20 years later: RCAP's legacy in Indigenous health system's governance - What about the next twenty?

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Introduction

In November 1996, the Royal Commission on Aboriginal People (RCAP) published its final landmark report which for the first time provided detailed comminity insights into a multitude of longstanding issues that were prevalent and problematic within the relationship between Aboriginal and non-Aboriginal peoples and governments in Canada. The 4,000-page, five volume report based on extensive consultation with Aboriginal peoples provided a blueprint for a new relationship, one that was based on reclaiming self-governance by exerting autonomy over factors that determine health including social, political, cultural, economic and spiritual affairs. The report's recommendations addressed a wide scope of health issues for which implementation still remains preliminary, fragmented, ineffective or simply absent.

The purpose of this paper is to discuss the progress made to date on key RCAP health-related recommendations. The following sections will discuss recommendations while highlighting areas of progress and ongoingshortcomings and the disconnects. The last section, which we call Moving Forward, provides a framework that will lead to a healthier future via legal and policy options that supports the *Truth and Reconciliation Report*[1] and the *United Nations Declaration*

[1] Truth and Reconciliation Commission of Canada (2015) "Honouring the truth, reconciling for the future: summary of the final report of the Truth and Reconciliation Commission of Canada, online: www.trc.ca.

on the Rights of Indigenous Peoples.[2] The framework we propose calls for action and implementation in Indigenous communities, governments, civil society and relevant institutions.

1. RCAP: Then and now

In the following section, specific recommendations made by RCAP are reviewed and government progress is noted.Ten key recommendations are grouped into four main areas:

- Government oversight, recognition and jurisdiction;
- Self-government, integration and responsiveness;
- Inclusiveness of all services; and
- Valuing Indigenous cultures, knowledges and practices

Each topic will be discussed as follows..

1.1. Federal government oversight, recognition of jurisdiction and obligations

In this section, we will discuss three recommendations related to the federal government's role in providing national leadership with regards to federal/provincial/territorial obligations to First Nations, Métis and Inuit in health and health care. Our review of RCAP's recommendations singled out three specific recommendations, outlined below:

> *Federal, provincial and territorial governments, and Aboriginal governments and organizations, must support the assumption of responsibility for planning health and social services by regional Aboriginal agencies and councils where these now operate, and the formation of regional Aboriginal planning… (3.3.12 page 237)*
>
> *Aboriginal organizations, regional planning and administrative bodies and community governments currently administering health and social services transform current programs and services into more holistic delivery systems that integrate or co-ordinate separate services. Aboriginal, federal, provincial and territorial governments incorporate in funding agreements plans for capital development and operating costs of a network of healing lodges. (3.3.11 page 224)*
>
> *Federal, provincial and territorial governments should commit themselves to providing the necessary funding, consistent with their jurisdictional*

[2] It should be noted that Canada's commitment to enacting the TRC Calls to Action includes a commitment to implement the UNDRIP as follows: "We call upon federal, provincial, territorial, and municipal governments to fuly adopt and implement the *United Nations Declaration on the Rights of Indigenous Peoples* as the framework for reconciliation" (Article 43); and "We call upon the Government of Canada to develop a national action plan, strategies, and other concrete measures to achieve the goals of the *United Nations Declaration on the Rights of Indigenous Peoples"* (Article 44).

> *responsibilities, to implement a co-ordinated and comprehensive human resources development strategy; to train 10,000 Aboriginal professionals over a 10-year period in health and social services.. (3.3.14 page 246)*

A number of interrelated themes emerge from these recommendations, namely, a) an explicit acknowledgement of federal/provincial/territorial jurisdiction, b) the need for federal/territorial/provincial governments to give space and invest in holistic health-informed healing lodges, and c) a commitment to train 10,000 Indigenous health and social services professionals. A discussion of each follows.

i) An explicit acknowledgement of federal/provincial/territorial jurisdiction

Little to no progress has been made on clarifying jurisdictional obligations. At the national level, the Indigenous health policy framework that existed in 1996 remains largely untouched. A review by Lavoie and colleagues of all federal and provincial health legislation and policies containing Indigenous–specific content shows that what exists in Canada was then and remains very much of a patchwork, marred with inconsistencies and numerous gaps.[3] Significant gaps exist within the federal government. Indeed, the federal government's position to date has been that services offered by the federal government are provided for humanitarian reasons, and as a matter of policy only. Obligations stemming from constitutionally protected Aboriginal and Treaty rights have clearly been ignored.[4] As a result, federal/provincial/territorial jurisdictional debates continue, perpetuating delays and gaps in services identified in RCAP's reports.[5]

In the case of **First Nations**, Jordan Rivers was a child with complex medical needs due to a rare neuromuscular disorder that could not be managed from his home in Norway House First Nation. Despite Jordan's physician and family agreeing to discharge him to a specialized foster home facility near his home reserve, Jordan was left to live the last of his life in a hospital while for over two years federal and provincial government officials argued on which government should pay for the specialized home care he needed in order to be discharged, the transportation costs and even tiny items like a showerhead.[6] The case was brought to national attention, and resulted in the adoption of the Jordan's Principle[7] by the federal and provincial governments across

[3] Lavoie et al. (2013). Aboriginal Health Policies in Canada: The Policy Synthesis Project. Prince George, BC.
[4] Boyer, (2014). Moving Aboriginal health forward: discarding Canada's legal barriers. Saskatoon, SK: Purich Publishing Ltd.
[5] Royal Commission on Aboriginal Peoples. (1996). Volume 1 - Looking forward, looking back. Ottawa, (1996). Volume 2 - Restructuring the relationship. Ottawa, (1996). Volume 3 - Gathering strength. Ottawa, (1996). Volume 4 Perspectives and realities. Ottawa, (1996). Volume 5 - A twenty year commitment. Ottawa.
[6] MacDonald, N. and Attaran, A. (2007) Jordan's Principle, governments' paralysis Editorial CMAJ August 14, 2007 vol. 177 no. 4 doi: 10.1503/cmaj.070950.
[7] Jordan's Principle is a child first principle used in Canada to resolve jurisdictional disputes within, and between governments, regarding payment for government services provided to First Nations children.

Canada.[8] On January 26, 2016 the Canadian Human Rights Tribunal ordered the federal government to take measures to fully adopt Jordan's Principle. On July 6, 2016, the federal government committed to invest $382 million dollars to implement a broader application. While this is positive advancement, the federal government continues to limit the application of Jordan's Principle to children living on reserve with a disability or a short term condition.[9]

Jurisdictional gaps have also been documented for First Nation adults seeking care in a variety of settings, leading to delays in access and negative outcomes. To date, the federal government continues to define its obligations to First Nations as limited to complementing what the provinces offer and as a "payor of last resort".[10] No province has clearly defined its area of jurisdiction in regards to First Nations. At the federal level, programs are defined nationally, and implemented across provinces, this in spite of provincial variations in the provision of services.

Following the 2002 Romanow Commission, which highlighted issues of jurisdictional debates as a priority, Indigenous regional planning processes emerged in British Columbia (the First Nations Health Authority), and the Manitoba (the Intergovernmental Committee on Manitoba First Nations` Health). The Manitoba table brings together high-level government officials from all relevant federal (regional representants from the First Nations and Inuit Health Branch of Health Canada, Indigenous and Northern Affairs) and provincial departments (finance, health, Aboriginal affairs, social services, etc) and the Assembly of Manitoba Chiefs. While this table has commissioned numerous studies, it has to date failed to effectively address systems-level jurisdictional barriers to care, largely because appointees remain accountable to their own department and government rather than to a cross-jurisdictional objective, and are not empowered to resolving issues than demand a flexible understanding of their department's obligations.

The BC First Nations Health Authority, in contrast, is empowered to addressing systems-level jurisdictional issues as they apply to First Nations and as they emerge in the province of British Columbia. Subsequent to extensive tripartite discussions between BC First Nations leadership, the Governments of British Columbia and Canada, in October 2013, the First Nation Health Authority took responsibility for all functions previously shouldered by the First Nations and Inuit Health Branch of Health Canada (FNIHB) in the province of British Columbia. This transfer of responsibility has resulted in new relationships between First Nations and provincial/regional health authorities, and a culture of problem solving. This new relationship is supported by an enabling infrastructure and it seems a very positive step forward that is a

[8] 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.
[9] First Nations Child & Family Caring Society of Canada, 2016, online: https://fncaringsociety.com/jordans-principle.
[10] For instance, clients who have dental coverage under another plan or program must submit their claims to their other **payers** first, see online: www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/newsletter-bulletin-eng.php

concrete demonstration that may have found inspiration in the RCAP report of 1997. In other provinces, tripartite discussions continue.

In the case of **Métis**, the long awaited Supreme Court of Canada *Daniels* decision (2016) has held that Métis are"Indians" under section 91(24) of the *Constitution Act, 1982*. The same decision also includes Non-Status peoples previously not recognized under section 91 (24) of the *Constitution Act, 1982*. The implications for federal responsibility for health care for Métis and Non-Status peoples is under discussion and will be determined in the future.

For **Inuit**, jurisdictional issues are somewhat less ambiguous. For those who live in Nunangat (Nunatsiavut in Labrador, Nunavik in Northern Quebec, Nunavut and Inuvialuit in the NWT), jurisdictional responsibilities are better defined. Inuit from the Inuvialuit or Nunavut who must travel to provincial jurisdictions (mainly Edmonton, Winnipeg, Ottawa and Montreal) to access care have the cost of their care paid by the territory of residence. Although support exists in these cities to provide accommodations and facilitate access to care, the transition from the north to southern urban settings is often difficult, especially when long term or permanent relocation is required. For Inuit living in Winnipeg for example, the Manotoba inuit Association is advocating for more culturally appropriate health services.

Confirming the requirement for jurisdictional clarity the Truth and Reconciliation Commission (TRC) Call to Action #20:

> 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 (page 3).

Twenty years after RCAP, it is disheartening to see similar themes being reiterated in the TRC recommendations, acknowledging that what little progress has been made is very uneven and generally is taking much longer than anticipated.

ii) The need for federal/territorial/provincial governments to invest in holistic health-informed healing lodges

Culturally appropriate mental health and healing services remain in their infancy, on reserve, across the north, and in many urban centres. Services that exist on-reserve are severely underfunded,[11] and as a result underdeveloped and focused on crisis intervention, instead of healing and prevention. The Aboriginal Healing Foundation, which was created in 1999 as a result of the RCAP, was defunded in 2014. The Aboriginal Healing Foundation played a pivotal role in funding healing initiatives across Canada. These initiatives were however funded on a

[11] Lavoie et al. (2005). The Evaluation of the First Nations and Inuit Health Transfer Policy. Winnipeg.

competitive basis, as projects.[12] It is unclear whether any of these projects might have reached sustainability, and might continue.

We note that the Truth and Reconciliation Commission has called for investments in Aboriginal Healing Centres, just like the RCAP had:

> 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 (page 3).

Clearly the Aboriginal community is reaching out for safe spaces for health and healing. We hope that this recommendation will result in tangible long term commitments, resulting in long term community-based programs, rather than short term projects. This would be an innovation.

iii) Indigenizing the health and social care workforce

Following ten years of untracktable actions or inaction, the federal government committed $100 million over five years (2005-2010) towards the creation of an Aboriginal Health Human Resources Initiative (AHHRI), to enhance the Indian and Inuit Health Careers Program (IIHCP). The objective of these programs was *to lay the foundation for longer term systemic changes in the supply, demand and creation of supportive working environments for Aboriginal health human resources*.[13] Overall expenditures in the programs totaled approximately $102M over 5 years (2005-2010). A study by Lecompte[14] showed that that the number of Aboriginal health professionals rose from 8,840 in 1996 to 21,805 in 2006 (for a net gain of 11,965). It is noteworthy that this progress was achived before the implementation of the AHHRI. Given the significant funding allocated and the realtively modest outcomes, it seems appropriate to request more detail on what has been accomplished, how much funding had been allocated and is a renewed and enhanced strategy needs to be contemplated.

The AHHRI has since supported health careers promotion at career days and science fairs, and funded 2,594 Aboriginal students (2006-2012) through the Indspire bursaries and scholarships program, a program designed to support studies..

1.2 Self-government, integration, representation and responsiveness

The RCAP reports highlighted two recommendations related to self-government.

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[12] *Ibid*.
[13] Evaluation Directorate. (2013). Evaluation of the First Nations and Inuit Health Human Resources Program 2008-09 to 2012-13. Ottawa: Health Canada and Public Health Agency of Canada.
[14] Lecompte. (2012). Aboriginal Health Human Resources: A Matter of Health *International Journal of Aboriginal Health* (Vol. 8, pp. 16-22).

> *Governments must recognize that the health of a people is a matter of vital concern to its life, welfare, identity and culture and is therefore a core area for the exercise of self-government by Aboriginal nations. Governments act promptly to conclude agreements recognizing their respective jurisdictions in areas touching directly on Aboriginal health; agree on appropriate. (3.3.2 page 632)*
>
> *RCAP recommendations apply generally to all aboriginal peoples including Inuit, Métis and Indians (First Nations) arrangements for funding health services under Aboriginal jurisdiction; and establish a framework, until institutions of Aboriginal self-government exist. . (3.3.3 page 632)*

To date, mechanisms put in place to support self-determination have been limited to First Nations living on-reserve and to Inuit living in their traditional territories. Métis and Non-status Indians and those living outside of their traditional territories, have been systematically excluded, this despite a growing population of First Nations, Métis and Inuit calling urban centres home for substantial periods of time.[15]

Administrative mechanisms that provide avenues for some level of self-determination (which more closely resembles self-administration) continues to perpetuate jurisdictional fragmentation, by separating health from other services, and creating barriers for service integration and adaptation. Recent research findings suggest that regimes of accountability that emerged in the mid 1990s, on the heels of the RCAP's release of recommendations, have made matters worse, resulting in decreased responsiveness in services,[16] in part associated with a decrease in on-reserve per capita funding over time.[17]

An exception is British Columbia, where unprecedented and substantial progress has been made through the transfer of funding and functions previously shouldered by FNIHB. Yet, even in that case, First Nations secured increased control over existing health services, but the funding provided was largely based on historical expenditures, rather than needs, and cannot support services that match recognized clinical guidelines in a number of key areas, including dental care.

[15] Lavoie et al. (2015). Missing pathways to self-governance: Aboriginal health policy in British Columbia. *The International Indigenous Policy Journal* (Vol. 5, pp. article 2).
[16] Lavoie et al. (2015). Negotiating barriers, navigating the maze: First Nations' experience of medical relocation *Canadian Public Administration* (Vol. 58, pp. 295–314).
[17] Lavoie. (2014). A Comparative Financial Analysis of the 2003-04 and 2009-10 Health Care Expenditures for First Nations in Manitoba. Prince George, BC.

1.3. Responsiveness of all services

The healthcare systems serving the healthcare needs of Indigneous peoples include federal/provincial and territorial services and Indigenous controlled services. Our review highlights two recommendations speaking to these specific issues.

> *Aboriginal, federal, provincial and territorial governments must acknowledge the determinants of health found in Aboriginal traditions and health sciences and endorse the fundamental importance of holism, - attention to whole persons in their total environment; equity, - equitable access to the means of achieving health and equality of outcomes in health status; control by Aboriginal peoples of the lifestyle choices, institutional services and environmental conditions that support health; and diversity, - an accommodation of the cultures and histories of First Nations, Inuit and Métis people that make them distinctive within Canadian society and that distinguish them from one another. (3.3.1 page 209)*

> *Non-Aboriginal service agencies and institutions involved in the delivery of health or social services to Aboriginal peoples, and professional associations, unions, and other organizations in a position to influence the delivery of health or social services to Aboriginal peoples undertake a systematic examination to determine how they can encourage and support the development of Aboriginal health and social service systems, and improve the appropriateness and effectiveness of mainstream services to Aboriginal peoples; engage representatives of Aboriginal communities and organizations in conducting such an examination. (3.3.23 page 268)*

Racism in healthcare continues to be reported, perpetuating frustration, distrust, delayed access to responsive care, poor outcomes and at times, tragedies.[18] Brian Sinclair was in a wheel chair and he died in the emergency department of the Health Sciences Centre in Winnipeg in September 2008. He recently had seen a family physician at a Winnipeg Regional Health Authority's primary care clinic.The physician referred him to the Health Sciences Centre emergency department. He was ignored by staff and security for thirty-four hours, where he died of complications of a readily treatable bladder infection.[19]

It appears the Brian Sinclair case exemplifies racial discrimination with the health care system in Canada. While, there has been increased attention paid over the past twenty years since the RCAP report, to the importance of culturally safe care, and increasingly, trauma-informed care in

[18] 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.
[19] Lavallee. (2005). Honouring Jordan: putting First Nations children first and funding fights second *Paediatric Child Health* (Vol. 10, pp. 527-529).

order to meet the healthcare needs of Canadians.[20] While this attention has not necessarily resulted in an overall improvement in health services, we note modest progress. For example, the Provincial Health Services Authority in BC created an Indigenous Cultural Safety program, to increase Indigenous-specific knowledge, to enhance individual self awareness and strengthen skills for any professional working directly or indirectly with Indigenous peoples.[21] Introduced in 2011, this program had trained 10,000 professionals by the end of 2014. Manitoba and Ontario are in the process of adapting the program to their own context. Emerging evidence from a study which used the program as in intervention with health professionals providing health services to Indigenous and non-Indigenous peoples living in marginaling circumstances indicate that the program is effective in transforming practice and ensuring better outcomes in non-profit healthcare organizations.[22] It is unclear if these findings might generalize to the broader healthcare community.

1.4 Valuing Indigenous cultures, knowledges and practices

As highlighted by RCAP, western educational instutitions and professional organizations have a key role in perpetuating or addressing the conditions that promote the marginalization of Indigenous peoples at all levels of the Canadian society, including in health care. Further, the same instutitions are actively displacing and devaluing Indigenous knowledges and traditional healing practices. We identified three relevant reocmmendations.

> *Post-secondary educational institutions involved in the training of health and social services professionals, and professional associations involved in regulating and licensing these professions, should collaborate with Aboriginal organizations and governments to develop a more effective approach to training and licensing that recognizes the importance and legitimacy of Aboriginal knowledge and Governments, health authorities and traditional practitioners should co-operate to protect and extend the practices of traditional healing and explore their application to contemporary Aboriginal health and healing problems.(3.3.21 page 266)*

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[20] Browne et al. (2011). Addressing trauma, violence and pain: Research on health services for women at the intersections of history and economics. In O. Hankivsky (Ed.), *Health Inequities in Canada - Intersectional Frameworks and Practices* (pp. 401-423). Vancouver: UBC Press; Browne et al. (2012). Closing the health equity gap: evidence-based strategies for primary health care organizations *Int.J.Equity Health* (Vol. 11, pp. 59).Brascoupé & Waters. (2009). Cultural Safety: Exploring the Applicability of the Concept of Cultural Safety to Aboriginal Health and Community Wellness *Journal of Aboriginal Health* (Vol. 5, pp. 6-41); Diffey & Lavallee. (2016). Is Cultural Safety Enough? Confronting Racism to Address Inequities in Indigenous Health. Manitoba: University of Manitoba.

[21] BC Provincial Health Services Authority, San'yas Indigenous Cultural Safety Training, online: http://www.sanyas.ca/home.

[22] Browne et al. (2015). Innovative responses to structural violence among vulnerable populations: Integrating trauma- and violence-informed care into routine primary health care practices *National Conference on Health and Domestic violence*. Washington DC.

> *Non-Aboriginal educational institutions and professional associations involved in the health and social services fields must sensitize practitioners to the existence of traditional medicine and healing practices, the possibilities for co-operation and collaboration, and the importance of recognizing, affirming and respecting traditional practices and practitioners. (3.3.23 page 268)*
>
> *Aboriginal traditional healers and bio-medical practitioners should strive actively to enhance mutual respect through dialogue and that they explore areas of possible sharing and collaboration. (page 337)*

Similar recommendations were reiterated by the TRC Call of Action:

> 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.(page 3)
>
> 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. (page 3)

While integrating western and traditional practices has been discussed for decades, at least in some settings,[23] no progress has been made to facilite this integration at the policy level. A handful of clinics across Canada currently operate with an integrated models of service delivery. More clinics have hired Elders to improve cultural safety and provide counselling services. In all cases we are aware of, funding remains an on-going issue.

Some legislation exists to protect Indigenous healing practices from the incroachment of other legislation. For examples, the *Yukon Heath Act* [24] and the *Ontario Regulated Health Professions Act* [25] requires the respect of traditional Aboriginal practitioners and healing practices. Other

[23] Gregory. (1988). An Exploration of the Contact Between Nurses and Indian Elders/Traditional Healers on Indian Reserves and Health Centres in Manitoba in D. Young (Ed.), *Health Care Issues in the Canadian North* (pp. 39-43). Edmonton: Boreal Institute for Northern Studies; D. Young et al. (1989). Cry of the Eagle: Encounters with a Cree Healer. Toronto: University of Toronto Press; D. E. Young et al. (1988). A Cree healer attempts to improve the competitive position of native medicine *Arctic Med.Res.* (Vol. 47 Suppl 1, pp. 313-316).
[24] *Bill C-39, The Yukon Act* (LS-422E) 2002.
[25] *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18.

legislation recognize Aboriginal traditional midwifery practices.[26] Finally, British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick and Prince Edward Island have adopted tobacco control legislation that specifies that the legislation does not apply to the use of tobacco for ceremonial purposes.[27] It is difficult to assess whether at least some of these legislated provisions emerged as a result of RCAP. It is noteworthy that some prepared it.

The Truth and Reconciliation Commission made a specific call to action on traditional healing:

> 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. (page 3)

Overall, the progress made on integrating Indigenous and western health and medical knowledge is dismal.

1.5 Key messages and next steps

To date, little process has been made to operationalize nine of the ten RCAP recommendaitons discussed above. A notable exception is the progress made in the training of Indigenous healthcare professionals.

In 2010, after 3 years of contesting the process, Canada finally expressed support for the *United Nation Declaration on the Rights of Indigenous People* (UNDRIP). This was followed by a full commitment to this implementation of UNDRIP in May 2016, by the Liberal government of Justin Trudeau. We note from the UNDRIP declaration two resolutions that echo some of the themes discussed above.

> 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 (UNDRIP, Article 23).
>
> 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 (UNDRIP, Article 24.1).

[26] *Midwifery Act,* 1991. S.O. 1991, c. 31.
[27] *Tobacco Reduction Act*, S.A. 2005, c. T-3.8; *The Tobacco Control Act*, S.A. 2001, c T-14; *The Non-Smokers Health Protection Act,* R.S.C. 1985, c 15; *Smoke-Free Ontario Act*, S.O. 1994, c. 10.

Canada's commitment to UNDRIP, and to reaffirming its relationship with First Nations, Métis and Inuit, gives us some confidence that the TRC resolutions may be seriously considered and acted upon.

2. Moving Forward

As we have noted from the above review, the RCAP recommendations have been either partially implemented or not implemented at all. The disproportionate burdens of ill health experienced by First Nations, Métis and Inuit peoples continue to be attributed to an uncoordinated and a fragmented health care system. This system is rooted in law and public policies that have created jurisdictional gaps resulting in bickering between federal, provincial and Indigenous governments as to who is responsible for First Nations and Inuit health care. The recent *Daniels*[28] decision has confirmed that Métis and Non-Status peoples are Indians within section 91(24) of the *Constitution Act, 1982*, it has not however been determined what the perimeters of this classification are. Government responsibilities will be determined in the years to come. It is our observation that the legislative and policy vacuum in which the federal government operates in regards to First Nations, Métis and Inuit health obligations, is the single most significant barriers to moving forward.

2.1 Reciprocal Accountability

Generally, the twenty year disconnect between the Canadian government and Indigenous peoples in Canada may be rooted in the lack of mutual accountability, or reciprocal accountability. The concept of reciprocal accountability has been defined as a process that:

> [T]wo (or multiple) partners agree to be held responsible for the commitments that they have voluntarily made to each other. It relies on trust and partnership around shared agendas rather than on hard sanctions for non-compliance to encourage the behaviour change needed to meet commitments. It is supported by evidence that is collected and shared among all partners.[29]

In keeping with this vision, leading Indigenous organizations in Canada have called for a shift to reciprocal accountability and the equal partnership that it entails. According to the Native Women's Association of Canada (NWAC), the end goal is healthy communities, and an accountability model that is "based on governments working in full partnership with First

[28] *Daniels v. Canada (Indian Affairs and Northern Development)*, 2016 SCC 12 [*Daniels*].
[29] OECD, Mutual accountability: emerging good practice, online: https://www.oecd.org/dac/effectiveness/49656340.pdf for the full report see: Liesbet Steer, Cecilie Wathne, Ruth Driscoll, Mutual Accountability at the Country Level - a Concept and Emerging Good Practice Paper, Overseas Development Institute (ODI), 2008OECD.

Nations, Métis and Inuit peoples of Canada"[30] is the required means. Similarly, the Assembly of First Nations (AFN) has stated that "combining efforts to lead toward enhanced mutual accountability for the results of program spending and support development toward increased First Nations responsibility and control" is necessary in order to bring general funding and service delivery up to the standards enjoyed by members of the broader Canadian society. More specifically, the AFN has proposed A First Nations Health Reporting Framework (FNHRF) as part of a "transformative plan to close the gap in health outcomes between Canadian People and Aboriginal Peoples". Reciprocal accountability is a core feature of this proposal:

> The FNHRF is being built on the concept of Reciprocal Accountability, specifically recognizing that there exists a severe imbalance of power between First Nations and the FPT [Federal, Provincial, and Territorial] governments. The FNHRF by way of taking control over the measurement of the performance of FPT governments in their success to meet their stated objectives will enable First Nations to use evidence to support future negotiations to ensure that First Nations interests are identified as priorities.[31]

Finally, the British Columbia's First Nations Health Authority (FNHA)[32] has been developed by First Nations for First Nations. It provides health service delivery for First Nations living in British Columbia. The FNHA identifies reciprocal accountability with government funders as a core feature that is essential to "[e]stablishing the principles and processes of reciprocal accountability for the success of this new health governance arrangement."[33] They list nine principles that guide reciprocal accountability:

- Clear roles and responsibilities for the partners
- Clear performance expectations
- Balanced expectations based on capacities
- Credible reporting
- Reasonable review and adjustment
- Ethics
- Community Level
- Regional Level

[30] Native Women's Association of Canada, 'Accountability for Results from an Aboriginal Women's Perspective' (2005).
[31] Assembly of First Nations, 'The Development of a First Nations Health Reporting Framework' (2006).
[32] The FNHA is an Indigenous-led health service delivery organization responsible for planning, designing, managing, and funding the delivery of health programs and services for First Nations people living in British Columbia. (for more information see: FNHA. 2015. First Nations Health Authority: Healing Through Wellness. http://www.fnha.ca/).
[33] First Nations Health Authority, 'British Columbia First Nation Perspectives on a New Health Governance Arrangment' (2011) at 6.

- Provincial / National Level

Although reciprocal accountability is a core commitment of the new fiscal arrangement with the British Columbia First Nation Health Authority and the government funders it remains in development for practical province-wide implementation.

Despite significant agreement in principle, reciprocal accountability frameworks do remain under-developed and under-implemented. To implement the process of mutual accountability, transparency is key. Transparency includes the involvement of those who are affected in development decisions. Rather than a top down decision-making process the decision-making process involves the rights holders which provides a level of trust building that is critical for a reciprocal relationship.

In Canadian health care systems, the service providers at the community level are completely dependent on the relationship, trust and accountability of others. The patient is reliant on the service provider, and the service provider is reliant on the funder through transfer or contribution agreements. Where health care responsibilities are equally balanced and accountable to each other, relationships are mutually beneficial and the healthcare at the community as a result is beneficial.

At the organizational level when the government funding agreements or the policies that govern healthcare are reflective of a top down approach or the "guardian and ward" approach,[34] then reciprocal accountability is not entrenched in a system that lacks transparency and works against the development of trust-based and equal partnerships. As a result, an improved health status among Indigenous peoples is not forthcoming because such a system does not allow for the creation of the kinds of relationships between funders, practitioners, and communities that are conducive to the open communication and priority setting that is necessary for effective, responsive care. In other words, reciprocal accountability would ideally permeate relationships between high level organizational agreements on strategic policies, funding and governance with community level partnerships, agreements and projects.

[34] The guardian and ward approach was brought into Canadian law in the early 1800s, it describes Indians as "wards" and incapable of making decisions on their own, it therefore following that the government were the guiardians and in a position to make decisions on behalf of their wards. This concept was replaced in law in 1982 by the *Guerin* decision which changed this to a legally enforceable fiduciary obliation. Unfortuntalty the guardian and ward theory still underpins much of policy affecting Indigneous peoples today. See: Boyer, Yvonne, *First Nations, First Nations, Métis and Inuit Health and the Law: A Framework for the Future,* PhD Dissertation, University of Ottawa 2011 at 337. See also, APTN (October 7, 2016) article on point: http://aptn.ca/news/2016/10/07/northern-ontario-doctors-rebel-over-health-canada-rules-that-breach-first-nation-patients-privacy/.

2.2 Fiduciary Obligations

If accountability frameworks are to adhere to the commitments to self-determination as outlined in the various TRC calls to action and the Articles within the UNDRIP, it is key that Indigenous perspectives on reciprocal accountability contribute significantly to our understanding of the concept. In this regard, Kornelsen *et al* have argued that an examination of the history and practice surrounding fiduciary obligations can create the necessary space for Indigenous perspectives on reciprocal accountability:

> [A] consideration of Indigenous perspectives on reciprocity and accountability is an essential yet mainly overlooked component of the development of effective and appropriate accountability models between Indigenous peoples and state-based funders.[35]

Since the beginning of the British assertion of sovereignty, the guiding principles of fiduciary law have governed Crown/Aboriginal relations.[36] This fiduciary obligation is formed in several ways, through the *Royal Proclamation of 1763* and historical protective relationship between Indigenous peoples in Canada and the State;[37] through the protective language of the early treaties that is rooted within the *sui generis* relationship; the constitutionally entrenched protections of 'Aboriginal and treaty rights', and subsequent case law[38] which further defines and solidifies these fiduciary obligations.

As Brian Slattery poignantly explains:

> The Crown has a general fiduciary duty toward native people to protect them in the enjoyment of their aboriginal rights and in particular in the possession and use of their lands. This general fiduciary duty has its origins in the Crown's historical commitment to protect native peoples from the inroads of British settlers, in return for a native undertaking to renounce the use of force to defend themselves and to accept instead the protection of the Crown as its subjects. In offering its protection, the Crown was animated less by philanthropy or moral sentiment than by the need to establish peaceful relationships with peoples whose friendship was a source of

[35] Kornelsen, Boyer, Lavoie and Dwyer. 2016 (fortcoming) Reciprocal Accountability and Fiduciary Duty: Implications for Indigenous Health in Canada Australia and New Zealand". *Australian Indigenous Law Review.*
[36] L.I. Rotman, *Parallel Paths: Fiduciary Doctrine and the Crown-Native Relationship in Canada* (Toronto: University of Toronto Press, 1996) at 4.
[37] *Royal Proclamation of 1763*, R.S.C. 1985, App. II, No. 1 [*Royal Proclamation*]. See also, *R. v. Sparrow*, [1990] 1 S.C.R. 1075, [1990] 3 C.N.L.R. 160 at 177, *Delgamuukw v. British Columbia*, [1997] 3 S.C.R. 1010, [1998] 1 C.N.L.R. 14 (S.C.C.), reversing in part (1993) 10 D.L.R. (4th) 470, [1993] 5 C.N.L.R. 1 (B.C.C.A.), varying in part [1991] 3 W.W.R. 97, [1991] 5 C.N.L.R. 1 (B.C.S.C.).at para. 200 *per* La Forest, J.
[38] *Calder v. British Columbia (Attorney General)*, [1973] S.C.R. 313, 34 D.L.R. (3d) 145, 7 C.N.L.C. 91; *Guerin v. R.*, [1984] 2 S.C.R. 335, [1985] 1 C.N.L.R. 120 and subsequent decisions.

> military and economic advantage, and whose enmity was a threat to the security and prosperity of the colonies. The sources of the general fiduciary duty do not lie, then, in a paternalistic concern to protect a 'weaker' or 'primitive' people, as has sometimes been suggested, but rather in the necessity of persuading native peoples, at a time when they still had considerable military capacities, that their rights would be better protected by reliance on the Crown than by self-help.[39]

Given these origins of the fiduciary relationship between Indigenous peoples and the Crown, it is of central importance to recognize that Indigenous peoples and conceptual frameworks were key to the development of the concept itself. The late Mohawk scholar, Patricia Monture, provides an insightful analysis of how the idea of 'Treaty philosophy' ought to inform understandings of the fiduciary relationship. [40] This perspective emphasises the relational processes that are necessary to maintain good relations or trust and mutual respect between sovereign entities rather than stipulating particular static rights. Treaties require a commitment to ongoing interaction and ceremony as a means to nurturing the relationships and to enable a sensitivity to the needs of each party such that responsibilities could become apparent and the relationship could be sustained for future generations.[41] As a result, practices of treaty-making between sovereign entities work to establish and maintain an "ethical community, that is, [a] community within which promises are kept."[42] This general ideal of treaty-making as reflecting the building and maintenance of relationships of mutual trust, reciprocity, and respect is ubiquitous in Indigenous scholarship on the topic.[43]

However, as a result of historical and ongoing colonial practices and the resultant power disparity between the Crown and Indigenous nations, current practice regarding fiduciary relationships is generally vulnerable to the Crown's discretion and potential abuse.The Supreme Court is clear that when a beneficiary relies on a fiduciary, the fiduciary carries a certain amount

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[39] Slattery, Brian, 'Understanding Aboriginal Rights' (1987) 66 *Canadian Bar Review* 727 at 62.
[40] Monture, P, 'The Experience of Fiduciary Relationships: Canada's First Nations and the Crown' in Law Commission of Canada and Association of Iroquois and Allied Indians (ed), *In Whom We Trust: A Forum on Fiduciary Relationships* (Law Commission of Canada, 2002) 151-182.
[41] Leroy Little Bear, 'Aboriginal Paradigms: Implications for Relationships to Land and Treaty Making' in Kerry Wilkins (ed), *Advancing Aboriginal Claims: Visions/Strategies/Directions.* (Purich Publishing Ltd, 2004) 26-38; J. R. Miller, *Compact, Contract, Covenant: Aboriginal Treaty-Making in Canada* (University of Toronto Press, 2009); Simpson, Leanne, *Dancing on Our Turtle's Back: Stories of Nishnaabeg Re-Creation, Resurgence and a New Emergence* (Arbeiter Ring Publishing, 2011).
[42] Asch, Michael, *On Being Here to Stay: Treaties and Aboriginal Rights in Canada* (University of Toronto Press, 2014).
[43] See also, Taiaiake Alfred, *Peace, Power, and Righteousness: An Indigenous Manifesto, 2nd Edition* (Oxford University Press, 2009); John Borrows, *Canada's Indigenous Constitution* (University of Toronto Press, 2010); Sákéj Henderson, '*Ayukpachi*: Empowering Aboriginal Thought' in Marie Battiste (ed), *Reclaiming Indigenous Voice and Vision* (UBC Press, 2000); Miller, J. R., *Compact, Contract, Covenant: Aboriginal Treaty-Making in Canada* (University of Toronto Press, 2009)

of discretion when discharging its duties. There are strict guidelines that govern the discretionary behavior of the fiduciary. Certain positive duties are imposed upon the federal government because of this fiduciary relationship. Core elements include the Crown's duty to provide full disclosure of its actions so as not to compromise Aboriginal or treaty rights and the requirements that the Crown refrain from acting in conflict of interest situations or benefit from its role as fiduciary. Case law provides that if there is any possibility of infringement on Aboriginal or treaty rights, meaningful consultation is required, and justification must be advanced to account for such infringement.

2.3 The Disconnect

Fiduciary law principles are also very strict in relation to conflict of interest situations: fiduciaries must not act in a conflict of interest situation, must not benefit from their positions, must provide full disclosure of their actions and may not compromise their beneficiaries' interests.[44]

The conflict of interest principles appear to be an oxymoron, however, when one examines the government's actions in matters impacting on Indigenous people. By way of example, the Crown has unilaterally decided what to do with the lands, interests and assets of its Aboriginal beneficiaries. The Crown derives its resources from the land base obtained through treaties and land surrenders and from taxes, and then uses its virtually unlimited resources to oppose Aboriginal court challenges to its powers, thereby benefiting from its position. By so doing, it literally converts its position from fiduciary to the discretionary beneficiary of its own position and power.[45]

The same analogy could be used in relation to health and health policy. The Non-Insured Health Benefits policy distributes health care resources for First Nations under the *Indian Act*. The Canadian government states that it is done though policy and not because of any government perceived legal obligation. An example of discretionary power the fiduciary has over the beneficiary is seen in this policy where a number of unilateral decision have been made that adversely affect First Nations health.[46] Moreover, in the case of the Canadian Human Rights Tribunal First Nations Child Welfare Case, the federal government spent over 3 million dollars

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[44] L.I. Rotman, Parallel Paths: Fiduciary Doctrine and the Crown-Native Relationship in Canada (Toronto: University of Toronto Press, 1996) at 180.

[45] As McNeil, notes, "[h]ow any infringement of Aboriginal rights can accommodate the Crown's fiduciary duty is somewhat of a puzzle, as it seems to violate the basic principle that a fiduciary is bound to act in the best interests of the person(s) to whom the duty is owed" McNeil, K, Section 91(24) Powers, the Inherent Right of Self Government, and Canada's Fiduciary Obligations‖. Paper presented to the Canadian Aboriginal Law Conference. Vancouver: Pacific Business and Law Institute, December, 2002 at 319.

[46] Health Canada (FNIHB). (2005). Medical Transportation Policy Framework July 2005. Ottawa.See also, Child Welfare Funding Timeline of Procedural delays, online: https://fncaringsociety.com/sites/default/files/Procedural%20Diagram%202007-2016.pdf.

in its unsuccessful attempts to have the case dismissed between 2007 and 2016. They argued that First Nation child welfare services should not be compared to those delivered to others in Canada and that this funding is NOT a service and therefore exempt from the Canadian Human Rights Act.[47] In September 2016, the Canadian Human Rights Tribunal has issued a second Compliance Order to compel the federal government to immediately rectify funding formulas to ensure First Nations children who live on reserve have access to health services on the same terms as all other Canadians.[48] It appears that the Canadian Human Rights Tribunal does not carry a legal force other than repeating its Orders, while the federal government selectively choses to listen or ignore its voice.

The federal government recognizes and affirms the government's unique constitutional obligations to Indigneous people but fails to implement these obligations to certain existing Aboriginal and treaty rights – including access to health and health care. Instead, Canada's health policies and guidelines affecting Indigneous health should be examined to ensure that they no longer reflect the outdated wardship model of Crown/Aboriginal relations but instead reflect the fiduciary relationship that the Supreme Court of Canada has stated properly characterizes Crown/Aboriginal relations.

3. Conclusion and Recommendations

RCAP has repeatedly stated that the Crown/Aboriginal relationships are not based on the Doctrine of Discovery, Terra Nullis or other nonsensical colonial justifications for the theft of land and lives, but the relationships are based on inherent Aboriginal rights and the treaty making process and these do not entail the relinquishing of inherent or treaty rights.[49]

Moreover, the fact that inherent Aboriginal and negotiated treaty rights are entrenched in the supreme law of Canada through section 35 of the *Constitution Act, 1982* is confirmation of the recognition of these inherent Aboriginal rights and the treaty making process between nations. The sovereignty of the nations signing the treaties are indicative of the ability of the parties to be self-determining and the recognition of a distinct legal order that is *sui generis* in nature. A key distinction is noted:

> While the *Canada Health Act* is geared to distributing health care to all Canadians equally, Aboriginal peoples argue that their constitutional difference is relevant to the just distribution of health rights and entitlements. Treatment of Aboriginal people as merely "other peoples" ignores their constitutional rights and creates inequality of services. The Supreme Court recognizes the constitutional supremacy

[47] Information Sheet, online: https://fncaringsociety.com/sites/default/files/Tribunal%20Briefing%20Note%20January%202016.pdf.
[48] See, CBC News, "Federal government failing to comply with ruling on First Nations child welfare: tribunal" September 15, 2016, online: http://www.cbc.ca/news/politics/human-rights-tribunal-failing-to-comply-1.3764233.
[49] Y. Boyer, Moving Aboriginal Health Forward: Discarding Canada's Legal Barriers (Purich Publishing 2014).

> of these rights and has provided guiding principles for the legislature, governments and courts. Aboriginal and treaty rights are remarkable sets of rights that recognize Aboriginal people as distinct rights bearing holders of unique customs, practices and traditions. Moreover, these rights are constitutionally entrenched in the Supreme law of Canada.[50]

For true accountability in health care it is critical that the recognition of these rights shape the Crown/Aboriginal relationships in health care funding. In the drafting of many Contribution Agreements, legislation and applicable documents clearly states that there is to be no interference with Aboriginal and treaty rights as protected by the *Constitution Act, 1982*. In fact, this non-interference clause is entrenched in the Constitution through section 25:

> The guarantee in this Charter of certain rights and freedoms shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada …[51]

The FNHA includes Aboriginal and treaty rights and the ensuing fiduciary obligations in its directives for a community engagement process that outlines the standards for a new health governance relationship based on reciprocal accountability in Directive 6,

> • Not impact on Aboriginal Title and Rights or the treaty rights of First Nations, and be without prejudice to any self-government agreements or court proceedings.
> • Not impact on the fiduciary duty of the Crown.
> • Not impact on existing federal funding agreement with individual First Nations, unless First Nations want the agreements to change.[52]

While reciprocal accountability is seen to be a critical component of an Aboriginal and treaty rights legal analysis, Kornelsen *et al* observe that: "[t]his kind of language is ubiquitous in funding agreements and policy statements, it has yet to be meaningfully operationalized in accountability frameworks."[53]

To effectively implement reciprocal accountability within this legal rights and a fiduciary framework a reconstruction of the perimeters of jurisdiction may be developed in a national

[50] Boyer, *ibid* at 167.
[51] *Constitution Act, 1982, being Schedule B to the Canada Act 1982* (U.K.), 1982, c.11 s. 25.
[52] First Nations Health Authority, online: http://www.fnha.ca/about/fnha-overview/directives.
[53] Kornelson, *supra* note 35.

unified federal policy based on catchment (including treaty catchment) areas rather than provincial boundaries,[54]

> [T]o be effective, the reoriented conceptual framework needs to be committed to the creation of Aboriginal and treaty rights catchment areas pertaining to policy, program, and delivery, rather than relying on existing provincial and territorial schemes… Such catchment areas can best resolve the complex issue of First Nation ethics, privacy, consent, and related issues of First Nation representivity…[55]

The restructuring of health care with the implementation of catchments may offer a natural clarity and a solution driven answer to the jurisdictional bickering and quagmire we have seen in the past twenty or more years.

We believe that the operationalization of the RCAP, the TRC and the UNDRIP recommendations requires the adoption of a national enabling First Nation, Métis and Inuit Health Policy inclusive of the following overarching principles:

i) **Reciprocal accountability agreements** that establish commitments to relationship-building amongst all stakeholders (round tables, etc) as a means to ensuring the ***process of reciprocity, trust-building, transparency*** are a key focus rather than simply focusing on adding a bi-directional arrow to existing models.

Reciprocal accountability means mutually shared responsibility between all the partners ranging from community (First Nations, Métis or Inuit) level to regional level to provincial level (provincial government, inclusive of health authorities) to a national level (federal governments) level to realize collective goals. It consists of the recognition that each party is "responsible for the effective operation of their part of the health system recognizing that the space occupied by each is interdependent and interconnected."[56] It also echoes the language of patient-centred care, which has gained currency in the healthcare literature over the past decade. In this regard, the FNHA stands as an innovative, perhaps radical, development that appears to be constructed in ways that can encourage the development of effective mutual accountability frameworks and effective, responsive care.

[54] Henderson. 2006. "First Nations Conceptual Frameworks and Applied Models on Ethics, Privacy, and Consent in Health Research and Information." First Nations Centre; National Aboriginal Health Organization. pp. 9-10.
[55] *Ibid*.
[56] First Nations Health Authority, Consensus Paper, online http://www.fnha.ca/Documents/FNHC_Consensus_Paper.pdf.

ii) Recognizing and implementing, the constitutional protections of Aboriginal and treaty rights to health; Inherent Indigenous rights to health; Crown/Indigenous fiduciary obligations.

A "disconnect" clearly exists between the government and First Nation, Métis and Inuit peoples regarding their poor health status. This disconnect cannot be relied upon to justify or maintain the status quo in relation to health status of First Nations Métis and Inuit without the acknowledgment that such continuance is owing to a disregard for existing constitutionally protected Aboriginal and treaty rights to health, a breach of the Crown's fiduciary obligations, a discriminatory exercise of discretion and a conflict of interest position from which the federal government continues to benefit.[57]

The federal government cannot continue to reasonably maintain that health services provided to First Nations and Inuit are "voluntary" and provided for "humanitatrian reasons" and not required by law but simply a matter of policy. Such a characterization is a discriminatory reading of Canada's commitments to provide the highest attainable standard of physical and mental health to *all* residents of Canada and to facilitate reasonable access to health services without financial or other barriers based on need.

The RCAP report made a credible evidence based case which supported the belief that Indigenous Peoples could reclaim management of their own affairs in a context of mutual trust and respect for the constitutional entrenchment of Aboriginal rights. Regrettably some twenty years has elapsed and very little has changed as reflected in the strikingly similar calls to action from the Truth and Reconciliation Commission[58].

Canada's health policies and guidelines affecting First Nation, Métis and Inuit must be examined to ensure that they no longer reflect the outdated wardship model of Crown/Aboriginal relations but instead reflect the fiduciary relationship that the Supreme Court of Canada has stated properly characterizes Crown/Aboriginal relations. In light of constitutional reform and judicial interpretations surrounding constitutionally protected Aboriginal and treaty rights, lawmakers and policy-makers should be compelled to accept the existence and implementation of Aboriginal and treaty rights to health in Canada.

As Canada readies to celebrate its 150th birthday in 2017 we need to move toward reconciliation to avert repetitive mistake that would commission yes another report in the future calling yet again for the same 'calls to action' that have been recommended since the RCAP in 1997. Thus,

[57] Y.M. Boyer, "Aboriginal Health – The Crown's Fiduciary Obligations" Discussion Paper Series #2, National Aboriginal Health Organization and the Native Law Centre of Canada (May 2004).
[58] See Call 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." (page 2)

we recommend implementation of an action plan in a process to be initiated in partnership with Aboriginal peoples, with an urgent mandate to blueprint the architecture of the unfinished business of confederation, that being eliminating inequality in health and well being for Aboriginal peoples and their ancestors.

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