdictions, as healers are specialized.[117]

Box 8, Traditional healer services travel policy

8.1 *Medical transportation benefits, within the client's region or territory of residence, may be provided for clients to travel to see a traditional healer or, where economical, for a traditional healer to travel to the community.*

8.2 *Medical transportation benefits to access traditional healer services must be preauthorized by FNIHB or a First Nations or Inuit health authority or organization. On an exception basis, authorization may be granted after the fact by FNIHB or a First Nations or Inuit health authority or organization when appropriate medical justification is provided and approved.*

8.3 *When the traditional healers selected by the client are outside of the client's region or territory of residence, travel costs will be reimbursed for travel to the regional or territorial border only.*

8.4 *The following criteria must be considered prior to approving medical transportation benefits for traditional healer services:*

i. the traditional healer is recognized as such by the local band, tribal council or health professional

ii. a licensed physician can confirm that the client has a medical condition

ii. if a licensed physician is not routinely available in the community, then a community health professional or FNIHB representative can confirm that the client has a medical condition.

[114] Reading, C. L., & Wien, F. (2009). *Health inequalities and the social determinants of Aboriginal peoples' health*: National Collaborating Centre for Aboriginal Health Prince George, BC.

Kyoon Achan, G., Eni, R., Kinew, K. A., Phillips-Beck, W., Lavoie, J. G., & Katz, A. (2021). The Two Great Healing Traditions: Issues, Opportunities, and Recommendations for an Integrated First Nations Healthcare System in Canada. *Health Syst Reform, 7*(1), e1943814. doi:10.1080/23288604.2021.1943814. https://www.ncbi.nlm.nih.gov/pubmed/34375567

[115] Ibid.

Tenbensel, T., Dwyer, J., & Lavoie, J. G. (2013). How not to kill the golden goose: Reconceptualising accountability relationships in community-based third sector organisations. *Public Administration Review, 16*(7), 925-944. doi:10.1080/14719037.2013.770054. http://dx.doi.org/10.1080/14719037.2013.770054

[116] A partial list includes: Moose Factory (FN) and Moosenee hospital in northeastern Ontario, Sioux Lookout Hospital and the hospital for Sick Children in Toronto, Ontario, Opaskwayak Cree Nation and St. Anthony's Hospital in the Pas, Northern Manitoba, a primary care clinic on the Six Nation reserve.

[117] Kyoon Achan (2021), op. cit.

Indigenous Services Canada supports access to traditional healers (Box 8)[118] although the policy is restrictive, in that it is limited to traditional healers located in one's region, to treat a condition recognized by a physician. The growth in the number of Indigenous physicians able and willing to support access to traditional healers might mitigate the shortcoming of this policy to some extend, still the premise is problematic, colonial and dated.

Integrated models of care have emerged primarily in settings outside of the Health Transfer Policy.[119] This begs the question, what structural barriers prevent transferred communities from pursuing the creation of integrated models of care. Noted barriers to such integration include cultural arrogance on the part of Western practitioners, lack of trust on the part of First Nation patients and healers, and fear of cultural appropriation and commercialization of traditional medicine.[120] Thus, while some progress is notable, substantial barriers remain.

A review of provincial and territorial legislation and policies containing Indigenous-specific provisions revealed a drafty patchwork of provisions, covering issues of traditional midwifery, ceremonial use of tobacco and instances where provincial governments might enter into agreements with Chief and Council for the provision of care. These provisions fail to clarify jurisdiction.[121] Evident in this patchwork is a lack of federal leadership guiding the provinces and territories towards articulating clear pathways for system integration to guarantee equitable access and continuity of quality care.

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[118] Indigenous Services Canada. (2019). *Non-Insured Health Benefits (NIHB) Medical Transportation Policy Framework for First Nations and Inuit (Interim)*. Ottawa. https://www.sac-isc.gc.ca/eng/1579891130443/1579891286837#a9

[119] Allen, L., Hatala, A., Ijaz, S., Courchene, E. D., & Bushie, E. B. (2020). Indigenous-led health care partnerships in Canada. *Canadian Medical Association Journal,, 192*(March 2), E208-E216. doi:https://doi.org/10.1503/cmaj.190728. https://www.cmaj.ca/content/192/9/E208.short

Redvers, N., & Blondin, B. (2020). Traditional Indigenous medicine in North America: A scoping review. *PLoS One, 15*(8), e0237531. doi:10.1371/journal.pone.0237531. https://www.ncbi.nlm.nih.gov/pubmed/32790714

[120] Allen et al. (2020), op. cit.

Redvers & Blondin (2020), op. cit.

[121] Lavoie et al. (2013), op. cit.

Halseth, R., & Murdock, L. (2020). *Supporting Indigenous Self-Determination in Health: Lessons Learned from a Review of Best Practices in Health Governance in Canada and Internationally*. Prince George BC: N. C. C. f. I. Health. https://www.nccih.ca/Publications/Lists/Publications/Attachments/317/Ind-Self-Determine-Halseth-Murdoch-EN-web-2020-12-02.pdf

4. FIRST NATION GOVERNANCE AND THE LEGISLATIVE FRAMEWORK: CONSIDERATIONS FOR RENEWAL

To summarise points made above, to date,

1. The federal government has opted to leave it to the courts to define Indigenous and Treaty Rights.
2. The courts, through Dreaver (1935) and Wuskwi Sipihk (1999), have ruled that a Treaty Right to Health, not restricted to Treaty 6, exists and should be understood in contemporary terms.
3. Federal policies related to health services provided on-reserve, have been positioned outside of Aboriginal and Treaty Rights discussions.
4. Federal obligations have been defined as complementary to the provinces, leading to continued confusion over federal-provincial obligations, jurisdictional gaps, and inequities.
5. Pathways to implement UNDRIP, the TRC Calls to Actions and Joyce's Principle have yet to be created.

Considerations for moving forward include two broad categories: the framing of the legislative instrument, and its content.

4.1 Framing the legislative instrument

The Canada Health Act, which is predicated on voluntary membership, shared principles and financial incentives for compliance, presents a viable option to benchmark Treaty obligations, and setting up mechanisms and processes for identifying and resolving jurisdictional confusion, and holding to account federal, provincial, territorial governments, health systems, health organizations, professional organizations, to investigate, address and prevent systemic and interpersonal racism.[122] Possible overarching principles could include:

- ✓ Portability of Indigenous rights;
- ✓ A commitment to addressing systemic racism; and
- ✓ Specific provisions for professional organizations, universities and colleges, health systems to address anti-Indigenous racism.

4.2 Considerations of the content of a distinction-based First Nation health legislation

First, the pursuit of a more equitable health care system for First Nations has to date been left to the goodwill of governments, teaching institutions, professional organizations, and health and social service organizations. In relation to health care, the federal government has continuously positioned its obligations as complementary to those of the provinces.[123] Despite jurisprudence, federal obligations remain undefined, leaving ambiguities and gaps. A key consideration then, could be to ensure that the legislation lists federal obligations, based on jurisprudence. This point was raised in UNDRIP, and in the TRC Call for Actions.

Second, tripartite agreements in each province and territory could entrench mechanisms to address jurisdictional obligations and gaps, and co-create solutions. Overseeing these agreements will require resourcing and mechanisms to impose solutions. Joyce's Principle recommended the creation of ombudsmen offices to ensure that obligations are honoured.

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[122] Lavoie, J. G. (2013). Policy silences: why Canada needs a National First Nations, Inuit and Metis health policy. *Int J Circumpolar Health, 72*, 22690. doi:10.3402/ijch.v72i0.22690. http://www.ncbi.nlm.nih.gov/pubmed/24380077

[123] Booz•Allen & Hamilton Canada Ltd. (1969), op. cit.

Third, the federally-funded on-reserve healthcare system is a healthcare system, providing essential insured and non-insured health services to First Nations. It is however funded with some limited core funding augmented with a collection of project-like funding, and implemented unequally across the country.[124] The approach is a patchwork, and had yet to be conceptualized and equipped by the federal government as a health care system. A key consideration then would be an explicit recognition of the on-reserve healthcare system as Canada's 14th healthcare system. The implication of this recommendation is an obligation to fund this system through transfers of payment, rather than a through collection of programs and projects, adequate funding for infrastructure, the implementation of electronic Medical Records, quality improvements process, etc. This may also require addressing the short-coming of provincial scope of practice regulations and legislation, which tends to be informed by urban-centric evidence, to ensure that scope of practice regulations can better serve rural and remote contexts.

Fourth, implementing the UNDRIP, TRC's Call to Action and Joyce's Principle require the recognition of rights and the operationalization of Indigenous rights through the endorsement of obligations, spelled out in these documents.[125] This includes specific obligations for federal and provincial governments, medical and nursing schools, and health organizations, shown in Box 9.

These recommendations provide pathways for addressing long standing outstanding issues undermining First Nations' health and access to care.

Box 9, Pathways to address First Nation health inequities: UNDRIP, TRC and Joyce's Principle

Federal government	• *Federal acknowledgement that inequities are a direct result of past policies;*
	• *Federal monitoring of progress towards health equity, using indicators co-developed with Indigenous peoples;*
	• *Federal financial support of existing and new Indigenous healing centres to address the physical, mental, emotional, and spiritual harm incurred because of past policies.*
Post-secondary institutions	• *Increase the number of Indigenous health professionals, ensure retention.*
	• *Cultural competency training for all healthcare professionals.*
	• *Medical and nursing schools in Canada to require all students to take a course dealing with Indigenous health issues.*
Professional organizations	• *Professional orders to include Indigenous peoples on their Boards*
Health organizations	• *Health organizations commit to continuous education, including cultural safety. Monitoring should be in place (Ombudsman), and a commitment to address any manifestation of racism against Indigenous peoples.*

[124] Lavoie (2007), op. cit.

[125] See Appendices I and II for a mapping of recommendations and Calls to Action from these sources.

5. CONCLUSION

Until now, the framework informing federal policy development has been that of a transfer of, at best, loosely defined federal responsibilities to First Nation organizations. Such transfer has been supported by a legislative patchwork. This fragmented approach, which continues to hinge on the off-loading of poorly defined federal responsibility for the health of First Nations onto the provinces, has perpetuated inequities, ignored Treaty obligations, and is misaligned with commitments to the implementation of UNDRIP and the TRC Calls to actions. I content that unless addressed, this approach will perpetuate inequities and reproduce the conditions that led to the tragic death of Ms Echaquan, of Mr Brian Sinclair,[126] and of the continued reports on interpersonal and systemic racism experienced by First Nations and other Indigenous groups.

As a result of self-government negotiations and the Health Transfer Policy, First Nations now manage a patchwork of health projects and programs, rather than a system. The recognition of the 14th healthcare system in Canada is necessary, and creating pathways to effectively integrate a full continuum of care across jurisdictions, is required.

Beyond health and health care, attention to First Nation determinants of health is required, including cultural continuity, environmental stewardship, community infrastructure and assets, educational systems, justice, employment and income, and food security.[127] Addressing these determinants will improve individual, family and community's health and reduce reliance on health and social services.

I hope that this document provides useful pathways to address these long standing and well documented issues.

In solidarity, always,

[126] Brian Sinclair Working Group. (2017). *Out of Sight: A summary of the events leading up to Brian Sinclair's death and the inquest that examined it and the Interim Recommendations of the Brian Sinclair Working Group*. https://www.dropbox.com/s/wxf3v5uh2pun0pf/Out%20of%20Sight%20Final.pdf?dl=0

[127] Loppie (2014), op. cit.

Greenwood (2015), op. cit.

APPENDIX I, MAPPING RIGHTS ACCORDING TO UNDRIP, THE TRC CALLS TO ACTION AND JOYCE'S PRINCIPLE

Focus	UNDRIP	TRC	Joyce's Principle
1. Implement health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties, including those who live off-reserve.		TRC Calls 18, 20	
2. Right, without discrimination, to the improvement of economic and social conditions, including… health and social security.	Article 21.1	TRC Call 18	
3. Right to determine and develop priorities and strategies for exercising their right to development.	Article 23		
4. Right to be actively involved in developing and determining health...and other social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.	Article 23		
5. Right to traditional medicines and health practices, including the conservation of their vital medicinal plants, animals and minerals.	Article 24.1	TRC Call 22, calling for inclusion in the healthcare system	
6. Right to access, without any discrimination, to all social and health services, regardless of jurisdiction.	Article 24.1		Article 1, VII, Article 2, I calls for an Ombudsman office for Indigenous health.
7. Equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.	Article 24.2	TRC Call 18	

APPENDIX II, MAPPING OBLIGATIONS ACCORDING TO UNDRIP, THE TRC CALLS TO ACTION AND JOYCE'S PRINCIPLE

Focus	UNDRIP	TRC	Joyce's Principle
1. Federal acknowledgement that inequities are a direct result of past policies		TRC Call 18	Article 3,I,III calls for government officials to denounce any manifestation of racism against Indigenous peoples and fund awareness campaigns.
2. Federal government monitoring progress towards health equity, using indicators co-developed with Indigenous peoples.		TRC Call 19	Article 1.IV
3. Federal government to financially support existing and new Indigenous healing centres to address the physical, mental, emotional, and spiritual harm incurred because of past policies.		TRC Call 21	Article 1.II, extended to all health and social services, with program funding equitable to that of the provinces.
4. Increase the number of Indigenous health professionals, ensure retention.		TRC Call 23	Article 4,II
5. Cultural competency training for all healthcare professionals.		TRC Call 23	Article 5,I
6. Medical and nursing schools in Canada to require all students to take a course dealing with Indigenous health issues.		TRC Call 24	Article 4,I, III-IV, adds inclusion of Indigenous people in teaching and decolonization
7. Professional orders to include Indigenous peoples on their Boards			Article 5, II
8. Health organizations commit to continuous education, including cultural safety. Monitoring should be in place (Ombudsman), and a commitment to address any manifestation of racism against Indigenous peoples.			Article 6

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