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The Governance of Indigenous Health

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Chapter 6

THE GOVERNANCE OF INDIGENOUS HEALTH

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State governance of Indigenous health in Canada is burdened by inequitable administrative structures and policy-based arrangements which were born of eras that denied the right of Indigenous peoples to self-govern. Although no longer resting on explicitly racist premises, this governance regime remains only partially aligned with Indigenous understandings of health and well-being. Moreover, no federal entity has assumed responsibility for a national governance structure, nor have the provinces and territories committed to a comprehensive governance structure to foster Indigenous health. The result is a cumbersome series of programs and policies with varying criteria for access, even among Indigenous populations within the same region. Governance of Indigenous health lacks the foundational principles that otherwise underpin health care governance in Canada.[1]

The unique constitutional dimensions of Indigenous status further challenge coherence in the system. These dimensions both overlap with and go beyond questions about state jurisdiction and obligations. From the perspective of the federal and provincial governments, Indigenous peoples are residents of provinces. As such, they have the same rights as any other resident to provincially insured health care services.[2] However, pursuant to section 91(24) of the *Constitution Act*, *1867*,[3] the federal government has jurisdiction over "Indians, and lands reserved for the Indians". Under this head of power, the federal government could and has played a role in supporting the health of people who are "Indians".[4] In practice, however, while the federal government provides health-related support for some First Nations people and Inuit, many Indigenous peoples are excluded from its Indigenous-specific health care supports. These "jurisdictional wasteland[s]", where neither the federal nor

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[1] For example, the *Canada Health Act*, R.S.C. 1985, c. C-6 identifies four foundational principles that are to structure all provincial health care regimes if those regimes are to receive transfer payments. See Chapter 3, The Role of Law in the Rise and Fall of Canadian Medicare, in this volume.

[2] See, *e.g.*, *Health Insurance Act*, R.S.O. 1990, c. H.6, s. 11; *Canada Health Act*, R.S.C. 1985, c. C-6, s. 2.

[3] (U.K.), 30 & 31 Vict., c. 3.

[4] The nature and scope of this role was recently considered in *Daniels v. Canada (Indian Affairs and Northern Development)*, [2016] S.C.J. No. 12, 2016 SCC 12 (S.C.C.) and is discussed further below.

provincial government will assume responsibility for Indigenous-specific health care, result in egregious health care gaps for Indigenous peoples.[5]

While Indigenous individuals and communities seek improved state-government support for health, they also seek it on their own terms. The right of Indigenous peoples to be actively involved in state government decisions about health and well-being is clearly supported by international law.[6] Indigenous control over Indigenous health governance is further motivated by the co-relation between Indigenous self-determination and Indigenous well-being,[7] a critical finding in light of the fact that Indigenous peoples' health, looked at from a wide variety of factors, consistently lags far behind that of non-Indigenous peoples in Canada.[8]

This chapter explores these dynamics of Indigenous health governance in Canada. It opens by describing how Indigenous peoples have successfully used constitutional arguments to assert their own vision of well-being, within the broader context of colonial oppression and attempts to erase Indigenous knowledge and culture. The chapter then tracks federal initiatives on Indigenous health, in their design and outcomes, and how they evolved into the contemporary state governance regime. The next part turns to provincial and self-government initiatives that have expanded, but also complicated, Indigenous health governance in Canada. The chapter closes by considering different ways in which provinces, territories and First Nations governments approach the regulation of traditional healers and midwives.[9] In an effort to recognize the human lives at the centre of state governance regimes, the chapter embeds stories of Indigenous children, their health and lives, within its exploration of Canadian law and policy on Indigenous health.

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[5] *Ibid.*, at para. 14; Constance MacIntosh, "Jurisdictional Roulette: Constitutional and Structural Barriers to Aboriginal Access to Health" in Colleen M. Flood, ed., *Just Medicare: What's in, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 193.

[6] *United Nations Declaration on the Rights of Indigenous Peoples,* UN GAOR, 61st Sess., Doc A/RES/61/295 (October 2, 2007) arts. 21, 23-24.

[7] Bonita Beatty, "Indigenous Health Governance and UNDRIP" in *The Internationalization of Indigenous Rights: UNDRIP in the Canadian Context — Special Report* (Waterloo: Centre for International Governance Innovation, 2014) 49; Michael Murphy, "Self-Determination as a Collective Capability: The Case of Indigenous Peoples" (2014) 15:4 J. of Human Development & Capabilities 320; Kiera Ladner, "Understanding the Impact of Self-Determination on Communities in Crisis" (2009) 5:2 J. of Aboriginal Health 88.

[8] Constance MacIntosh, "Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations" in Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, eds., *Canadian Health Law and Policy*, 4th ed. (Toronto: LexisNexis, 2011) 575 at 597-609.

[9] This flow resonates with the four eras of policy that are described by Josée G. Lavoie, Evelyn L. Forget & Annette J. Browne, "Caught at the Crossroad: First Nations, Health Care, and the Legacy of the Indian Act" (2010) 8(1) Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 83. Other authors identify two eras, see *e.g.*, Miranda D. Kelly, "Toward a New Era of Policy: Health Care Service Delivery to First Nations" (2011) 2:1 The International Indigenous Policy Journal, Article 11.

A. UNDERSTANDING THE POLITICAL PRESENT THROUGH THE LIVED PAST

"J.J." and Makayla Sault are 11-year old Mohawk (Kamienkahagen) girls, who with their families, rejected western medical recommendations in assertion of a different vision of how to live and die well.

As reported in *Hamilton Health Sciences Corp. v. H. (D.)*, J.J. was diagnosed with acute lymphoblastic leukemia in August 2014.[10] Her physicians asserted a 90 to 95 per cent chance that chemotherapy would cure her cancer.[11] J.J. underwent 11 days of chemotherapy before her mother, D.H., withdrew consent for the chemotherapy in pursuit of an alternative course of treatment that drew upon traditional Aboriginal health care practices. D.H.'s First Nations Band supported her decision as an exercise of Aboriginal rights protected under the *Constitution Act, 1982*.[12] Against D.H.'s decision to withdraw consent, McMaster Children's Hospital sought a court order to have J.J. declared a child in need of protection, which would permit Brant Child and Family Services to seize J.J. and resume chemotherapy. They believed this would be in the child's best interests. The judge who heard the application, Edward J., declined to make the order. He wrote "I cannot find that J.J. is a child in need of protection when her substitute decision-maker has chosen to exercise her constitutionally protected right to pursue their traditional medicine over the applicant's stated course of treatment of chemotherapy."[13]

Like J.J., Makayla Sault from the Mississaugas of the New Credit First Nation was a Mohawk girl of 11 who was diagnosed with acute lymphoblastic leukemia, in March of 2014. Makayla sought to discontinue chemotherapy to pursue alternative treatment including traditional Aboriginal medicines. Legal intervention by Brant Family and Children's Services was again considered in this case, but Makayla was found to have fully understood the nature of her condition and to have the capacity to make her own treatment choice, even if from the perspective of western medicine, this choice would likely culminate in a preventable death. When Makayla relapsed, she chose not to resume chemotherapy and died two months later in January 2015. When J.J.'s cancer returned, D.H. re-commenced chemotherapy, while having J.J. continue to participate in traditional Aboriginal healing practices.

These stories, of the refusal of western medicine and its authority, for traditional Aboriginal health care practice, provoked a heated and polarizing debate. Most of those who disagreed with the ruling of Edward J. in *Hamilton Health Sciences Corp. v. H. (D.)* framed the core issue as a conflict between a child's right to life and constitutionalized Indigenous rights, which tilted

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[10] [2014] O.J. No. 5419, 2014 ONCJ 603 (Ont. C.J.) [hereinafter "*Hamilton Health Sciences*"], as amended by [2015] O.J. No. 2214, 2015 ONCJ 229 [hereinafter "*Joint Endorsement*"] (all concur about the nature of the general flow).

[11] *Hamilton Health Sciences*, at paras. 1-3.

[12] Being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.

[13] *Hamilton Health Sciences*, at para. 83.

decisively in favour of pursuing medically indicated treatment that was predicted to preserve life. In deciding otherwise, health care providers criticized the court as betraying the Indigenous community, that "we as a society have failed these girls; this failure undermines the trust and respect that the Aboriginal community so importantly deserves."[14] Those who agreed with Edward J.'s decision tended to argue that Indigenous patients should have the right to access both western and Indigenous healing practices, with the freedom to choose between them.[15] One Mohawk physician characterized the issue as not being about medical choice, but of political self-determination: "[T]his is not just about medical choice … . This is about indigenous people reclaiming their wholeness as people. This isn't about religion; it isn't about choice. It's about being who we are."[16]

The stories of J.J. and Makayla show that health governance occupies a highly charged interface between state and Indigenous governance. These stories speak to profound differences of perspective and practice in what it means to live (and potentially die) well, differences not just epistemological but also paradigmatic. Indigenous individuals and communities in and through health care engage in practices of legal and political resurgence, a conscious resistance to being captured by and subsumed within western values and legal regimes.

In their submissions before the court in *Hamilton Health Sciences Corp.*, the Band argued that D.H.'s decision to withdraw consent for her daughter's chemotherapy was an exercise of Aboriginal rights, recognized and affirmed by section 35(1) of the *Constitution Act, 1982*.[17] Over the last 30 years, the meaning of this provision has been interpreted many times, but usually in the context of conflicts over resources to protect against an otherwise legitimate exercise of state power that unduly infringes on the modern day exercise of historically sourced practices, customs or traditions identified as integral to the culture of an Aboriginal people.[18] Before this case, section 35(1) had never been invoked to protect a treatment decision in the health care context.

Edward J. affirmed the claim and held that Aboriginal healing practices are protected by section 35(1) of the *Constitution Act, 1982* and as such reasoned that:

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[14] Conrad Fernandez, *et al.*, Letter to the Editor, "Protecting the welfare of all Canadian children" (January 27, 2015) C.M.A.J., online: http://www.cmaj.ca/content/187/3/162.full/reply#cmaj_el_727917.

[15] Laura Eggerston, "Doctors Should Collaborate with Traditional Healers" (2015) 187:5 C.M.A.J. E153, online: http://www.cmaj.ca/content/187/5/E153.full; Lisa Richardson & Matthew B. Stanbrook, "Caring for Aboriginal Patients Requires Trust and Respect, Not Courtrooms", Editorial (2015) 187:3 C.M.A.J. 162, online: http://www.cmaj.ca/content/187/3/162.full.

[16] Dr. Karen Hill as quoted in Eggerston, *ibid.*, at E153.

[17] *Hamilton Health Sciences Corp.*, at para. 62.

[18] See *R. v. Van der Peet*, [1996] S.C.J. No. 77, [1996] 2 S.C.R. 507 at para. 65 (S.C.C.). For a discussion of how the historically based customs are recognized as necessarily evolving to remain relevant within the contemporary moment, see *R. v. Sappier*; *R. v. Gray*, [2006] S.C.J. No. 54, [2006] 2 S.C.R. 686 (S.C.C.).

> I cannot find that J.J. is a child in need of protection when her substitute decision-maker has chosen to exercise her constitutionally protected right to pursue their traditional medicine over the applicant's stated course of treatment of chemotherapy.[19]

Moreover, Edward J. refused to condition or otherwise qualify that right on the validation of western medical science.[20] He wrote:

> D.H.'s decision to pursue traditional medicine for her daughter J.J. is her [A]boriginal right. Further, such a right cannot be qualified as a right only if it is proven to work by employing the western medical paradigm. To do so would be to leave open the opportunity to perpetually erode [A]boriginal rights.[21]

Edward J. did not clearly state whether any other ground in the health care context could justifiably limit the right. Under section 35(1), an infringement of Aboriginal rights can be justified if undertaken for a sufficiently compelling and valid legislative purpose, and in a manner consistent with the Crown's fiduciary duty (which is often illustrated by showing, for example, that there was meaningful consultation when the legal regime was developed, and any outstanding infringement was shaped to be minimally impairing).[22] In a follow-up set of reasons, Edward J. referenced how section 35(1) Aboriginal rights are exercised within a layered legal context, and gestured toward a justification standard for their infringement. He wrote that "the Aboriginal right to use traditional medicine … must be considered, among other factors, in any analysis of the best interests of the child"[23] while also emphasizing that a core tenet of Haudenosaunee culture is "the ultimate respect accorded to their children".[24] One reading of this statement is that the constitutionally protected Aboriginal right is subsumed within a statutory or common law best interests of the child test. Another reading is that the Aboriginal right is always presumptively exercised in line with cultural values that already prioritize the child's best interests.

J.J. and her mother, D.H., left the jurisdiction before the application in their case was heard. D.H. may have left because she did not trust that the Canadian legal system would value or respect her choice. She may have rejected the very proposition that the state could legitimately claim to know or understand her child's best interests and thus pursue them. The history of Indigenous health governance in Canada supports such suspicions. This history cannot be divorced from the larger context in which it is embedded. That context has been thick with practices to promote cultural assimilation, undermine Indigenous legal and political structures, and actively devalue Indigenous knowledge about matters

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[19] *Hamilton Health Sciences Corp.*, at para. 83.

[20] *Ibid.*, at paras. 81-82.

[21] *Ibid.*, at para. 81.

[22] *R. v. Sparrow*, [1990] S.C.J. No. 49, [1990] 1 S.C.R. 1075 at 1113 (S.C.C.).

[23] *Joint Endorsement*, Appendix at para. 83a.

[24] *Ibid.*, at para. 4.

that include healing practices and how to pass culture from one generation to the next.

Early relations between settlers and Indigenous peoples were marked by nation-to-nation agreements to enable peaceful co-existence and commitments from European states to protect Indigenous peoples from interference from their settler population.[25] However, this dynamic shifted with settler populations expanding and Indigenous populations becoming weaker due to introduced diseases decimating communities and the loss of traditional food sources such as buffalo. Within this context, the dominion government asserted *de facto* control over the lives of Indigenous peoples and their lands in many regions of Canada. Its vision of the relationship between Indigenous political communities and itself was epitomized in the *Constitution Act, 1867*, in which "Indians" were audaciously deigned to be a subject of federal jurisdiction along with the postal service and navigational buoys.[26]

The opening paragraphs of the Truth and Reconciliation Commission's report on Indian Residential Schools identifies how, for "over a century, the central goals of Canada's Aboriginal policy" included causing "Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada."[27] Children who had been seized from their parents and taken to Indian Residential Schools fell victim to and died from highly contagious illnesses for which the government was unwilling to provide adequate care and for which the government repeatedly blamed the children's genetic make-up.[28] Some children were returned to the communities when they were close to death, and thus acted as unwitting vectors for spreading illness. Recent revelations verified that Indigenous children at residential schools were used as test subjects for medical experiments for vaccines.[29]

The devastation inflicted by introduced disease explains why treaties negotiated at the end of the 19th century — when residential schools were introduced — involved assurances that Indigenous signatories would have access to European healing knowledge and practices.[30] The treaties did not

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[25] Canada, Indigenous and Northern Affairs Canada, *1752 Peace and Friendship Treaty*, online: https://www.aadnc-aandc.gc.ca/eng/1100100029040/1100100029041; *Treaty of Niagara*, *1764*; *Royal Proclamation, 1763* (U.K.), reprinted in R.S.C. 1985, App. II, No. 1.

[26] (U.K.), 30 & 31 Vict., c. 3, ss. 91(24), 91(5), 91(9).

[27] Truth and Reconciliation Commission of Canada, "Canada's Residential Schools: The History, Part 1 – Origins to 1939" in *TRC Final Report*, vol. 1 (Montreal & Kingston: McGill-Queen's University Press, 2015) at 3.

[28] *Ibid.*, at 379, 395, 410-413.

[29] *Ibid.*, at 423.

[30] Canada, Indigenous and Northern Affairs, *Treaty No. 6 between Her Majesty the Queen and the Plain and Wood Cree Indians and other Tribes of Indians at Fort Carleton, Fort Pitt and Battle River with Adhesions* (1876), online: http://www.aadnc-aandc.gc.ca/eng/1100100028710/1100100028783, refers to the Queen granting assistance in the case of pestilence, and of providing a "medicine chest". Records support similar assurances having been negotiated during at least four other treaties. See Constance MacIntosh, "Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations" in Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, eds., *Canadian Health Law and Policy*, 4th ed. (Toronto: LexisNexis, 2011) 575 at 591.

involve the Indigenous signatories agreeing to abandon their healing practices. Nonetheless, the federal government has consistently refused to recognize any responsibility for health support as a manifestation of health-based treaty rights, leading in some instances to treaty signatories litigating for health care supports.[31]

The overall relationship between the Canadian state and Indigenous peoples has been historically dominated by prejudice. Indigenous peoples were cast by the state as "wards" who needed evolutionary guidance to leave their Indigeneity behind and adopt the knowledge, values and practices of the Europeans.[32] The project of erasing Indigenous people's cultural and political identity, including their healing practices, was enacted through criminal legislation, policy and everyday persecutory practice.[33] This enabled a new status quo where the majority of Indigenous healers were forced to abandon their practices, and Western healing practices became dominant as the only legitimate approach to health and healing.[34] The historic and continuing harms of colonialism's epistemological legacy lends nuance to Edward J.'s refusal in *Hamilton Health Sciences Corp.* to give deciding weight to western medicine's

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[31] A 1935 decision found the treaty promise extended to "all the medicines, drugs, or medical supplies which they might need free of charge": *Dreaver v. R.* (1935), 5 C.N.L.R. 92 (Ex. Ct.). Litigation during the 1960s and '70s found the language of the treaty limited the provision to medication, and also rendered it discretionary: *R. v. Johnston*, [1966] S.J. No. 220, 56 D.L.R. (2d) 749 (Sask. C.A.); *R. v. Swimmer*, [1970] S.J. No. 272, 17 D.L.R. (3d) 476 (Sask. C.A.). Judicial commentary from 1999, however, reflected the principles of treaty interpretation that had developed under section 35(1) of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, which, among other principles, requires contextualizing the terms of treaty documents and recognizing that Indigenous signatories were unable to review the documents to ensure their honest recital of the agreement. The more recent cases were identified as likely wrongly decided, and the treaty right was described as likely extending to "a full range of contemporary medical services": *Wuskwi Sipihk Cree Nation v. Canada (Minister of National Health and Welfare)*, [1999] F.C.J. No. 82, [1999] 4 C.N.L.R. 293 at para. 14 (F.C.T.D.).

[32] *St. Catharines Milling & Lumber Co. v. Ontario (Attorney General)*, [1887] S.C.J. No. 3, 13 S.C.R. 577 (S.C.C.). For a discussion of how evolutionary theory informed Canadian colonial legislation regarding Indigenous peoples, see Constance MacIntosh, "From Judging Culture to Taxing 'Indians': Tracing the Legal Discourse of the 'Indian Mode of Life'" (2009) 47:3 Osgoode Hall L.J. 399 at 405-421.

[33] For example, legislation was passed to ban important cultural ceremonies, which played the role of cementing obligations, enabling spiritual well-being and healing, within Indigenous communities. See, *e.g.*, *Indian Act*, R.S.C. 1927, c. 98, s. 141. Policies and practices of assimilation and cultural erasure are perhaps best known with regards to the imposition of the Indian Residential School regime, the goal of which was described by Duncan Campbell Scott in his remarks to the special committee on the *Indian Act* in 1920 as a process that would lead to there not being "a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question, and no Indian Department, that is the whole object of this Bill" (as quoted in E Brian Titley, A Narrow Vision: Duncan Campbell Scott and the Administration of Indian Affairs in Canada (Vancouver: UBC Press, 1986) at 50.)). While practice had been to force attendance, this practice was codified in 1920 with amendments to the *Indian Act*, s. 10(1).

[34] Canada, *Report of the Royal Commission on Aboriginal Peoples*, vol. 3 (Ottawa: Communication Group, 1996) at 193.

assessment of traditional medicines in the recognition and protection of Aboriginal rights in health care.

Canada has a long and unfortunate history in the use of state law and policy to oppress Indigenous peoples' healing knowledge and practise, while foregoing its own legal duties to provide health support, as part of the larger colonial project to undermine Indigenous political and cultural identity. This history is not from the distant past, but known through lived memory, and directly experienced in the lives and deaths of Indigenous peoples.

B. FEDERAL INTERVENTIONS IN INDIGENOUS HEALTH

1. EARLY FEDERAL INTERVENTIONS IN HEALTH: DISCRETIONARY AND DISCRIMINATORY

The state government's actions to displace Indigenous healing included inserting its own vision of appropriate health support, which was both discretionary, thus attracting minimal accountability, and discriminatory, with the harms caused still ongoing.

The federal *Indian Act*, which provides that the federal Governor in Council may make regulations "to provide medical treatment and health services for Indians", suggested a significant role for the federal government in providing health care.[35] This power, however, was never exercised. No regulations appear to have ever been passed. While disavowing any legal obligation to act, the dominion undertook — for what it characterized as humanitarian reasons — to provide limited and specific health supports for Indigenous peoples through internal policies.[36]

Historically, the federal government would bring a physician on annual visits to reserve communities to pay treaty annuities. In the early 1900s, the Crown created an administrative structure to oversee some health care delivery on reserves.[37] Access to these supports, however, was tied to registered "Indian" status under the legislated criteria of the *Indian Act*. As a result, between 1869

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[35] *Indian Act*, R.S.C. 1985, c. I-5, s. 73(1)(g).

[36] Constance MacIntosh, "Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations" in Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, eds., *Canadian Health Law and Policy*, 4th ed. (Toronto: LexisNexis, 2011) 575 at 592. See also Constance MacIntosh, "Jurisdictional Roulette: Constitutional and Structural Barriers to Aboriginal Access to Health" in Colleen M. Flood, ed., *Just Medicare: What's in, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 193; Constance MacIntosh, "Indigenous Peoples and Mental Health: The Role of Law and Policy" in Jennifer A. Chandler & Colleen M. Flood, eds., *Law and Mind: Mental Health Law and Policy in Canada* (Toronto: LexisNexis, 2016) 419.

[37] James B. Waldram, D. Ann Herring & T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural and Epidemoligical Perspectives*, 2d ed. (Toronto: University of Toronto Press, 1997) at 149-56. For a more in-depth description, see Constance MacIntosh, "Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations" in Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, eds., *Canadian Health Law and Policy*, 4th ed. (Toronto: LexisNexis, 2011) 575 at 592-94.

and 1985, an Indigenous individual's ability to access Indigenous-specific federal health supports turned on criteria unilaterally crafted by the federal government to determine if a person qualified for "status". These criteria included gender, marital status, patrilineage and residence on reserve lands. With legislative changes in 1985, marital relationships became irrelevant and gender became far less relevant as a determinative factor for whether an individual would qualify for registered Indian status.[38]

The mapping of the *Indian Act*'s registration criteria onto the right to access health and other services splintered First Nations communities. It also excluded other groups of Indigenous peoples such as the Metis from accessing federal health support. Provinces declined to fill the gap, seeing Aboriginal-specific health needs as within the scope of federal jurisdiction. Those who were outside of this regime were left in the same position as other provincial residents — who did not have provincially insured health coverage until at least 1962. While being in the same position as other provincial residents who also lacked access to publicly funded care may not seem egregious, this fact needs to be put into proper context. Traditional healing knowledges and practices that had served Indigenous peoples since time immemorial had been banned and morally condemned, yet the Canadian government did nothing to fill these health care gaps that it created.

2. TRANSITIONING TO THE PRESENT: THE INDIAN HEALTH POLICY AND THE GOVERNANCE OF COMMUNITY CARE

Pictou Landing Band Council v. Canada (Attorney General) is a case about Jeremy Meawasige, a severely disabled aboriginal teenager, diagnosed with hydrocephalus, cerebral palsy, spinal curvature and autism.[39] Jeremy is in need of full-time personal care, which his mother Maurina Beadle, a Mi'kmaq resident of the Pictou Landing First Nation, provided until she suffered a stroke in 2010. Her First Nations band came to her assistance, covering $8,200 per month for Jeremy's home care costs, almost 80 per cent of their home and community care budget for the whole community. The band asked the federal government for additional funding, but was refused. The federal government argued that pursuant to its various policies, it would not provide more than $2,200 per month if Maurina chose to keep her son at home with her. If she was willing, however, to place Jeremy in a provincial institution, federal government policies authorized coverage of the full costs, approximately $10,500 per month.

The federal state continues to govern Indigenous health on a largely unilateral and discretionary basis, refusing to acknowledge any legal obligation

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[38] For a more detailed discussion of some of the harms which have resulted from this approach, see Constance MacIntosh, "Relational Theory and Indigenous Health: Insights for Law Reform and Policy" in Jocelyn G. Downie & Jennifer J. Llewellyn, eds., *Being Relational: Reflections on Relational Theory and Health Law and Policy* (Vancouver: UBC Press, 2012) 230 at 238-246.

[39] [2013] F.C.J. No. 367, 2013 FC 342 (F.C.) (decision was appealed, and the appeal subsequently withdrawn).

to provide health support. Governance-through-policy creates minimal accountability and enables political whim to play a significant role in decision-making and resource-allocation.[40] This can have tragic consequences, including the removal of Aboriginal children from their homes as a condition of accessing necessary health care, thus perpetuating the assimilation goals which drove the residential school regime.

In the late 1970s, the federal government sought to reduce its spending on Indigenous health, despite Indigenous health lagging far behind that of non-Indigenous Canadians. This provoked a backlash, which culminated in the 1979 Federal *Indian Health Policy*.[41] The policy represents an important structural change in federal Indigenous health governance, namely Aboriginal self-governance in health. The policy's stated and admirable goal is to improve "the level of health in Indian communities, generated and maintained by Indian communities themselves".[42] Until the release of this policy, any Indigenous-specific health care supports were designed and administered by the federal government, with little to no input from Indigenous peoples themselves. The policy's language suggested that governance over the health of Indigenous peoples would be returned to their hands. This policy was followed by the 1988 Federal Health Transfer Policy ("FTP"), under which control over the administration of federally created and delivered community health programs on reserves could be devolved or transferred to First Nations reserve communities.

There are several types of agreements that the FTP contemplates, which involve the communities having greater or lesser discretion over the community health programs.[43] One type of agreement merely devolves administrative control for specific programs for one year with a pre-assigned budget. A second type has a three- to five-year span, permits the First Nation some scope to design new programs and comes with a general funding envelope. Communities who wish to enter this sort of arrangement, which is the most common, are required to also administer several programs including communicable disease control. The third type of agreement requires considerable capacity, as it involves designing and delivering programs as well as developing an over-arching health management scheme.

Despite First Nation communities' eager willingness to shoulder these governance responsibilities, the FTP is not without complications. First, the FTP, and indeed the Federal *Indian Health Policy*, still only contemplate

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[40] Constance MacIntosh, "Indigenous Mental Health: Imagining a Future where Action Follows Obligations and Promises" Alta. L. Rev. [forthcoming in 2017].

[41] Health Canada, *Indian Health Policy 1979* (Canada: Health Canada Medical Services Branch, 1979).

[42] *Ibid*.

[43] For a comprehensive description of these programs, see Constance MacIntosh, "Envisioning the Future of Aboriginal Health under the Health Transfer Process" (2008) Health L.J. 67 at 68-73. For commentary on the policy's strengths and shortcomings, see Constance MacIntosh, "Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations" in Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, eds., *Canadian Health Law and Policy*, 4th ed. (Toronto: LexisNexis, 2011) 575 at 599-605.

supporting, for the most part, the heath of persons who live on First Nation reserves who also qualify for status under the *Indian Act.* Thus, this grant of modest health governance powers supports a particular perspective on what sort of Indigenous community counts as a political and cultural entity. It continues to splinter families and communities, and to support inequitable access to health care as between Indigenous individuals and even within families.

The FTP also largely operates as a controlled administrative delegation, restricting the ability of First Nations communities to provide care on their own terms. The scope of what the community can do is strictly defined by the terms of the delegated program. Communities must fit their needs into the offered boxes. A variation exists in a few programs, where the communities can apply for short-term project-specific funding, where they must convince the federal government that their idea fits the scope of the program in question. This is how programming in areas including mental health and solvent abuse is developed and funded.[44] Clearly, community-generated ideas are likely relevant and culturally appropriate. Unfortunately, funding for such programs is available on a per capita basis, meaning that those communities who are doing well are able to direct their capped resources to primary interventions, while those communities which are currently struggling are likely to expend their allocation of resources coping with crisis situations and their fall-outs.[45] The governance structure, which recognizes equity as advanced through a head count, rather than need, thus perpetuates inequalities between communities.

Ironically, First Nation reserve communities have long been recognized by the federal government as having the power to act to improve health. The *Indian Act* delegates powers to band councils (which are the federally created and recognized governing body for First Nation communities) to pass regulations to "provide for the health of residents on the reserve and to prevent the spreading of contagious and infectious diseases".[46] Acting on this power, though, is limited due to the relative poverty of First Nation communities — thus it is the funding that accompanies the FTP that makes community self-governance in health a reality.

The arbitrary if not discriminatory terms of health transfer agreements thus leave many communities struggling to support themselves. Maurina Beadle's story is an example of one such struggle. Her community, Pictou Landing First Nation, had been devolved the power to administer home care support. Under the agreement, the community was required to administer the program, and the

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[44] Programming in these areas is possible through the Building Healthy Communities program, and the Brighter Futures Program. For a detailed discussion of these programs, see Constance MacIntosh, "Indigenous Peoples and Mental Health: The Role of Law and Policy" in Jennifer A. Chandler & Colleen M. Flood, eds., *Law and Mind: Mental Health Law and Policy in Canada* (Toronto: LexisNexis, 2016) 419.

[45] This concern was identified in 2003. It appears to have remained unaddressed. See Constance MacIntosh, "Indigenous Mental Health: Imagining a Future where Action Follows Obligations and Promises" Alta. L. Rev. [forthcoming in 2017].

[46] *Indian Act*, R.S.C. 1958, c. I-5, s. 81(1)(a).

federal government was required to fund it, in a manner that was consistent with or comparable to provincial standards.[47] This pattern is common for many of the transferred or delegated programs. The federal commitment to support the community was, in principle, bolstered by a further commitment called "Jordan's Principle".[48]

Jordan's Principle was named after an Indigenous child named Jordan River Anderson, who had multiple disabilities and who spent the first few years of his life in a hospital, several hundred kilometres from his parents' reserve home. When he was three-years-old, it was determined that he could be transferred to a home setting, and in particular into a home care setting operated by his family's First Nations Band. The required home care supports were expensive, however, and although it was clear that state support was to be provided, both the federal government and the government of Manitoba denied jurisdictional responsibility for funding the supports. They fought over jurisdictional assignment until Jordan's death, still in the hospital, two years later, at the age of five. He never returned home.

Jordan's story made its way to the House of Commons, which, in 2007, unanimously endorsed a motion called Jordan's Principle. The heart of the principle is a commitment that Indigenous children are to receive the same standard of care as non-Indigenous children, and that this care will not be delayed due to jurisdictional uncertainty. Rather, if jurisdictional responsibility is unclear, the government that is first approached is required to take immediate funding responsibility, with any jurisdictional conflict to be worked out after the fact.[49]

When the Pictou Landing Band Council approached the federal government for additional funding, consistent with provincial "extraordinary funding" guidelines, to cover the home care that Jeremy and his mother Maurina Beadle required, the federal government refused. It argued that the province had a policy of not providing extraordinary funding to status First Nation children on reserves, and so they could not do so as they were bound to follow provincial practices. (Such a policy presumably reflects the fact that provincial jurisdiction would not extend to such children.) The federal government also argued that it was bound by a provincial treasury board directive, which indicated that requests for extraordinary funding would not be approved. The directive in question was of no force, however, having recently been challenged in a provincial court, and found inconsistent with the legislated extraordinary

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[47] *Pictou Landing Band Council v. Canada (Attorney General)*, [2013] F.C.J. No. 367, 2013 FC 342 at para. 79 (F.C.).

[48] Adam Nathanson, "Legislating Jordan's Principle: An Indirect Success" (2011) 34:3 Man. L.J. 215; The Jordan's Principle Working Group, *Without denial, delay or disruption: Ensuring First Nations children's access to equitable services through Jordan's Principle* (Ottawa: Assembly of First Nations, 2015).

[49] *House of Commons Debates*, 39th Parl., 2d Sess., Vol. 142, No. 31 (December 5, 2007) at 1730 (Hon. Mario Laframboise), online: http://www.parl.gc.ca/HousePublications/Publication.aspx?Doc=31&Language=E&Mode=1&Parl=39&Pub=Hansard&Ses=2.

funding provisions.[50] The federal government regarded itself as bound by the (non-enforceable) provincial directive, prohibiting it from funding extraordinary care for First Nations children residing on reserves.

On judicial review of the federal government's refusal, Mandamin J. expressed a level of astonishment at the government's position. He ultimately concluded that the Federal government had wrongly exercised its discretion, had failed to fund in accordance with provincial standards and had violated Jordan's Principle. Mandamin J. ordered that extraordinary funding be immediately provided.[51] Jeremy remains in his home community, living with his mother, and receiving the same level of care that non-Indigenous children receive. Had it not been for his community's willingness to fight, Jeremy, like Jordan, would have lived out his days in an institution. This is the capriciousness of governance through internally designed policy.

Unfortunately, the underfunding of transferred community health programs appears to be an ongoing and widespread problem. Historic underfunding practices, for example, are perpetuated by community-health-funding envelopes being calibrated against factors such as the level of funding provided the year before the program was transferred to the community rather than on the basis of community need. Recommendations calling for funding formulas to be revisited have not been adopted.[52] Consequently, communities who transferred more recently receive considerably higher funding than those who transferred early in the history of the policy, revealed in support for health centres serving comparable communities ranging from $430 to $1,418 per capita.[53] Moreover, communities still have limited ability to control programming from the bottom up. Communities find themselves administering community health programs that are seriously understaffed and underserviced, and which, as transferred programs that the federal government designed, are inadequate to meet actual needs and priorities. On this basis, the FTP fails international legal standards, which guarantee Indigenous peoples the right to "determine and develop priorities and strategies" for health, and that obligate states to "take the necessary steps" to progressively realize the "highest attainable standard of physical and mental health" for Indigenous peoples.[54]

Indigenous peoples have been forced to turn to the courts to seek redress for human rights violations resulting from the federal underfunding of community health programs. Historically, provinces asserted that their child health and

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[50] *Nova Scotia (Department of Community Services) v. Boudreau*, [2011] N.S.J. No. 193, 2011 NSSC 126 (N.S.S.C.).

[51] *Pictou Landing Band Council v. Canada (Attorney General)*, [2013] F.C.J. No. 367, 2013 FC 342 at para. 119 (F.C.).

[52] See, *e.g.*, Health Canada, *Management Action Plan — First Nations and Inuit Home and Community Care Summative Evaluation — March 2009* (October 16, 2009) at 1.

[53] Josee G. Lavoie, Evelyn Forget & John D. O'Neill, "Why Equity in Financing First Nations On-Reserve Health Services Matters: Findings from the 2005 National Evaluation of the Health Transfer Policy" (2007) 2:4 Healthcare Policy 79 at 93.

[54] *United Nations Declaration on the Rights of Indigenous Peoples*, UN GAOR, 61st Sess., Doc A/RES/61/295 (October 2, 2007) arts. 23, 24(2).

social welfare programs did not extend to reserves, because of section 91(24) placing "Indians" under federal jurisdiction. The federal government acted slowly to fill the need, and developed a policy-based program whose objective was to ensure First Nations children received culturally appropriate child welfare services reasonably comparative to services provided to other provincial residents. In practice, the federal government funds program delivery either through a local devolved First Nation child and family organization, or, if there is no such organization, through transferring funds to provincial/territorial child welfare agencies.

In the *First Nations Child and Family Caring Society of Canada v. Canada (Minister of Indian Affairs and Northern Development)* case, a claim was brought under the *Canadian Human Rights Act*[55] that the child and family services delivered through First Nations agencies on reserves were funded in a discriminatory manner.[56] Among other evidence, it was determined that where provincial bodies delivered the services, they received two to four times more funding from the federal government than what First Nations were receiving to deliver the same services. Evidence also illustrated that the federal funding formulas provided a fixed sum to First Nation agencies — set in the 1990s — for supporting children who live with their families. This sum was far below actual need. However, the federal government's practice was to provide the actual costs for supporting Indigenous children if they are removed from the home and placed into foster care. Thus the regime created a very real incentive for impoverished parents, and for First Nations agencies, to place Indigenous children into foster care. Once again, the system was structured to result in Indigenous children being under-served as long as they stayed with their families, with the capricious twist that the under-servicing was mitigated if the community did not try to self-administer but rather allowed the province to deliver aspects of the programming.

The claim also argued that the federal government had inserted a wrongfully narrowed definition of Jordan's Principle into its program manuals, namely that the principle only applied when multiple governments were involved *and* the child had multiple disabilities.[57] This approach varied considerably from the House of Commons motion that created the principle, which focused on Indigenous children being guaranteed the same standard of care as non-Indigenous children, and without delay. The federal government's program definition resulted in delays in service access, and arbitrary and inequitable exercises of power. The *Caring Society* claims were successful. The federal government was ordered by the Human Rights Tribunal to immediately cease discriminating against First Nations children, comply with Jordan's Principle and fund Indigenous children according to need and without delay.

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[55] R.S.C. 1985, c. H-6.

[56] [2016] C.H.R.D. No. 2, 2016 CHRT 2 (Canadian Human Rights Tribunal) [hereinafter "*Caring Society*"].

[57] *Ibid.*, at paras. 359-360.

Since the decision in *Caring Society* was released in January 2016, the Tribunal has twice issued compliance orders against Canada, and expressed concern that the ministry continues to redefine Jordan's Principle.[58] The federal government continues to not comply with several of the Tribunal's orders. Rather, they schedule consultations with First Nations communities on matters such as determining the cost of living, while assigning only incremental increases in funding.

The federal government's position is that "[u]nilateral [federal] action … to decide how to address these important issues would be contrary to the Government's commitment to . . . building a relationship based on recognition of rights, respect, cooperation and partnership".[59] Canada's response has been widely perceived as disingenuous if not cruel given that as long as the underfunding persists, the economic discrimination pressures Aboriginal families to place their children into foster care.

Despite the very real criticisms and concerns of discriminatory underfunding practices, the FTP and other delegations of governance in health have generally been associated with improving the health of Indigenous communities.[60] Indeed, community control — over aspects of health and other significant areas such as education and child welfare — is itself appearing to be a co-relation of improved health.[61] This begs the question of what communities could accomplish in terms of improving their health if they were not knowingly underfunded, and the governance structure truly supported Indigenous control over health programming.

3. GOVERNANCE OF PRIMARY CARE AND HEALTH CARE BENEFITS

Drianna Ross was a two-month-old First Nations girl from a remote northern Indigenous community. In 2011, she died from complications associated with a methicillin-resistant staphylococcus aureus ("MRSA") infection, despite her parents repeatedly attending the nursing station that was created to serve their community, seeking assistance for Drianna's extremely high fever and breathing difficulties. In the inquest following her death, testimony confirmed that, "in

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[58] *Ibid.*, at para. 32.

[59] *Ibid.* Canadian Human Rights Tribunal, Respondent's Further Reply Submissions re Immediate Relief, T-1340-7008 (July 6, 2016) at para. 23, online: https://fncaringsociety.com/sites/default/files/Federal%20government%20compliance%20report_July%206%2C%202016.pdf.

[60] Paul Webster, "Local control over Aboriginal health care improves outcome, study indicates" (November 24, 2009) 181:11 C.M.A.J. E249.

[61] Josée Lavoie, *et al.*, "The Where to Invest Project"(Centre for Aboriginal Health Research, 2010) at v; Josée G. Lavoie, *et al.*, "Have investments in on-reserve health services and initiatives promoting community control improved First Nations' Health in Manitoba?" (August 2010) 71:4 Soc. Sci. & Med. 717 at 723; Michael J. Chandler & Christopher E. Lalonde, "Cultural Continuity as a Moderator of Suicide Risk Among Canada's First Nations" in Laurence J. Kirmayer & Gail Guthrie Valaskakis, eds., *Healing Traditions: The Mental Health of Aboriginal People in Canada* (Vancouver: UBC Press, 2009) 221 at 238-40.

southern Canada, if a patient the same age as Drianna Ross had MRSA, they would be admitted to hospital and treated, whereas in the north, because of its prevalence, MRSA is frequently left untreated."[62] Each time her parents attended the nursing station, they were sent home with the advice to try Tylenol and wait out the fever. Drianna never saw the only local physician. The nurse who saw Drianna indicated she had no experience with, nor education concerning, caring for such an ill infant. When Drianna was finally medivaced to a hospital, her accompanying records were incomplete and made no reference to her fever. Testimony at the inquest described the paper-based filing system at the nursing station as "atrocious" with frequent "confusion and errors with respect to medication and tests".[63] After being transferred, Drianna declined quickly, and died before appropriate intervention had ever commenced. No explanation was offered for why she was not assessed for a condition that was "prevalent" and "frequently left untreated" in her home community. While J.J.'s mother, D.H., fought to be outside of the western health care system, Drianna's family sought care within that system and, despite all their actions, did not receive it.

The inaccessibility that Drianna experienced is a consequence of an Indigenous health care governance regime characterized by gross underfunding, ineffective coordination and institutional practices which discriminate against Indigenous peoples by subjecting them to a standard of care in primary care that would be unacceptable in the Canadian south. The report of the inquest into Drianna's death asserted that "the acceptance of MRSA as a fact of life in northern communities cannot be tolerated".[64]

Pursuant to the constitutional division of powers, provinces are responsible for providing physician services to provincial residents. When reserve communities are in remote areas, however, the federal government supports on-reserve health care though nursing stations that have part-time physician-coverage.[65] These important services, however, are again managed by a web of policies, not laws or regulations, in a climate of underfunding. Part of the challenge is that when sound federal policies are enacted, they often sit unimplemented (or without the funding required to implement them available). The nursing station regime provides many examples of such situations.

In recognition that nurses working at nursing stations may encounter emergencies or needs within their legislated scope of practice, but unlikely to be encountered in general training, Health Canada made it mandatory for such nurses to complete specialized courses in five specific areas.[66] A 2010 internal Health Canada audit revealed that many of the Health Canada nurses staffing the

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[62] Provincial Court of Manitoba, *Report on Inquest and Recommendations of The Honourable Judge Don Slough* (December 17, 2015) at para. 25.

[63] *Ibid.*, at para. 19.

[64] *Ibid.*, at para. 27.

[65] Office of the Auditor General of Canada, *Reports of the Auditor General of Canada: Report 4 — Access to Health Services for Remote First Nations Communities* (Spring 2015) at paras. 4.1, 4.6.

[66] *Ibid.*, at paras. 4.24-4.26.

stations had not received the mandatory training. A 2015 audit by the Auditor General of Canada surveyed 45 Health Canada nurses in Manitoba and Ontario, and found that only 1 of the 45 surveyed nurses had completed all five of the mandatory courses. Such a situation would likely incur federal liability had it elevated the mandatory policy to a legislated requirement. The nurse who treated Dianna indicated in the Inquiry that she never received training on Pediatric Advanced Life Support, one of the five mandatory courses. She simply was not trained to care for an infant as ill as Drianna.

A not dissimilar situation has arisen with essential services. In 2013, Health Canada identified and defined "essential health services" for each remote nursing station it oversees. The assessment was nursing-station specific, and related to factors such as the size of the community and its health needs. However, Health Canada did not determine if the stations were capable of actually delivering the services that it had labeled "essential" and therefore did not assess if additional funding, staff, equipment or training was required to build their capacity. Nor did Health Canada inform the relevant First Nation community of the defined services that they could expect to receive, effectively disabling the communities for calling the government to account for its failure.[67]

Unlike essential services in a provincial setting, there is no overarching legislation requiring their delivery, nor articulating consequences for a failure to deliver them. The administration of essential health services by internal policies rather than legal regulation avoids accountability and does not enable a clear means to enforce compliance. Essentially, much of the work of governing health care in Indigenous communities operates outside the rule of law.

Another route by which the federal government provides direct support for status First Nation individuals to access primary care is through the Non-Insured Health Benefits Program ("NIHB"). This program has been in place for several decades, and was developed to supplement the health care benefits that are provided by provinces to all provincial residents. It essentially mirrors the sorts of additional health-related expenses that are usually covered by provinces for persons receiving social assistance, such as prescription medicines, medical devices, eyeglasses and dental work. The NIHB, like the FTP, was designed without Indigenous input, and exists only as a policy grounded in no recognized legal obligation by the federal government.

The receipt of benefits under the NIHB program, however, is once again tied to registered status under the *Indian Act*. During the inquest into Drianna's death, testimony was offered evidencing an inability of First Nations persons living in remote communities to access NIHB benefits due to complications surrounding registering for Indian status, a claim that was confirmed in a 2015 audit by the Auditor General of Canada.[68] Metis and non-Status First Nations persons are also excluded from the NIHB and other such federal benefits programs on the basis that they do not qualify to be registered as Indians under

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[67] *Ibid.*, at paras. 4.57-4.63.

[68] *Ibid.*, at para. 4.79.

the terms of the *Indian Act.* Provincial governments, with the exception of Alberta for Metis peoples and Ontario for all Aboriginal peoples, have resisted Aboriginal-specific programming on the basis that Aboriginal people fall under federal jurisdiction (*i.e.*, that the federal distinction between registered First Nations and other Aboriginal peoples is legally incorrect).

Metis and non-status First Nations persons have persisted in advancing arguments that tying health benefits to status under the *Indian Act* is arbitrary and unjust, violates their *Charter*[69] rights as well as international law, and has been a cause in their continuing poor health status. They have long sought inclusion in the Aboriginal-specific programming and policies offered to status First Nations persons, despite the flaws in those programs. The Supreme Court of Canada recently agreed that the federal government's position was wrong.

Justice Abella, writing for the court in *Daniels v. Canada (Indian Affairs and Northern Development)*, found that non-status First Nations persons and Metis persons count as "Indians" for the purposes of the *Indian Act*.[70] The case had been framed in terms of a request for declarations. The federal government argued a declaration should not be issued because it would have no practical utility in that a finding of federal jurisdiction would not create a legally enforceable duty to legislate or act. Justice Abella was not convinced. She found that declarations would have practical utility because the consequence of both federal and provincial governments denying legislative authority for Metis and non-status First Nations persons has been to leave them in a jurisdictional wasteland. The court endorsed the following findings of the trial judge, Phelan J.

> One of the results of the positions taken by the federal and provincial governments and the "political football — buck passing" practices is that financially [Métis and non-status Indians] have been deprived of significant funding for their affairs … .
>
> … the political/policy wrangling between the federal and provincial governments has produced a large population of collaterally damaged [Métis and non-status Indians]. They are deprived of programs, services and intangible benefits recognized by all governments as needed.[71]

Justice Abella was clear in her reasons that she expected the declaration to compel action. She wrote that issuing a declaration would ensure "accountability",[72] and that the clear assignment of constitutional jurisdiction would "have enormous practical utility" for Metis and Non-Status First Nations persons, who have had "to rely more on *noblesse oblige* than on what is obliged by the Constitution".[73] She also found it was beyond doubt that a fiduciary

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[69] *Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982*, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.

[70] [2016] S.C.J. No. 12, 2016 SCC 12 (S.C.C.).

[71] *Ibid.*, at para. 14, citing the trial decision at paras. 107-108.

[72] *Ibid.*, at para. 15.

[73] *Ibid.*, at para. 12.

relationship exists between all Indigenous peoples and the Crown,[74] and referred to the constitutionally entrenched obligation on the part of Parliament to seek "reconciliation with *all* of Canada's Aboriginal peoples".[75] It is evident that the court expected the declaration to result in Metis and non-status First Nations persons finally receiving federal support for their health care needs.

C. PROVINCIAL AND INDIGENOUS GOVERNANCE INITIATIVES

Historic approaches to Indigenous health governance were characterized by prejudice in design and capriciousness in delivery, along with unilateral state control. Although these approaches continue, they now operate in concert with First Nations communities administering programs and, in some instances, designing program content as well. There is also a growing transition toward substantive Indigenous control over health care design and delivery. That is, broad-scale Indigenous governance or co-governance over Indigenous health. These include treaties and provincial regimes.

1. SELF-GOVERNMENT AGREEMENTS AND JURISDICTION OVER HEALTH

Band councils have long had authority under the *Indian Act* to pass by-laws concerning health, but this power has had restricted value in practice due to factors such as bands lacking independent funding and limited scope to address infractions.[76] Where self-government agreements are negotiated, on the other hand, communities receive considerable cash transfers for compensation, along with enhanced control over resources and development on traditional lands — thus opening up independent revenue sources. In self-government agreements, communities are released from the *Indian Act*. They can restructure their relationship with the province and the federal government, and explicitly claim jurisdictional space for themselves over matters including health care.

The Nisga'a Treaty (which became effective in 2000) recognizes the right of the Nisga'a Lisims Government to "make laws in respect of health services on Nisga'a land",[77] with any conflict between Nisga'a law and provincial or federal law concerning organization and delivery structure resulting in Nisga'a law prevailing.[78] Where the Nisga'a Treaty approaches health through general or blanket provisions, the more recent *Labrador Inuit Land Claims Agreement* from 2005 sets out detailed terms regarding the power of the Nunatsiavut Government regarding health. It recognizes the right to the Nunatsiavut

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[74] *Ibid.*, at para. 53.

[75] *Ibid.*, at para. 37.

[76] *Indian Act*, R.S.C. 1985, c. I-5, s. 81(1)(a).

[77] *Nisga'a Final Agreement* (April 27, 1999) at c. 11, s. 82, online: http://www.nnkn.ca/files/u28/nis-eng.pdf [hereinafter "*Nisga'a Treaty*"].

[78] *Ibid.*, at c. 11, s. 84.

Government to make laws concerning, for example, requirements for obtaining informed consent from Inuit for medical care, the provision of mental health support services and the creation of community health programs as well as injury prevention, disease control and environmental health.[79] There do not appear to have been implementation evaluations, nor any litigation concerning health services under such agreements. It is challenging to determine whether or how these agreements have enhanced health and well-being. Insofar as they seem to align with realizing indigenous governance rights under international law, they are clearly a positive development.

2. LARGE-SCALE PROVINCIAL APPROACHES

Both British Columbia and Ontario have advanced province-wide initiatives, which stand as contrasting examples. Ontario is identified as model for how provincial governments can create governance structures that can broadly support Indigenous health.[80] Ontario's approach is structured to be inclusive and to involve broad Indigenous representation on decision-making bodies. Ontario launched an Aboriginal Healing and Wellness Strategy ("AHWS") in 1994, seeking to develop culturally appropriate programs and services to address poor experiences of health and also high levels of family violence.[81] They did not exclude individuals from the strategy, or deny them services, based on factors such as whether the individual had registered Indian status. Their programs, located both on and off reserves, include healing lodges, youth treatment centres, mental health programs and family violence programs; they directly serve approximately 42,000 individuals annually.

Until 2010, the AHWS was overseen by a Joint Management Committee that included Indigenous political representatives from urban, rural and remote First Nations, Metis and Inuit.[82] After this time, the structure shifted due to Ontario developing Local Health Integration Networks, which were responsible for regional decisions, and which would also include an Aboriginal Health Council. In all cases, the governing bodies are to adhere to Ontario's Aboriginal Health Policy. This policy has been described as the most comprehensive policy currently in place in Canada to address Indigenous health, covering matters including:

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[79] *Labrador Inuit Land Claims Agreement* (January 22, 2005), s. 17.13.1, online https://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ/STAGING/texte-text/al_ldc_ccl_fagr_labi_labi_1307037470583_eng.pdf. (the Agreement became law with the passage of the *Labrador Inuit Land Claims Agreement Act*, S.C. 2005, c. 27).

[80] Josée G. Lavoie, *et al.*, "Missing Pathways to Self-Governance: Aboriginal Health Policy in British Columbia" (2015) 6:1 The International Indigenous Policy Journal, Article 2 at 10.

[81] Ontario, Minister of Community and Social Services "Backgrounder: Ontario's Aboriginal Healing and Wellness Strategy" (November 20, 2014), online: https://news.ontario.ca/mcss/en/2014/11/ontarios-aboriginal-healing-and-wellness-strategy.html.

[82] Josée G. Lavoie, *et al.*, "Missing Pathways to Self-Governance: Aboriginal Health Policy in British Columbia" (2015) 6:1 The International Indigenous Policy Journal art. 2 at 11.

> … accessing inequities in Aboriginal health programming, responding to Aboriginal priorities, adjusting existing programs to respond more effectively to needs, supporting the reallocation of resources to Aboriginal initiatives, and improving interactions and collaboration between ministry branches … .[83]

Ontario's approach has been contrasted with the recent innovations arising in British Columbia. British Columbia's 2005 *Transformative Change Accord and the First Nations Health Plan*[84] set a course for supporting First Nations persons with registered Indian status, but did not embrace the larger Indigenous community. Various framework agreements were negotiated, and a First Nations Health Authority ("FNHA") was created. The focus that emerged was transferring control and funding for existing federally designed health programs to the new FNHA. For example, funding and authority to administer the NIHB Program was transferred, along with the community health programs under which communities could seek project-specific funding, such as the National Aboriginal Youth Suicide Prevention Strategy and the Aboriginal Diabetes Initiative.[85] The FNHA is considered to hold promise for improving the health of British Columbian status First Nations persons by virtue of being run by First Nations.[86] It is troubling that the approach seems to follow the federal transfer model, a model that has been critiqued as only enabling self-administration, continuing the situation where policy is made for and not by First Nations, and the entity seems to exist more as a service-delivery organization than a political one. It is also troubling because of the continuing exclusion of non-status First Nations persons and Metis people, who remain invisible as Aboriginal peoples.

D. CONTEMPORARY GOVERNANCE OF TRADITIONAL HEALERS AND ABORIGINAL MIDWIVES

Aboriginal healing practices are today governed by a multitude of approaches that reflect different power dynamics and different levels of recognition of Aboriginal healing traditions as a part of the broader healthcare system.

Canada's Truth and Reconciliation Commission recently criticized the marginalization of Aboriginal healing practices in the Canadian health care system, and called for the system "to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration

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[83] National Collaborating Centre for Aboriginal Health, *Looking for Aboriginal Health in Legislation and Policies, 1970 to 2008: The Policy Synthesis Project*, (June 2011) at 29, online: http://www.nccah-ccnsa.ca/docs/Looking%20for%20Aboriginal%20Health%20in%20Legislation%20and%20Policies%20-%20June%202011.pdf.

[84] http://www.nccah-ccnsa.ca/docs/social%20determinates/FirstNationsHealthImplementationPlan_Combo_LowRes.pdf

[85] First Nations Health Authority, "What We Do: Funding Arrangements" (2017), online: http://www.fnha.ca/what-we-do/funding-arrangements.

[86] Joe Gallagher, Joseph Kiet Mendez & Trevor Kehoe, "The First Nations Health Authority: A transformation in healthcare for BC First Nations" (2015) 28:6 Healthcare Management Forum 255.

with Aboriginal healers and Elders where requested by Aboriginal patients".[87] This call to action was one of the many items that the Commission concluded was necessary to build a new relationship of mutual respect and understanding between Indigenous and non-Indigenous peoples, as part of dismantling the colonial relationship and the harm it caused and continues to perpetuate.

Indigenous healing practices currently occupy an inconsistent position in provincial and territorial legislation, although they are no longer the targets of criminal sanction. Ontario is illustrative of a common approach across much of Canada. Ontario simply excludes traditional Aboriginal healers and midwives from any provincial professional regulation.[88] The lack of regulation could be read, on the one hand, as a reflection of the inability (or illegitimacy) of state bodies to determine standards of practice and thus deferring to Indigenous peoples or communities on practice standards. On the other hand, some have cautioned that "many Aboriginal people and health professionals do not have the traditional knowledge necessary to distinguish a traditional healer from a charlatan."[89] One obvious consequence of Ontario's regulatory approach is that it makes no attempt to bring Aboriginal healers into dialogue with other health care providers.

A few provinces are completely silent on traditional healers.[90] As a result, in provinces such as British Columbia, for example, it may be an offence for an Aboriginal person to engage in traditional healing practices. One would expect that such a charge would be answered with a section 35[91] defence, but it does seem odd that provincial legislators fail to even acknowledge that such practices exist.

In the case of midwives, we see a different approach. Many provinces have chosen to ensure Indigenous representation in the representative colleges. For example, the by-laws of the College of Midwives of Manitoba require a standing committee that advises on midwifery care for Aboriginal women (called the Kagike Danikobidan), and all of the members of that committee must be Aboriginal.[92] This committee, in turn, appoints one of its members to the Board

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[87] Truth and Reconciliation Commission of Canada, *Calls to Action* (Winnipeg: 2015) at para. 22, online at: <http://www.trc.ca/websites/trcinstitution/File/2015/Findings/Calls_to_Action_English2.pdf>.

[88] For example, *Regulated Health Professions Act*, S.O. 1991, c. 18, s. 35(1), does not apply to "aboriginal healers and midwives". This stands in contrast to other non-Western healing practices which are regulated in Ontario; see *Traditional Chinese Medicine Act*, *2006*, S.O. 2006, c. 27.

[89] Marion A. Maar & Marjory Shawande, "Traditional Anishinabe Healing in a Clinical Setting: The Development of an Aboriginal Interdisciplinary Approach to Community-based Aboriginal Mental Health Care" (2010) J. of Aboriginal Health 18 at 20.

[90] British Columbia's *Health Professions Act*, R.S.B.C. 1996, c. 183 does not carve out an exception for Aboriginal traditional healers, nor does there appear to be any stand-alone legislation.

[91] Constitution Act, 1982, s. 35.

[92] The by-laws exist under the *Midwifery Act,* C.C.S.M., c. M125.

of Assessors, the Standards Committee and the Council of the College.[93] If Kagike Danikobidan disagrees with a Council decision, they have the power to require a reconsideration and bring in a mediator.[94]

Nunavut's approach goes a step further by requiring all continuing education programs and professional development programs to include instruction in "traditional Inuit midwifery knowledge, skills and judgment".[95] The legislation contemplates a role for this material in the basic training program as well. Thus midwives are not deemed competent unless they have been trained in Indigenous practices.

Where communities have entered into self-government agreements, the trend seems to be that the communities seize explicit jurisdiction to regulate traditional healers and their standards of practice. For example, the Tsawwassen First Nation Final Agreement recognizes the First Nation as having law-making authority over Aboriginal healers, which prevail over any inconsistent provincial or federal laws, and to establish standards of practice and codes of ethics.[96] The *Miawpukek First Nation's Self-Government Agreement-in-Principle* requires it to define qualifications that include "standards … of competence, ethics and quality of practice that are reasonably required to protect the public" and safeguard confidentiality.[97]

The regulation of traditional practices in Yukon appear to already align with the Truth and Reconciliation Commission's Call to Action. Its legislation embraces and promotes Indigenous healing practices. In particular, the legislation includes a provision to protect Aboriginal practices "as a viable alternative for seekers of health and healing services", and also mandates the Minister to "promote mutual understanding, knowledge, and respect between the providers of health" offered in the health care systems "and the providers of traditional aboriginal nutrition and healing".[98] Such legislation is an explicit rejection of colonial practice. This raises the question of whether the relationship between J.J. and her mother, and the health care team and the hospital would have been as confrontational had such legislation been in place in Ontario.

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[93] These are pursuant to the College of Midwives of Manitoba, *Bylaw No. 1* (as amended January 28, 2010), ss. 9.1(b), 16.12(a), 14.1, 15.1, 16.13, online: http://www.midwives.mb.ca/docs/cmm-by-laws-2011.pdf.

[94] *Ibid.*, at 8.9.

[95] *Midwifery Profession Act*, S.Nu. 2008, c. 18, s. 6.1.

[96] *Tsawwassen First Nation Final Agreement* (2007), c. 15, ss. 85, 87, 88, online: www.aadnc-aandc.gc.ca/eng/1100100022706/1100100022717. There are analogous provisions in other self-government agreements, for example, *Westbank First Nation Self-Government Agreement* (2003), Part XVII, s. 193, online: https://www.aadnc-aandc.gc.ca/eng/1100100031766/1100100031768#chp17; *Yale First Nation Final Agreement* (2011), s. 3.17.4, online: https://www.aadnc-aandc.gc.ca/eng/1336657835560/1336658472497; *Tla'amin Final Agreement* (2014), c. 15, s. 85, online: https://www.aadnc-aandc.gc.ca/eng/1397152724601/1397152939293.

[97] Indigenous and Northern Affairs Canada, *Miawpukek First Nation Self-Government Agreement-in-Principle* (2013) at 8.9(a), online: https://www.aadnc-aandc.gc.ca/eng/1402322568771/1402322859715#chp8.

[98] Yukon *Health Act*, R.S.Y. 2002, c. 106, s. 5(1), (2).

E. CONCLUSION

Indigenous health care is poorly governed and the site of considerable political tension. This is evidenced by the arbitrary way in which policies are often designed, the patchwork manner in which care is delivered, the scarcity of mechanisms to foster legal accountability and the Indigenous parties turning to litigation to address discrimination. These failings, in turn, manifest in the lives and deaths of Indigenous individuals. Exceptions to these generalizations are present. More emerge as Indigenous communities partner with provinces or otherwise take governing roles, and new legal and practice norms emerge.