INDIGENOUS HEALTH IN FEDERAL, PROVINCIAL, AND TERRITORIAL HEALTH POLICIES AND SYSTEMS

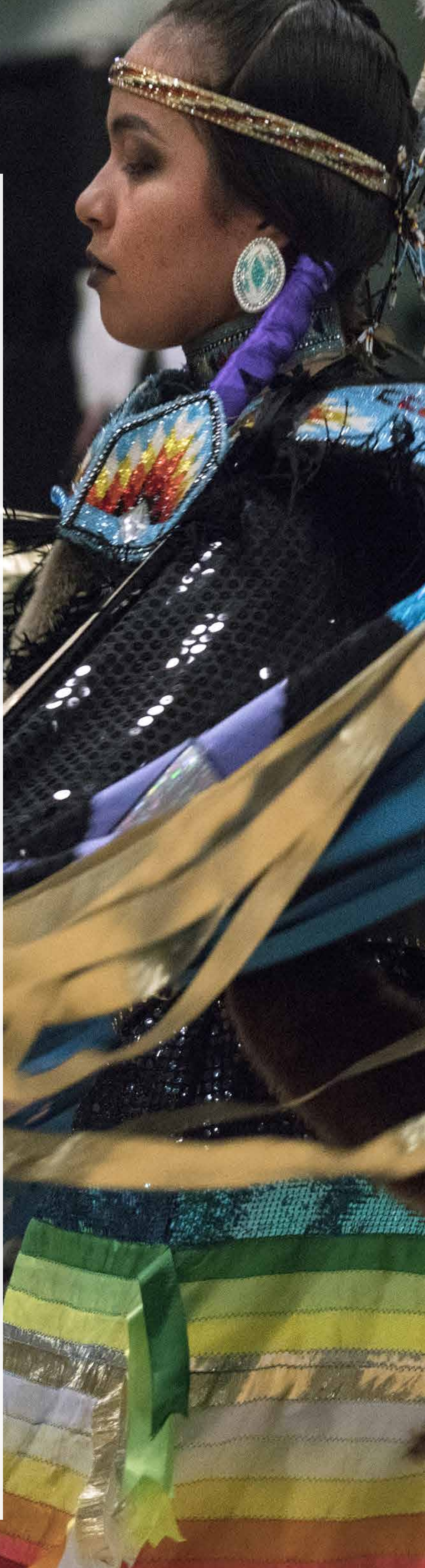
Denise Webb, MSc

National Collaborating Centre
for Indigenous Health

Centre de collaboration nationale
de la santé autochtone

SOCIAL DETERMINANTS

Front and Back Cover Photo © Credit: iStockPhoto.com, ID 837093262
Inner Cover Photo © Credit: iStockPhoto.com, ID 930513570



The NCCIH uses an external blind review process for documents that are research based, involve literature reviews or knowledge synthesis, or undertake an assessment of knowledge gaps. We would like to acknowledge our reviewers for their generous contributions of time and expertise to this manuscript.

See the related NCCIH report: *Looking for Aboriginal Health in Legislation and Policies, 1970 to 2008*. Lavoie et al. (2011). National Collaborating Centre for Aboriginal Health.

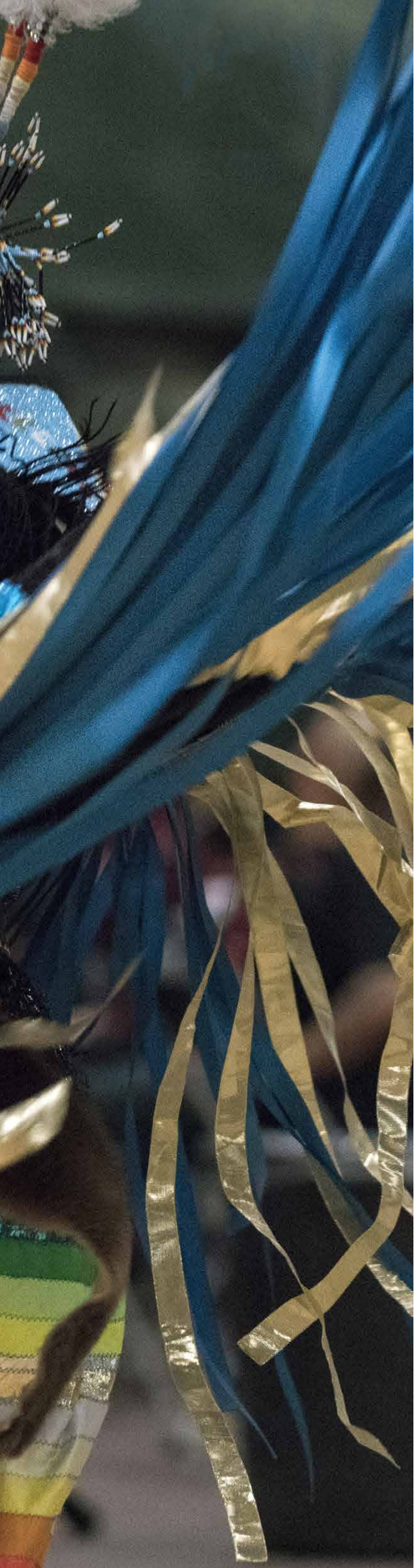
Citation: Webb, D. (2022). *Indigenous health in federal, provincial, and territorial health policies and systems*. National Collaborating Centre for Indigenous Health.

La version française est également disponible au ccnsa.ca sous le titre : *La santé des Autochtones dans les politiques et les systèmes fédéraux, provinciaux et territoriaux.*

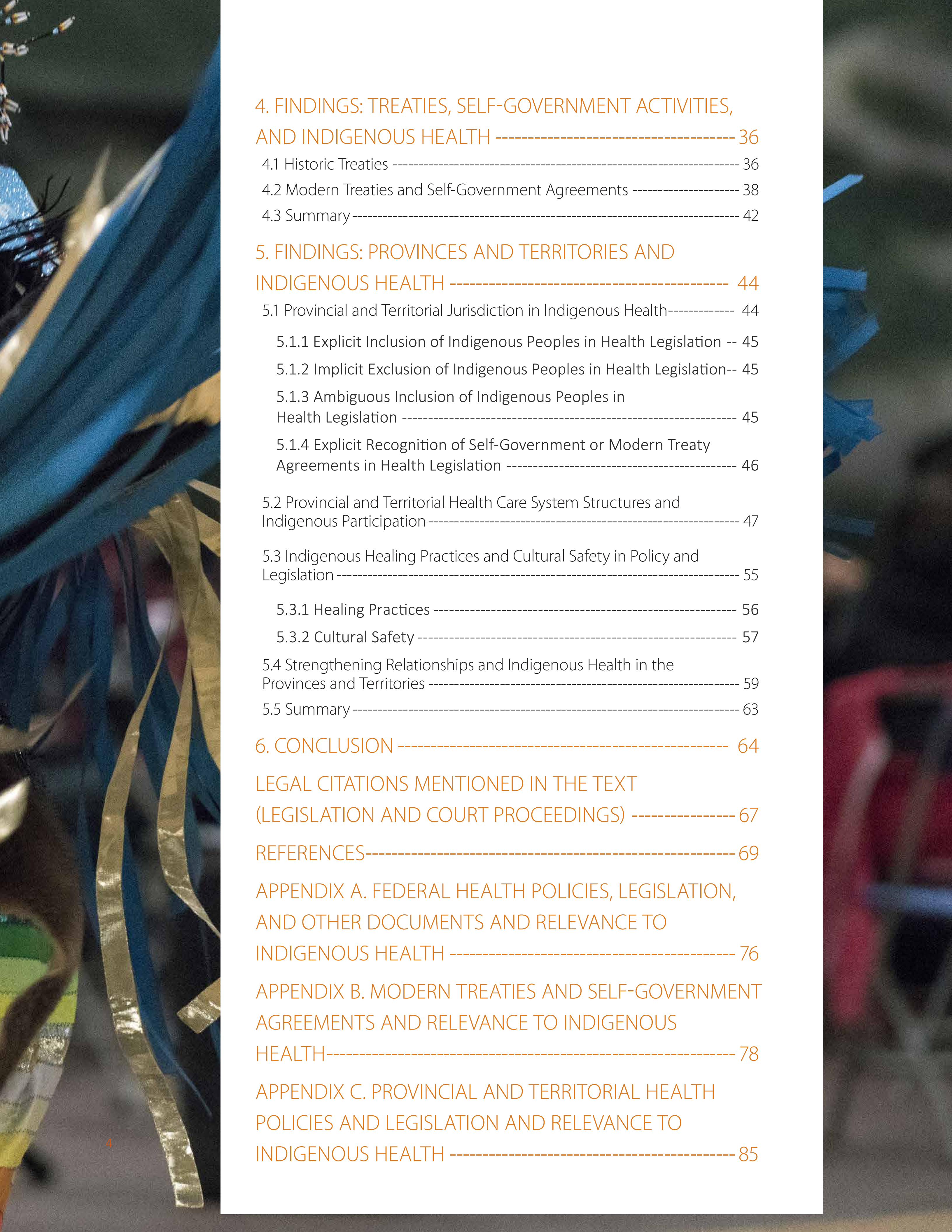
For further information or to obtain additional copies, please contact:

National Collaborating Centre for Indigenous Health (NCCIH)
3333 University Way
Prince George, British Columbia
V2N 4Z9 Canada
Tel: (250) 960-5250
Fax: (250) 960-5644
Email: nccih@unbc.ca

ISBN (print): 978-1-77368-372-0
ISBN (online): 978-1-77368-375-1



CONTENTS



LIST OF ACRONYMS

AB: Alberta

BC: British Columbia

CIRNAC: Crown Indigenous Relations and Northern Affairs Canada

FNHA: First Nations Health Authority

FNIHB: First Nations Inuit Health Branch

ISC: Indigenous Services Canada

MB: Manitoba

NB: New Brunswick

NFLD: Newfoundland and Labrador

NIHB: Non-Insured Health Benefits

NIMMIWG: National Inquiry into Missing and Murdered Indigenous Women and Girls

NS: Nova Scotia

NTHSSA: Northwest Territories Health and Social Services Authority

NU: Nunavut

NWT: Northwest Territories

ON: Ontario

PEI: Prince Edward Island

PHSA: Provincial Health Services Authority

QC: Quebec

RCAP: Royal Commission on Aboriginal Peoples

RHA: Regional Health Authority

SHA: Saskatchewan Health Authority

SK: Saskatchewan

TRC: Truth and Reconciliation Commission of Canada

UNDRIP: United Nations Declaration on the Rights of Indigenous Peoples

YK: Yukon

1. BACKGROUND

Indigenous[1] health care in Canada is best described as a "patchwork" of loosely woven together legislation, policies, treaties, and tripartite agreements between and across provincial, territorial, federal, and Indigenous governments and jurisdictional boundaries (Lavoie et al., 2011, p. 11). In 2011, the National Collaborating Centre for Indigenous Health (NCCIH) investigated the patchwork, piecing together the links to Indigenous health within federal, provincial, and territorial health policies and legislation in Canada (Lavoie et al., 2011). This report aims to update and expand this work.

The Indigenous health policy patchwork provides a comprehensive landscape to generate policy lessons and comparisons; however, at the same time it creates confusion and inconsistencies regarding responsibility to fund, deliver, and regulate Indigenous health care (Lavoie, 2018; Lavoie et al., 2016b; Young, 1984). Policy research has long documented the outcomes to such jurisdictional confusion, repeatably citing issues of sufficient gaps in service delivery, as well as inequitable access to necessary care that is both timely and culturally appropriate for Indigenous Peoples and communities (Lavoie, 2018; Lavoie et al., 2015, 2016b; Mashford-Pringle, 2013; Walker et al., 2018; Young, 1984).

Origins of the patchwork trace back to historic colonial policies and the resulting organization of Canada's health care system. Upon European settlement on Indigenous lands, colonizers implemented the *British North America Act* (1867) (now the *Constitution Act* [1867]) to establish the Dominion of Canada and with it, administrative structures to delegate delivery of health care services. The Act states that matters of health care are to be of provincial and territorial jurisdiction and in Section 91(24), entrenches matters of status First Nations under federal responsibility. Inuit were later included under Section 91(24) as part of a 1939 Supreme Court of Canada's interpretation of the Act.

As a result, Canada approaches health service delivery and policy development through a decentralized model, through a complex network of fourteen health care systems: one for every province and territory, and one operated by the First Nation and Inuit Health Branch (FNIHB) of Indigenous Services Canada (ISC). Provincial and territorial health care systems

---

[1] A note on terminology: In the context of this report, "Indigenous" refers collectively to status and non-status First Nations, Inuit, and Métis Peoples, the original inhabitants of what is now known as Canada. "Aboriginal" is also referenced in this report, pursuant of Section 35 of the *Constitution Act* (1982), and includes "Indian, Inuit and Métis." The term "Indian," although problematic due to racist and colonial roots, is the legal term used to refer to status First Nations as regulated under the *Indian Act* and is thus only referenced in this report when referring to the Act. The term "Indigenous" will be used above "Aboriginal" throughout this report as is it aligns with international understandings of Indigenous Peoples, as reflected in the United Nations Declaration on the Rights of Indigenous Peoples, and is considered to be more respectful as it acknowledges Indigenous Peoples as original inhabitants and recognizes distinct and separate Nations (Animikii Inc, 2020). "Aboriginal" will thus only be used when in reference to the terminology adopted by policies, legislation, and juridical proceedings. Specific terms (First Nations, Inuit, Métis) will be used when referring to distinct Indigenous groups.


© Credit: iStockPhoto.com, ID 458465561

Health care policies and legislation across the many health systems in Canada articulate their responsibilities in Indigenous health in different ways (if at all), with the health care needs and priorities of non-status First Nations, Inuit, and Métis Peoples in urban environments often falling through the cracks.

are responsible for health care provided to residents of their jurisdiction, while the FNIHB plans, finances, and delivers select primary and preventative health programs for status First Nations and Inuit communities in the provinces and the Yukon (Lavoie et al., 2016b). Other arrangements between the FNIHB and First Nations and Inuit communities exist, with varying degrees of FNIHB involvement in health care planning and delivery depending on self-government and tripartite agreements (e.g., the James Bay and Northern Quebec Agreement [1975], the British Columbia Tripartite Framework Agreement on First Nation Health Governance [2011]), as well as delivery of specific programming such as the FNIHB Non-Insured Health Benefits Program (discussed further in Sections 3, 4, and 5). Indigenous-led health governance models and the private sector also play separate as well as some complementary roles within this network.

Of note, the *Canada Health Act* (1984) is a foundational document for each provincial and territorial health care system, as it sets criteria and conditions that each system must meet in order to receive federal cash contributions to support their health systems operations. Criteria is based on principles of public administration, comprehensiveness, universality, portability, and accessibility. The Act aims to ensure the protection, promotion, and restoration of health and well-being of all residents of Canada, with implicit inclusion of Indigenous Peoples (de facto as provincial and territorial residents) (*Canada Health Act*, 1984). The Act does not explicitly address status or non-status First Nations, Inuit, or Métis health care, nor any jurisdictional responsibilities in this regard. There is thus little federal direction or clarification on the roles provinces and territories must play in the protection and delivery of health care for Indigenous Peoples. What's more, as the Act focuses on federal cash transfers to provinces and territories, the five guiding principles for health care delivery focus on provincial and territorial health care systems and therefore do not apply to care delivered on reserve (which is considered a federal responsibility).

Section 91(24) of the *Constitution Act* (1867) was also later interpreted by the Supreme Court of Canada in 2016 to establish and recognize Métis and non-status First Nations under federal responsibility (*Daniels v. Canada*, 2016). The implications of this decision pertaining to federal responsibilities in matters of Métis and non-status First Nations health care are yet to be determined and defined (Boyer et al., 2021). As a result, the federal government continues to only fund or provide some health programs to First Nations communities on reserve, and fund “the provision of certain community health programs for Inuit living in Inuit Nunangat” (ISC, 2021c, p. 1). Meanwhile, health care for Inuit living in southern regions, Métis, and non-status First Nations living off reserve is primarily considered to fall under provincial and territorial jurisdiction (ISC, 2021c). This arrangement is again without any clear federal-level policy or legislative provisions to help guide or inform provinces and territories of their responsibilities in terms of Indigenous-specific care. Health care policies and legislation across the many health systems in Canada articulate their responsibilities in Indigenous health in different ways (if at all), with the health care needs and priorities of non-status First Nations, Inuit, and Métis Peoples in urban environments often falling through the cracks (Lavoie 2018, 2016b; Walker et al., 2018).

Limited policy direction regarding Indigenous health care is particularly problematic when considering health program gaps and limiting provincial health care budgets. When federal policies shift and the availability of their Indigenous health programs change, provinces are expected to allocate funding and fill program gaps (Boyer, 2014). This can be challenging for provinces with smaller health care budgets compared to others, and for those with greater proportions of First Nations residents, such as Manitoba and Saskatchewan (Lavoie et al., 2010). Without clear legislation to ensure accountability of jurisdictions, like that of the *Canada Health Act*, equitable and sustainable access to health programs for all Indigenous Peoples, regardless of location, suffers. The federal government has recently committed to developing a new distinctions-based Indigenous health legislation (see Section 3), deeming these issues and others to be of critical importance to inform ongoing discussions and its current development (ISC, 2022d).

In recent years, federal, provincial, and territorial governments have since implemented policies and legislation in efforts to gradually improve equitable access to health care for Indigenous Peoples. Examples include, but are not limited to, implementing Jordan’s Principle and the Inuit Child First Initiative on national scales to improve access to care for First Nations and Inuit children (Blackstock, 2012; ISC, 2020); ensuring availability of culturally safe and appropriate health services (e.g., British Columbia’s *Patient Safety Culture Policy*, 2022 [PHSA, 2022]); and instilling efforts to restore relationships with Indigenous communities and redress historical jurisdictional fragmentation regarding the delivery of care (Vancouver Coastal Caucus et al., 2012) (further examples are discussed in Section 5). Moreover, many First Nations, Inuit, and Métis communities have entered, or are in the process of entering, into tripartite agreements between provincial or territorial, federal, and their local governments to establish Indigenous-led health care structures operating alongside

© Credit: iStockPhoto.com, ID 1029925490

or adjacent to provincial or territorial systems (discussed in Section 5).

Some jurisdictions have also worked to promote and create opportunities for Indigenous Peoples to exercise self-determination within the health care system, as called on governments by national reports (e.g., The Royal Commission Royal Commission on Aboriginal Peoples [RCAP], Truth and Reconciliation Commission [TRC] of Canada, and National Inquiry into Missing and Murdered Indigenous Women and Girls [NIMMIWG]) and international human rights legal instruments (i.e., United Nations Declaration on the Rights of Indigenous Peoples [UNDRIP]). Indigenous self-determination in health care is the ability to control and fully participate in all realms of health care planning and delivery and is one of the most significant determinants of individual and collective health and well-being (Halseth & Murdock, 2020). In the context of health care systems, however, these opportunities are often reduced to self-administration activities (Abele et al., 2021), as decision-making powers are often derived from and confined by heavy oversight and control that stems from colonial government structures and policies (RCAP, 1996b). For instance, Ontario recently legislated its support for Indigenous self-determination in health care, stating responsibilities of the Minister to recognize "the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities" (Ontario's *Connecting Care Act*, 2019, preamble); however, this authority derives from the provincial government and is restricted by the financial and resource restraints of the provincial health care system. Based on the complexities and realities of self-determination in health care systems, this report adopts 'self-determination' as an umbrella term to denote any opportunities to participate in activities that fall within the realm of self-determination, while also highlighting opportunities that are more in line with self-administration.

Such policy developments designate space to regulate and improve Indigenous health care in Canada; however, they also add to the patchwork, rendering it difficult to capture a full picture on Indigenous health care. As much of the literature continues to focus on individual health system or policy reforms, a cross-jurisdictional understanding is needed to monitor progress, identify persistent gaps, and develop a landscape which may be used to compare strategies and generate policy lessons. In achieving this task, we collect and catalogue all federal, provincial, and territorial health policies and legislation developed and implemented as of April 2022 with relevance to Indigenous health and health care and are guided by the following research objectives:

1. Develop a comparative inventory of federal, provincial, and territorial health policies and legislation that make specific mention of First Nations, Inuit, and/or Métis Peoples.
2. Develop a comparative inventory of modern treaties and self-government agreements and document their health-related provisions and opportunities for self-determination in care.
3. Identify emerging trends in terms of jurisdictional fragmentation and coordination.
4. Identify opportunities for Indigenous participation in shaping health policy, programs, and services as entrenched in institutional arrangements.
5. Identify emerging trends in terms of recognition and respect for Indigenous cultural safety and appropriateness in provincial and territorial health care spaces.
6. Explore federal, provincial, and territorial approaches to restore and strengthen relationships with Indigenous Peoples within the health care system.

1.1 Definitions in Context

The concepts of health policies and legislation merit further explanation and definition. Health within a neo-colonial policy context is narrowly defined, with a focus on prevention, treatment, and financial management of disease (Chenier, 2002; De Leeuw et al., 2014). Within this realm, 'health' in 'health care policy' focuses on "health care as the organised enterprise of curing or caring for disease, disability, and infirmity, and includes efforts at regulating and organising health care professions, pharmaceuticals, financing of the healthcare system, and access to healthcare facilities" (De Leeuw et al., 2014, p. 3). This understanding of health conflicts with First Nations, Inuit, and Métis diverse knowledges systems surrounding health and well-being, which together generally define health as holistic, considering physical, social, mental, and spiritual elements, and interconnected with a wide range of determinants (also known as the Indigenous determinants of health[2]) such as education, housing, environment, public systems, colonialism, racism, land, and spirituality (Greenwood et al., 2018; Loppie & Wien, 2022).

Federal policy documents such as the Lalonde Report (1974) present broadened views on health to acknowledge socio-economic and environmental predictors and to understand health beyond solely the absence of disease (Lalonde, 1974). The Lalonde Report is thus considered foundational to the growth and recognition of public health and health promotion in health care policy development (Rutty et al., 2010). Governments responded to the report by forming new health promotion roles and expanding the scope of public health activities (i.e., immunization, environmental health, disease control, etc.) (Rutty et al., 2010). However, the neo-colonial approach to health care policy within jurisdictions' Ministries of Health continues to focus on the management of disease (Chenier, 2002; De Leeuw et al., 2014), while broadened views of health promotion and public health are adopted by separate public health departments or organizations, with varying levels of coordination between health care and public health departments (Allin et al., 2018). This siloed and fragmented structure of health care poses structural barriers to operationalize more holistic understandings of health, as well as limitations to this report. As a search through all departmental policies and legislation is beyond the capacities of the current project, this report focuses on federal, provincial, and territorial Ministries of Health and health care policies (employing De Leeuw et al.'s [2014] definition explained above) and does not thoroughly investigate public health policies that address a wider scope of the Indigenous determinants of health. We therefore document and follow a robust methodology which may be adapted to support research on other government ministries and departments to then piece together and capture a more holistic view of Indigenous health in policies and legislation (see Section 2 for limitations of the report).

Defining the interrelated notions of policy and legislation is also important. Policy may be considered as an outcome of legislation and as a formal or informal means of achieving goals set out by laws, standards, and regulations – all aspects of legislation (De Leeuw et al., 2014). Alternatively, legislation may be understood as a type of instrument used to implement a policy (Bemelmans-Videc et al., 1998). Finally, both legislation and policy may also be considered as formal instruments used to achieve an overarching objective established by actors with authority to assign such objectives (Jenkins, 1978). In this report, we consider policy and legislation as formal or official documents that instruct how a system or structure

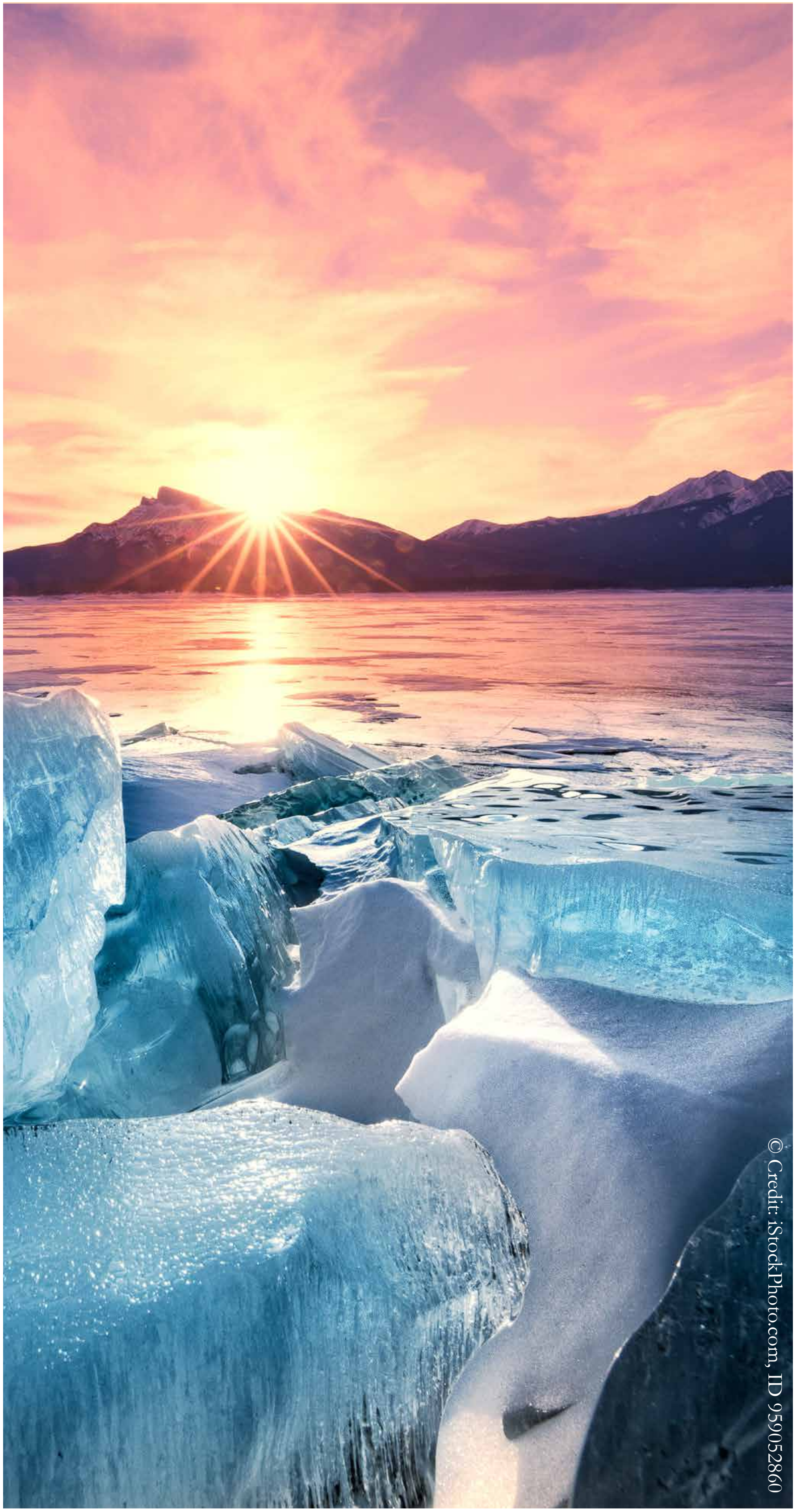
---

[2] See Greenwood et al. (2018) for a detailed discussion on Indigenous determinants of health.

is to achieve government or policy actor decisions, objectives, or goals in relation to matters of health and health care. Policy instruments may include educational tools, financial incentives, or rules and laws embedded in health policy and legislative documents (e.g., policy statements, frameworks, as well as health legislation, standards, or regulations) (Bemelmans-Videc et al. 1998).

1.2 Organization of the Report

The following sections explore the methodology and discuss the findings in accordance with the research objectives, categorized as federal policies and legislation (Section 3), modern treaties and self-government agreements (Section 4), and provincial and territorial policies and legislation (Section 5). We conclude the report with insights for further learning and a series of appendices to complement the findings. As this report aims to support critical analysis and inform policy research and discussions at all levels of government, we also hope to inform meaningful change and highlight important policy innovations for the benefit, health, and well-being of Indigenous Peoples and all communities.



© Credit: iStockPhoto.com, ID 95905860

2. METHODS

This report reviews primarily grey literature, collected from October 2021 to April 2022, that is written or translated in English and publicly available on the internet. In scope, we focus on Canada and any federal, provincial, and territorial policies and legislation; treaty and self-government agreements (signed as of April 2022); and other related health care system initiatives or principles as applicable. There are two search strategies: one to gather government health policies and legislation (research objective #1), and a second to gather treaties and self-government agreements (research objective #2). The remaining four research objectives coincide with the work and findings of these two search strategies.

2.1 Search Strategy #1: Federal, provincial, and territorial health policies and legislation

Federal health policies and legislation were identified through federal departments and databases, including: Health Canada, Public Health Agency of Canada, Indigenous Services Canada, Library of Parliament, and Government of Canada Publications. Institutional websites of the five national Indigenous organizations the federal government often engages with (i.e., Assembly of First Nations, Inuit Tapiriit Kanatami, Métis National Council, Congress of Aboriginal Peoples, and Native Women's Association of Canada) were consulted to fill information gaps and collect further context on policies and legislation. Academic databases were also searched for peer-reviewed literature, including: Canadian Legal Information Institute (CanLII), Canadian Research Index, Canadian Periodicals Index, and Google Scholar. Provincial health policies and legislation were identified through institutional websites of provincial and territorial Ministries of Health, Legislative Assemblies, and centralized health authorities and agencies, supplemented by the CanLII to fill gaps as needed. When applicable, a combination of the following key words and search terms were used: (First Nation(s) OR Métis OR Inuit OR Inuk OR Indigenous OR Aboriginal OR Native OR Indian) AND (health OR wellness OR well*being OR traditional OR healing OR medicine OR medical OR practices).

Health policies and legislation were included in the report based on any mentioning of First Nations, Inuit, and/or Métis Peoples in the context of health and health care. Examples of this include, although are not limited to, provisions regarding access to, management of, or participation in health care and health policy making; delivery of culturally appropriate health services; respect for traditional healing practices or medicines; or establishment of jurisdiction for the delivery of care.

All included health policies and legislation were then charted in Microsoft Excel, including the document title, year of establishment,[3] with excerpts showcasing their relevance to Indigenous health. Federal

---

[3] Establishment in the context of this report refers to when legislation is given Royal Assent and when policies are implemented.

documents were grouped together based on similarities and organized into the following categories: historic documents, jurisdiction in care, strengthening relationships, and federal departments and mandates. Of note, the category 'strengthening relationships' refers to policies, legislation, or other related documents identified in the search (e.g., Memorandums of Understanding, guidelines) that aim to improve Indigenous health from a health care system-level through establishing or restoring government-to-government relations between Indigenous and non-Indigenous peoples and nations. Provincial and territorial documents were similarly grouped together and organized into the following categories: organization of the health care system, jurisdictional responsibilities, traditional healing practices and cultural safety, and strengthening relationships.

2.2 Search Strategy #2: Modern treaties and self-government agreements

For this objective we include historic treaties (numbered treaties) and their interpretations in the federal, provincial, and territorial courts; federal policy with regards to the treaty and self-government agreement process; and all modern treaties and self-government agreements[4] in relation to health signed as of April 2022. Accordingly, we identified information through CanLII for case laws and interpretations; the Crown-Indigenous Relations and Northern Affairs Canada (CIRNAC) institutional website for federal policies; and the CIRNAC institutional website as well as Indigenous government websites for modern treaties and self-government agreements. Of note, the search for interpretations of historic treaties primarily focused on Treaty 6, and its implications for Indigenous health through the Medicine Chest Clause. Search terms and key words in this regard were thus a combination of: (treaty OR treaties OR treaty 6 OR treaty six OR medicine chest OR medicine chest clause) AND (First Nation(s) OR Métis OR Inuit OR Inuk OR Indigenous OR Aboriginal OR Native OR Indian). Inclusion criteria was dependent on relevance to Indigenous health. Documents were then charted in Microsoft Excel, citing the document title; year of court proceedings, policy implementation, or agreement signed; and excerpts of relevance to health or health care.

2.3 Limitations

There are a few notable limitations to this report. First, and as noted above, the neo-colonial definition of health adopted by Ministries of Health is limiting in its ability to capture a holistic understanding of Indigenous health in policies and legislation. To overcome this issue, we document our methodology so as to assist future research on other government ministries and departments. Second, the language restriction to English is a limitation, as it may underestimate the sources available from French-speaking provinces such as Quebec and New Brunswick, as well as sources from Nunavut written in Inuktitut. Further work is recommended to address this gap. Finally, by limiting the search to sources publicly available on the internet, information may be missed, and the number of relevant policies and legislation included in this report may be underreported. We thus use multiple resources to locate policy and legislative documents, such as CanLII, in addition to institutional websites of Ministries of Health.

---

[4] Modern treaties, also known as Comprehensive Land Claims Agreements, are signed in areas where historic treaties were never negotiated and include Indigenous organizations or nations, federal, and provincial or territorial governments as signatories. Self-government agreements are written forms describing how First Nations governments will exercise their inherent and constitutionally protected right to self-government and may be established within or in association with modern treaties or as entirely separate entities (CIRNAC, 2019).

3. FINDINGS: THE FEDERAL GOVERNMENT AND INDIGENOUS HEALTH

This section explores the relationship between the Government of Canada and Indigenous Peoples' health as mediated by historic and current policies, legislation, and intergovernmental structures. While historical documents continue to set the foundation in how the federal government approaches and interprets its responsibilities to Indigenous health care, there have been minimal additions to Health Canada's repository of Indigenous health policies of recent. Key updates include amendments to the *Constitution Act* (1982) and *Indian Act* (1876); a reorganization of federal departments to establish Indigenous Services Canada; and further national efforts to strengthen relations with Indigenous Peoples in line with reconciliation. We begin with an overview of key historical federal policies and legislation, then move into descriptions of current federal departments, mandates, and policies in Indigenous health; disputes in federal jurisdiction regarding Indigenous health care provision; and national policy efforts to strengthen relationships with Indigenous Peoples and improve Indigenous health. We then summarize the findings with insights for future research. Appendix A outlines all documents identified in this section.

3.1 Historic Federal Policy and Legislation

Prior to colonization and European contact, the health and well-being of Indigenous Peoples and communities flourished. Holistic medicine and treatment aligned with diverse knowledge systems and teachings, and care was delivered by medicine people and traditional healers trusted by the community (Hill, 2003).

Although these practices remain active and serve prominent roles in Indigenous health care today, colonization perpetuated disruptive practices into the management and delivery of Indigenous health care for and by communities, through the foundation of historic, colonial policies.

3.1.1 The Doctrine of Discovery

The Doctrine of Discovery dates back to the 15th century and was a legal instrument used to establish justified grounds for colonization. The doctrine granted land ownership and title to European settlers upon their land "discovery" and rendered Indigenous Peoples ineligible to claim rightful territorial ownership as original occupants (Reid, 2010). Rather, Indigenous Peoples were restricted to rights of occupation and land

While the Royal Proclamation recognized and preserved First Nations sovereignty over their lands and territories, and promised protection from unlawful European settlement, it did so through mechanisms that simultaneously worked to "enlarge [the Crown's] powers by creating a process to take land away from First Nations".


© Credit: iStockPhoto.com, ID 1215506340

use, authorized by the settler "discoverer" (Miller, 2010; Reid, 2010). The Pan American Health Organization (2019) describes the historical context of the Doctrine, explaining:

> The colonial States deemed themselves as "civilized" and Indigenous peoples and cultures as "savage," in order to legitimize the unlawful taking of lands and resources and the superimposing of Western European culture, institutions, and languages …. The savage/civilized dichotomy and Spain's interest in asserting land rights over territories "discovered" by Columbus in his 1492 journey to the Americas prompted Pope Alexander VI to issue the Papal Bull Inter Caetera …, which recognized land ownership by Christian peoples …, effectively negating Indigenous title by declaring the land terra nullius—owned by no one. The Papal Bull in turn gave rise to the Doctrine of Discovery …, which codified the ineligibility of non-Christian peoples to hold title over lands and resources. (p. 69)

Together, the Papal Bull Inter Caetera, the notion of *terra nullius*, and the Doctrine of Discovery were used across international borders to extinguish Indigenous rights to lands and resources (Pan American Health Organization, 2019). Discriminatory ideals of European superiority and Indigenous inferiority conspired a societal norm that Indigenous Peoples should have limitations on their rights to self-determination and governance, as well as receive lesser rights than their non-Indigenous counterparts (Miller, 2010). These ideals sustained long-lasting effects on Indigenous health care, found in measuring the health outcomes of Indigenous Peoples and in assessing the availability of Indigenous-specific culturally safe care in mainstream health care options (Pan American Health Organization, 2019). Many centuries later, the Government of Canada identified the Doctrine of Discovery as "racist, scientifically false, legally invalid, morally condemnable and socially unjust" (p. 2) in its *United Nations Declaration on the Rights of Indigenous Peoples Act* (2021). Yet, the impacts of the Doctrine on Indigenous self-determination, including in matters of health, have instilled an underlining bias evident in policies and legislation that remain in force today (Pan American Health Organization, 2019).

3.1.2 The Royal Proclamation (1763)

The Royal Proclamation (1763) provides a foundation to the treaty process between the British Crown and Indigenous governments and continues to inform relationships between Indigenous and non-Indigenous peoples, as well as the federal approach to Indigenous inherent rights (Mashford-Pringle, 2011). The Proclamation established the British Crown in the North Americas, and declared First Nations Peoples as sovereign people, whose ancestral land may not be ceded unless otherwise negotiated through treaties and approved by the Crown. It was a legal instrument used to form an alliance between the British Crown and First Nations, however, with an underlining agenda to control and manage Indigenous lands and place limits on self-governance. While the Royal Proclamation recognized and preserved First Nations sovereignty over their lands and territories, and promised protection from unlawful European settlement, it did so through mechanisms that simultaneously worked to "enlarge [the Crown's] powers by creating a process to take land away from First Nations" (Borrows, 1997, p. 160). In other words, through the Royal Proclamation the Crown established a means to preserve First Nations' land sovereignty, while also expanding its dominion over First Nations land and asserting itself as the gatekeeper to the treaty process (Borrows, 1997).

Parallels to this mechanism are in full force today. In the case of health care, modern treaties and self-government agreements with arrangements to assume local control over the administration and delivery of care must stem from agreements and negotiations established between Indigenous and non-Indigenous governments, approved by the Crown. Moreover, from the lens of the federal government, Indigenous land, health, and other social and economic rights continue to be largely considered under federal regulation. Naturally, these mechanisms and perspectives thus continue to influence relationships between Indigenous and non-Indigenous nations, with long-lasting effects.

3.1.3 British North America Act (1867)

The British North America Act (BNA) (1867) established the Dominion of Canada and with it, the legislative powers and authority of the federal, provincial, and territorial jurisdictions. The BNA deemed matters of First Nations peoples under federal jurisdiction and matters of health care and other social services under provincial and territorial purview. This, of course, created grounds for an ongoing jurisdictional debate regarding matters of health care for Indigenous Peoples in the provinces and territories.

In 1982 the BNA was amended to assume Canada's full independence of Britain (and retitled the *Constitution Act*, 1867), as well as enshrine the *Canadian Charter of Rights and Freedoms* and rights of Indigenous Peoples under the Act (amended and retitled the *Constitution Act*, 1982).

Section 35 of the *Constitution Act* (1982) affirms Aboriginal and treaty rights of First Nations, Inuit, and Métis peoples in Canada, recognizing Métis peoples as Aboriginal Peoples for the first time in Canadian law. Rights in this context may refer to rights to practices, customs, and traditions that are collectively held by Indigenous Peoples (Craft & Lebihan, 2021), as well as rights stemming from historic or modern treaties, or self-government agreements. Furthermore, Section 91(24) of the *Constitution Act* (1867) reaffirms federal jurisdiction in and responsibility to matters of status First Nations peoples. Prior to the 1982 amendments, Section 91(24) was earlier interpreted and confirmed to include Inuit by the Supreme Court of Canada in 1939 (Supreme Court of Canada, 1939), while Métis and non-status First Nations were later included in the *Daniels Decision* in 2016 (*Daniels v. Canada*, 2016). This recognition broadens the federal government's fiduciary responsibility to Indigenous Peoples to be inclusive of all Indigenous groups, as recognized in Section 35 of the *Constitution Act*, 1982.

The 1939 Supreme Court of Canada decision is reflected in the eligibility criteria to receive federally funded health programs and services, as eligibility extends to status First Nations and Inuit. However, the *Daniels Decision,* and its associated outcomes for Métis and non-status First Nations, has yet to be incorporated into federal policy and implications regarding federal provision of or responsibilities to health care for Métis and non-status First Nations is yet to be defined (Boyer et al., 2021). As noted previously, the federal government continues to consider Métis and non-status First Nations health care to fall under provincial and territorial jurisdiction, although without any clear policy direction provided to provinces and territories (ISC, 2021c); consequently, creating jurisdictional confusion and ambiguities, as well as gaps and inequities in service delivery (Lavoie, 2018; MacIntosh, 2017).

3.1.4 Indian Act (1876)

The *Indian Act* was implemented in 1876 as a legal instrument to assert federal control over First Nations identity and to assimilate communities into settler society. The Act regulates eligibility to obtain First Nations status, based on colonial derived criteria to be legally considered an 'Indian' and receive federal benefits, access programs, and exercise certain rights (Crey & Hanson, 2009). In regards to health, under Section 73 of the Act, the Governor in Council is allotted authority to make regulations concerning health care in prevention, treatment, and management for status First Nations living on reserve; and under Section 81(1), First Nation Band Councils have authority to make by-laws to provide for and protect the health of community members. The *Indian Act* does not, however, extend to Inuit nor Métis peoples and communities.

The *Indian Act* has received several updates over the years to amend or repeal discriminatory and overtly racist and sexist provisions. This report identifies two recent amendments. In 2010, Bill C-3, *Gender Equity in Indian Registration Act,* was passed, amending the *Indian Act* to remove gender inequalities regarding a transfer of First Nations status from one generation to the next. Previous amendments ensured First Nations women regained status previously lost through marriage (Bill C-31 in 1985), while Bill C-3 was passed to correct discriminatory ranking of First Nations status amongst their descendants.[5] These changes nevertheless influence whether First Nations parents and children will receive access to federally-funded health care services and programs, as managed under Section 73 of *Indian Act*; as well as the planning of community budgets to ensure adequate funds and resources are available for all members, in accordance with Section 81(1) (Lavoie & Forget, 2011).

Bill S-3, *An Act to Amend the Indian Act in Response to the Superior Court of Quebec Decision in Descheneaux v. Canada*, was passed in 2017 and in force as of 2019. Bill S-3 further repealed discriminatory provisions based on sex and generational transfer of First Nations status. In this case, second generation cut-offs were removed and the feasibility to gain status improved, for those without sufficient official documentation of ancestry proving relationships to First Nation women.[6]

Clatworthy (2017) projected changes to First Nation status eligibility as a result of Bill S-3, using 2016 data from the Indian Register and the 2011 Statistics Canada National Household Survey. Based on the Indian Register, Clatworthy (2017) predicted an incremental growth of 86,917 persons entitled to First Nations registration under the *Indian Act* (a growth from 1,108,551 persons based on Bill C-3 amendments). Analysis based on the National Household Survey predicted, at a minimum, an incremental increase of 99.0% of the total population entitled

---

[5] For more detailed information and a comparison of Bill C-31 and C-3, see Assembly of First Nations. (n.d.-a).

[6] For more detailed information of Bill S-3, see Assembly of First Nations. (n.d.-b).

to First Nations status, with the vast majority of eligible persons residing off-reserve (Clatworthy, 2017). Both predictions are assumed to be under-estimations. In each scenario, the population of those entitled to First Nations status is expected to substantially increase as a result of Bill S-3 amendments, thereby also indicating an anticipated growth in health service and program eligibility for First Nations, as well as financial and resource needs for communities both on and off-reserve.

3.2 Government of Canada Departments and Indigenous Health

Indigenous Services Canada (ISC) and Crown Indigenous Relations and Northern Affairs Canada (CIRNAC) are the two primary federal government departments responsible for matters of Indigenous health policy and health care (ISC), Indigenous and treaty rights, and self-government activities (CIRNAC). Indigenous health care was formally managed by Health Canada. From the 1940s, National Health and Welfare (now Health Canada) was tasked with managing the beginning of universal health coverage for all residents of Canada, as well as the Indian and Northern Health Services branch for First Nations and Inuit health programs and public health education (Cameron, 1959; Mashford-Pringle, 2011). From then on, Health Canada oversaw health care delivery, planning, priority setting, and policy making for First Nations and Inuit health through the current department – First Nations and Inuit Health Branch (FNIHB). Both Health Canada responsibilities regarding Indigenous health and the FNIHB shifted to ISC in 2017.

At the same time, CIRNAC absorbed matters of treaty rights and self-government activities from its predecessor, Indigenous and Northern Affairs Canada (INAC). These departmental shifts stem from a delayed response of the federal government to the Royal Commission on Aboriginal Peoples (Philpott, 2017), which in 1996 recommended the development of:

> An Aboriginal Relations Department Act and an Indian and Inuit Services Department Act to create new federal departments to discharge federal Crown obligations to recognized Aboriginal nations and peoples and replace the Department of Indian Affairs and Northern Development. (RCAP, 1996b, p. 977)

This proposal came from the demonstrated need to reconfigure how the federal government engages with Indigenous Peoples regarding treaty relationships and respect for Indigenous Peoples as nations and "distinct political entities" (RCAP, 1996b, p. 976). To that end, in 2019 the federal government passed the


© Credit: iStockPhoto.com, ID 1329251224

Department of Indigenous Services Act and Department of Crown Indigenous Relations and Northern Affairs Act. For the purposes of this report and to maintain our scope, the following sections focus on ISC and its Indigenous health policies.

3.2.1 Indigenous Services Canada

Indigenous Services Canada's mandate is to "work collaboratively with partners to improve access to high quality services for First Nations, Inuit and Métis… [and] support and empower Indigenous peoples to independently deliver services and address the socio-economic conditions in their communities" (ISC, 2022b, para. 1). Furthermore, as per the *Department of Indigenous Services Act* (2019), ISC is mandated to ensure equitable access to health care services to all Indigenous Peoples, inclusive of First Nations, Inuit, and Métis; promote Indigenous ways of knowing and doing in health care; and assist in building Indigenous community capacity to uptake responsibilities in health service provision. However, programs and services funded by ISC continue to restrict eligibility to status First Nations and Inuit, despite the department's mandate and the 2016 *Daniels Decision* (ISC, 2021c).

This report identifies six policies and one upcoming piece of legislation regulated and administered by ISC: the Indian Health Policy, the Health Transfer Policy, the Medical Transportation Policy, the Traditional Healer Services Travel Policy, the Dental Benefit Policy Framework, the Pharmacy and Medical Supplies and Equipment Benefit Policy Framework, and a proposed Distinctions-Based Indigenous Health Legislation (in development).

Indian Health Policy (1979)

The Indian Health Policy was developed in 1979 by then Minister of Health, David Crombie. It is a two-page document outlining three broad pillars to improve First Nations health: 1) build community capacity, 2) strengthen traditional relationships between First Nations peoples and the federal government, and 3) improve Canada's health system as it relates to First Nations peoples. The Indian Health Policy aims to direct a federal role in Indigenous health care, while also urging provinces and territories to fill health service gaps, and First Nations community's "to play an active, a more positive role in the health system and in decisions affecting their health" (Crombie, 1979, p. 2). The Indian Health Policy only mentions First Nations, was never legislated, and did not include an implementation plan nor strategy; yet it remains the guiding framework and mandate for FNIHB (FNIHB, 2012). The policy has yet to receive any updates or revisions to address its shortcomings.

Health Transfer Policy (1989)

The Health Transfer Policy was introduced in 1989 and is an outcome of the Indian Health Policy that aims to increase community-based participation and facilitate transfer of control over the administration and delivery of health services and programs provided by the FNIHB to local communities (Lavoie et al., 2011). First Nations and Inuit communities may apply to the FNIHB to enter into varying levels of transfer agreements and funding models (i.e., set, fixed, flexible, or block funding; originally called transferred and integrated), each model depicting whether funds are subject to change or reallocation (Kyoon-Achan et al., 2021). The differing types of agreements depend on community size, need, and capacity, as determined by ISC (ISC, 2021b). Each transfer offers varying levels of flexibility in terms of the community's control in the management of funds and in the design, delivery, and selection of health programs (ISC, 2021b).

The FNIHB defines and regulates eligible programs to be funded by the transfer agreement and outlines acceptable provider qualifications, objectives, and activity criteria for each program. Eligible programs include, although are not limited to, Nutrition North Canada, Aboriginal Diabetes Initiative, Children's Oral Health Initiative, and Mental Health Crisis Intervention Teams (Health Canada, 2018). Among the eligible programs and services, FNIHB also defines four mandatory health programs, each of which must be embedded within each transfer agreement: 1) communicable disease control and management, 2) clinical and client care, 3) home and community care, and 4) environmental public health (ISC, 2021b). Each transfer stems from a contribution agreement between the Indigenous community and the federal government, although communities may also sign project-based contribution agreements to focus on and deliver individual health programs (ISC, 2021b). Health Transfer Policy agreements thereby differ from arrangements established under self-government activities that are bound by legislation. The policy's framework is restricted by heavy oversight of the federal government, looser in structure and subject to change, and geared towards Indigenous communities who have yet to sign self-government or modern treaty (land claims) agreements.

The Health Transfer Policy continues to support community uptake of health administration activities in Indigenous health care provision; although evaluations and critiques of the policy throughout the years shed light on several barriers that influence effective application on the ground (Gregory et al., 1992; Kyoon-Achan et al., 2021; Lavoie et al., 2005; Mashford-Pringle, 2013). For example, programs funded by the policy and administered by the community are operated separately from other federally-funded services (such as services offered at community nursing stations), without any form of coordination between the two in order to facilitate data sharing or provide continuity of care (Kyoon-Achan et al., 2021). Furthermore, the structure of the Health Transfer Policy, and its associated mandatory programs, has historically been and continues to be developed without sufficient participation of Indigenous communities who use the policy and carry knowledge on how best to tend to their needs (Gregory et al., 1992; Mashford-Pringle, 2013). Changes have been made to increase eligible programs and roles to support greater local control in health program delivery (ISC, 2021a); however, this practice has historically not been completed at an efficient pace to align with evolving community-based needs (Lavoie et al., 2005). Policy initiatives such as Jordan's Principle are thus sometimes employed to fill program gaps (Sinha et al., 2022). To this end, evaluations and critiques highlight the Health Transfer Policy as yet another patch in the Indigenous health policy patchwork and magnify the need for policy revisions and improvements to address systemic barriers, informed by community experience.

The Medical Transportation Policy (2005)

The Medical Transportation Policy functions under the FNIHB Non-Insured Health Benefits (NIHB) program – a supplementary health insurance program that provides coverage for First Nations and Inuit for services otherwise not covered by provincial or territorial health plans, such as dental and vision care, medical supplies, and medical transportation. The Medical Transportation Policy funds travel for status First Nations or Inuit recognized by Inuit Land Claims Agreements for medically necessary health care services that are unavailable on reserve or in their community (ISC, 2019). The policy outlines types of services eligible for coverage (e.g., diagnostic tests order by physicians, access to NIHB services such as vision, dental, or mental health care), as well as those excluded (e.g., appointments outside Canada, "compassionate travel") (ISC, 2019).

The Medical Transportation Policy was originally established in 2005 and has since received evaluations highlighting its strengths and weaknesses (Lavoie et al., 2015, 2016a; Office of the Auditor General of Canada, 2015). For instance, while the policy improves physical and economic access to care, evaluations have shown service gaps and administrative burdens that can delay travel (Lavoie et al., 2015, 2016a; Office of the Auditor General of Canada, 2015). Consequently, the Medical Transportation Policy and other NIHB programs are currently under joint review by the FNIHB and Assembly of First Nations to identify gaps and improve access to services. In 2019, ISC released the interim Medical Transportation Policy, with notable revisions and additions reflective of past policy evaluations by Indigenous communities, scholars, and allies. For example, preventative screening services, such as breast cancer screening, have been added to eligible services under the interim policy, a significant service gap previously identified by Lavoie et al. (2016a). Furthermore, criteria for funding support of non-medical escorts has also expanded to include escorts for expecting mothers whose trip is for the purpose of childbirth (ISC, 2019). Previously, the 2005 edition of the Medical Transportation Policy did not include any provisions related to pregnancy, especially in terms of funding travel for family members or others to accompany expecting mothers. Lawford and Giles (2012) describe the consequences of this previous gap in terms of stress-inducing and isolating experiences for mothers, their families, and communities. Other provisions within the Medical Transportation Policy have also been updated and further revisions are anticipated.

Traditional Healer Services Travel Policy (2005)

The Traditional Healer Services Travel Policy is embedded within the Medical Transportation Policy and funds travel to reach, or bring to community, Traditional Healers (ISC, 2019). To be eligible under the policy framework, the Traditional Healer must be recognized by the Indigenous community and the client must have confirmation of a medical condition by a licensed physician, community health professional, or FNIHB representative. The policy does not, however, define the role of a Traditional Healer nor the criteria to assume a "medical condition."

The policy's geographic boundaries and administrative procedures are also problematic. Under the policy directives, clients may only apply to receive

Traditional Healer services within their designated FNIHB region or territory. If the client seeks, or is geographically closer, to Traditional Healer services outside their designated FNIHB region, the policy will only reimburse travel expenses to the FNIHB regional or territorial border (ISC, 2019). Thus, some First Nations or Inuit clients may be funded for travel that far exceeds practical or economically efficient distances that cross FNIHB regional lines. This barrier may not only increase costs, and consequently reduce the policy's budget, but can also delay care and inhibit equitable access to traditional healing services.

Dental, Pharmacy, and Medical Supplies and Equipment Benefit Policies

ISC also oversees policies to guide the administration of dental, pharmaceutical, and medical supplies and equipment benefits available through the NIHB program. These policies include the Dental Benefit Policy Framework (2014) and the Pharmacy and Medical Supplies and Equipment Benefit Policy Framework (2010). Each framework guides and directs the administration of their respective health benefits for eligible First Nations and Inuit clients. As each policy details, the objective of their benefit is to provide fair, equitable, and cost-effective access to care and resources, and to improve First Nations and Inuit overall health status, according to individual-based needs (FNIHB, 2010; ISC, 2014).

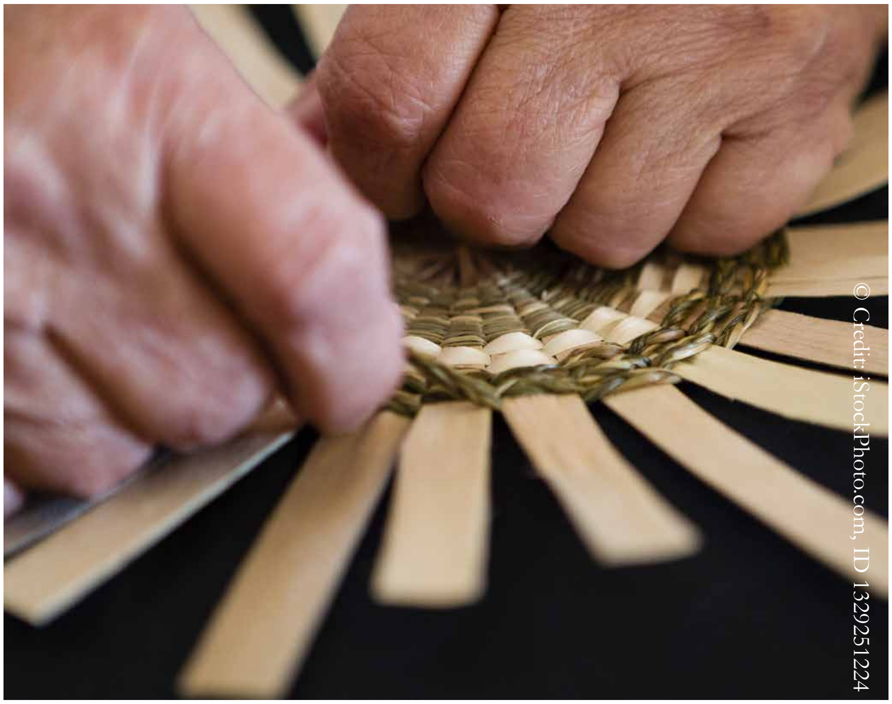
These two policies (the Dental Benefit Policy Framework [2014] and the Pharmacy and Medical Supplies and Equipment Benefit Policy Framework [2010]) are not without limitations. Policy research outlines the structural issues in regards to the financial management of dental benefits, which often delay or restrict access to dental care and treatments for First Nations (Quiñonez et al., 2009). Equitable and reliable pharmaceutical coverage for First Nations and Inuit is also hampered by a number of policy issues, such as unpredictable denial of drug coverage claims, delayed or restrictive access to select drugs, as well as an inconsistent formulary regulated by the FNIHB and provided through the NIHB program (Wale et al., 2015). The NIHB formulary is determined on a national level and often does not align with formularies developed by the provinces and territories (Wale et al., 2015). This becomes problematic when the NIHB formulary falls short of necessary drugs, and jurisdictions expect or rely on the NIHB to fill gaps in prescription drug coverage for First Nations and Inuit (Lavoie et al., 2016a; Wale et al., 2015). Lavoie et al. (2016a) explain challenges with this issue in relation to cancer care drug coverage. Researchers note the potential for jurisdictional disputes over the responsibility to fund necessary drugs and the risk this poses in adding "unnecessary logistical complexities, stress and [...] non-adherence or a refusal to seek care" (Lavoie et al., 2016a, p. 7).

New Distinctions-Based Indigenous Health Legislation

In January 2021, the federal government announced its plan for a new distinctions-based Indigenous Health Legislation to improve access to high quality, culturally safe, and relevant health services free of racism and discrimination (ISC, 2022d). The legislation is being co-developed with national and regional Indigenous organizations; provincial, territorial, and self-governing Indigenous governments; health professionals; and the public through a series of engagement events and dialogue. This announcement came as a long-anticipated response to repeated incidences of structural and systemic anti-Indigenous racism within Canada's health care systems, notably marked by the tragic deaths of Brian Sinclair in 2008 and more recently, Joyce Echaquan in 2020 (Gouldhawke, 2021; ISC, 2022d).

In 2008, Brian Sinclair, a member of the Sagkeeng First Nation, died while waiting to be triaged and receive care in a Winnipeg hospital. A near 10-year inquiry into Brian Sinclair's

Despite Supreme Court of Canada interpretations, and fiduciary responsibilities entrenched in the Constitution Act (1867), the Government of Canada continues to be of the position that federal services provided to Indigenous Peoples are delivered "for humanitarian reasons and as a matter of policy only", thereby refusing acknowledgement of and repudiating its legal obligation.



© Credit: iStockPhoto.com, ID 1329251224

death found anti-Indigenous racism, discrimination, and stereotyping to be direct causes, and that minimal action was taken by health or legal systems following the incident to address the structural and systemic issues tied to his death (Brian Sinclair Working Group, 2017). Despite the inquiry and its recommendations to prevent reoccurrences, a decade later Joyce Echaquan, a member of the Atikamekw Nation, suffered a similar fate. In September 2020, Joyce Echaquan captured on livestream video the anti-Indigenous racism and discrimination that she was subjected to by health care professionals shortly before her death in a Quebec hospital (Atikamekw Nation, 2020). The video sparked public outrage and amplified the need to take policy action to end racialized maltreatment by health care and other professionals (Gouldhawke, 2021). By November 2020, Atikamekw Nation created Joyce's Principle, which seeks to:

> guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health. Joyce's Principle requires the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health. (Atikamekw Nation, 2020, p. 10)

Federal and provincial governments were presented with Joyce's Principle and urged to develop and implement response strategies. Plans to develop a new distinctions-based Indigenous health legislation were subsequently released, and a series of co-development engagement events were launched to define the scope of the proposed legislation (ISC, 2022d). In February 2022, an open dialogue event took place to hear from Indigenous academics, students, Knowledge Keepers, health care professionals, and others involved in Indigenous health and well-being, so as to inform the content, structure, and development process of the health legislation (ISC, 2022a). The event identified reoccurring themes that capture key recommendations. For example, informants recommended the legislation take a holistic, culturally appropriate approach that is inclusive of Indigenous determinants of health; addresses anti-Indigenous racism and discrimination to create and sustain safe environments to seek and receive care; increases Indigenous control and support communities in realizing full self-determination in health and health care delivery structures; addresses ongoing jurisdictional issues that impede equitable access to care; and instills jurisdictional accountability measures (ISC, 2022a). Informants also emphasized the importance of meaningful relationships, Indigenous leadership, and community-level engagement to guide the development process of the health legislation, as well as hearing from diverse populations, including the voices of women, children, and 2SLGBTQQIA[7] peoples (ISC, 2022a). Further events are currently underway (ISC, 2022d).

3.3 Federal Jurisdiction in Indigenous Health Care and Disputes with Provinces and Territories

Despite Supreme Court of Canada interpretations (*Daniels v. Canada*, 2016), and fiduciary responsibilities entrenched in the *Constitution Act* (1867), the Government of Canada continues to be of the position that federal services provided to Indigenous Peoples are delivered "for humanitarian reasons and as a matter of policy only" (p. 52), thereby refusing acknowledgement of and repudiating its legal obligations (Boyer et al., 2021). Under this framework, only status First Nations and Inuit living in traditional territories are eligible to receive (most) federally funded health services, and Métis, non-status First Nations, and Inuit and others living in urban centres are considered under provincial and territorial jurisdiction (Boyer, 2014). As this responsibility comes with little direction or support provided by the federal government, provinces and territories are quick to dispute financial responsibilities to provide care and fill health service gaps and, in most cases, hold the federal government accountable for First Nations health care under the *Indian Act* (Boyer, 2014). The legal discrepancies and limited accountability that stems from the Government of Canada regarding its role in Indigenous health breeds grounds for jurisdictional confusion, ambiguities, and disputes that significantly jeopardize equitable access to care, time and time again (Boyer, 2014; Boyer et al., 2021; Nguyen et al., 2020; Palmer et al., 2017; Sinha et al., 2022). Although a limited approach in terms of reach, Jordan's Principle offers one effective response to jurisdictional ambiguities affecting First Nations children.

Jordan's Principle was introduced in 2007 under the Private Member's Motion No. 296. It is a child-first principle, intended to ensure that First Nations children are not "denied, or delayed receipt of, government services available to all others due to payment disputes" between jurisdictions (Blackstock, 2012, p. 368). This principle came after the passing of Jordan River Anderson, of Norway House Cree Nation. At age two, Jordan River Anderson spent two unnecessary years in hospital awaiting resolution to jurisdictions arguing about the responsible party to finance his at-home care. Jordan passed away while waiting, never spending time in his home community (Blackstock, 2012). A similar program, the Inuit Child First Initiative, has also since been developed to support and tend to the health, social, and educational needs of Inuit children recognized by an Inuit land claim organization (ISC, 2020). Equivalent federal programs for Métis and non-status First Nations children have yet to be developed.

There have since been attempts to legislate Jordan's Principle so as to provide structure and accountability to its full

---

[7] 2SLGBTQQIA: Two Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex and Asexual Plus people

© Credit: iStockPhoto.com, ID 467170226

implementation on a national level. The Private Member's Bill C-249, *First Nations Children's Health Protection Act* (*An Act to ensure that appropriate health care services are provided to First Nations children in a timely manner*), was introduced in the House of Commons in 2009 but did not succeed to the second reading in the legislature. Provincially in Manitoba, Private Member's Bills 203 and 233, *the Jordan's Principle Implementation Act*, were introduced in 2008; however, neither passed the second reading in the legislative assembly (Nathanson, 2011). As Private Member's Bills do not often become law, Bills C-249, 203, and 233, they rather garnered national and public attention on the issue and sparked inter-governmental discussions and agreements on how to effectively implement Jordan's Principle[8] (Nathanson, 2011). The First Nations Child and Family Caring Society of Canada (FNCFCSC) and the Assembly of First Nations have since advocated and worked for improved eligibility criteria for users and types of services, as well as equitable allocation of funding and resources to support all First Nations children through a series of Canadian Human Rights Tribunal remedial orders (ISC, 2021d). Recently, the tribunal found that "Canada's definition and implementation of Jordan's Principle was inadequate and excessively narrow which resulted in discriminatory service gaps, delays and denials of services for First Nations children" (*FNCFCSC et al. v. Attorney General of Canada*, 2020).

As of January 2022, the Government of Canada, FNCFCSC, Assembly of First Nations, and other Indigenous organizations have come together to discuss a "global resolution" and to compensate those affected by the discriminatory underfunding and administration of Jordan's Principle, as delivered by the federal government (ISC, 2022c). Compensation was made available to those wrongfully removed from their homes to receive care, as well as those denied or delayed in seeking services under the government's previously narrow scope and definition of the Principle. At the time of writing, further efforts to fully eliminate such discriminatory actions are underway (ISC, 2022c); however, much work remains to be done. A recent report on Manitoba's implementation of Jordan's Principle reveals that delays to receiving timely access to care persist and removal of children from their homes and families through voluntary placement agreements are becoming normalized to access needed services (Sinha et al., 2022). This practice not only subjects

---

[8] Introducing Private Members' Bills is a common tactic used by policy actors to indirectly affect policy outcomes by gaining attention and prompting discussion on particular issues (Blidook, 2010).

children to the Child Welfare System only to receive necessary care, but also disproportionally impacts children of different abilities and living on reserve, therefore raising several systemic and structural issues that remain ongoing (Sinha et al., 2022).

The provinces of Manitoba and Ontario have also responded to Jordan's Principle through legislation and policy. In Manitoba, the *Spirit Bear Day Act* (2021) commemorates Jordan's Principle and establishes May 10 as an annual day of remembrance for the province. In Ontario, the preamble to the province's *Child, Youth and Family Services Act* (2017) upholds Jordan's Principle regarding the administration of child and family services, stating:

> Where a First Nations, Inuk or Métis child is otherwise eligible to receive a service under this Act, an inter-jurisdictional or intra-jurisdictional dispute should not prevent the timely provision of that service, in accordance with Jordan's Principle. (Child Youth and Family Services Act, S.O. 2017, c. 14. s. 1.)

Other arrangements exist through intergovernmental agreements and memorandum of understandings between federal and provincial or territorial governments to adopt Jordan's Principle (e.g., Alberta's *Memorandum of Understanding on Implementation of Jordan's Principle* [Government of Alberta, 2018]).

3.3.1 Indigenous Jurisdiction in Health Care as per the Indian Act

In addition to federal jurisdiction and provincial and territorial absorbed responsibility, local First Nations governments may also respond to community-based needs as per Section 81(1) of the *Indian Act*. With this, local First Nations' governance oversees and protects widespread community health and health care through implementation of health-related bylaws. Several examples stem from the COVID-19 global pandemic, as communities faced extraordinary challenges and responded through policies in alignment with their needs and priorities. For example, Snuneymuxw First Nation's *Covid-19 By-Law (2020-01)* sought to restrict and regulate the number of visitors entering into the community as well as group numbers for social gatherings. Kashechewan (Albany) First Nation implemented COVID-19 related bylaws in areas of public safety, store hours, education, community events, church and ceremonial services, among many others, with assertion that the community will implement and enforce its own policies and directives according to the advice of the community's Pandemic Taskforce Committee, as opposed to provincial rules and regulations regarding COVID-19 (Kashechewan (Albany) First Nation, 2020). Lastly, the Heiltsuk Indian Band (2020) *By-Law 21* sets out to implement independent, local provisions regarding the protection of the community and spread of the COVID-19 virus.

Many Indigenous communities also establish health care systems that function alongside or independent of provincial or territorial systems and are regulated by Indigenous jurisdiction. These are often born out of self-government and/or modern treaty agreements (see Section 4).

3.4 Strengthening Relationships and Indigenous Health

Over the past two decades, reconciliation between Indigenous and non-Indigenous governments, communities, and individuals has been a topic of federal policy discussions, as national reports and inquiries bring forward the intergenerational harm, trauma, and genocide done onto Indigenous Peoples in Canada as a direct result of colonialism and its associated policies (e.g., TRC, NIMMIWG). With each report are policy recommendations, including some pertinent to Indigenous health, for all levels of government to adopt and steer their efforts toward paths of reconciliation. The federal government responds to each report with a commitment; with some commitments leading to policy or legislative change. This report identifies five national reports commissioned and one international instrument adopted by Canada that are intended to restore and strengthen relationships between Indigenous and non-Indigenous peoples, as well as Indigenous health. Table 1 at the end of this section notes the health-specific recommendations of the reports.

3.4.1 Royal Commission on Aboriginal Peoples (1996)

The Royal Commission on Aboriginal Peoples (RCAP) was established in 1991 and completed in 1996. Funded by the federal government, the RCAP set out to investigate historic and contemporary relationships between Indigenous and non-Indigenous peoples through an in-depth consultation and engagement process with First Nations, Inuit, and Métis communities across Canada. Relations are explored with respect to a wide range of societal issues, under overarching topics of health and healing, economic development, housing, education, among many others. The RCAP was released in a series of five volumes, each covering different topics and with related policy recommendations to restore relationships and foster meaningful change. All recommendations are summarized in *Volume 5 – Renewal: A Twenty-Year Commitment*, with health-related recommendations in *Volume 3 – Gathering Strength* (RCAP, 1996a). Over 25 years since its release, all levels of government continue to steadily work towards and implement RCAP recommendations, although many recommendations have yet to be addressed (Boyer et al., 2021).

3.4.2 Kelowna Accord (2005)

The Kelowna Accord, officially known as the document *First Ministers and National Aboriginal Leaders Strengthening Relationships and Closing the Gap*, was a 10-year commitment announced by federal, provincial, and territorial governments, and national Indigenous leaders to close gaps in the quality of life between Indigenous and non-Indigenous peoples in Canada, and to restore relationships using a distinctions-based[9] approach. The commitment followed an 18-month long engagement process between all parties and focused on four broad priority areas to improve Indigenous health and quality of life: education, housing, economic opportunities, and health (Patterson, 2006). Within each are recommendations for culturally relevant policies and programs that are inclusive of Indigenous participation and leadership at all stages of implementation. Table 1 outlines the health-specific policy recommendations.

An entire section of the report is dedicated to paving the path forward to strengthen relationships between Indigenous Peoples and tripartite governments, citing "these relationships will be based on enhanced collaboration, effective working partnerships and mutual respect" (First Ministers and National Aboriginal Leaders, 2005, p. 9). The report then describes actionable next steps targeting the unique needs and priorities of First Nations, Inuit, and Métis peoples separately.

Despite its origins in collaboration, respect, and dedicated commitment, the Kelowna Accord did not reach full implementation by the federal government. Months after the Accord was announced, the 2006 federal election saw Stephan Harper's Conservative government replace Paul Martin's Liberal government. Through the *Kelowna Accord Implementation Act* (2008), the federal government legislated its commitment to the

---

[9] In this report, distinctions-based perspectives and approaches mean to consider First Nations, Inuit, and Métis Peoples separately and distinctively, respecting their unique cultures, histories, rights, and circumstances.

Accord; however, the change in parliament shifted the policy agenda, and the Accord did not receive adequate financial or resource attention to sustain meaningful change (Kelly, 2011). The Accord was later tabled, with many of its recommendations of continued relevance today.

3.4.3 The Truth and Reconciliation Commission of Canada (2015)

The Truth and Reconciliation Commission (TRC) of Canada was a national initiative born out of the *Indian Residential Schools Settlement Agreement* (2006), a class-action settlement between Residential School Survivors and responsible parties of the federal government and church representatives. The agreement established the TRC, which set out to listen and learn from Residential School Survivors from across Canada, and to inform the non-Indigenous population of the past and the truths about Residential Schools (TRC, 2015). Through national to community level engagement, the Commission documented survivors' experiences of the residential school system and its long-lasting impacts and consequences on individuals, families, and communities.

The findings of the TRC were released in 2015, along with a set of 94 Calls to Action, intended to "redress the legacy of residential schools and advance the process of Canadian reconciliation" (TRC, 2015, p. 1). The Calls to Action touch on many sectors of Canadian society, including health. Calls to Action 18-24 (described in Table 1) provide direction to improve access to culturally safe and responsive healthcare services, and to develop an Indigenous-led health policy. In 2015, the Government of Canada accepted the TRC final report and made a commitment to fully implement all Calls to Action, in partnership with Indigenous communities, the provinces and territories, and the Canadian population (Prime Minister of Canada, 2015). Work in this area remains ongoing.

3.4.4 National Inquiry into Missing and Murdered Indigenous Women and Girls (2019)

The National Inquiry into Missing and Murdered Indigenous Women and Girls was the federal government's response to the TRC's Call to Action #41.[10] As the Government of Canada explains:

> The National Inquiry conducted in-depth study and analysis between September 2016 to December 2018 on missing and murdered Indigenous women and girls, including LGBTQ and Two Spirit people, collecting information from community and institutional hearings; past and current research; and forensic analysis of police records. The Inquiry also gathered evidence from over 1,400 witnesses, including survivors of violence, the families of victims, and subject-matter experts and Knowledge Keepers. (Women and Gender Equality Canada, 2020)

In 2019, findings from the inquiry were consolidated into a two-volume final report, *Reclaiming Power and Place: The Final Report of the NIMMIWG*. The final report includes the testimonies and truths of family members and survivors, detailing the impacts of colonialism and colonial policies, and human rights violations as some of the root causes of violence against Indigenous women, girls, and Two-Spirit people. A total of

---

[10] TRC Call to Action #41: "we call upon the federal government, in consultation with Aboriginal organizations, to appoint a public inquiry into the causes of, and remedies for, the disproportionate victimization of Aboriginal women and girls. The inquiry's mandate would include: (1) Investigation into missing and murdered Aboriginal women and girls. (2) Links to the intergenerational legacy of residential schools." (TRC, 2015).

Many Indigenous women continue to be subjected, at alarming rates, to forced and coerced sterilization without their free, prior, and informed consent (Ataullahjan et al., 2021, 2022).

© Credit: iStockPhoto.com, ID 951179576

231 Calls for Justice accompany the final report, aimed at spearheading policy changes and identifying tangible next steps for all levels of government; industries, institutions, and services; and all Canadians (NIMMIWG, 2019). The Calls for Justice include distinction-based actions that respond to the specific needs of First Nation, Inuit, Métis, and 2SLGBTQQIA communities.

Table 1 outlines the Calls for Justice pertinent to Indigenous health, with many speaking to the importance of equitable and safe access to culturally relevant and trauma-informed care, and the cultural safety training of health care professionals (NIMMIWG, 2019). The federal government has since released the *National Action Plan: Ending Violence Against Indigenous Women, Girls, and 2SLGBTQQIA+ People* (2021), developed in consultation and partnership with provincial, territorial, and Indigenous governments and national Indigenous organizations. The plan provides a framework to guide governments, organizations, and individuals in their next steps to end violence against Indigenous women, girls, and 2SLGBTQQIA+ peoples, and outlines how progress is to be measured and monitored (Core Working Group, 2021). Current efforts to address the Calls for Justice in accordance with the National Action Plan are underway.

3.4.5 Forced and Coerced Sterilization of Persons in Canada (2021, 2022)

In June 2021 and July 2022, the Standing Senate Committee on Human Rights (referred to hereafter as the Senate Committee) released its preliminary and final reports on the troubling and horrific realities of forced and coerced sterilization practices, disproportionally affecting Indigenous and other marginalized women in Canada (Ataullahjan et al., 2021, 2022).[11] Each report outlines the direct links between racism and forced and coerced sterilization, as well as the colonizing and genocidal agendas that underpin the practice and target Indigenous women and girls (Ataullahjan et al., 2021, 2022).

Forced and coerced sterilization is a longstanding issue in Canada, with practices dating back to the 20th century (Ataullahjan et al., 2021). Federally-run "Indian hospitals"[12] were a common location for the procedure, while some provinces maintained health policies up until the 1970s to support the practice and legalize its use for "unfit" mothers (Ataullahjan et al., 2021, p. 17). These policies were overturned in the 1970s; however, many Indigenous women continue to

---

[11] See the NCCIH report: *Informed choice and consent in First Nations, Inuit and Métis women's health services* (2021) for a more detailed discussion on the implications of forced and coerced sterilization amongst Indigenous women.

[12] "Indian hospitals" were established by the Government of Canada during the 20th century to segregate treatment of First Nations and Inuit peoples from non-Indigenous peoples. Many institutions ceased operations with the introduction of Medicare in the 1960s, however, some hospitals remain in operation such as the Norway House Cree Nation Centre of Excellent in Manitoba (Lux, 2018, p. 1; Northway House Cree Nation Centre of Excellence, n.d.).

be subjected, at alarming rates, to forced and coerced sterilization without their free, prior, and informed consent (Ataullahjan et al., 2021, 2022). As evidence of the Senate Committee's report highlights, the historical context of the procedure deems forced and coerced sterilization of Indigenous women "consistent with how other medical services have sometimes been offered to Indigenous Peoples as attempts to control their bodies while criminalizing Indigenous health and reproductive practices" (Ataullahjan et al., 2021, p. 22).

The Senate Committee's report found all jurisdictions in Canada have policies that ensure health care professionals obtain free, prior, and informed consent from patients for any medical intervention (Ataullahjan et al., 2021), and that "freedom from unwanted interference with one's body and reproductive rights are protected under Canadian and international human rights frameworks" (Ataullahjan et al., 2022, p. 25). Yet, the final report recounts survivor testimonies of Indigenous women from across the provinces and territories on the current realities of ongoing forced and coerced sterilization. Survivors describe their experiences of being denied adequate time and space to make informed decisions, free from any stressors or vulnerabilities (such as the effects of medication, child birth, post-child birth, etc.), as well as being provided insufficient information to understand and evaluate risks and weigh all options (Ataullahjan et al., 2021, 2022). In many cases, survivors were coerced into the procedure through means of false or misinformation and intimidation (Ataullahjan et al., 2022).

The impacts of forced and coerced sterilization on health and well-being extend beyond survivors and affect the lives of their families and communities (Ataullahjan et al., 2022). Many survivors experience depression and post-traumatic stress disorder following sterilization procedures, as well as anxiety and fear that cultivates a distrust with the health care system and is shared by both the survivors and their family (Ataullahjan et al., 2022). The Senate Committee's report explains the links between the practice and "erasure of Indigenous lineages", explaining how "several survivors and expert witnesses described [forced and coerced sterilization] as amounting to genocide" (Ataullahjan et al., 2022, p. 24).

Thirteen recommendations informed by survivors and witnesses are provided at the conclusion of the Senate Committee's final report (Ataullahjan et al., 2022). These recommendations are summarized in Table 1. Measures to ensure accountability of health care professionals, criminalization of the procedure, rightful acknowledgement and compensation for survivors, proper consent procedures, enhanced education, increased recruitment of and support for Indigenous health care providers, and improved data collection and reporting methods are at the forefront the committee's recommendations to inform policy and end forced and coerced sterilization and its violations on basic human rights for Indigenous women (Ataullahjan et al., 2022). At the time of writing, a response from the Government of Canada on the report's findings and recommendations is pending. Future work in this area to assess the federal response and evaluate progress is recommended.

3.4.6 United Nations Declaration on the Rights of Indigenous Peoples

In 2007, the United Nations introduced the Declaration on the Rights of Indigenous Peoples (UNDRIP), a human rights instrument and universal framework used to understand and protect the minimum standards for the survival, dignity, and well-being of Indigenous Peoples around the world (United Nations, 2007). Canada adopted UNDRIP into federal legislation in 2021, following a history of shifting policy agendas and polarizing public debates.

In 2010, Stephan Harper's Conservative government announced its support of the Declaration on the stipulation that UNDRIP is seen as a non-legal means detached from obligatory changes to domestic or international law (INAC,[13] 2010). With the shift in government in 2015, Justin Trudeau's Liberal government announced its full and unrestricted support to the Declaration (Lightfoot, 2020). Soon after, an NDP Member of Parliament proposed a Private Member's Bill to fully adopt UNDRIP into law. The Bill proceeded to the Senate; however, it was stalled before its final reading due to Conservative party opponents concerned with notions of free, prior, and informed consent embedded in the Declaration (King, 2020; Lightfoot, 2020). In 2019, Trudeau's Liberal government was re-elected, and this time promised to co-develop legislation with Indigenous partners to keep Canada accountable to fully implement UNDRIP (Lightfoot, 2020). The federal *United Nations Declaration on the Rights of Indigenous Peoples Act* later came into force in June 2021. The Act provides a framework for implementation, as well as reconciliation between Indigenous and non-Indigenous peoples and governments. The Act also states that all laws in Canada must align with UNDRIP, and that progress must be monitored through annual reporting to Parliament *(United Nations Declaration on the Rights of Indigenous Peoples Act,* 2021). Engagement activities involving Indigenous organizations are currently underway to work towards effective implementation of the Act (Government of Canada, 2022). Table 1 notes the UNDRIP articles absorbed under the Act with particular relevance to health.

Prior to adoption of the UNDRIP into federal law, British Columbia was the first jurisdiction in Canada to introduce its own legislation to implement the UNDRIP, trailblazing the path for other jurisdictions. In 2019, British Columbia passed the *Declaration on the Rights of Indigenous Peoples Act,* designed to align all British Columbia laws, policies, and practices with the UNDRIP, and to establish the Declaration as the province's "framework for reconciliation" (*Declaration on the Rights of Indigenous Peoples Act,* 2019). Other provinces and territories have since followed suit and are in the early stages of implementing their own legislation (e.g., Private Member's Bill in Ontario, UNDRIP Implementation Working Group in Northwest Territories) (King, 2020). Section five of this report further details Indigenous health policies and legislation across the provinces and territories.

Despite formal adoption, public debate and criticism surrounding Canada's and British Columbia's decision to entrench the Declaration into law remains in strife today (Lightfoot, 2020; Mager, 2021). Proponents in favor of the Declaration being made into law explain how UNDRIP affirms and protects Indigenous Peoples' inherent and collective rights to self-government and sovereignty over Indigenous lands, territories, and resources – all similar provisions to those under Section 35 of the *Constitution Act* (1982) – and how the Declaration is already being used to interpret human rights and Aboriginal treaty rights in provincial and territorial court decisions[14] (Lightfoot, 2020; Mager, 2021). Meanwhile, opponents express concerns with Article #32.2 and its assertion of Indigenous Peoples' right to "free and informed consent prior to the approval of any project affecting their lands or territories and other resources" (United Nations, 2007) – that is, the right as sovereign nations to collective self-determination over matters affecting Indigenous lands. Critics consider free, prior, and informed consent as a measure to assert "Indigenous veto" over resource projects and developments (Mager, 2021, p. 17); however, this position is quickly debunked when faced

---

[13] Now Crown-Indigenous Relations and Northern Affairs Canada.

[14] Examples of court cases and decisions with citation and/or reference to the UNDRIP in interpretation of Aboriginal and treaty rights include: *Acadia First Nation v. Canada (Attorney General), [2013] NSSC 284; Newfoundland and Labrador (Attorney General) v. Uashaunnuat (Innu of Uashat and of Mani-Utenam)*, [2020] SCC 4.

with the meaning of informed consent (King, 2020; Lightfoot, 2020; Mager, 2021). As Mager (2021) explains, "the Declaration recognizes that 'the consenting party has self-determination to make an informed decision about a matter affecting them,' not that Indigenous peoples have unilateral decision-making capabilities" (Kung, 2019, as cited in Mager, 2021, p. 17).

Furthermore, proponents of the Declaration have made additional cautionary arguments concerning Article #46 and its "fundamental flaw" impacting effective application of UNDRIP (King, 2019, p. 1). Article #46 reads:

> Nothing in this Declaration may be interpreted as implying for any State, people, group or person any right to engage in any activity or to perform any act contrary to the Charter of the United Nations or construed as authorizing or encouraging any action which would dismember or impair, totally or in part, the territorial integrity or political unity of sovereign and independent States. (United Nations, 2007, p. 28)

It is evident that the final article swiftly restores power back to the colonial states, providing leeway to defy the Declaration at the states' discretion, based on any perceived threat to their "territorial integrity or political unity" (King, 2019). This article effectively asserts colonial states' power without protection of nor grounds to uphold Indigenous inherent rights and sovereignty and have rights prevail in times of conflict. Arguments such as these are important indicators of the ongoing work that is needed and lessons that lay ahead for each colonial state's journey in seeking anti-colonial approaches to health policy and legislation, as well as important markers for Indigenous nations as they seek self-determination.

© Credit: iStockPhoto.com, ID 847040536

Strengthen Relationships and Improve Indigenous Health

National Report/ Legislation	Year	Relevance to Indigenous Health
Royal Commission on Aboriginal Peoples (RCAP)	1996	Calls on federal, provincial, and territorial governments to acknowledge Indigenous determinants of health; support and establish Indigenous-led health governance models and community infrastructure; respect and integrate traditional healing practices in bio-medicine; increase the number of Indigenous Peoples in health care roles and education; and modify post-secondary health programs and professional development courses to integrate Indigenous knowledge's and healing practices as well as improve the cultural appropriateness, effectiveness, and awareness of all students and professionals (Recommendations #3.3.1 – 3.3.25, of Volume 3, Chapter 3).
First Ministers and National Aboriginal Leaders Strengthening Relationships and Closing the Gap (Kelowna Accord)	2005	Through collaboration at all levels of government, aims to improve the health status of all Indigenous Peoples in Canada through holistic and distinctions–based approaches. Proposes committed efforts to "improve delivery of and access to health services; ensure that Aboriginal peoples benefit fully from improvements to Canadian health systems; and put in place health promotion and disease prevention measures as well as programs that will address other determinants of health (e.g., housing, education)" (p. 8).
Truth and Reconciliation Commission of Canada (TRC)	2015	Calls on all levels of government to acknowledge the impacts of colonial policies such as residential schools on the current state of Indigenous determinants of health and to establish healing centres to address these affects. Recommends measurable goals and evaluation strategies to improve health outcomes and address the health needs of off-reserve Indigenous Peoples. Calls on governments to: respect and promote Indigenous healing practices; increase the number of Indigenous Peoples working in and studying health care; ensure access to cultural competency training and courses on Indigenous health issues, UNDRIP, Treaties and rights, and Indigenous teachings for all health professionals and students (Calls to Action #18 – 24).
National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG)	2019	Calls on all levels of government to recognize and protect the rights of Indigenous women, girls and 2SLGBTQQIA peoples; support Indigenous-led and community-based health services and improve accessibility of culturally appropriate and trauma-informed care, healing services, and preventative programs through distinctions-based approaches; prevent jurisdictional disputes that result in denial of rights and services; support Indigenous self-determination in health service planning and delivery; provide ongoing cultural safety and competency training for health care professionals; train and hire Indigenous Peoples to fill health care roles; and provide 2SLGBTQQIA health education for youth and health service providers (Calls for Justice #3.1 – 3.7, 7.1 – 7.9, 16.7 – 16.10, 17.4, 17.8, 17.23, 18.26 – 18.31).
Forced and Coerced Sterilization of Persons in Canada (Standing Senate Committee on Human Rights)	2021, 2022	Recommends the federal government issue a formal apology and criminalize forced and coerced sterilization as per the Criminal Code of Canada; study the health impacts; develop and improve consent frameworks and procedures; mandate training for all health care professionals on "the physician/patient fiduciary relationship, bodily autonomy, and medical self-determination," as well as Indigenous cultural safety and competency; compensate survivors; increase public education; invest in community-based Indigenous midwifery; recruit and retain Indigenous health care providers; improve methods to collect and publish anonymized data on the issue; and establish a parliamentary committee to monitor progress (Recommendations #1-13).
United Nations Declaration on the Rights of Indigenous Peoples Act (Government of Canada)	2021	Recognizes and protects Indigenous Peoples' right, without discrimination, to the improvement of their health and to be actively involved in developing and determining health through Indigenous-led institutions. States Indigenous Peoples' right to traditional medicines and health practices; right to access all health services without any discrimination; and right to the "enjoyment of the highest attainable standard of physical and mental health." States all levels of government must take appropriate action to ensure these rights are realized and progress is monitored (Articles #21.1, 23, 24.1, 24.2, 29.3).

Table 1 demonstrates that the policy recommendations of each national report (RCAP, Kelowna Accord, TRC, NIMMIWG, Forced and Coerced Sterilization of Persons in Canada) share several similarities and are often repeated from one report to the next. Much of the health-related policy recommendations provided in the RCAP in 1996 are directly recycled to subsequent reports, notably: to improve health outcomes and address Indigenous determinants of health (noted in the RCAP, Kelowna Accord, TRC); improve access to care through community-based and Indigenous-led approaches (RCAP, Kelowna Accord, TRC, NIMMIWG, Forced and Coerced Sterilization of Persons in Canada); promote and integrate traditional healing practices in western bio-medicine (RCAP, TRC); implement supportive measures to increase the number of Indigenous Peoples in health care professional roles and education, and improve access to cultural safety and competency training for both practitioners and students (RCAP, TRC, NIMMIWG, Forced and Coerced Sterilization of Persons in Canada); and modify post-secondary education and professional development programs in health care to integrate and promote Indigenous knowledges and practices (RCAP, TRC). Boyer et al. (2021) review the implementation of key health-focused RCAP recommendations in the last 20 years, finding some progress in areas of Indigenous recruitment and retention in health care provider roles, as well as in improving access to culturally safe and trauma-informed care. However, minimal progress was found in areas of supporting self-determination in health care (or more so self-administration) for all Indigenous Peoples, and in adequately funding and promoting the integration of traditional healing practices into Western models of care (Boyer et al., 2021). Regardless of the incremental progress, the mere pattern of repeated health policy recommendations suggests more work needs to be done to effectively and meaningfully respond to the careful work of each national report. As a complete evaluation of each report's progress is beyond the scope of this report, further work is recommended.

3.5 Summary

The Government of Canada has a fiduciary relationship with and responsibility to First Nations, Inuit, and Métis peoples, bound by federal legislation and Supreme Court of Canada interpretations (*Constitution Act*, 1867; Supreme Court of Canada, 1939; *Daniels v. Canada*, 2016). Yet, in terms of health care provision, the Government of Canada continues to regard this relationship to be one with status First Nations and Inuit living in traditional territories only, and to be a "matter of policy and not through any legal obligation" (Boyer, 2014, p. 150). The absence of federal acknowledgement of legal responsibilities, coupled with provincial and territorial resistance to fill health service gaps, fosters jurisdictional confusion and disputes that perpetuate inequitable access to care for First Nations, Inuit, and Métis peoples. Current discussions on the proposed distinctions-based Indigenous health legislation may address these issues, by way of articulating and holding the federal government accountable to its legal obligations to Indigenous health care and instilling a communicative mechanism between jurisdictions that will effectively fill health service gaps according to the priority issues as identified by distinct Indigenous groups. Until that time comes, policy programs such as Jordan's Principle and the Inuit Child First Initiative work to fill health service gaps for status First Nations and Inuit children; yet, in terms of Jordan's Principle, many shortcomings remain (Sinha, et al. 2022).

Furthermore, despite administrative and financial barriers, many First Nation communities across Canada continue to assert inherent rights to self-government in health care, through local policy grounded in public health and health protection, as well as by reclaiming authority over the administration and delivery of on-reserve health services (Heiltsuk Indian Band, 2020; Mashford-Pringle, 2013; Snuneymuxw First Nation, 2020). Federal policies such as the Indian Health Policy, Health Transfer Policy, Medical Transportation Policy, and the Traditional Healer Services Travel Policy also continue to play significant roles in the structure and delivery of First Nations and Inuit health care; however, administrative barriers, heavy federal oversight, and the exclusion of Métis and non-status First Nations create further obstacles and inequities in managing the delivery of and accessing culturally safe and Indigenous-led care.

As the federal government continues to embark on a path towards reconciliation with Indigenous Peoples to redress historic and current legacies of harmful colonial policies and discriminatory practices in health care, documents such as the RCAP, Kelowna Accord, TRC, NIMMIWG, Forced and Coerced Sterilization of Persons in Canada, and UNDRIP must be at the forefront of all next steps. There is much promise in new federal developments, such as the *United Nations Declaration on the Rights of Indigenous Peoples Act* (2021) and current co-developments for a new distinctions-based Indigenous health legislation (ISC, 2022d). However, accountability structures are needed, and policy gaps must be filled to ensure inclusion of all First Nations, Inuit, and Métis peoples.

© Credit: iStockPhoto.com, ID 860736790

4. FINDINGS: TREATIES, SELF-GOVERNMENT ACTIVITIES, AND INDIGENOUS HEALTH

Historic (numbered) treaties, modern treaties, and self-government agreements play a significant role in addition to federal, provincial, and territorial policies in the governance of Indigenous health. Historic treaties are the numbered treaties, signed between 1871-1921 (CIRNAC, 2020); whereas modern treaties, also known as Comprehensive Land Claims Agreements, are signed in areas where historic treaties were never negotiated. CIRNAC defines modern treaties as:

> …typically tripartite, including Indigenous organizations or nations, the Crown, and provincial/territorial governments as signatories. They provide clarity and predictability with respect to land and resource rights, ownership, and management. The rights defined in them are constitutionally protected. (CIRNAC, 2019, p. 4)

Comparatively, self-government agreements are written forms describing how Indigenous governments and communities will exercise their inherent and constitutionally protected right to self-government. These agreements may be established within or in association with modern treaties, or as entirely separate entities. Self-government agreements typically establish governance structures, which may or may not include additional provisions specific to jurisdiction in health or other services (CIRNAC, 2019).

There has been much activity in the last few decades in the development of treaties and self-government agreements. Although Treaty 6 continues to be a foundational numbered treaty with respect to health, due to its Medicine Chest Clause written in the text, interpretations in the Canadian judicial system have since expanded its scope to apply to other treaty territories and further recognition of oral agreements for health care through the treaty signing process are coming to light (Craft & Lebihan, 2021). Furthermore, several modern treaties and self-government agreements have been signed, almost all with relevance to health and health care in some capacity. The following sections navigate these updates, highlighting significant elements to Indigenous health and health care provision.

4.1 Historic Treaties

Historic treaties often involved the exchange of services, resources, and materials for Indigenous Peoples' traditional lands, in the settler's pursuit to expand westward in what is now known as Canada. Section 35 of the *Constitution Act* (1982) protects and affirms treaty rights to such services, resources, and materials negotiated through the treaty process. There are a variety of historic treaties in Canada, such as the Treaties of Peace and Neutrality signed between 1701-1760, Peace and Friendship Treaties signed between 1725-1779, Upper Canada Land Surrenders and the Williams Treaties signed between 1764-1862 and in 1923, Robinson Treaties and Douglas Treaties signed between 1850-1854, and the Numbered Treaties signed between 1871-1921 (CIRNAC, 2020). This report focuses on the numbered treaties and their implications on Indigenous health, specifically through the sixth numbered treaty.

Eleven numbered treaties were signed in total, with only Treaty 6 including specific provisions related to health care access in its text. It states: "a medicine chest shall be kept at the house of each Indian Agent for the use and benefit of the Indians at the direction of such agent" (Treaty No. 6, 1876). The Medicine Chest Clause has received varied Supreme Court interpretations concerning its application and meaning. In the 1935 *Dreaver v. The King* decision (Opekokew, 1996), Justice Angers adopted a broadened view, finding the clause to mean "that the Indians were to be provided with all the medicines, drugs or medical supplies which they might need entirely free of charge" (*Dreaver v. The King,* 1935, as cited in Opekokew, 1996). This interpretation was the first to characterize the federal role as one to fund health care as negotiated under Treaty 6, while respecting Indigenous self-determination in defining the health care need and necessary medicines or medical supplies for which the government must respond. As this decision was a victory for First Nations communities, it was not publicly reported until the 1970s (Opekokew, 1996), and therefore had little impact on subsequent court cases.

In 1966, the Supreme Court of Saskatchewan ruled in the *Johnston Appeal* that the Medicine Chest Clause "does not give to the Indian an unrestricted right to the use and benefit of the 'medicine chest' but such rights as are given are subject to the direction of the Indian agent"; a decision contradictory to *Dreaver v. The King* and absent of any self-determining principles (*R. v. Johnston*, 1966). This decision rather established an authoritative position of the federal government to determine the legitimacy of the First Nations health care need, as well as eligibility to receive services. The *Johnston Appeal* was met with a polarized debate concerning its narrow approach. Indigenous communities and treaty signatories consider the Medicine Chest Clause to reflect the Treaty right to health and wellness,[15] borne out of all written and oral promises made at the time of negotiations (Craft & Lebihan, 2021; Lavoie et al., 2016b). Meanwhile, the federal government largely portrays its role in Indigenous health care to be an act of goodwill and policy, not in accordance to Aboriginal and treaty rights as protected by the Constitution (Boyer, 2014; Lavoie et al., 2016b).

Further judicial interpretations restore the broadened perspective of Treaty 6 and its application in health care, including: *Saanichton Marina Ltd. v. Claxton* in British Columbia (1989), *Wuskwi Sipihk Cree Nation v. Canada* (1999), and *Health Sciences Association of Alberta v. Siksika Health Services* in Alberta (2017). The latter case, *Health Sciences Association of Alberta v. Siksika Health Services,* confirms provisions under the Medicine Chest Clause to be flexible and in favor of Indigenous Peoples and communities, describing the *R. v. Johnston* decision (1966) as a "wrong approach in its literal and restrictive reading of the medicine chest clause" (*Health Sciences Association of Alberta v. Siksika Health Services*, 2017).

The Medicine Chest Clause continues to influence health care provision on Treaty 6 territory in many forms today. For instance, in March 2020, Samson, Ermineskin, Louis Bull Tribe, and Montana First Nations of Maskwacis declared a state of emergency in response to the global COVID-19 pandemic and its restraints on their health care system (Dubois, 2020). With this announcement, the First

---

[15] For further information on the Treaty right to health, as well as the other numbered treaties and their relevance to Indigenous health, please see Craft & Lebihan (2021).

Nations activated the Medicine Chest Clause to call on the federal government to provide necessary health care supports (supplies, infrastructure, staffing), as per the treaty obligations, and to help work through any potential outbreaks (Dubois, 2020). Canada has responded through a collaborative approach with the Assembly of First Nations, regional chiefs, and other COVID-19 response committees to ensure the needs of First Nations communities are properly addressed (Narine, 2020).

Other numbered treaties also discussed and negotiated health care provisions, although these provisions did not reach treaty text and are thus not always considered by the federal government (Craft & Lebihan, 2021). Historic treaties 1-5 included implied commitments to health care, while treaties 7-11, received verbal commitments (Craft & Lebihan, 2021). In 2017, the Alberta provincial court interpreted Treaty 7 to include the same benefits as under the Treaty 6 Medicine Chest Clause, on the grounds of oral promises made at the time of Treaty 7 negotiations between the Crown to the five signatory First Nations: the Kainai (Blood), Siksika (Blackfoot), Piikani (Peigan), Nakoda (Stoney), and Tsuu T'ina (Sarcee). Each First Nation was determined to have the treaty right to health care resources protected by Section 35 of the *Constitution Act* (1982). The Alberta provincial court explains:

> …treaties were written in advance by the federal government and did not record all the promises made by the Crown during treaty negotiations. As a result, verbal promises made during the negotiations are considered part of the treaty obligations. (*Health Sciences Association of Alberta v. Siksika Health Services,* 2017).

This interpretation is of much significance, as it may apply to other historic treaties, such as Treaties 8, 9, 10, 11, where oral promises had also taken place (Craft & Lebihan, 2021). However, further court interpretations pertaining to these treaty nations have yet to be identified.

4.2 Modern Treaties and Self-Government Agreements

Modern treaties (or Comprehensive Land Claims Agreements) and self-government agreements (the written form to detail how First Nations will exercise their inherent right to self-government) were initiated in the 1970s. Modern treaties came first, following the landmark Supreme Court of Canada case, *Calder v. Attorney General of British Columbia* (1973).

In 1973, the Nisga'a Nation challenged the province of British Columbia, claiming its nation had never lawfully extinguished their Aboriginal title to their traditional lands and territory through any legal or treaty means (*Calder v. Attorney General of British Columbia*, 1973). In other words, the Nisga'a Nation turned to the


© Credit: iStockPhoto.com, ID 519270910

judicial system to assert their land sovereignty and ownership. This claim was previously introduced in, and dismissed by, the British Columbia provincial court and Court of Appeal. At the Supreme Court of Canada, six out of seven judges recognized and acknowledged the existence of Aboriginal title to the Nisga'a Nation prior to European settlement in their final decisions; although they were evenly split on whether or not such titles continued to exist in the Nisga'a territory following colonial laws and British Columbia's adoption under the British Crown (*Calder v. Attorney General of British Columbia*, 1973). One judge ruled against the claim, based on a technicality within the court process.

Nevertheless, for the first time in Canadian history, the Supreme Court of Canada acknowledged the existence of Aboriginal title to land as a valid legal concept in Canadian common law. Furthermore, the legal concept of Aboriginal title to land derived and was accepted from traditional Indigenous legal systems, as opposed to colonial law (Salomons, 2009). This acknowledgement paved the path forward for Canada to adopt a new policy position regarding treaty and land negotiations with Indigenous communities and their unceded territories; thus, leading to the federal Comprehensive Land Claims Policy and the beginning of modern treaty negotiations.

The Comprehensive Land Claims Policy (1973) sets out the terms and conditions for how the federal government approaches Aboriginal title, rights, and land claims, through a negotiation process between Indigenous communities and the provinces and territories (CIRNAC, 2019, 2020). The negotiation process established Comprehensive Land Claims Agreement in areas where historic treaties do not exist. The James Bay and Northern Quebec Agreement (1975) was the first Comprehensive Land Claims Agreement to result from the policy and continues to be a key example for other communities interested in stating their land claim (Appendix B provides further details on the James Bay and Northern Quebec Agreement).

The Comprehensive Land Claims Policy was later updated in 1981 and 1986 to reflect developments and adjust the negotiation process based on user feedback and measures found to be discriminatory (McKnight, 1986). Of particular concern was the initial requirement to extinguish all Aboriginal rights and titles upon establishment of a settlement agreement. Indigenous groups and leaders found this "blanket extinguishment" (p. 6) to affect Aboriginal rights unrelated to the land claim and to be largely inconsistent with Section 35 of the *Constitution Act* (1982) and its specific intention to affirm and protect Aboriginal rights and titles (McKnight, 1986). The policy was thus revised to implement alternative approaches to rights extinguishment, as well as to narrow its scope to focus on use of and title to land and resources, distancing the policy from any other rights outside this realm (McKnight, 1986).

The Comprehensive Land Claims Policy has since gone into, and is currently under, an internal review by the Government of Canada and national Indigenous organizations, with engagement opportunities to involve the public (Aboriginal Affairs and Northern Development Canada [AANDC], 2014). The interim policy, *Renewing the Comprehensive Land Claims Policy Towards a Framework for Addressing Section 35 Aboriginal Rights*, was released in 2014. The new policy intends to be developed "incrementally" and to act as a "starting point for discussions with partners" (AANDC, 2014, p. 3). The key focal points of the policy updates are to better align the Comprehensive Land Claims Policy with Section 35 of the *Constitution Act* (1982), as well as ensure treaty and other agreement processes are grounded in principles of reconciliation with Indigenous Peoples. These updates include provisions to construct agreement negotiations with predictability, clarity, and "without the need for extinguishment" of Aboriginal rights and titles (AANDC, 2014, p. 7). The interim policy remains in effect to date.

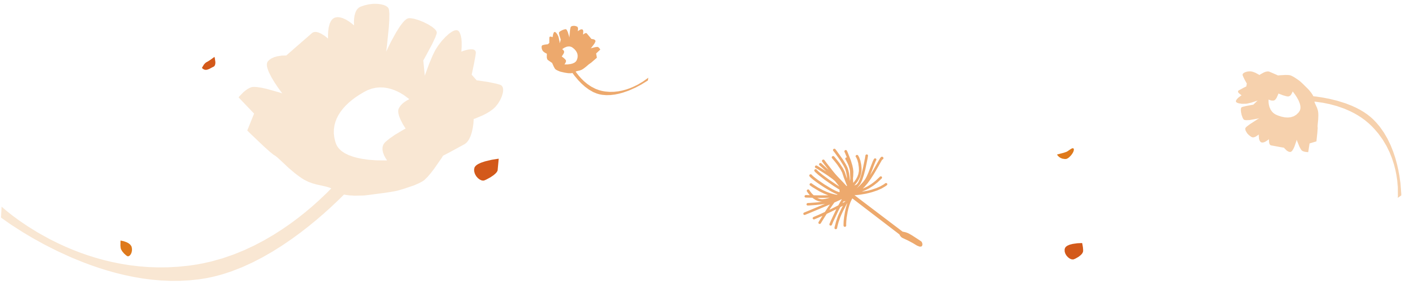
Self-government agreements between First Nations, Inuit, or Métis communities, and the Government of Canada were introduced into the public and political spheres in the 1990s. In 1995, the federal government implemented the Inherent Right to Self-Government Policy, which continues to be of relevance in today's political context (CIRNAC, 2019). The policy reiterates the federal government's recognition of Indigenous People's inherent rights to self-government, as affirmed under Section 35 of the *Constitution Act* (1982) and expressed in modern and historic treaty relationships (Irwin, 1995). Moreover, the policy outlines the process to reach and implement self-government agreements; describes varying approaches for Indigenous communities to define how they will exercise self-government, through mediums such as new or existing treaties, individual agreements, legislation, contracts, or memorandums of understanding; and defines areas in which communities may negotiate individual agreements to assume control in health, social services, housing, education, among other sectors (Irwin, 1995).

This report found 32 completed modern treaty and self-government agreements, 28 of which have specific provisions related to Indigenous health. Appendix B lists each of the modern treaties and self-government agreements, along with a description of their relationship to Indigenous health or health care, as applicable. Table 2 outlines the key findings.

© Credit: iStockPhoto.com, ID 985158944

Table 2. Key Findings in Comparing Modern Treaty and Self-Government Agreements

Finding	Modern Treaty/Self-Government Agreements
Includes provisions to ensure Indigenous representation at their signatory provincial or territorial policy tables, so as to inform health care policy discussions based on community experiences and priorities	• Champagne and Aishihik First Nations Final Agreement (1993) • Nacho Nyak Dun First Nation Final Agreement (1993) • Teslin Tlingit Council Final Agreement (1993) • Vuntut Gwitchin First Nation Final Agreement (1993) • Little Salmon/Carmacks First Nation Final Agreement (1997) • Selkirk First Nation Final Agreement (1997) • Tr'ondëk Hwëch'in Final Agreement (1998) • The Ta'an Kwach'an Council Final Agreement (2002) • Kluane First Nation – Final Agreement (2003) • The Kwanlin Dun First Nation Final Agreement (2005) • Délı̨nę - Sahtu Dene and Metis - Self-Government Agreement (2016)
Includes provisions pertaining to First Nations and Inuit law-making authority on matters concerning public health, management of health care, and administration of health programs and services	• Northeastern Quebec Agreement (1978) • Sechelt Indian Band Self-Government Act (1986) • Nunavut Land Claims Agreement (1993) • Nisga'a Final Agreement (2000) • Carcross/Tagish First Nation Final Agreement (2005) • Tsawwassen First Nation Final Agreement (2007) • Maa-nulth First Nations Final Agreement (2009) • Sioux Valley Dakota Nation Self-Government Agreement (2014) • Tla'amin Nation Final Agreement (2014)
Establishes community jurisdiction to authorize, license, and regulate the practice of Aboriginal healers	• Nisga'a Final Agreement (2000) • Tsawwassen First Nation Final Agreement (2007) • Tla'amin Nation Final Agreement (2014)
Establishes community jurisdiction to regulate traditional healing services and medicines specific to the signatory community	• Westbank First Nation Self-Government Agreement (2005) • Sioux Valley Dakota Nation Self-Government Agreement (2014) • Délı̨nę - Sahtu Dene and Metis - Self-Government Agreement (2016)




© Credit: iStockPhoto.com, ID1402218965

Historic and modern treaties and self-government agreements continue to influence the administration, financial management, and delivery of health care services in and by Indigenous communities today.

Finally, some agreements have also gone on to incorporate, or are in the process of establishing, Indigenous-led and governed health care authorities responsible for the administration and delivery of health care services and programs for their signatory community. Some notable examples include, although are not limited to: the Cree Board of Health and Social Services of James Bay, of the James Bay and Northern Quebec Agreement; the Nunavik Regional Board of Health and Social Services, of the Nunavik Inuit Land Claims Agreement; the Nisga'a Valley Health Authority, of the Nisga'a Final Agreement; and the Tłįchǫ Community Services Agency, of the Tłįchǫ Land Claims and Self-Government Agreement.[16]

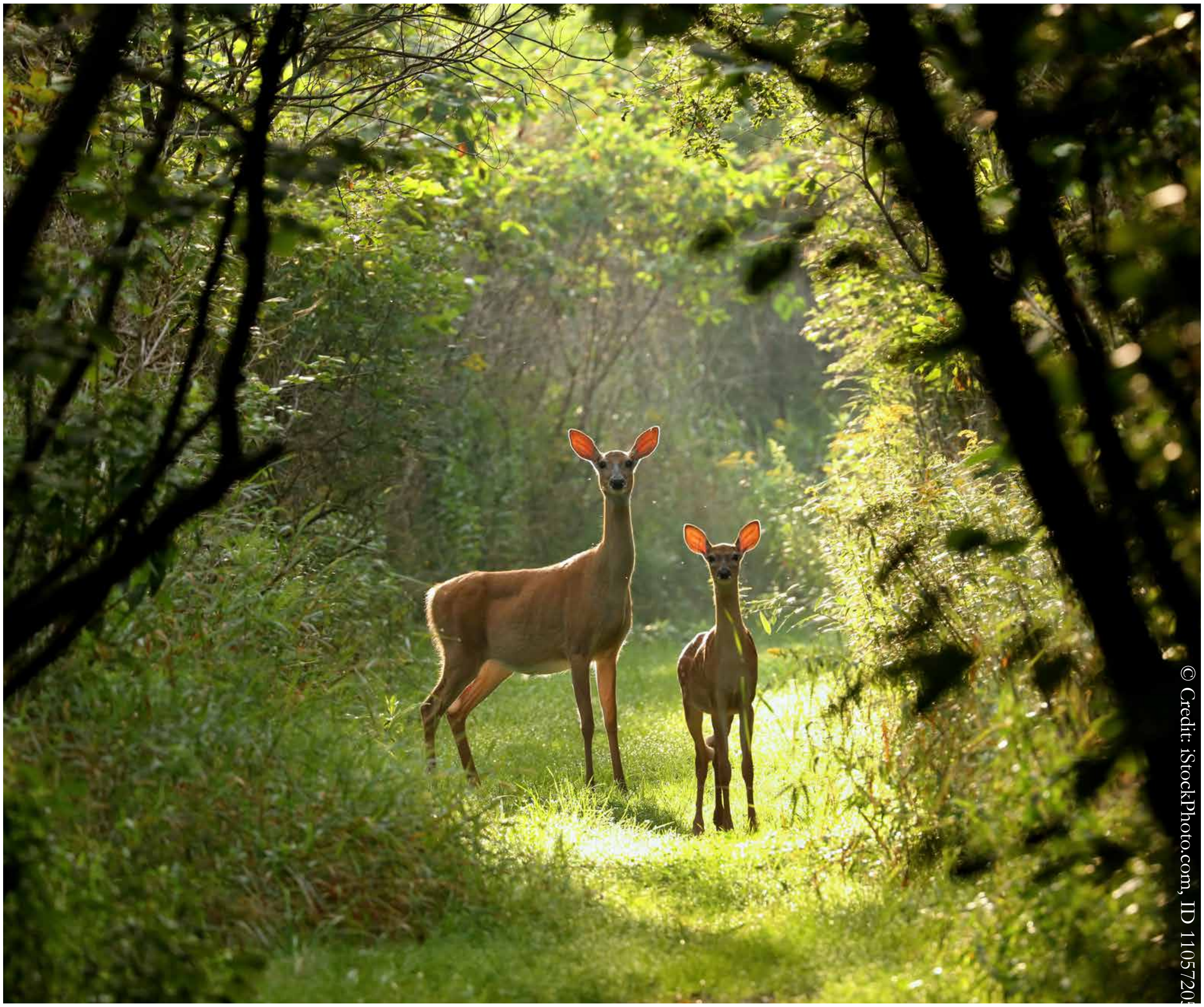
A few agreements embed unique provisions to direct how health care is to be managed for signatory communities. For example, the Sioux Valley Dakota Nation Self-Government Agreement (2014) establishes Sioux Valley Dakota Nation jurisdiction in matters of health and health care services; however, it asserts that laws made under this authority must align with the principles and program criteria established under the *Canada Health Act* (1984). Thus, this is the only self-government agreement to draw on all five principles of public administration, comprehensiveness, universality, accessibility, and portability in its consideration for health care delivery. Portability is of significant importance when considering issues surrounding coordination of care and the need for actions such as Jordan's Principle (see Section 3.2). Furthermore, the Délı̨nę - Sahtu Dene and Metis - Self-Government Agreement (2016) is the only self-government agreement to include provisions that aim to establish and regulate an *ongoing* intergovernmental and data sharing relationship between all signatory parties. Within this relationship, each party must meet at least once every two years to discuss the delivery of health care programs in the Délı̨nę District, as well as health care priorities and other matters related to the agreement. Each party must also consistently share information relevant to the delivery of health programs in the Délı̨nę District. Barriers and limitations to data sharing in health care is a significant issue that currently impacts the continuity of care in many northern Indigenous communities (Kyoon-Achan et al., 2021). Thus, the provision to ensure information sharing between parties is particularly promising in its capacity to improve and sustain delivery of quality health care.

4.3 Summary

Historic and modern treaties and self-government agreements continue to influence the administration, financial management, and delivery of health care services in and by Indigenous communities today. Treaty 6 is the only historic treaty to include health care provisions in its treaty text, with Treaties 1-5 and 7-11 having implied and oral commitments, and

---

[16] Other Indigenous governed health agencies are also discussed in detail in Halseth & Murdock (2020).



© Credit: iStockPhoto.com, ID 1105720

Treaty 7 being later interpreted in the Alberta provincial court on similar grounds as Treaty 6, based on verbal promises made at the time of negotiations. In terms of modern treaties and self-government agreements, this report identifies 32 completed agreements, 28 of which include provisions related to health care. Several agreements share similarities in their provisions granting First Nations, Inuit, and Métis communities authority in law-making and other regulatory activities in health care, while others have gone so far as to establish Indigenous-led and governed health authorities. Each agreement is an opportunity to advance Indigenous health care, fill service gaps, and ensure equitable and safe delivery of culturally appropriate care. Agreements may also serve as informative tools for new and ongoing negotiations for all levels and types of government involved, especially to inform and investigate the use of unique provisions such as ensuring portability of health services (Sioux Valley Dakota Nation Self-Government Agreement) and ongoing data sharing to improve the continuity of care (Déline̜ - Sahtu Dene and Metis - Self-Government Agreement).

5. FINDINGS: PROVINCES AND TERRITORIES AND INDIGENOUS HEALTH

Much like the federal government, the provinces and territories also approach Indigenous health care and relationships with Indigenous Peoples in varying ways through their health policy, legislation, and health care delivery systems. Some provincial and territorial policies and legislation more effectively fill the service gaps for non-status First Nations and Métis compared to others, such as the Aboriginal Health Policy in Ontario (Ontario Ministry of Health, 1994) and Métis Health Benefits Policy in the Northwest Territories (Northwest Territories Health and Social Services Authority [NTHSSA], 2021). However, jurisdictional ambiguities often remain in terms of how health service provisions apply to Indigenous Peoples (see Section 5.1). Moreover, many provinces and territories have undergone health care system reforms in the last decade, amending their health legislation to reorganize how care is delivered and how Indigenous communities are able to participate in the process sustainably (see Section 5.2).

In this section we describe the differing provincial and territorial approaches to Indigenous health through their health policies and legislation, exploring the following topics in line with the research objectives: jurisdiction establishment in Indigenous health care; opportunities for Indigenous participation in shaping health policy, programs, and services; recognition and respect for Indigenous healing practices and cultural safety in care; and approaches to restore and strengthen relationships with Indigenous Peoples within the health care system. Appendix C outlines all policies and legislation identified in this section.

5.1 Provincial and Territorial Jurisdiction in Indigenous Health

Each provincial and territorial health care system is governed by a series of health care legislation, often Medical, Hospital, and Public Health Acts, that outline and regulate the structure and functions of the health care system and ministerial responsibilities in matters of health care delivery, standards of care, and public health and safety. Federal policy and its stance on Indigenous health care provision creates jurisdictional divides and ambiguities for the administration of health services, fostering a convoluted system to outline and regulate Indigenous health care (Lavoie et al., 2016b). Provinces and territories (in regions uninvolved in self-government or modern treaty agreements) can be

inadvertently left to fill program gaps and ensure equitable access to clinical and administrative services for Indigenous Peoples within their mainstream health care system, with little direction or support from the federal government (Lavoie, 2018). In other cases, differential access to care remains.

To date, the Northwest Territories (NWT) is the only jurisdiction to fill health program gaps with respect to Métis Peoples and the federal Non-Insured Health Benefits Program (NIHB). Briefly, the *Métis Health Benefits Policy* (1995) in the NWT provides supplementary health coverage for Métis living in the territory and who are otherwise ineligible to receive care under the federal NIHB program. The policy and its eligibility criteria were updated in 2021, in response to access barriers and to more properly align with the UNDRIP articles (NTHSSA, 2021). While this policy fills program gaps, it is not intended to address jurisdictional responsibilities in Indigenous health care, nor explain how Métis fit into or are addressed by the mainstream health care system in the territory. Thus, there is merit in investigating how each jurisdiction in Canada approaches and articulates their role in overseeing or engaging in Indigenous health care as entrenched in their health legislation.

5.1.1 Explicit Inclusion of Indigenous Peoples in Health Legislation

Alberta and Nunavut are the only jurisdictions to explicitly include Indigenous Peoples in their health legislation. Alberta's *Public Health Act* (2000) and *Regional Health Authorities Act* (2000) include Métis by acknowledging Métis settlements, as established by Alberta's *Metis Settlements Act* (2000). Métis settlements are considered municipalities for whom the Acts and their public health and health care provisions apply. Likewise, Nunavut is the only territory to express its jurisdiction in health care for Inuit in its *Public Health Act* (2016), likely as a result of the Inuit Land Claims Agreement.

5.1.2 Implicit Exclusion of Indigenous Peoples in Health Legislation

Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia, and Prince Edward Island (PEI) all imply that health care provision on First Nation reserves is outside their jurisdictional responsibility, likely to align with federal responsibility in this area (see Appendix C). All provinces, except PEI, state that the health minister responsible for public health or health care may enter into agreements with Canada and First Nations band councils, as regulated under the *Indian Act*, for the purpose of carrying out duties under their respective Act. PEI is slightly different as in its *Public Health Act* (1988), the province signifies its separation from on-reserve health care provision by noting that in a public health emergency, the minister responsible may disclose information to Canada or First Nations bands to plan their response, thereby implying exclusion of First Nation bands from all other provisions under the Act.

5.1.3 Ambiguous Inclusion of Indigenous Peoples in Health Legislation

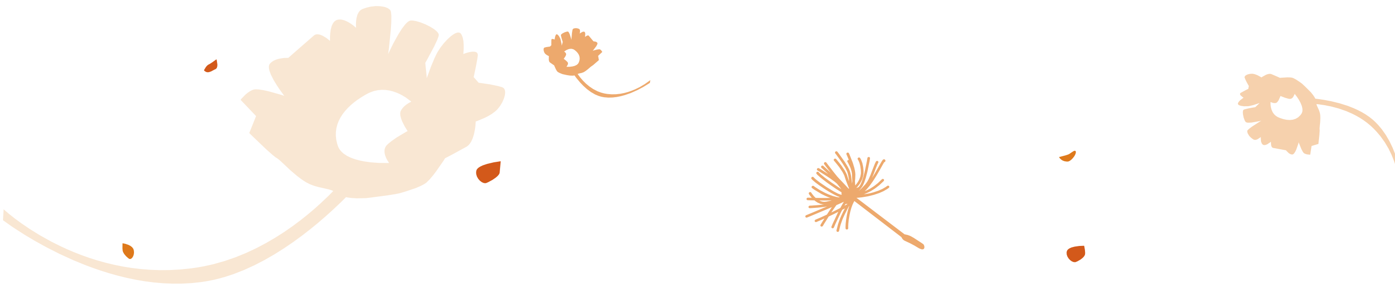
British Columbia, Ontario, and the Yukon all suggest jurisdiction and responsibility in Indigenous health care, however, by using collective umbrella terms such as "Indigenous" or "Aboriginal" communities in their articulation, unspecifying whether these identifiers include all First Nations, Inuit, and Métis populations, as well as in reference to First Nations living on or off reserve (or both). For example, the *Public Health Act* (2008) in British Columbia, asserts the minister's authority to develop health plans to address the needs of "aboriginal peoples." In Ontario, the *Local Health System Integration Act* (2006) states health networks must annually report "data relating specifically to Aboriginal health issues," and the *Connecting Care Act* (2019) ensures the minister will engage with "Indigenous communities" prior to developing health plans. In the Yukon, the *Health Act* (2002) ensures the minister fosters partnerships and collaboration with "aboriginal groups" for the development and implementation of health services.

Furthermore, three provinces – Manitoba, Ontario, and New Brunswick – include conflicting provisions in their health legislation to suggest both inclusion and exclusion of jurisdictional responsibilities in Indigenous health care. While each jurisdiction states that health ministers may enter into agreements with First Nation communities to administer the Act, in the same legislation there are also requirements to engage with First Nation band councils to develop provincial health plans (*Regional Health Authorities Act* [1996] in Manitoba); establish Indigenous health councils to advise on health and service delivery issues (*Ministry of Health and Long-Term Care Act* [1990] in Ontario); as well as ensure Indigenous representation in appointments to Boards of Health (*Regional Health Authorities Act* [2011] in New Brunswick). Without further identification or the use of distinctions-based terminology, these provisions render points of confusion when interpreting the Act and provincial responsibilities in Indigenous health care.

5.1.4 Explicit Recognition of Self-Government or Modern Treaty Agreements in Health Legislation

Many provinces and all three territories are involved in self-government or modern treaty agreements that contain provisions regarding health and health care (see Section 4 and Appendix B). With this review, we found health legislation in Quebec, Northwest Territories (NWT), Newfoundland and Labrador (NFLD), and the Yukon to respect treaty rights as negotiated under modern treaty and self-government agreements signed within boundaries of their jurisdiction. In Quebec, legislation that describes the province's health care system (*Act Respecting Health Services and Social Services* [1991]) respects the autonomy of the Cree Board of Health and Social Services of James Bay, established under the James Bay and Northern Quebec agreement, deeming it separate from the Act and the provincial minister's authority. The Act also establishes the Nunavik Regional Board of Health and Social Services, to respect the autonomy of the Kativik Regional Government on matters of health and social services. The Act's provisions still apply to the Nunavik Regional Board of Health and Social Services, although application is subject "to the special provisions enacted by [the] Act" (*Act Respecting Health Services and Social Services,* 1991, s. 530.2).

In the Northwest Territories, the *Hospital Insurance and Health and Social Services Administration Act*



(1988) respects the autonomy of the Tłı̨chǫ Community Services Agency, established under the *Tłı̨chǫ Community Services Agency Act* (2005) and the Tłı̨chǫ Land Claims and Self-Government Agreement. A chairperson from the Tłı̨chǫ Community Services Agency must, however, sit on the board of management for the Northwest Territories Health and Social Services Authority to help inform decision-making.

In Newfoundland and Labrador, the *Health and Community Services Act* (1997) and *Public Health Protection and Promotion Act* (2018) both uphold Labrador Inuit jurisdiction and rights in health care, stating that the *Labrador Inuit Land Claims Agreement Act* (2005) shall take precedence over other Acts when met with conflicting provisions. Similarly, Yukon's *Health Act* (2002) states that all Yukon Land Claim and Self-Government Agreements shall prevail in times of conflict between Acts and territorial provisions regarding health. Other modern treaties such as the Inuvialuit Final Agreement (1984) between Inuvialuit, and the governments of Yukon, Northwest Territories, and Canada, and the Nisga'a Final Agreement (2000) between Nisga'a Nation and the governments of British Columbia and Canada, have led to health care divisions of government (e.g., Health and Wellness Division of the Inuvialuit Regional Corporation) and agencies (e.g., Nisga'a Valley Health Authority); however, this review did not identify any further examples of provincial or territorial health legislation that acknowledge these agreements.

5.2 Provincial and Territorial Health Care System Structures and Indigenous Participation

Indigenous self-determination in health care – the ability to control and fully participate in all realms of health care planning and delivery – is one of the most significant determinants of individual and collective health and well-being (Halseth & Murdock, 2020).[17] Opportunities to exercise self-determination within a health care system are not only in design and delivery roles, but also include active participation in the health policy cycle (i.e., problem identification, policy formulation, decision making, implementation, evaluation [Howlett et al., 2015]) and in decision-making and priority setting to influence how and what care is delivered.

Within these opportunities, however, there are limitations. Self-determining activities in the context of a health care system are often reduced to self-administration activities (Abele et al., 2021), as decision-making powers are derived from and confined by heavy oversight and control that stems from colonial government structures and policies (RCAP, 1996b). In considering 'self-determination' as an umbrella term to mark activities that fall within the realms of self-determination, Table 3 below demonstrates how six provinces (BC, MB, ON, NS, and NB) and all three territories have entrenched mechanisms in their health policies or legislation to ensure Indigenous participation within the health care system to some degree.

---

[17] For further information and details on Indigenous self-determination in health care in both national and international contexts, see Halseth & Murdock (2020).

Table 3. Indigenous Participation in Health Care Systems, as Entrenched in Health Policy and Legislation

Jurisdiction	Health Care System	Indigenous Participation	Supporting Document
BC	First Nations Health Authority	The FNHA is led and governed by the First Nations Health Council, in partnership with BC First Nations, the Provincial Health Services Authority, and the Regional Health Authorities across the province. First Nation communities fully participate in health care planning and delivery.	British Columbia Tripartite Framework Agreement on First Nation Health Governance (2011)
	Provincial Health Services Authority	The Cultural Safety and Humility Committee must inform and direct the development and delivery of culturally safe health policies and services, pertinent to Indigenous health care provided across the province.	Board Policy – Terms of Reference: Cultural Safety and Humility Committee (2021)
SK	Saskatchewan Health Authority	Indigenous Health Representatives are to provide "insight and input throughout the policy development process through meaningful engagement as key stakeholders, members of policy working groups and policy council members to ensure policy development, implementation is respectful and culturally responsive" (p. 9).	Saskatchewan Health Authority Policy Framework (2018)
MB	Shared Health*	Regional Health Authorities must consult with First Nations Band Councils in developing any health plans and establishing priorities, as the Regional Health Authority considers appropriate.	*Regional Health Authorities Act* (1996)
ON	Ontario Health	Established Aboriginal Health Access Centres – Indigenous-led and community-based primary care centres, serving all Indigenous Peoples across Ontario	Aboriginal Health Policy (1994)
		Ontario Health must engage with Indigenous communities to establish an Indigenous Health Planning entity to inform operational planning processes "in a manner that recognizes the role of Indigenous peoples in the planning and delivery of health services in their communities" (s. 44(2)(a)).	*Connecting Care Act* (2019)
		Ministry of Health and Long-Term Care must establish an Indigenous Health Council to advise on issues related to health and service delivery for Indigenous Peoples.	*Ministry of Health and Long-Term Care Act* (1990), 2019, c. 5, Sched. 2, s. 1.

Jurisdiction	Health Care System	Indigenous Participation	Supporting Document
NS	Nova Scotia Health Authority	Community health boards, responsible for developing health plans and setting local priorities, must have cultural representation reflective of communities being served; however, Indigenous-specific criteria are not specified. Rather, First Nations peoples may self-identify in their application to join the Board.	Health Authorities Ministerial Regulations (2015) of the *Health Authorities Act* (2014)
NWT	Northwest Territories Health and Social Services Authority	A chairperson from the Tłı̨chǫ Community Services Agency must sit on the territorial board of management to inform affairs of the health authority.	*Hospital Insurance and Health and Social Services Administration Act* (1988), 2015, c. 14, s. 2.
NU	Government of Nunavut	Community Health and Wellness Committees are to provide advice and recommendations to municipal council concerning local public health issues.	Public Health Act (2016)
NB	Vitalité and Horizon Regional Health Networks	Aboriginal representation must be included in appointments to Regional Health Authority Boards to help control and manage the business and affairs of the authority.	*Regional Health Authorities Act* (2011)
YK	Government of Yukon	Partnership and collaboration with Aboriginal peoples and groups must be ongoing to inform all planning, implementation, and evaluation of the health services in the territory.	*Health Act* (2002)
		A First Nations Health Committee must oversee First Nations Health Services offered at Yukon hospitals; the Hospital Board of Trustees must include participation of Yukon First Nations. Mandates development of a First Nations Employment Equity and Training Policy and a policy implementation plan. The policy must aim to remedy the under-representation of First Nations in the delivery of health care services and improve the quality of care.	*Hospital Act* (2002)

* The province of Manitoba is currently undergoing the transition to Shared Health, a central arms-length agency to coordinate and standardize care. Shared Health currently works collaboratively with Regional Health Authorities to coordinate health care services. Although a centralized administrative model to health care, service delivery will remain under the Regional Health Authorities, at the direction of the Ministry of Health. As Manitoba's health care system is changing and evolving, information relevant to this report may be missed.

Some jurisdictions such as Ontario, the Yukon, and Nunavut have adopted unique policy positions in their legislation to further support and embed elements of Indigenous self-determination within their health care systems to varying degrees, although some initiatives fall under self-administration (i.e., to be "within the aegis of federal control over decision making" [Abele et al., 2021, p. 23]). In Ontario, the *Aboriginal Health Policy* (1994) remains a vital framework for the province in its direction for ensuring Indigenous involvement in health policy and program planning, implementation, and evaluation in their communities. It has since led to the establishment of Indigenous-led and operated Aboriginal Health Access Centres (AHACs), funded by the Ontario government. These centres provide community-based primary care, serving on- and off-reserve First Nations, Inuit, and Métis communities in urban, rural, and northern locations. AHACs are an innovative model of health service and program delivery, grounded in principles of the *Aboriginal Health Policy* and its commitment to supporting self-determination and improving Indigenous health care in the province (Halseth & Murdock, 2020).

The Yukon also takes a unique, hands-on approach to support Indigenous self-administration in health care. At the same time as establishing the First Nations Health Committee, the Yukon's *Hospital Act* (2002) states the Committee must develop a *First Nations Employment and Training Policy* to address under-representation of First Nations in health care positions. This provision entrenches a mechanism to build capacity and secure space to train and hire First Nations Peoples and sustain their participation in the delivery of care (a recommendation heard from the RCAP, TRC, and NIMMIWG national reports). The Yukon is the only jurisdiction in Canada to contain a provision such as this in their health legislation. Finally, the new *Public Health Act* (2016) came into force in Nunavut to replace the previous legislation adopted from the Northwest Territories. The new Act reflects Inuit Qaujimajatuqangit (traditional Inuit knowledge), responds to the unique needs of Inuit, and ensures Inuit self-determination by "promoting policies, processes, activities and behaviors that enable Nunavummiut to increase their control over and improve their health" (*Public Health Act,* S.Nu. 2016, c. 13, s. 2(b)). It is the only Public Health Act to explicitly plan for and address increased control of Indigenous Peoples in a territorial (or provincial) health care system in Canada.

Provincial and territorial health care system structures also play a role in determining how opportunities to exercise self-determination and administration in decision and policy-making

© Credit: iStockPhoto.com, ID 1423206775

The health care system reform in British Columbia (BC), led by the First Nations Leadership Council, is perhaps the most innovative reform to address Indigenous self-determination and administration in the provincial health care system through centralization.

processes will occur and on which level of the health care system (e.g., local/regional or provincial) (Allin et al., 2018; Marchildon, 2019). In the 1990s most provinces and territories regionalized their health care systems to operate and administer care on a local level through regional health authorities (Allin et al., 2018; Lavoie et al., 2011). The regionalized model is known to plan health care and tailor service delivery around localized needs and priorities – an efficient method capable of ensuring active Indigenous participation to effectively respond to the unique health, resource, and financial needs of distinct Indigenous communities and populations (Lavoie et al., 2012). Yet, previous research found most regionalized models in Canada had not included mechanisms to ensure Indigenous representation or participation in health system planning, decision-making, or priority setting (Lavoie et al., 2011; Lavoie et al., 2012).

In the last two decades, most provinces and territories have begun or already centralized their regionalized health care systems to consolidate former regional health authorities and establish centralized health agencies (Allin et al., 2018; Marchildon, 2019). Single health agencies vary in their role in overseeing either the delivery of health services and/or administrative functions such as financial management, policy making, and priority setting (Allin et al. 2018). Common motivations to adopt centralized models to health care are mainly in their capacity to reduce health care costs by increasing purchasing power, improve efficiency and use of resources spread across all service providers, remove duplicate administrative tasks, and reduce the size of bureaucracy within health care systems (Allin et al., 2018). As such, four provinces (AB, SK, NS, PEI) and one territory[18] (NWT) have since centralized both delivery and administrative functions within their health care system; five provinces (BC, MB, ON, QC, NB) have centralized their administrative functions and continue to work through regional organization for delivery; and only one province (NFLD) remains a decentralized model for both administration and delivery functions (Allin et al., 2018, 2020; NTHSSA, n.d.; Ontario Ministry of Health, 2021). As many reforms are new or in development, there is very little evaluative evidence that explores changes to health system performance (Allin, 2020) or suggests a direct impact of centralization on Indigenous participation within health care systems. Thus, this review rather identifies some promising examples of Indigenous participation to come out of the reform process.

The health care system reform in British Columbia (BC), led by the First Nations Leadership Council, is perhaps the most innovative reform to address Indigenous self-determination and administration in the provincial health care system through centralization. While the Provincial Health Services Authority and five Regional Health Authorities continue to organize and deliver care in BC, First Nations-specific health care services are organized and administered by the First Nations Health Authority (FNHA) – the first and only province-wide First Nations health governance structure to

---

[18] The remaining two territories also operate centralized health care systems, although their centralized models are not entirely due to health system reform. Nunavut's centralized health care system is a by-product of the Nunavut Land Claims Agreement (1993) and separation from the Northwest Territories. The territorial government manages all primary and some secondary care, while tertiary and specialized care is purchased from the provinces of AB, MB, and ON (Marchildon et al., 2021). Likewise, the Government of Yukon also manages all and delivers some health services in one department; however, organization is fragmented and works in silos (McLennan et al., 2020).

exist in the country. FNHA was established in 2013, resultant of the Tripartite First Nations Health Plan and the British Columbia Tripartite Framework Agreement on First Nation Health Governance, signed in 2007 and 2011 respectively, by the Governments of Canada, BC, and the First Nations Health Society (now FNHA), and endorsed by the First Nations Health Council (First Nations Leadership Council et al., 2007; Government of Canada et al., 2011). The agreement led to a phased transfer of responsibilities and control over health care from Health Canada to the FNHA. The FNHA centralizes administrative functions and coordinates health service delivery within its single agency (Allin et al., 2018), while also working in collaboration with five distinct FNHA regional divisions and the five BC Regional Health Authorities to plan and deliver primary care as well as a wide range of health programs. Within this model, cultural safety and humility, as well as First Nations perspectives on health and wellness, are embedded within all health services, and First Nation communities may fully participate in health care planning and delivery (FNHA, n.d.; O'Neil et al. 2016). The FNHA continues to be a critical example for other jurisdictions in and outside of Canada to improve and sustain Indigenous participation and governance in health care systems (O'Neil et al. 2016), leading initiatives such as Tajikeimɨk in Nova Scotia (Smith, 2022).

Tajikeimɨk (Mi'kmaw Health & Wellness) is a new and developing health and wellness organization led by Chiefs and Health Directors from each of the 13 Mi'kmaw First Nations in Nova Scotia (Tajikeimɨk, n.d). The organization will assume health administration responsibilities while still in partnership with the Nova Scotia Health Authority (Smith, 2022), and transform health delivery in a way that "will build on, grow and evolve the health and wellness services and programs used by Mi'kmaw people in Nova Scotia, with a focus on high-quality, culturally safe and wholistic approaches" (Tajikeimɨk, n.d., n.p.). While still in early development, Tajikeimɨk is projected to model after the FNHA (Smith, 2022). Its framework thus demonstrates yet another innovative approach to exercise Indigenous self-determination in health care while working in partnership with provincial health care systems.

Health system reform is also underway in the Yukon. In 2021, the Government of Yukon committed to 76 distinct recommendations proposed by the Putting People First Report,[19] including a centralized reform

---

[19] Putting People First Report (2020) is a report commissioned by the Government of Yukon to review health and social programs and services in the territory in efforts to improve service efficiency, cost effectiveness, and user experiences (McLennan et al., 2020).


© Credit: iStockPhoto.com, ID 1204042285

of the health care system and First Nations partnership as a key component to the reform (Government of Yukon, 2021; McLennan et al., 2020). To that end, Yukon is to establish "Wellness Yukon," an arms-length government agency to deliver basic health services and contract with non-governmental organizations to deliver specialty care, and with this, "partner with First Nations governments… in the long-term planning of health and social services that meet community needs and are culturally safe" (McLennan et al., 2020, p. 33). Inclusion of First Nations communities in the Yukon is embedded throughout the reform recommendations, including further support to retain First Nation health care providers, as well as "partner with Yukon First Nations to develop and implement a comprehensive and coordinated approach to cultural safety and humility that prevents racism" (McLennan et al. 2020, p. 89). Establishment of Wellness Yukon is currently ongoing.

Lastly, Ontario's health care system is currently under reform to establish Ontario Health, a centralized administrative agency (Allin, 2020). In the preamble to legislation guiding the reform, the province asserts recognition of "the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities" (Connecting Care Act, S.O. 2019, c. 5, s. 1). Indigenous Health Planning "entities" are also expected to inform the reform process (s. 44(2)(a)).

Although not entrenched in legislation, Table 4 outlines further examples from British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, and the Northwest Territories that have established more informal Indigenous-led advisory boards, councils, or committees designed to represent and voice the health needs and priorities of Indigenous Peoples within their jurisdiction and health care system. These structures often share health information and guide health program development to address local needs and interests. For instance, the Wisdom Council and Elder Circle in Alberta was established in 2012 (Alberta Health Services, n.d.). It guides the Indigenous Wellness Core of Alberta Health Services to ensure the delivery of culturally appropriate services and represent the health needs of Indigenous Peoples in Alberta. The Traditional Knowledge Keepers Advisory Council in Saskatchewan involves nine Elders representing the nine Indigenous linguistic groups in the province and guides and directs the work of the Saskatchewan Health Authority (SHA, n.d.). In the Northwest Territories, the Indigenous Advisory Body aims to guide policies and programs, as well as identify and inform best practices to incorporate traditional knowledge and healing approaches in care for the Northwest Territories Health and Social Services Authority (Ministry of Health and Social Services, 2018).

Table 4. Indigenous Participation Mechanisms in Provincial and Territorial Health Care Systems (not entrenched in policy or legislation)

Jurisdiction	Committee	Focus of Committee
British Columbia	Aboriginal/Indigenous Health Improvement Committee of Northern Health RHA	"Action-oriented, collaborative groups that work together to support health and wellness for Indigenous Peoples, families and communities in Northern BC" (Indigenous Health, n.d.)
Alberta	Wisdom Council and Elder Circle	Guides the Indigenous Wellness Core of Alberta Health Services, to ensure delivery of culturally appropriate services, and represent the health needs of Indigenous Peoples in Alberta (Alberta Health Services, n.d.)
Saskatchewan	Traditional Knowledge Keepers Advisory Council	Involves nine Elders representing the nine Indigenous linguistic groups in Saskatchewan; guides and directs the work of the Saskatchewan Health Authority (SHA, n.d.)
Manitoba	Provincial Indigenous COVID-19 Collaboration Table	Originally established in response to the COVID-19 pandemic, the Table brings together representatives from the provincial health care system, regional health authorities, FNIHB, municipalities, and First Nations, Inuit, and Métis organizations "to ensure that all emergent issues were addressed expediently" (Lavoie et al., 2020, p. 15). The Table is projected to continue operations beyond the pandemic.
Ontario	Indigenous Health Committee and Aboriginal Health Services Advisory Committee	Established by Southwest and North West Local Health Integration Networks (LHINs). Committees partner with local Indigenous communities to advise on health priorities and align programs with community-based needs (Southwest LHIN, n.d.; North West LHIN, n.d.)
	Indigenous and Intergovernmental Relations Unit	Works with Indigenous partners to enhance planning, assessing, and delivery of public health programs and services to reflect community needs (Ministry of Health and Long-Term Care, 2018)
New Brunswick	Indigenous Liaison Committee	Advises the Horizon RHA on the particular health care needs, concerns, and interests of First Nations in the province, as well as ensures cultural sensitivity in the provision of all health care services (Horizon Health Network, n.d.)
Northwest Territories	Indigenous Advisory Body	Guides policies, programs, and the implementation of the health and social services system in the territory; as well as identifies and informs best practices to incorporate traditional knowledge and healing approaches in current health care practices (Ministry of Health and Social Services, 2018)

While Tables 3 and 4 demonstrate a variety of mechanisms to support Indigenous participation within the health care system, such approaches concentrate on primary health care delivery and provide limited opportunities to influence decision-making within hospitals. The Yukon is the only jurisdiction to legislate and protect First Nations participation through a First Nations Health Committee to operate across all Yukon hospitals (*Hospital Act*, R.S.Y. 2002, c. 111). Other hospital-run and local initiatives are likely to take place, although are not identified in provincial or territorial health legislation.

Moreover, participation mechanisms primarily center around participation in health boards or advisory committees to weigh in on health priorities. Lavoie et al. (2016b) discuss the potential downfalls to this method, as most advisory positions are often just that – positions to advise on health issues, without official decision-making authority. Their findings highlight that "the appointment of a First Nations, Métis or Inuit individual on a board, tasked to represent all Indigenous peoples in the region, itself contradicts the principle of self-determination" (Lavoie et al., 2016b, p. 69). As such, it is a colonial method that pan-Indigenizes policy issues and disregards the diverse needs and interests of distinct Indigenous groups. Lessons to avoid this issue come to light when looking to traditional governance models and values that uphold space to exercise Indigenous Peoples' inherent right to self-determination (RCAP, 1996b). The RCAP describes attributes of traditional governance models, explaining:

> In most Aboriginal nations, political life has always been closely connected with the family, the land and a strong sense of spirituality. In speaking to […] governance traditions, many Aboriginal people emphasized the integrated nature of the spiritual, familial, economic and political spheres. While some Canadians tend to see government as remote, divorced from the people and everyday life, Aboriginal people generally view government in a more holistic way, as inseparable from the totality of communal practices that make up a way of life. (RCAP, 1996b, p. 111)

Within this worldview and through these connections are the strengths and resources necessary to exercise self-determination for both individuals and communities. Moreover, along with family, the land, and a sense of spirituality, "individual autonomy and responsibility, the rule of law, the role of women, the role of elders, […] leadership, consensus in decision making, and the restoration of traditional institutions" (RCAP, 1996b, p. 112) are all important aspects embedded in traditional governance structures – elements that are either absent or siloed in colonial structures of government and power. In stepping away from colonial states and learning from and incorporating traditional teachings, health care systems may learn ways to support true Indigenous self-determination over health, well-being, and wellness. This discussion, of course, raises the question of what this may look like in practice. In considering Indigenous self-determination over health, one may reverse the perspective and begin by asking what colonial structures, approaches, or actions would interface with Indigenous governance structures, and how may such structures, approaches, or actions conform to Indigenous self-determining health care systems?

5.3 Indigenous Healing Practices and Cultural Safety in Policy and Legislation

The last couple of decades have seen a gradual shift in public and political awareness, recognition, and respect for Indigenous healing practices and the importance of cultural safety in all facets of the health care system. Provinces and territories have responded in similar, yet unique ways, in their health policy and legislation. Each topic is explored in turn.

5.3.1 Healing Practices

In recent years, there has been a slow and steady increase in the number of provinces and territories that have legislated recognition and respect for Indigenous healing and medicinal practices. In this context, Indigenous healing, often also referred to as Aboriginal and/or traditional healing practices, are colonial umbrella terms used in an attempt to capture all forms of Indigenous healing and medicine ways, provided by Indigenous Healers, midwives, among other examples (Robbins & Dewar, 2011). When adopted by health policies and legislation, such terms are often used in a broader sense, without regard for or distinction to particular Indigenous groups and their approaches to medicine and health care. The RCAP defines traditional healing as "practices designed to promote mental, physical and spiritual well-being that are based on beliefs which go back to the time before the spread of western, 'scientific' bio-medicine" (Velimirovic, 1990, as cited in RCAP, 1996a, p. 325) and the term Indigenous/Aboriginal Healer as:

> …people whose skills, wisdom and understanding can play a part in restoring personal well-being and social balance, from specialists in the use of healing herbs, to traditional midwives, to elders whose life experience makes them effective as counsellors, to ceremonialists who treat physical, social, emotional and mental disorders by spiritual means. (RCAP, 1996a, p. 337)

Both the RCAP and TRC urge all levels of government to protect and improve access to traditional healing and medicine ways in health care systems, as well as to develop policies that will support and facilitate respectful collaboration between Indigenous Healers and bio-medical practitioners, both in theory and practice, and in education and health care settings (RCAP, 1996a; TRC, 2015). Provinces and territories have since responded in a variety of ways through their health legislation.

© Credit: iStockPhoto.com, ID 1304500565

In provincial Regulated Health Professions Acts in Alberta, Manitoba, Ontario, and Prince Edward Island, and the *Health Act* and *Hospital Act* in the Yukon, "traditional aboriginal practices" (AB); "traditional healing services provided by an aboriginal healer" (MB, ON, PEI); "traditional aboriginal nutritional and healing practices" (YK), and "First Nation traditional medicine and diet" (YK) are recognized, respected, and affirmed as protected health professions and health service options in health care (see Appendix C). Furthermore, the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes are exempt from provincial and territorial Tobacco Control Acts and regulations in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick, Nova Scotia, Prince Edward Island, Yukon, and the Northwest Territories (see Appendix C).

Indigenous midwifery practices are also recognized and respected in varying ways in British Columbia, Manitoba, Ontario, and Nunavut. In British Columbia, Indigenous midwives may register their practice with the BC College of Nurses and Midwives, and those practicing on First Nations reserves are exempt from restricted activities under the Midwives Regulation of the *Health Professions Act* (2008). In Manitoba, the College of Midwives is mandated to establish a standing committee to advise on issues related to midwifery care for Indigenous women (*Midwifery Act*, 1997). In Ontario, there is flexibility in practicing under the title of "Aboriginal Midwife", and those practicing under this title are exempt from provincial regulations (*Midwifery Act*, 1991). Lastly, traditional Inuit midwifery is protected in Nunavut by territorial legislation, and educational institutions are instructed to develop content based on "traditional Inuit midwifery knowledge, skills and judgment for midwifery training and refresher programs, and midwifery professional development programs" (*Midwifery Profession Act*, 2008, s. 6.1).

5.3.2 Cultural Safety

Indigenous cultural safety has begun to surface in provincial and territorial health policy and legislation as of recent. The Northwest Territories defines cultural safety in health care policy as "an outcome where Indigenous peoples feel safe and respected, free of racism and discrimination, when accessing health and social services care" (Ministry of Health and Social Services, 2018, p. 29). In 2020, the BC Ministry of Health commissioned an investigative report into Indigenous-specific racism and discrimination within the provincial health care system. The findings are summarized in the final report: *In Plain Sight: Addressing Indigenous-Specific Racism and Discrimination in B.C. Heath Care* (Turpel-Lafond, 2020). The report uncovers striking numbers and oral accounts of widespread systemic racism, discrimination, and stereotyping against Indigenous Peoples, families, and health care workers resulting "in a range of negative impacts, harm, and even death" (p. 6); with disproportionate impacts on Indigenous women and girls seeking care. The findings of the report extend beyond hospitals in BC, as parallel events are observed across the country. Examples can be found in Ontario hospitals, which recently acknowledged anti-Indigenous racism as a systemic issue, stating "the fear and mistrust that Indigenous peoples have of institutions that should be seen as places of safety and care is, sadly, valid" (King, 2021, p. 1), as well as in the tragic deaths of Brian Sinclair in Manitoba and Joyce Echaquan in Quebec. The BC *In Plain Sight* report further provides 24 recommendations for the BC government, institutions, and the population, all of which may be adopted by neighboring jurisdictions. Recommendation #2 specifically calls on the provincial government, in partnership with Indigenous Peoples, to develop "policy foundations and implement legislative changes to require anti-racism and 'hard-wire' cultural safety… in existing laws, policies, regulations and practices" in a way that is consistent with the UNDRIP (Turpel-Lafond, 2020, p. 61). Similarly, other federal documents, such as the TRC report, have also called for cultural competency training for all health care professionals (see TRC, 2015); and Joyce's Principle urges all health and social organizations to put cultural safety measures in place for the safety of Indigenous Peoples (Atikamekw Nation, 2020).

With increased public and political awareness on the need to address anti-Indigenous racism within health care systems across the country, some jurisdictions are responding through policy interventions to adopt or integrate cultural safety into new or existing health policies and standards of practice. With this report we found such interventions in British Columbia, Saskatchewan, Yukon, Northwest Territories, and Nunavut.

British Columbia is one of the leading provinces involved in Indigenous cultural safety, trailblazing innovative initiatives to integrate cultural safety into both health care policy and practice. In 2015, the Provincial

Health Services Authority (PHSA) of BC and the BC Regional Health Authorities signed a Declaration of Commitment (2015) to ensure cultural safety and humility across the province and within each organization. The commitment is based on the principle that "cultural safety must be understood, embraced and practiced at all levels of the health system including governance, health organizations and within individual professional practice" (FNHA, 2015, p. 2). The commitment serves as a model for the Northwest Territories (signed its Cultural Safety Declaration of Commitment in 2019 [Government of NWT, 2019]) and the Yukon (expected to sign a similar document with establishment of Wellness Yukon [McLennan et al., 2020]). In 2021, the PHSA of BC later implemented a Board Policy and Terms of Reference to establish a Cultural Safety and Humility Committee. The committee is tasked to inform, direct, and hold the province accountable to ensure Indigenous cultural safety is integrated in the development and delivery of all health policies and services (PHSA et al., 2021). Moreover, the province also alludes to Indigenous-specific culturally safe practices in the PHSA *Patient Safety Culture Policy*, established in 2022. The policy respects Indigenous self-determination in health care, noting that "within a health care context, this means exercising the inherent right to quality health care while challenging the Systemic Racism that is embedded within health care systems" (PSHA, 2022, p. 1). The PHSA further commits itself to integrating Indigenous cultural safety in all policies and procedures as a measure to address systemic racism within its institution and improve health equity for Indigenous Peoples (PHSA, 2022).

Finally, and most recently, the BC FNHA collaborated with the Health Standards Organization (HSO) to develop the first *British Columbia Cultural Safety and Humility Standard*, publicly released in June 2022. Together, the FNHA and HSO worked with the province, Indigenous health policy experts, and health care providers to establish culturally safe standards of care that will enable health care organizations and systems to develop, implement, and evaluate strategies to address anti-Indigenous racism and create a culturally safe environment (HSO, 2022; FNHA, 2022). The policy resource came as a response to the eighth recommendation of the BC *In Plain Sight* report[20] and is the first of its kind in Canada (FNHA, 2022). The resource is also informed by the NIMMIWG, TRC, and RCAP, and includes clauses for establishing "a culture of accountability that includes zero tolerance for Indigenous-specific racism and discrimination" (p. 3), to ensuring "organizational leaders collaborate with First Nations, Métis, and Inuit peoples and communities to incorporate a holistic approach to health and wellness into the organization's models of care" (HSO, 2022, p. 36).

In Saskatchewan, the *Saskatchewan Health Authority Policy Framework* (2018) outlines the roles of Indigenous Health Representatives to not only inform policy development, but also ensure all health policies are respectful and culturally responsive. According to the province, cultural responsiveness falls within the realms of cultural safety, and is understood as "respecting where people are from and including their culture in the design and delivery of services… an active process of seeking to accommodate the service to the client's cultural context, values and needs" (Armstrong, 2009, as cited in

---

[20] Recommendation 8 of the *In Plain Sight* report recommends: "That all health policy-makers, health authorities, health regulatory bodies, health organizations, health facilities, patient care quality review boards and health education programs in B.C. adopt an accreditation standard for achieving Indigenous cultural safety through cultural humility and eliminating Indigenous-specific racism that has been developed in collaboration and cooperation with Indigenous peoples" (Turpel-Lafond, 2020).

Federation of Saskatchewan Indian Nations, 2021, p. 7). This concept is also seen in the province's *Cultural Responsiveness Framework* (2021). The framework stems from the Saskatchewan Health Authority's commitment to Truth and Reconciliation with First Nations in Saskatchewan, first committed by signing the Memorandum of Understanding on First Nations Health and Well-Being between the Governments of Canada and Saskatchewan and the Federation of Saskatchewan Indian Nations (Federation of Saskatchewan Indian Nations, 2021). The framework guides the integration of First Nations cultures in all aspects of the provincial health care system and in patient-and-family centered services and programs.

In the territories, the Yukon's *Health Act* (2002) mandates cultural sensitivity and responsiveness as a guiding principle for the development of all health and social service policies and programs, while the Northwest Territories expresses its commitment to Indigenous cultural safety in the mission statement of the Northwest Territories Health and Social Services Authority and instructs health care providers to deliver culturally safe care as per the *Medical and Professional Staff Bylaws* (2018). In 2021, the territory announced its commitment to develop a *NWT Cultural Safety Framework* that will respond to the TRC Calls to Action and ensure cultural safety and anti-racism are fully embedded in the territory's health care system (Government of NWT, 2021).


© Credit: iStockPhoto.com, ID 157619476

Finally, Nunavut integrates culturally safe practices within its *Mental Health Act* (1988). The Act states that medical practitioners may consult with an Elder to provide involuntary psychiatric assessments for patients who speak an Inuit language fluently and do not speak English or French. The patient and Elder must know each other and be from the same community and cultural background. The Elder may assess whether the patient is suffering from a mental disorder that may result in bodily harm to themselves or others. This provision falls within the definition of a culturally safe environment, as it creates a safe environment, respectful of language and responsive to cultural needs "without challenge, ignorance or denial of an individual's identity" (Turpel-Lafond, 2020, p. 11).

5.4 Strengthening Relationships and Indigenous Health in the Provinces and Territories

As with the federal government, some provinces and territories demonstrate efforts to restore relationships with Indigenous Peoples, in line with their role in reconciliation and in response to national reports and policy recommendations, such as those articulated in the TRC and NIMMIWG final reports, as well as in international policy instruments such as the UNDRIP. The *Forced and Coerced Sterilization of Persons in Canada* report, completed by the Standing Senate Committee on Human Rights in June 2021 and July 2022, brings to the forefront human rights violation issues affecting Indigenous women; however, it is newly released and thus awaits federal, provincial, and territorial government responses. To that end, the following discussion focuses on the provincial and territorial health system responses to the TRC, NIMMIWG, and UNDRIP reports, finding these efforts to typically stem from legislation or policy, Memorandums of Understanding (MOU) and other agreements, or public inquiries to investigate relationships between the province and Indigenous Peoples.

In 2019, British Columbia took legislative action to restore relationships with Indigenous Peoples and was the first jurisdiction (and only province) in Canada to formally adopt the UNDRIP into provincial legislation. The *Declaration on the Rights of Indigenous Peoples Act* (2019) implements the Declaration and holds the provincial government accountable to develop an action plan in partnership with Indigenous communities to monitor progress and establish next steps. Under the Act, all BC laws must align with the Declaration, including those of the Ministry of Health. This Act served as a model for federal law and the *United Nations Declaration on the Rights of Indigenous Peoples Act* implemented in June 2021 (see section 3). In the same year the Saskatchewan Health Authority (SHA) took policy efforts to formally commit to implementing all TRC Calls to Action relevant to health and health care through its *Saskatchewan Health Authority Commitment to Truth and Reconciliation* (SHA, 2019). With this, the SHA commits to structuring its organization around "culturally responsive" actions (p. 1), including dedicating support and resources to uplift traditional worldviews, medicines, and practices that respect a holistic perspective and approach to health and well-being of Indigenous Peoples receiving care in the province. This commitment was reaffirmed in 2021.[21]

Apart from policies and legislation, Memorandums of Understanding and other agreements (e.g., partnership accords, charters on relationship principles) are common approaches to strengthen relationships between health care systems and Indigenous Peoples. This report identifies examples in British Columbia (Fraser Salish Regional Caucus et al., 2020), Alberta (Siksika Nation, 2021), Saskatchewan (Métis Nation of Saskatchewan et al., 2018), Manitoba (Southern Chiefs Organization Inc et al., 2020), Ontario (Nishnawbe Aski Nation et al., 2017), and New Brunswick (Madawaska et al., 2021). Each agreement differs, although they share similar characteristics in their objectives to improve the health and well-being of Indigenous Peoples in the province, by way of establishing working relationships with signatory parties and instilling mechanisms to monitor progress such as annual reporting. As such, agreements in British Columbia, Alberta, and Ontario are described as "relationship" and "relationship-strengthening" documents (Nishnawbe Aski Nation et al., 2017; Siksika Nation, 2021; Vancouver Island Regional Caucus et al., 2016).

In British Columbia, each Regional Health Authority signed a Partnership Accord with the First Nations Health Authority and First Nations Health Council between 2012 and 2016, in efforts to improve Indigenous health through working partnerships and shared responsibilities (First Nations Health Council: Interior Region Health Nation Executive et al., 2012; First Nations Health Council: North Regional Health Caucus et al., 2012; Fraser Salish Regional Caucus et al., 2020; Vancouver Coastal Caucus et al., 2012; Vancouver Island Regional Caucus et al., 2016). The agreement with Fraser Health Authority was later updated in 2020 to align with and respond to UNDRIP (Fraser Salish Regional

---

[21] Other jurisdictions such as Manitoba and Nova Scotia have begun the legislation process to implement their commitment to reconciliation with Indigenous Peoples, although without direct inclusion of the provincial health care systems. Examples include: Bill 18, *The Path to Reconciliation Act*, 5th Session, 40th Legislature of Manitoba, 2021; Bill 21, *Truth and Reconciliation Commitment Act*, 1st Session, 64th General Assembly of Nova Scotia, 2021.

Caucus et al., 2020). Similar agreements are also in response to UNDRIP and aim to improve health outcomes of Indigenous Peoples in Saskatchewan (Métis Nation of Saskatchewan et al., 2018) and Manitoba (Southern Chiefs Organization Inc et al., 2020). Other agreements in New Brunswick (Madawaska et al., 2021) and Ontario (Nishnawbe Aski Nation et al., 2017) respond to the TRC health-related Calls to Action. Furthermore, a Memorandum of Understanding in Alberta is implicit in its relation to Indigenous-specific national or international documents; however, it also aims to strengthen relationships with Siksika Nation by building capacity and increasing opportunities within the health care system to support self-determination (Siksika Nation, 2021). Agreements in Manitoba (Southern Chiefs Organization Inc et al., 2020) and Ontario (Nishnawbe Aski Nation et al., 2017) work with the federal government to operationalize these objectives in their intent to transform health care delivery for signatory Indigenous communities through the development of Indigenous-led health governance models. This transformative approach was seen in previous agreements between the Athabasca Dene of northern Saskatchewan and governments of Canada and Saskatchewan, which then established the Athabasca Health Authority in 1994 (Athabasca Health Authority, n.d.).[22]

Health care system strategic plans may also guide planning and delivery of health services in a way that focuses on and respects relations with Indigenous Peoples living in the geographic area covered by health authorities. Although phased and time-sensitive approaches, strategic plans in Alberta and Manitoba demonstrate clear examples of health system commitments and proposed action to strengthen relationships. Alberta's *Indigenous Health Commitments: Roadmap to Wellness* (2020) provides a guiding framework for Alberta Health Services to collaborate and work in partnership with Indigenous Peoples, communities, and nations in the province so as to improve health outcomes and access to care in a way that understands and respects distinct Indigenous nations' worldviews and healing traditions (Alberta Health Services, 2020). The framework outlines four strategic directions with accompanying goals; each goal in alignment with the UNDRIP articles and/or TRC Calls to Action. In Manitoba, two regional health authorities (RHA) have implemented an Indigenous Health Strategy, one modelled after another. Each strategy aims to guide the RHA and its Indigenous partners "toward a shared understanding that addressing health inequities cannot occur in isolation, but rather through working together" (Interlake-Eastern RHA, 2021, p. 1; Northern Health Region, 2017, p. 2). Both also present four strategic directions to strengthen partnerships; ensure culturally safe environments in health care; address health inequities; and improve mental wellness, each with accompanying objectives in line with the TRC Calls to Action.

Ontario employs an additional unique approach to inform its efforts and restore relationships with Indigenous Peoples through the health care system. In 2018, the province released a guiding framework for health care professionals to learn the fundamentals of forming meaningful and respectful relationships with Indigenous partners in the province (Ministry of Health and Long-Term Care, 2018). The guidebook serves as a preliminary tool to inform readers on Indigenous determinants of health, community governance structures, engagement approaches, and relationship models in health care. It also includes a discussion on the

---

[22] Further Memorandums of Understanding specific to Indigenous health and relationships may be missed by this report, as many are currently underway, and others are in flux. Future work is recommended in this area.

© Credit: iStockPhoto.com, ID 1364504787

Regardless of their jurisdictional role, many provinces and all the territories instill mechanisms in their health policies and legislation to support Indigenous participation and self-administration in the health care system, often in leadership or decision-making roles for the planning and delivery of health programs and services.

OCAP® Principles (ownership, control, access, and possession [First Nations Information Governance Centre, n.d.]) to guide the collection and use of health information. The framework is unique in its design and capacity to bridge communication between colonial and Indigenous governments or community partners, in a way that is both respectful and informed.

Finally, British Columbia and Quebec are the only provinces to have commissioned public inquiries into the relationships between Indigenous Peoples and the provincial health care system. The *In Plain Sight* (2020) report in British Columbia investigates systemic anti-Indigenous racism and discrimination in the provincial health system, offering recommendations to confront the underlying causes and "establish a renewed foundation for Indigenous peoples' access to, interaction with, and treatment by the health care system" (Turpel-Lafond, 2020, p. 60). Moreover, Quebec's Viens Commission (the *Public Inquiry Commission on Relations Between Indigenous Peoples and Certain Public Services in Québec: Listening, Reconciliation and Progress*, 2019) focuses on the interactions of First Nations and Inuit with provincial public service authorities (Viens, 2019). The report was tasked "to determine the underlying causes of all forms of violence, discrimination, or differential treatment with respect to Indigenous women and men when certain public services are delivered in Québec" (Government of Quebec, 2021, p. 1). Although initially targeting police and justice authorities, the Viens Commission also investigated First Nations and Inuit experiences within the health system and offered policy recommendations to restore relationships and redress health inequities and barriers to care caused by colonialization and colonial ideals rooted in racism, discrimination, and harmful stereotypes. Of its 142 recommendations, the report recommends Quebec amend current legislation to instill "cultural safeguards" in the health care system (Viens, 2019, p. 370), as well as adopt the UNDRIP to ensure all Quebec laws align with the Declaration, as with British Columbia and the federal government (Viens, 2019). Legislative developments borne of these inquiries are yet to surface at provincial levels; however, policy efforts are observed in British Columbia in response to the *In Plain Sight* (2020) report at both provincial and local health system levels (e.g., PHSA, 2022; PHSA et al., 2021; Interior Health, 2021).

5.5 Summary

The link between provincial and territorial policies and legislation to Indigenous health care provision is convoluted to say the least. Only a small number of provinces articulate their jurisdiction or role in Indigenous health care in explicit terms. Other jurisdictions are either implicit or ambiguous, or resort to modern treaty and self-government agreements to clarify responsibilities. Regardless of their jurisdictional role, many provinces and all the territories instill mechanisms in their health policies and legislation to support Indigenous participation and self-administration in the health care system, often in leadership or decision-making roles for the planning and delivery of health programs and services. Innovative approaches to support Indigenous self-determination in health care have also surfaced with the trend to establish centralized health care administration and delivery models.

Furthermore, respect and recognition of traditional healing practices and Indigenous cultural safety in health care are components to care that have gained traction in provincial and territorial health legislation in recent years. This is especially the case in terms of regulation of health practices and practitioners, and in health care delivery.

Lastly, as with the federal government, some provinces were found to demonstrate efforts to restore relationships with Indigenous Peoples, in line with their role in reconciliation and in response to national and international reports and recommendations such as the TRC Calls to Action, NIMMIWG Calls for Justice, and UNDRIP articles. To that end, some provinces have implemented responsive policies and legislation, memorandums of understanding and other non-legally binding agreements, frameworks to guide respectful and meaningful relationship building with Indigenous partners, and/or public inquiries to investigate and restore relationships.

Across the provinces and territories, different strategies are employed to manage, inform, and respect Indigenous health care, with many similarities as well as distinct differences in approaches. For instance, both Ontario and Saskatchewan established mechanisms to inform Indigenous health care policies by way of mandating space to support Indigenous participation. However, Ontario's mechanisms are entrenched in legislation, while in Saskatchewan, this initiative is only bound by policy and thereby more easily subject to change. These sorts of differences exist across Canada, presenting ample opportunity to cross-compare strategies and learn from policy lessons. As almost every jurisdiction in Canada has now responded to the TRC, NIMMIWG, and/or the UNDRIP in some way, there continues to be public attention and pressure to improve health care systems in a manner consistent with Indigenous rights, cultural safety, and respect and recognition for traditional practice and knowledge systems.

6. CONCLUSION

Indigenous health care, and provisions to guide its organization, management, and delivery, is becoming increasingly prominent in federal, provincial, and territorial policy and legislative spaces as well as through self-government arrangements and activities. Much of the policy and legislation developments are in response to Indigenous-led calls to redress the detrimental and discriminatory legacies of colonial policies and to implement evidence-informed policy solutions based on true experiences of those affected. Through this report we see the influence of national reports, such as the RCAP, in informing federal government departmental shifts to establish Indigenous Services Canada; as well as the TRC to shape provincial health care and Indigenous-specific strategic plans in Alberta and Manitoba. International instruments such as the UNDRIP also inform both federal and provincial legislation, as Governments of British Columbia and Canada formally adopt the Declaration into their legislature and parliament. Provincial and territorial investigative reports carry similar influences, as those conducted in British Columbia, Quebec, and the Yukon shed light on and offer recommendations to confront systemic anti-Indigenous racism in their health care systems – British Columbia responding through development of cultural safety policies and the Yukon Government expressing commitments to do the same.

Despite such efforts, history tells us that federal commitments to policy changes tied to national Indigenous-led reports are notoriously followed by resistance, debate, and delays that span across decades. We observe these incidences with the federal government's commitment to the RCAP recommendations in 1996 that has seen little progress in terms of health (Boyer et al., 2021); commitment to the Kelowna Accord in 2005 that was met with a lack of political will and eventually dropped (Kelly, 2011); commitment to the TRC Calls to Action in 2015, which is currently battling incremental progress (Jewell & Mosby, 2021); and the long awaited adoption of the UNDRIP articles, beginning with political resistance in 2007 and finalizing with legal commitments in 2021. These actions, coupled with recycled recommendations from each report to the next, amplify the need for dedicated and concerted efforts to coordinate and establish implementation strategies between Indigenous and non-Indigenous parties at all levels of governments and health care systems, as well as frameworks to ensure accountability. There is much promise in the anticipated development of a new federal distinctions-based Indigenous health legislation; however, so long as efforts continue to be siloed and from a colonial approach and deviation of power, one may expect gradual progress, with Indigenous participation from an administrative perspective only and subsequent policies to address Indigenous health in isolation from all other determinants of health and well-being.

To that end, this report lends a high-level picture and understanding of the Indigenous health policy landscape across jurisdictions in Canada, identifying a few notable gaps along the way. First are the gaps in federal recognition and acknowledgement of its fiduciary responsibility and legal obligation to all Indigenous groups, reflected in its official position on and eligibility criteria to federal policies and programs. Second, treaty rights to health care are yet to be acknowledged by the federal government with respect to all treaty negotiations dealing with matters of health. Third, jurisdiction in Indigenous health care consists of a mixture of some explicit, and other ambiguous, provisions in the articulation of provincial and territorial roles and responsibilities. Fourth, opportunities for Indigenous participation within health care systems, as protected in provincial and territorial health policies and legislation, more often fall under the realms of self-administration than self-determination, with even fewer opportunities for any participation in hospital settings. Fifth, although some provinces have included provisions to recognize and respect Indigenous healing practices and professions in their health legislation, others have not. Sixth, while cultural safety initiatives are taking place, only British Columbia, Saskatchewan, and the three territories have implemented strategies to ensure Indigenous cultural safety and address anti-Indigenous racism within their health care system to some degree through legislative and policy efforts. Seventh, and lastly, as only British Columbia and the Government of Canada have fully adopted the UNDRIP, there is a need to promote efforts and further align the Declaration with all provincial and territorial health laws and policies, while also taking note of the strengths and weaknesses each UNDRIP article holds.

In sum, the research objectives guiding this report have been met, as comparative inventories of federal, provincial, and territorial health policies and legislation, as well as modern treaties and self-government agreements that make specific mention of First Nations, Inuit, and/or Métis Peoples and health, are consolidated in Appendices A, B, and C. We also learn about jurisdictional fragmentation and coordination in Indigenous health care bound by either loose or more rigid policies in federal, provincial, and territorial health care system spaces (such as Jordan's Principle and the *Constitution Act* [1867] in terms of federal policies concerning jurisdiction; and the *Connecting Care Act* [2019] in Ontario and the *Public Health Act* [2000] in Alberta articulating provincial jurisdiction). Moreover, Table 3 in Section 5.2 denotes opportunities for Indigenous participation in shaping health policy, programs, and services as entrenched in institutional arrangements, while Section 5.3 explores emerging trends amongst many provinces and territories in asserting recognition and respect for Indigenous healing practices and cultural safety both in their health policy and legislation. Finally, this report identifies several unique ways that federal, provincial, and territorial governments are working towards restoring and strengthening relationships with Indigenous Peoples within the health care system.

As this report highlights the policy and legislative efforts at federal, provincial, and territorial levels, it is important to note that there remains much work to be done to explore efforts at local levels on the ground. In future discussions we must also be cognizant of the value and importance of learning from traditional governance structures and the elements that support the realization of Indigenous self-determination in health care systems. There is undoubtedly untapped potential deriving from traditional governance models that are connected through spiritual, familial, economic, and political realms, and embody a holistic structure that contrasts with the current colonial state (RCAP, 1996b). The RCAP documents traditional models and teachings and thus provides a rich resource to help guide jurisdictions' progress on reconciliation efforts and support the transition from self-administration to creation of self-determination spaces within their health care systems (RCAP, 1996b). For these reasons and more, further work is highly recommended to explore traditional governance models and teachings and the related implications on the current state of health care systems in Canada. This work may then lead into an investigation on how best to collaborate and work between both structures (traditional and colonial) in order to fully and sustainably revitalize and uplift Indigenous self-determination over all aspects of health and well-being. However, at the forefront of this work we must also be asking how we can support nations to be self-determining in health in accordance with their rights and their choices in doing so.

Nevertheless, with each finding comes new questions for further research and insights to inform future and ongoing policy discussions. Although we identify improvements and additions to federal, provincial, and territorial health policy repositories regarding Indigenous health, we hope to present this work as a continuum, aiming to support the next generation of health policy research and discussions at all levels of government.

© Credit: iStockPhoto.com, ID 1132711527

LEGAL CITATIONS MENTIONED IN THE TEXT (LEGISLATION AND COURT PROCEEDINGS)

Acadia First Nation v. Canada (Attorney General), [2013] NSSC 284.

Act Respecting Health Services and Social Services, R.S.Q. 1991, c. S-4.2. (Quebec)

Alberta Metis Settlements Act, R.S.A. 2000, c. M-14. (Alberta)

Alberta Public Health Act, R.S.A. 2000, c. P-37. (Alberta)

An Act to Amend the Indian Act in Response to the Superior Court of Quebec Decision in Descheneaux c. Canada, S.C. 2017, c. 25. (Quebec)

Bill 230, *Spirit Bear Day Act*, 4th Session, 41st Legislature of Manitoba, 2021. (Manitoba)

British North America Act, 1867. c. 3. (Canada)

Calder et al. v. Attorney-General of British Columbia, [1973] SCR 313. (British Columbia)

Canada Health Act, RSC 1984. c. C-6. (Canada)

Child Youth and Family Services Act, S.O. 2017. c. 14. s. 1. (Ontario)

Connecting Care Act, S.O. 2019, c. 5, s. 1. (Ontario)

Constitution Act, 1867. 30 & 31 Victoria, c. 3 (U.K.). (Canada)

Constitution Act, 1982. c. 11. (Canada)

Daniels v. Canada (Indian Affairs and Northern Development), [2016] SCC 12. (Canada)

Declaration on the Rights of Indigenous Peoples Act, S.B.C. 2019, c. 44. (British Columbia)

Department of Indigenous Services Act, S.C. 2019, c. 29, s. 336. (Canada)

First Nations Child & Family Caring Society of Canada et al. v. Attorney General of Canada (representing the Minister of Indigenous and Northern Affairs Canada), [2020] CHRT 36. (Canada)

Gender Equity in Indian Registration Act, S.C. 2010, c. 18. (Canada)

Health Act, R.S.Y. 2002, c.106. (Yukon)

Health and Community Services Act, S.N.L. 1996, c. P-37.1. (Newfoundland and Labrador)

Health Authorities Act, S.N.S. 2014, c. 32. (Nova Scotia)

Health Professions Act, Midwives Regulation (B.C. Reg 281, 2008). (British Columbia)

Health Sciences Association of Alberta v. Siksika Health Services, [2017] CanLII 72953. (Alberta)

Hospital Act, R.S.Y. 2002, c. 111. (Yukon)

Hospital Insurance and Health and Social Services Administration Act, R.S.N.W.T. 1988, c. T-3. (Northwest Territories)

Indian Act, RSC 1985. c. 1-5. (Canada)

Kelowna Accord Implementation Act, S.C. 2008, c. 23. (Canada)

Labrador Inuit Land Claims Agreement Act, S.C. 2005, c. 27. (Canada)

Local Health System Integration Act, S.O. 2006, c. 4. (Ontario)

Mental Health Act, R.S.N.W.T. 1988, c. M-10. (Northwest Territories)

Midwifery Act, C.C.S.M. 1997, c. M125. (Manitoba)

Midwifery Act, S.O. 1991, c. 31. (Ontario)

Midwifery Profession Act, S.Nu. 2008, c. 18. (Nunavut)

Ministry of Health and Long-Term Care Act, R.S.O. 1990, c. M.26. (Ontario)

Newfoundland and Labrador (Attorney General) v. Uashaunnuat (Innu of Uashat and of Mani-Utenam), [2020] SCC 4. (Newfoundland and Labrador)

Public Health Act, R.S.P.E.I. 1988, c. P-30.1. (Prince Edward Island)

Public Health Act, S.B.C. 2008, c. 28. (British Columbia)

Public Health Act, S.Nu. 2016, c. 13. (Nunavut)

Public Health Protection and Promotion Act, S.N.L. 2018, c. P-37.3. (Newfoundland and Labrador)

Regional Health Authorities Act, C.C.S.M. 1996, c. R34. (Manitoba)

R. v. Johnston, [1966] 56 DLR (2d) 749. (Saskatchewan)

Regional Health Authorities Act, R.S.A. 2000, c. R-10. (Alberta)

Regional Health Authorities Act, R.S.N.B. 2011, c. 217. (New Brunswick)

Saanichton Marina Ltd. v. Claxton, [1989] CanLII 2721. (British Columbia)

Supreme Court of Canada (Committee of the Privy Council), [1939] SCR 104. (Canada)

Tłı̨chǫ Community Services Agency Act, S.N.W.T. 2005, c. 7. (Northwest Territories)

United Nations Declaration on the Rights of Indigenous Peoples Act, S.C. 2021, c. 14. (Canada)

Wuskwi Sipihk Cree Nation v. Canada (Minister of National Health and Welfare), [1999], 164 FTR 276, 4 C.N.L.R. 293. (Canada)

REFERENCES

Abele, F., Alexiuk, E., Herb George, S., & MacQuarrie, C. (2021). Completing Confederation: The necessary foundation. In K. Graham & D. Newhouse (Eds.), *Sharing the land, sharing a future: The legacy of the Royal Commission on Aboriginal Peoples* (pp. 19-49). University of Manitoba Press.

Aboriginal Affairs and Northern Development Canada (AANDC). (2014). *Renewing the comprehensive land claims policy: Towards a framework for addressing section 35 Aboriginal rights*. Government of Canada.

Alberta Health Services. (n.d.). *Indigenous Wellness Core.* https://www.albertahealthservices.ca/findhealth/service.aspx?Id=1069951

Alberta Health Services. (2020). *Indigenous health commitments: Roadmap to wellness.* https://www.albertahealthservices.ca/assets/info/ihp/if-ihp-indigenous-health-commitments.pdf

Allin, S. (2020, January 23). A new wave of centralized governance and planning across Canada's provinces. *European Observatory on Health Systems and Policies*. https://eurohealthobservatory.who.int/monitors/health-systems-monitor/analyses/hspm/canada-2020/a-new-wave-of-centralized-governance-and-planning-across-canada-s-provinces

Allin, S., Sherar, M., Peckham, A., & Marchildon, G. (2018). *Rapid review 10: Province-wide services.* North American Observatory on Health Systems and Policies.

Animikii Inc. (2020). *Why we say "Indigenous" instead of "Aboriginal".* https://animikii.com/news/why-we-say-indigenous-instead-of-aboriginal#:~:text=Indigenous%20comes%20from%20the%20Latin,respects%20their%20claims%20over%20it.

Assembly of First Nations. (n.d.-a). *What is Bill C-31 and Bill C-3?* https://www.afn.ca/wp-content/uploads/2020/01/16-19-02-06-AFN-Fact-Sheet-Bill-C-31-Bill-C-3-final-revised.pdf

Assembly of First Nations. (n.d.-b). *Bill S-3 amendments.* Assembly of First Nations.

Ataullahjan, S., Bernard, W. T., Audette, M., Boyer, Y., Gerba, A., Hartling, N. J., Martin, Y., & Omidvar, R. (2022). *The scars that we carry: Forced and coerced sterilization of persons in Canada – Part II.* Standing Senate Committee on Human Rights, Senate of Canada.

Ataullahjan, S., Bernard, W. E. T., Hartling, N. J., Boyer, Y., Martin, Y., Mégie, M-F., Ngo, T. H., Pate, K., & Tannas, S. (2021*). Forced and coerced sterilization of persons in Canada.* Standing Senate Committee on Human Rights, Senate of Canada.

Athabasca Health Authority. (n.d.). *A place for Northern People to heal.* https://www.athabascahealth.ca/organization/Pages/default.aspx

Atikamekw Nation. (2020). *Joyce's Principle.* Council of the Atikamekw of Manawan and the Council de la Nation Atikamekw. https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief___Eng.pdf

Bemelmans-Videc, M., Rist, R., & Vedung, E. (Eds.) (1998). *Carrots, sticks & sermons: Policy instruments and their evaluation.* Routledge Taylor & Francis Group.

Blidook, K. (2010). Exploring the role of 'legislators' in Canada: Do Members of Parliament influence policy? *Journal of Legislative Studies, 16*(1), 32-56.

Blackstock, C. (2012). Jordan's Principle: Canada's broken promise to First Nations children? *Paediatrics & Child Health, 17*(7), 368-370.

Borrows, J. (1997). Wampum at Niagara: The Royal Proclamation, Canadian legal history, and self-government. In M. Asch (Ed.), *Aboriginal and treaty rights in Canada* (pp. 155-172). University of British Columbia Press.

Boyer, Y. (2014). Chapter 4: The law is a determinant of health; Chapter 5: Aboriginal and Treaty rights to health. In D. Ward (Ed.), *Moving Aboriginal health forward: Discarding Canada's Legal Barriers* (pp. 92-155). Purich Publishing Limited.

Boyer, Y., Lavoie, J., Kornelsen, D., & Reading, J. (2021). Twenty years later: The RCAP legacy in Indigenous health system governance – what about the next twenty? In K. Graham & D. Newhouse (Eds.), *Sharing the land, sharing a future: The legacy of the Royal Commission on Aboriginal Peoples* (pp. 50-76). University of Manitoba Press.

Brian Sinclair Working Group. (2017). *Out of sight: A summary of the events leading up to Brian Sinclair's death and the inquest that examined it and the interim recommendations of the Brian Sinclair Working Group.* https://libguides.lib.umanitoba.ca/ld.php?content_id=33973085

Cameron, G. D. W. (1959). The department of national health and welfare. *Canadian Journal of Public Health, 50*(8), 319-336.

Chenier, N. M. (2002). *Health policy in Canada*. Library of Parliament, Parliamentary Research Branch.

Clatworthy, S. (2017). *An assessment of the population impacts of select hypothetical amendments to Section 6 of the Indian Act*. Four Directions Project Consultants: Indigenous and Northern Affairs Canada.

Core Working Group. (2021). *2021 Missing and murdered Indigenous women, girls, and 2SLGBTQQIA+ people national action plan: Ending violence against Indigenous women, girls, and 2SLGBTQQIA+ people*. Crown-Indigenous Relations and Northern Affairs Canada.

Craft, A., & Lebihan, A. (2021). *The treaty right to health: A sacred obligation*. National Collaborating Centre for Indigenous Health.

Crey, K., & Hanson, E. (2009). *Indian Status*. Indigenous Foundations, University of British Columbia. https://indigenousfoundations.arts.ubc.ca/indian_status/

Crombie, D. (1979). *Indian Health Policy*. Health and Welfare Canada.

Crown-Indigenous Relations and Northern Affairs Canada (CIRNAC). (2019). *Implementation of modern treaties and self-government agreements. July 2015 – March 2018 provisional annual report*. Government of Canada.

Crown-Indigenous Relations and Northern Affairs Canada (CIRNAC). (2020). *Treaties and agreements*. Government of Canada.

De Leeuw, E., Clavier, C., & Breton, E. (2014). Health policy – why research it and how: Health political science. *Health Research Policy and Systems, 12*, 55.

Dubois, S. (2020). Maskwacis activates 'medicine chest' treaty clause, declaring state of emergency. *CBC News, Edmonton*, March 24.

Federation of Saskatchewan Indian Nations. (2021). *Cultural responsiveness framework*. https://allnationshope.ca/userdata/files/187/CRF%20-%20Final%20Copy.pdf

First Nations Health Authority (FNHA). (n.d.). *FNHA overview*. https://www.fnha.ca/about/fnha-overview

First Nations Health Authority (FNHA). (2015). *Declaration of commitment*. https://www.fnha.ca/Documents/Declaration-of-Commitment-on-Cultural-Safety-and-Humility-in-Health-Services.pdf

First Nations Health Authority (FNHA). (2022, June 14). *FNHA and HSO release BC Cultural Safety and Humility Standard*. https://www.fnha.ca/about/news-and-events/news/fnha-and-hso-release-bc-cultural-safety-and-humility-standard

First Nations Health Council: Interior Region Health Nation Executive., & Interior Health Authority. (2012). *Partnership Accord*. First Nations Health Authority. https://www.fnha.ca/Documents/Interior_Partnership_Accord.pdf

First Nations Health Council: North Regional Health Caucus., Northern Health Authority., & Interim First Nations Health Authority. (2012). *Northern Partnership Accord*. First Nations Health Authority. https://www.fnha.ca/Documents/Northern_Partnership_Accord.pdf

First Nations Information Governance Centre. (n.d.). *The First Nations principles of OCAP®*. https://fnigc.ca/ocap-training/

First Nations Inuit Health Branch (FNIHB). (2010). *Pharmacy and medical supplies and equipment benefit - Non-Insured health benefits: Policy framework*. Health Canada. https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/nihb-ssna/provide-fournir/pharma-prod/med-list/pharma-ms_e-em_fm-eng.pdf

First Nations Inuit Health Branch (FNIHB). (2012). *First Nations and Inuit health strategic plan: A shared path to improved health*. Health Canada. https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/pubs/strat-plan-2012/strat-plan-2012-eng.pdf

First Nations Leadership Council, Government of Canada, & Government of British Columbia. (2007). *Tripartite First Nations health plan*. First Nations Health Authority. https://www.fnha.ca/Documents/TripartiteFNHealthPlan.pdf

First Ministers and National Aboriginal Leaders. (2005). *First ministers and national Aboriginal leaders: Strengthening relationships and closing the gap*. https://caid.ca/Kelowna2005.pdf

Fraser Salish Regional Caucus, Fraser Health Authority, & First Nations Health Authority. (2020). *Fraser Partnership Accord*. First Nations Health Authority. https://www.fraserhealth.ca/-/media/Project/FraserHealth/FraserHealth/Health-Topics/Aboriginal-Health/Cultural-safety/Signed-Partnership-Accord-2020---2023.pdf?rev=89b13c6becb04219a1c846c9ca7485e0

Government of Alberta. (2018). *Memorandum of understanding on implementation of Jordan's Principle in Alberta*. https://open.alberta.ca/publications/mou-implementation-of-jordans-principle-in-alberta

Government of Canada. (2022). *Implementing the United Nations Declaration on the Rights of Indigenous Peoples in Canada: Next steps*. https://www.justice.gc.ca/eng/declaration/index.html

Government of Canada, Government of British Columbia, & First Nations Health Society. (2011). *British Columbia tripartite framework agreement on First Nation health governance*. https://www.fnha.ca/Documents/framework-accord-cadre.pdf

Government of Northwest Territories. (2019). *Cultural safety declaration of commitment*. https://www.hss.gov.nt.ca/sites/hss/files/resources/declaration-commitment-cultural-safety-english.pdf

Government of Northwest Territories. (2021). *Response to Motion 29-19(2): Systemic racism*. https://www.ntassembly.ca/sites/assembly/files/td_442-192.pdf

Government of Quebec. (2021). *Follow-up to the Viens Commission*. https://www.quebec.ca/en/government/quebec-at-a-glance/first-nations-and-inuit/viens-commission

Gouldhawke, M. (2021). *The failure of federal Indigenous healthcare policy in Canada*. Yellowhead Institute.

Government of Yukon. (2021). Development of public health agency underway as Putting People First implementation continues. *News Release,* No. 21-487. https://yukon.ca/en/news/development-public-health-agency-underway-putting-people-first-implementation-continues

Greenwood, M., de Leeuw, S., & Lindsay, N. M. (2018). *Determinants of Indigenous Peoples' health: Beyond the social*. Canadian Scholars Press.

Gregory, D., Russell, C., Hurd, J., Tyance, J., & Sloan, J. (1992). Canada's Indian Health Transfer Policy: The Gull Bay Band experience. *Human Organization, 51*(3), 214-222.

Halseth, R., & Murdock, L. (2020). *Supporting Indigenous self-determination in health: Lessons learned from a review of best practices in health governance in Canada and Internationally*. National Collaborating Centre for Indigenous Health.

Health Canada. (2018). *First Nations and Inuit Health Branch: Program plan*. Government of Canada.

Health Standards Organization (HSO). (2022). *HSO 75000:2022(E) British Columbia Cultural Safety and Humility standard*. https://healthstandards.org/standard/cultural-safety-and-humility-standard/#:~:text=This%20is%20the%20first%20edition,Columbia%20(BC)%2C%20Canada.

Heiltsuk Indian Band. (2020). *Heiltsuk Indian Band By-Law 21*. http://www.heiltsuknation.ca/wp-content/uploads/2021/01/2020-03-31-Disease-Emergency-Bylaw-v2-2.pdf

Hill, D. W. (2003). *Traditional medicine in contemporary contexts: Protecting and respecting Indigenous knowledge and medicine*. National Aboriginal Health Organization.

Horizon Health Network. (n.d.). *Indigenous Liaison Committee*. https://horizonnb.ca/about-us/horizon-board/committees/indigenous-liaison-committee/

Howlett, M., & Giest, S. (2015). Policy cycle. *International Encyclopedia of the Social & Behavioral Sciences, 2,* 288-292.

Indigenous and Northern Affairs Canada (INAC). (2010). *Canada's statement of support on the United Nations Declaration on the Rights of Indigenous Peoples*. Government of Canada. https://www.rcaanc-cirnac.gc.ca/eng/1309374239861/1621701138904

Indigenous Health. (n.d.). *Aboriginal/Indigenous Health Improvement Committees*. Northern Health.

Indigenous Services Canada (ISC). (2014). *Dental benefit policy framework: Non-Insured Health Benefits Program*. Government of Canada.

Indigenous Services Canada (ISC). (2019). *Non-Insured Health Benefits (NIHB) medical transportation policy framework (interim)*. Government of Canada.

Indigenous Services Canada (ISC). (2020). *Supporting Inuit children*. Government of Canada. https://www.sac-isc.gc.ca/eng/1536348095773/1536348148664

Indigenous Services Canada (ISC). (2021a). *Annual report to Parliament*. Government of Canada.

Indigenous Services Canada (ISC). (2021b). *First Nations and Inuit health funding agreement models*. Government of Canada. https://www.sac-isc.gc.ca/eng/1583774026965/1583774050718

Indigenous Services Canada (ISC). (2021c). *Indigenous health care in Canada*. Government of Canada. https://www.sac-isc.gc.ca/eng/1626810177053/1626810219482

Indigenous Services Canada (ISC). (2021d). *Timeline: Jordan's Principle and First Nations child and family services*. Government of Canada. https://www.sac-isc.gc.ca/eng/1500661556435/1533316366163

Indigenous Services Canada (ISC). (2022a). *An open dialogue Indigenous health legislation: Summary report. Government of Canada*. https://www.sac-isc.gc.ca/eng/1656016750223/1656016765403

Indigenous Services Canada (ISC). (2022b). *Mandate*. Government of Canada. https://www.sac-isc.gc.ca/eng/1539284416739/1539284508506

Indigenous Services Canada (ISC). (2022c). *Agreements-in-principle reached on compensation and long-term reform of First Nations child and family services and Jordan's Principle.* Government of Canada. https://www.canada.ca/en/indigenous-services-canada/news/2022/01/agreements-in-principle-reached-on-compensation-and-long-term-reform-of-first-nations-child-and-family-services-and-jordans-principle.html

Indigenous Services Canada (ISC). (2022d). *Co-developing distinctions-based Indigenous health legislation.* Government of Canada.

Interior Health. (2021). *AB0200 – Aboriginal cultural safety & humility.* Kelowna: Interior Health Authority.

Interlake-Eastern Regional Health Authority (RHA). (2021). *Regional Indigenous health strategy – A beginning for future consultation and collaboration*. Interlake-Eastern RHA.

Irwin, R. (1995). *Aboriginal self-government: The government of Canada's approach to implementation of the inherent right and the negotiation of Aboriginal self-government*. Ministry of Indian Affairs and Northern Development, Government of Canada.

Jewell, E., & Mosby, I. (2021). *Calls to Action accountability: A 2021 status updated on reconciliation.* Yellowhead Institute.

Jenkins, W. I. (1978). *Policy analysis: A political and organizational perspective.* M. Robertson Publishers.

Kashechewan (Albany) First Nation. (2020). *Kashechewan (Albany) First Nation council resolution, 2020-18-0923.* Kashechewan (Albany) First Nation.

Kelly, M. (2011). Toward a new era of policy: Health care service delivery to First Nations. *The International Indigenous Policy Journal, 2*(1), 11.

King, A. (2021). Partially paralyzed Indigenous man left in wheelchair he can't operate outside Toronto ER files complaint. *CBC News, Toronto,* June 30.

King, H. (2019). *UNDRIP's fundamental flaw.* Open Canada. https://opencanada.org/undrips-fundamental-flaw/

King, H. (2020). *Manufacturing free, prior, and informed consent: A brief history of Canada vs. UNDRIP*. Yellowhead Institute.

Kyoon-Achan, G., Kinew, K. A., Phillips-Beck, W., Lavoie, J., & Katz, A. (2021). Collaborative and systems approach to transforming primary health care in Manitoba First Nations communities. *International Journal of Indigenous Health, 16*(1), 191-207.

Lalonde, C. (1974). *A new perspective on the health of Canadians: A working document.* Ministry of National Health and Welfare. https://publications.gc.ca/site/eng/9.692294/publication.html

Lavoie, J. (2018). Medicare and the care of First Nations, Métis and Inuit. *Health Economics, Policy, and Law, 13,* 280-298.

Lavoie, J., Boulton, A. F., & Gervais, L. (2012). Regionalization as an opportunity for meaningful Indigenous participation in healthcare: Comparing Canada and New Zealand. *The International Indigenous Policy Journal, 3*(1), 2.

Lavoie, J., Clark, W., Romanescu, R., Phillips-Beck, W., Star, L., & Dutton, R. (2020). Mapping Manitoba's health policy response to the outbreak. In A. Rounce & K. Levasseur (Eds.)*, COVID-19 in Manitoba: Public policy responses to the first wave* (pp. 9-25). University of Manitoba Press.

Lavoie, J., & Forget, E. (2011). Legislating identity: The legacy of the Indian Act in eroding access to care. *The Canadian Journal of Native Studies, 31*(1), 125-138.

Lavoie, J., Forget, E., & Browne, A. (2010). Caught at the crossroad: First Nations, health care, and the legacy of the Indian Act. *Pimatisiwin: A journal of Aboriginal and Indigenous Community Health, 8*(1), 83-100.

Lavoie, J., Gervais, L., Toner, J., Bergeron, O., & Thomas, G. (2011). *Looking for Aboriginal health in legislation and policies, 1970 to 2008: The policy synthesis project.* National Collaborating Centre for Indigenous Health.

Lavoie, J., Kaufert, J., Browne, A. J., & O'Neil, J. (2016a). Managing Matajoosh: Determinants of First Nations cancer care decisions. *BMC Health Services Research, 16*, 402.

Lavoie, J., Kaufert, J., Browne A. J., O'Neil, J. D., Sinclair, S., & Bluesky, K. (2015). Negotiating barriers, navigating the maze: First Nation people' experience of medical relocation. *Canadian Public Administration, 58*(2), 295-314.

Lavoie, J., Kornelsen, D., Boyer, Y., & Wylie, L. (2016b). Lost in maps: Regionalization and Indigenous health services. *Healthcare Papers, 16*(1), 63-73.

Lavoie, J., O'Neil, J., Sanderson, K., Elias, B., Mignone, J., Bartlett, J., Forget, E., Burton, R., Schmeichel, C., & McNeil, D. (2005). *The evaluation of the First Nations and Inuit Health Transfer Policy. Final report: Volume 1, Executive summary.* First Nations Inuit Health Branch: Health Canada.

Lawford, K., & Giles, A. (2012). An analysis of the Evaluation Policy for pregnant First Nations women in Canada. *AlterNative: An International Journal of Indigenous Peoples, 8*(3), 329-342.

Lightfoot, S. (2020). *Unfinished business: Implementation of the UN Declaration on the Rights of Indigenous Peoples in Canada.* Essay no. 3., Institute for Research on Public Policy. https://centre.irpp.org/research-studies/unfinished-business-implementation-of-the-un-declaration-on-the-rights-of-indigenous-peoples-in-canada/#:~:text=It%20simply%20requires%20the%20province,and%20action%20plan%20are%20unclear.

Loppie, C., & Wien, F. (2022). *Understanding Indigenous health inequalities through a social determinants model.* National Collaborating Centre for Indigenous Health.

Lux, M. (2018). Indian hospitals in Canada. *The Canadian Encyclopedia*. https://www.thecanadianencyclopedia.ca/en/article/indian-hospitals-in-canada

MacIntosh, C. (2017). Indigenous mental health: Imagining a future where action follows obligations and promises. *Alberta Law Review, 54*(3), 589-610.

Madawaska, Tobique, Woodstock, Kingsclear, St. Mary's, and Oromocto First Nations, Vitalité Health Network, & Horizon Health Network. (2021). *Wolastoqewi addiction and mental health services Memorandum of Understanding*. Province of New Brunswick.

Mager, J. (2021). Indigenous rights and Canadian wrongs: British Columbia's Bill 41 and the United Nations Declaration on the Rights of Indigenous Peoples. *On Politics: Journal of the University of Victoria Undergraduates of Political Science, 14*(2), 12-20.

Marchildon, G. (2019). *Assessing health system decentralization in Canada using decision space analysis*. Montreal: 4th International Conference on Public Policy.

Marchildon, G. P., Lavoie, J. G., & Harrold, H. J. (2021). Typology of Indigenous health system governance in Canada. *Canadian Public Administration, 64*(4), 562-586.

Mashford-Pringle, A. (2011). How'd we get here from there? American Indians and Aboriginal Peoples of Canada health policy. *Pimatisiwin: A journal of Aboriginal and Indigenous Community Health, 9*(1), 153-175.

Mashford-Pringle, A. (2013). *Self-determination in health care: A multiple case study of four First Nations communities in Canada* [Doctoral Dissertation]. Dalla Lana School of Public Health, University of Toronto.

McKnight, B. (1987). *Compressive Land Claims Policy*. Ministry of Indian Affairs and Northern Development, Government of Canada.

McLennan, B., Green, G., Marchildon, G., Strand, D., & Zelmer, J. (2020). *Putting people first: The final report of the comprehensive review of Yukon's health and social programs and services.* Government of Yukon.

Métis Nation of Saskatchewan., & Saskatchewan Health Authority. (2018). *Memorandum of understanding: Working toward a healthier population*. https://metisnationsk.com/wp-content/uploads/2019/03/MOU-Saskatchewan-Health-Authority-2018.07.pdf

Miller, R. J. (2010). *Discovering Indigenous lands: The doctrine of discovery in the English colonies.* Oxford University Press.

Ministry of Health and Long-Term Care. (2018). *Relationship with Indigenous communities' guideline*. Government of Ontario, Population and Public Health Division.

Ministry of Health and Social Services. (2018). *Caring for our people: Cultural safety action plan 2018-2020*. Government of Northwest Territories.

Narine, S. (2020). 'No one is safe until we are all safe,' says national chief on the roll-out of COVID-19 vaccines. *Windspeaker*, December 11.

Nathanson, A. (2011). Legislating Jordan's Principle: An indirect success. *Manitoba Law Journal, 34*(3), 215-232.

National Collaborating Centre for Indigenous Health (NCCIH). (2019). *Same centre – new name!* https://www.nccih.ca/595/NCCIH_in_the_News.nccih?id=445#:~:text=The%20National%20Collaborating%20Centre%20for%20Indigenous%20Health%20(NCCIH)&text=As%20of%20May%2030th%2C%202019,for%20Indigenous%20Health%20(NCCIH).

National Collaborating Centre for Indigenous Health (NCCIH). (2021). *Informed choice and consent in First Nations, Inuit and Métis women's health services.* https://www.nccih.ca/495/Informed_Choice_and_Consent_in_First_Nations,_Inuit_and_M%C3%A9tis_Women%E2%80%99s_Health_Services.nccih?id=323

National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG). (2019). *Reclaiming power and place: The final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. Government of Canada.

Nguyen, N. H., Subhan, F. B., Williams, K., & Chan, C. B. (2020). Barriers and mitigating strategies to healthcare access in Indigenous communities of Canada: A narrative review. *Healthcare, 8*(2), 112.

Nishnawbe Aski Nation, Government of Canada, & Government of Ontario. (2017). *Charter of relationship principles: Governing health system transformation in the Nishnawbe Aski Nation territory*. Government of Canada. https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/charter-nan.html

North West Local Health Integration Network (LHIN). (n.d.). *North West LHIN Indigenous health*. http://www.northwestlhin.com/goalsandachievements/Indigenous-Health.aspx

Northern Health Region. (2017). *Indigenous health strategy*. Manitoba. https://northernhealthregion.com/wp-content/uploads/2019/02/6015_Northern_Health_Region-Indigenous_Health_Strategy_-_Revised_June_14_2017_-_Approved.pdf

Northway House Cree Nation Centre of Excellence. (n.d.). *About NHCN Health Centre of Excellence: Project history*. https://nhcnhealthcentre.ca/project-history/

Northwest Territories Health and Social Services Authority (NTHSSA). (n.d.). *About us*. https://www.nthssa.ca/en/about-us

Northwest Territories Health and Social Services Authority (NTHSSA). (2018). *Medical and professional staff bylaws*. https://www.nthssa.ca/en/medical-and-professional-staff-bylaws

Northwest Territories Health and Social Services Authority (NTHSSA). (2021). *Backgrounder: Métis Health Benefits Policy*. https://www.gov.nt.ca/sites/flagship/files/documents/backgrounder_-_mhb_policy_en.pdf

Office of the Auditor General of Canada. (2015). *Access to health services for remote First Nations communities*. Government of Canada. https://www.oag-bvg.gc.ca/internet/English/parl_oag_201504_04_e_40350.html

O'Neil, J., Gallagher, J., Wylie, L., Bingham, B., Lavoie, J., Alcock, D., & Johnson, H. (2016). Transforming First Nations' health governance in British Columbia. *International Journal of Health Governance, 21*(4), 229-244.

Ontario Ministry of Health. (1994). *New directions: Aboriginal health policy for Ontario*. Government of Ontario. https://ofifc.org/wp-content/uploads/2020/03/Aboriginal-Health-Policy-for-Ontario-full-document.pdf

Ontario Ministry of Health. (2021). *Facts about Home and Community Care Support Services*. https://www.health.gov.on.ca/en/common/system/services/lhin/facts.aspx

Opekokew, D. (1996). *The nature and status of the oral promises in relation to the written terms of the treaties*. Privy Council Office, Canada, Royal Commission on Aboriginal Peoples. https://publications.gc.ca/site/eng/9.830032/publication.html

Palmer, K., Tepper, J., & Nolan, M. (2017*)*. Indigenous health services often hampered by legislative confusion. *Healthy Debate,* September 21.

Pan American Health Organization. (2019). *Just societies: Health equity and dignified lives. Report of the Commission of Pan American Health Organization on Equity and Health Inequalities in the Americas*. https://iris.paho.org/handle/10665.2/51571

Patterson, L. (2006). *Aboriginal roundtable to Kelowna Accord: Aboriginal policy negotiations, 2004-2005*. Library of Parliament, Government of Canada.

Philpott, J. (2017). *Speech for the Honourable Jane Philpott, Minister of Indigenous Services - Partners in reconciliation: Recognizing and respecting Indigenous health*. Indigenous and Northern Affairs Canada.

Prime Minister of Canada. (2015). *Statement by Prime Minister on release of the final report of the Truth and Reconciliation Commission*. Government of Canada. https://pm.gc.ca/en/news/statements/2015/12/15/statement-prime-minister-release-final-report-truth-and-reconciliation

Provincial Health Services Authority (PHSA). (2022). *Patient safety culture policy*. Government of British Columbia.

Provincial Health Services Authority (PHSA) & BC Emergency Health Services. (2021). *Board policy – Terms of reference: Cultural Safety and Humility Committee*. Government of British Columbia.

Quiñonez, C., & Lavoie, J. (2009). Existing on a boundary: The delivery of socially uninsured health services to Aboriginal groups in Canada. *Humanity & Society, 33,* 35-55.

Reid, J. (2010). The Doctrine of Discovery and Canadian law. *Canadian Journal of Native Studies, 2*(2010), 335-359.

Robbins, J. A., & Dewar, J. (2011). Traditional Indigenous approaches to healing and the modern welfare of traditional knowledge, spirituality and lands: A critical reflection on practices and policies taken from the Canadian Indigenous example. *The International Indigenous Policy Journal, 2*(4), 2.

Royal Commission on Aboriginal Peoples (RCAP). (1996a). Gathering strength. *Report of the Royal Commission on Aboriginal Peoples, Volume 3*. Government of Canada. https://data2.archives.ca/e/e448/e011188230-03.pdf

Royal Commission on Aboriginal Peoples (RCAP). (1996b). Restructuring the relationship. *Report of the Royal Commission on Aboriginal Peoples, Volume 2*. Government of Canada. https://data2.archives.ca/e/e448/e011188230-02.pdf

Rutty, C., & Sullivan, S. C. (2010). *This is public health: A Canadian history*. Canadian Public Health Association.

Salomons, T. (2009). *Calder Case*. University of British Columbia: Indigenous Foundations. https://indigenousfoundations.arts.ubc.ca/calder_case/#:~:text=Calder%20v.&text=Their%20appeal%20was%20a%20landmark,Supreme%20Court%20concluded%20was%20groundbreaking.

Saskatchewan Health Authority (SHA). (n.d.). *Traditional Knowledge Keepers Advisory*. https://www.saskhealthauthority.ca/your-health/conditions-diseases-services/indigenous-health/traditional-knowledge-keepers-advisory

Saskatchewan Health Authority (SHA). (2018). *Policy framework*. SHA.

Saskatchewan Health Authority (SHA). (2019). *Saskatchewan Health Authority commitment to Truth and Reconciliation*. https://www.saskhealthauthority.ca/sites/default/files/2021-06/TRC-commitment-statement-signed.pdf

Siksika Nation. (2021). *Siksika Nation – Alberta Health Relationship Agreement signing*. Siksika Health Services.

Sinha, V., Sangster, M., Gerlach, A. J., Bennett, M., Lavoie, J. G. & Lach, L., Balfour, M., & Folster, S. (2022). *The implementation of Jordan's Principle in Manitoba: Final report.* Assembly of Manitoba Chiefs.

Smith, E. (2022). New Mi'kmaw health authority receives nearly $9M in federal funding. *CBC News*, *Nova Scotia,* January 24.

Snuneymuxw First Nation. (2020). *Snuneymuxw First Nation Covid-19 by-law (2020-01).* https://www.snuneymuxw.ca/sites/default/files/news/Signed%20SFN%20Covid19%20Bylaw.pdf

Southern Chiefs Organization Inc., & Government of Canada. (2020). *Memorandum of understanding between: Southern Chiefs' Organization Inc. (SCO) and the Government of Canada (Canada).* https://scoinc.mb.ca/wp-content/uploads/2021/06/Health-Transformation-MOU-June-18-2020-wcag.pdf

Southwest LHIN. (n.d.). *Indigenous Health Committee*. Southwest LHIN.

Tajikeimɨk. (n.d.). *Mi'kmaw health and wellness*. https://mhwns.ca/

Treaty No. 6. between Her Majesty the Queen and the Plains and Wood Cree Indians and other tribes of Indians at Fort Carlton, Fort Pitt and Battle River. (1876). Queen's Printer.

Truth and Reconciliation Commission (TRC) of Canada. (2015). *Truth and Reconciliation Commission Reports*. McGill-Queen's University Press.

Turpel-Laford, M. E. (2020). *In plain sight: Addressing Indigenous-specific racism and discrimination in B.C. health care*. Engage BC, Government of British Columbia.

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

Vancouver Coastal Caucus, Interim First Nations Health Authority, & Vancouver Coastal Health. (2012) *Vancouver Coastal partnership accord.* https://www.fnha.ca/Documents/Vancouver_Coastal_Partnership_Accord.pdf

Vancouver Island Regional Caucus, Island Health, & First Nations Health Authority. (2016) *Vancouver Island Partnership Accord.* https://fnhc.ca/wp-content/uploads/2021/09/Vancouver-Island-Partnership-Accord-2016.pdf

Viens, J. (2019). *Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec: Listening, reconciliation and progress. Final report.* Government of Quebec.

Wale, E., & Lavoie, J. (2015). Defined by 0.11%: Policies delimiting access to prescription drugs for First Nations people in British Columbia. *International Journal of Indigenous Health, 10*(2), 151-165.

Walker, J., Harris, S., Thomas, J., Mae Phillips, M., & Stones, A. (2018). A national legacy framework for comprehensive and sustainable access to mental health services for Indigenous children and youth mental health in Canada. *The Canadian Journal of Native Studies, 38*(2), 145-164.

Women and Gender Equality Canada. (2020). *Backgrounder – National Inquiry into Missing and Murdered Indigenous Women and Girls*. Government of Canada.

Young, T. K. (1984). Indian Health Services in Canada: A sociohistorical perspective. *Social Science & Medicine, 18*(3), 257-264

APPENDIX A. FEDERAL HEALTH POLICIES, LEGISLATION, AND OTHER DOCUMENTS AND RELEVANCE TO INDIGENOUS HEALTH

Document	Year	Relevance to Indigenous Health
Royal Proclamation	1763	Respects First Nations as sovereign states to manage own affairs, unless otherwise negotiated through Treaties and with approval of the Crown
British North America Act, 1867. c. 3.	1867	Section 91(24) affirms federal jurisdiction in and responsibility to matters of status First Nations peoples. Later interpreted by Supreme Court of Canada decisions in 1939 and 2016 to include Inuit, Métis, and non-status First Nations.
Indian Act, RSC 1985. c. 1-5.	1876	Grants Governor in Council authority to make regulations regarding First Nation health care, as well as Band Councils' authority to implement health-related bylaws in the community
Supreme Court of Canada (Committee of the Privy Council), 1939 SCR 104, [1939].	1939	Interprets Section 91(24) of the *British North America Act* (1867) (now *Constitution Act* [1867]) to include Inuit, expanding the federal fiduciary responsibility
Indian Health Policy	1979	Establishes three broad goals for the federal government in terms of improving First Nations health: community development, strengthening relationships, and strengthening Canada's health care system as it relates to Indigenous Peoples
Constitution Act, 1982. c. 11.	1982	Assumes Canada's full independence of Britain and enshrines the *Canadian Charter of Rights and Freedoms* and the rights of Indigenous Peoples under the Act. Section 35 affirms Aboriginal and treaty rights of First Nations, Inuit, and Métis peoples in Canada, recognizing Métis peoples as Indigenous Peoples for the first time in Canadian law
Health Transfer Policy	1989	Policy program intended to build community capacity and transfer control of health care administration and planning to Indigenous communities
Kelowna Accord	2005	Provides policy recommendations to improve delivery of and access to health services for Indigenous Peoples, with recognition for a variety of determinants of health

Document	Year	Relevance to Indigenous Health
Medical Transportation Policy	2005	Policy program intended to fund travel expenses to receive care outside home communities
Traditional Healer Services Travel Policy	2005	Policy program intended to fund travel expenses to receive care from Traditional Healers outside home communities
Jordan's Principle	2007	Child-first principle to ensure First Nations children receive care according to their needs, ahead of solving any jurisdictional disputes regarding the financing of care
Kelowna Accord Implementation Act, S.C. 2008, c. 23	2008	Implements the Kelowna Accord, based on a 10-year commitment
Dental Benefit Policy Framework	2014	Policy framework provides guidance and direction to the administration of the dental benefit under the Non-Insured Health Benefits Program
Truth and Reconciliation Commission of Canada	2015	Calls to Action #18 – 24 provide policy recommendations to improve access to culturally safe and appropriate care, including recommendations for health care professionals and institutions
United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)	2016	Canada's signage of UNDRIP, the international human rights instrument and framework to understanding the minimal standards for the survival, dignity, and well-being of Indigenous Peoples. Articles #21.1, 23, 24.1, 24.2, 29.3 are pertinent to aspects of Indigenous health.
Daniels v. Canada (Indian Affairs and Northern Development), 2016 SCC 12, [2016] 1 S.C.R. 99.	2016	Interprets Section 91(24) of the *Constitution Act* (1867) to include Métis and non-status First Nations, expanding the federal fiduciary responsibility
National Inquiry into Missing and Murdered Indigenous Women and Girls	2019	Calls for Justice #3.1 – 3.7, 7.1 – 7.9, 16.7 – 16.10, 17.4, 17.8, 17.23, 18.26 – 18.31 provide policy recommendations to improve access to culturally safe and appropriate care, including distinctions-based recommendations for health care professionals and institutions
Department of Indigenous Services Act, S.C. 2019, c. 29, s. 336.	2019	Establishes federal department responsible for Indigenous health care and health policy planning and implementation
United Nations Declaration on the Rights of Indigenous Peoples Act, S.C. 2021, c. 14.	2021	Facilitates the implementation of UNDRIP into all laws in Canada, ensuring their alignment with the declaration
Distinctions-Based Indigenous Health Legislation	*In development*	Policy intended to improve access to high quality, culturally safe, and relevant health services free of anti-indigenous racism. Currently under co-development with national and regional Indigenous organizations; provincial, territorial, and self-governing Indigenous governments; health professionals; other knowledge holders; and the public through a series of engagement events

APPENDIX B. MODERN TREATIES AND SELF-GOVERNMENT AGREEMENTS AND RELEVANCE TO INDIGENOUS HEALTH[23]

Agreement	Year	Signatories	Relevance to Indigenous Health
James Bay and Northern Quebec Agreement	1975	James Bay Cree, Nunavik Inuit, and governments of Quebec and Canada	Provides the basis for the creation of the Cree Board of Health and Social Services of James Bay, the health service provider for those residing in the treaty territory.
Northeastern Quebec Agreement	1978	Naskapi Nation, and governments of Quebec and Canada	Establishes Naskapi Nation authority for the delivery and administration of health services, in partnership with the Quebec provincial health care system; establishes a provisional Health and Social Services Consultative Committee to overlook health care across the treaty territory.
Inuvialuit Final Agreement/ Western Artic Claim	1984	Inuvialuit, and governments of Yukon, Northwest Territories, and Canada	Establishes the Inuvialuit Regional Corporation, and with it, the Health and Wellness Division. Health programs and services are delivered by the Health and Wellness Division, through contribution agreements signed between federal and territorial governments and Inuit Tapiriit Kanatami. The final agreement also establishes the Social Development Program, designed to advise territorial government in health-related matters and programs, such as dental care and nutrition.
Sechelt Indian Band Self-Government Act	1986	Sechelt First Nation, and governments of British Columbia and Canada	Establishes Sechelt First Nation authority for enacting laws regarding health services on Sechelt lands.

---

[23] Other modern treaties and self-government agreements have been signed, although fall outside the scope of health care services and provision, and are thus not included in the report. Examples include the Mi'Kmaq Education Agreement (1998) and Anishinabek Nation Education Agreement (2017).

Agreement	Year	Signatories	Relevance to Indigenous Health
Gwich'in Comprehensive Land Claim Agreement	1992	Gwich'in Tribal Council, and governments of Canada and the Northwest Territories	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care. However, delivery of health services is to be negotiated through separate self-government agreements.
Nunavut Land Claims Agreement	1993	the Inuit of the Nunavut Settlement Area (represented by the Tungavik Federation of Nunavut) and the Government of Canada	Establishes the territory of Nunavut, and with it the responsibility and control over the administration and delivery of health care and health services.
Champagne and Aishihik First Nations Final Agreement	1993	Champagne and Aishihik First Nations, and governments of the Yukon and Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care; as well as negotiate a devolution of powers to divide and share responsibility for the design, delivery, and administration of programs relating to health and social services. The agreement also states signatories may negotiate guaranteed representation on territorial government commissions, councils, boards, and committees, to inform matters related to health care.
Nacho Nyak Dun First Nation Final Agreement	1993	Nacho Nyak Dun First Nation, and governments of the Yukon and Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care; as well as negotiate a devolution of powers to divide and share responsibility for the design, delivery, and administration of programs relating to health and social services. The agreement also states signatories may negotiate guaranteed representation on territorial government commissions, councils, boards, and committees to inform matters related to health care.
Teslin Tlingit Council Final Agreement	1993	Teslin Tlingit Council, and governments of the Yukon and Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care; as well as negotiate a devolution of powers to divide and share responsibility for the design, delivery, and administration of programs relating to health and social services. The agreement also states signatories may negotiate guaranteed representation on territorial government commissions, councils, boards, and committees to inform matters related to health care.

Agreement	Year	Signatories	Relevance to Indigenous Health
Vuntut Gwitchin First Nation Final Agreement	1993	Vuntut Gwitchin First Nation and governments of the Yukon and Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care; as well as negotiate a devolution of powers to divide and share responsibility for the design, delivery, and administration of programs relating to health and social services. The agreement also states signatories may negotiate guaranteed representation on territorial government commissions, councils, boards, and committees to inform matters related to health care.
Sahtu Dene and Metis Comprehensive Land Claim Agreement	1994	Sahtu Tribal Council (representing the Dene of Colville Lake, Déline, Fort Good Hope and Fort Norman and the Metis of Fort Good Hope, Fort Norman and Norman Wells in the Sahtu Region of the Mackenzie Valley) and government of Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care. However, delivery of health services is to be negotiated through separate self-government agreements.
Little Salmon/ Carmacks First Nation Final Agreement	1997	Little Salmon/ Carmacks First Nation and governments of the Yukon and Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care; as well as negotiate a devolution of powers to divide and share responsibility for the design, delivery, and administration of programs relating to health and social services. The agreement also states signatories may negotiate guaranteed representation on territorial government commissions, councils, boards, and committees to inform matters related to health care.
Selkirk First Nation Final Agreement	1997	Selkirk First Nation and the governments of the Yukon and Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care; as well as negotiate a devolution of powers to divide and share responsibility for the design, delivery, and administration of programs relating to health and social services. The agreement also states signatories may negotiate guaranteed representation on territorial government commissions, councils, boards, and committees to inform matters related to health care.

Agreement	Year	Signatories	Relevance to Indigenous Health
Tr'ondëk Hwëch'in Final Agreement	1998	Tr'ondëk Hwëch'in and the governments of the Yukon and Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care; as well as negotiate a devolution of powers to divide and share responsibility for the design, delivery, and administration of programs relating to health and social services. The agreement also states signatories may negotiate guaranteed representation on territorial government commissions, councils, boards, and committees to inform matters related to health care.
Nisga'a Final Agreement	2000	Nisga'a Nation and the governments of British Columbia and Canada	Grants the Nisga'a Lisims Government authority in law-making pertaining to health, providing the basis to later establish the Nisga'a Valley Health Authority, responsible for the delivery and administration of health services and programs. Also permits Nisga'a Lisims Government authority to authorize or license Aboriginal Healers practicing on Nisga'a Lands; however, restricts the authority to regulate products or substances regulated under federal or provincial laws.
Metis Settlements Act, R.S.A. 2000, c. M-14.	2000	Government of Alberta and the Metis Settlements General Council representing: Buffalo Lake, East Prairie, Elizabeth, Fishing Lake, Gift Lake, Kikino, Paddle Prairie, and Peavine Metis Settlements	Establishes eight Métis settlements in Alberta, to create a land base that will "provide for the preservation and enhancement of Metis culture and identity and to enable the Metis to attain self-governance under the laws of Alberta" (s. 0.1(a)). Settlements have authority to create bylaws to promote the health, safety, and welfare of its residents, as well as in areas of public health.
The Ta'an Kwach'an Council Final Agreement	2002	Ta'an Kwach'an Council and the governments of the Yukon and Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care; as well as negotiate a devolution of powers to divide and share responsibility for the design, delivery, and administration of programs relating to health and social services. The agreement also states signatories may negotiate guaranteed representation on territorial government commissions, councils, boards, and committees to inform matters related to health care.

Agreement	Year	Signatories	Relevance to Indigenous Health
Kluane First Nation – Final Agreement	2003	Kluane First Nation and governments of the Yukon and Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care; as well as negotiate a devolution of powers to divide and share responsibility for the design, delivery, and administration of programs relating to health and social services. The agreement also states signatories may negotiate guaranteed representation on territorial government commissions, councils, boards, and committees to inform matters related to health care.
Tłı̨chǫ Land Claims and Self-Government Agreement	2003	The Tłı̨chǫ Nation and governments of the Northwest Territories and Canada	States the territorial government and the Dogrib Treaty 11 Council must negotiate an agreement to provide for the management, administration, and delivery of health programs on Tłı̨chǫ lands, in a manner that respects and promotes the Tłı̨chǫ language, culture, and way of life; providing the basis to later establish the Tłı̨chǫ Community Services Agency and its Health and Social Services branch of the Tłı̨chǫ government.
Labrador Inuit Land Claims Agreement	2005	Inuit of Labrador and governments of Newfoundland and Labrador, and Canada	Provides the basis to establish the Nunatsiavut Government and its Department of Health and Social Development, which is responsible for the management and delivery of health and health care.
Carcross/Tagish First Nation Final Agreement	2005	Carcross/Tagish First Nation and governments of the Yukon and Canada	Grants Carcross/Tagish First Nation the authority to enact laws regarding the provision of health care; however, excluding licensing and regulation of facility-based services off Settlement Land.
The Kwanlin Dun First Nation Final Agreement	2005	Kwanlin Dun First Nation and governments of the Yukon and Canada	Provides the basis to establish corporations which may initiate, fund, and/or administer programs or initiatives related to health and health care; as well as negotiate a devolution of powers to divide and share responsibility for the design, delivery, and administration of programs relating to health and social services. The agreement also states signatories may negotiate guaranteed representation on territorial government commissions, councils, boards, and committees to inform matters related to health care.
Westbank First Nation Self-Government Agreement	2005	Westbank First Nation and the Government of Canada	Establishes Westbank First Nation's jurisdiction in the regulation of traditional Okanagan medicinal practices and practitioners on Westbank lands; however, restricts authority to regulate products, substances, and licensing of health practitioners regulated under provincial or federal laws. As per the agreement, Westbank First Nation may also enter into separate agreements with other governments or agencies to negotiate the delivery of health services or the application of provincial or other health standards on Westbank lands.

Agreement	Year	Signatories	Relevance to Indigenous Health
Nunavik Inuit Land Claims Agreement	2007	Nunavik Inuit and the Government of Canada	Consolidates authority of the Inuit of Nunavik over institutions created by the 1975 James Bay and Northern Quebec Agreement and establishes the Nunavik regional government. The agreement does not include specific provisions pertaining to health or health care.
Tsawwassen First Nation Final Agreement	2007	Tsawwassen First Nation and the governments of British Columbia and Canada	Establishes Tsawwassen First Nation authority to authorize or license Aboriginal Healers practicing on Tsawwassen lands; however, restricts the authority to regulate medical and health practitioners, as well as products and substances regulated under federal or provincial laws. Grants Tsawwassen First Nation authority to enact laws pertaining to health services and public health provided by Tsawwassen institutions on Tsawwassen lands; and states signatories may negotiate separate agreements regarding administration of federal and provincial health services and programs by a Tsawwassen Institution on Tsawwassen Lands.
Maa-nulth First Nations Final Agreement	2009	Maa-nulth First Nations: Huu-ay-aht First Nations, Ka:'yu:'k't'h'/ Che:k:tles7et'h' First Nations, Toquaht Nation, Uchucklesaht Tribe, Ucluelet First Nation, and governments of British Columbia and Canada	Grants each Maa-nulth First Nation Government the authority to make laws pertaining to health services provided on their respective land base.
Eeyou Marine Region Land Claims Agreement	2012	The Crees of Eeyou Istchee and the Government of Canada	Agreement does not include specific provisions to health or health care. Rather, provisions regarding health service administration and delivery may be interpreted from, and are applied to beneficiaries of, the James Bay and Northern Quebec Agreement.
Sioux Valley Dakota Nation Self-Government Agreement	2014	Sioux Valley Dakota Nation and the Government of Canada	Establishes Sioux Valley Dakota Nation jurisdiction in matters of public health and the provision of health services. Laws made under this authority must align with the principles and program criteria established under the *Canada Health Act*. Sioux Valley Dakota Nation may also implement laws to regulate traditional medicine practices and practitioners.

Agreement	Year	Signatories	Relevance to Indigenous Health
Tla'amin Nation Final Agreement	2014	Tla'amin Nation and the governments of British Columbia and Canada	Establishes Tla'amin Nation authority to authorize or license Aboriginal Healers practicing on Tla'amin lands; however, restricts the authority to regulate health practices or practitioners regulated under federal or provincial laws. Grants Tla'amin Nation authority to enact laws regarding health services and public health provided by Tla'amin institutions on Tla'amin lands; however, restricts authority to regulate health services provided by provincial health institutions or agencies. Signatories may negotiate a separate agreement regarding the delivery and administration of federal and provincial health services and programs, not including those provided by a Tla'amin institution.
Délı̨nę - Sahtu Dene and Metis - Self-Government Agreement	2016	Sahtu Dene, Metis of Délı̨nę, and the governments of Northwest Territories and Canada	Establishes Délı̨nę Got'ı̨nę Government jurisdiction regarding the regulation of traditional healing services; however, restricts the authority to regulate products or substances, as well as medical or health practices or practitioners regulated under federal or provincial laws. Signatories may negotiate a separate agreement concerning the administration and delivery of territorial and/or federal health programs and services in the Délı̨nę District. The Government of the Northwest Territories must consult with the Délı̨nę Got'ı̨nę Government when proposing the creation or restructuring of a health authority in the Délı̨nę District. Furthermore, signatories and their respective governments must nurture an intergovernmental relationship to consistently share information relevant to the delivery of health programs in the Délı̨nę District, and to meet biannually to discuss: (a) the delivery of health care programs in the Délı̨nę District, (b) health care priorities, and (c) any agreements reached pursuant to other sections of the agreement.
Cree Nation Governance Agreement	2017	The Crees of Eeyou Istchee and the Government of Canada	Establishes authority and protects self-governance of the Crees of Eeyou Istchee on land previously subject to federal jurisdiction under the James Bay and Northern Quebec Agreement. Grants the Crees of Eeyou Istchee authority to make laws on local governance issues. The agreement does not include provisions related to health or health care.
Manitoba Métis Self-Government Recognition and Implementation Agreement	2021	Manitoba Metis Federation Inc. and the Government of Canada	Establishes federal recognition and support for Manitoba Métis to exercise their inherent right to self-determination and self-government, through the Manitoba Metis Federation Inc. The agreement does not include provisions related to health or health care.

APPENDIX C. PROVINCIAL AND TERRITORIAL HEALTH POLICIES AND LEGISLATION AND RELEVANCE TO INDIGENOUS HEALTH

Jurisdiction	Document	Year	Relevance to Indigenous Health
British Columbia	*Medicare Protection Act,* R.S.B.C. 1996, c. 286.	1996	Describes British Columbia's Medicare health coverage system. Does not include Indigenous-specific provisions.
	Tobacco and Vapour Products Control Act, R.S.B.C. 1996, c. 451.	1996	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act and its regulations.
	Public Health Act, S.B.C. 2008, c. 28.	2008	Provides direction for the province in matters of public health. Section 3(2)(a): states the minister may develop a health plan to identify and address the health needs of particular groups, with specific mention to Indigenous Peoples.
	Health Professions Act, Midwives Regulation (B.C. Reg 281, 2008)	2008	States Indigenous midwives may register their practice with the BC College of Nurses and Midwives. Exempts Indigenous midwives practicing on First Nations reserves from provincial regulations and restrictions.
	BC Tripartite Framework Agreement on First Nation Health Governance	2011	Establishes the First Nations Health Authority, a province wide First Nations health governance model, responsible for the planning and delivery of care for First Nations Peoples across British Columbia.
	Declaration of Commitment	2015	Commits the Provincial Health Services Authority and the Regional Health Authorities in British Columbia to advance cultural humility and safety within their organizations and health delivery practices.
	Declaration on the Rights of Indigenous Peoples Act, S.B.C. 2019, c. 44.	2019	Initiates full implementation of the UNDRIP in British Columbia, ensuring all laws in the province align with UNDRIP declarations.
	Board Policy – Terms of Reference: Cultural Safety and Humility Committee	2021	Establishes the Cultural Safety and Humility Committee tasked to ensure development of policies and delivery of health services across the province align with principles and practices of Indigenous cultural safety.
	Patient Safety Culture Policy	2022	Commits the Provincial Health Services Authority to integrating Indigenous cultural safety in all policies and procedures as a measure to address systemic racism and improve health equity for Indigenous Peoples.
	British Columbia Cultural Safety and Humility Standard	2022	Policy resource to be used by health care organizations and systems to develop, implement, and evaluate strategies to address anti-Indigenous racism and create a culturally safe environment.

Jurisdiction	Document	Year	Relevance to Indigenous Health
Alberta	*Alberta Public Health Act*, R.S.A. 2000, c. P-37.	2000	Provides direction for the province in matters of public health. Defines Métis settlements as municipalities included under the Act and its provisions.
	Prevention of Youth Tobacco Use Act, R.S.A. 2000, c. P-22.	2000	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act and its regulations for those under 18 years of age.
	Regional Health Authorities Act, R.S.A. 2000, c. R-10.	2000	Establishes the centralized, provincial health care system. Defines Métis settlements as municipalities included under the Act and its provisions.
	Health Professions Act, Social Workers Profession Regulation (AB Reg 82/2003)	2003	Exempts Aboriginal practices from restricted activities under the Act. States: "regulated members are permitted to provide psychosocial intervention using traditional aboriginal practices if the member has received training and guidance in the use of traditional aboriginal approaches and is recognized by an aboriginal community..." (s. 12).
	Tobacco, Smoking and Vaping Reduction Act, S.A. 2005, c. T-3.8.	2005	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act and its regulations.
	Alberta Health Act, S.A. 2010, c. A-19.5.	2010	Describes Alberta's health coverage system. *Does not include Indigenous-specific provisions.*
Saskatchewan	*Public Health Act,* S.S. 1994, c. P-37.1.	1994	Provides direction for the province in matters of public health. Section 4 states: "for the purpose of carrying out this Act according to its intent, the minister may enter into agreements with… the Government of Canada or… an Indian band or any other person," establishing First Nation bands as outside the Act and its regulations.
	Tobacco and Vapour Products Control Act, S.S. 2001, c. T-14.1	2001	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act and its regulations.
	Tobacco Control Amendment Act, S.S. 2010, c. 34	2010	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act and its regulations.
	Provincial Health Authority Act, S.S. 2017, c. P-30.3	2017	Establishes the centralized, provincial health care system. Section 4-3(2)(h) states: "the provincial health authority may, for the purpose of carrying out its responsibilities pursuant to this Act… enter into agreements with the Government of Canada or… Indian bands", establishing First Nation bands as outside the Act and its regulations.
	Saskatchewan Health Authority Policy Framework	2018	Establishes Indigenous Health Representatives to provide insight and advise the policy development process within the provincial health care system, ensuring the process is respectful and culturally responsive.
	Saskatchewan Health Authority Commitment to Truth and Reconciliation	2019	Commits the Saskatchewan Health Authority to implement the TRC Calls to Actions with relevance to health and health care, as well as to become a culturally responsive organization.

Jurisdiction	Document	Year	Relevance to Indigenous Health
Manitoba	*Smoking and Vapour Products Control Act,* C.C.S.M. 1990, c. S150.	1990	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act and its regulations.
	Regional Health Authorities Act, C.C.S.M. 1996, c. R34.	1996	Establishes the provincial health care system. States: "the minister may enter into agreements for the purposes of this Act and the regulations with...an Indian Band, with the approval of the Lieutenant Governor in Council" (s. 5(1)(c)), establishing First Nation bands as outside of Act and its regulations. States regional authorities must consult with Indian Bands for the preparation of a proposed regional health plan "as the regional health authority considers appropriate" (s. 24(2)).
	Midwifery Act, C.C.S.M. 1997, c. M125	1997	Recognizes and respects Indigenous Midwifery care, stating the council must establish "a standing committee to advise the college on issues related to midwifery care to aboriginal women" (s. 8(5)(b)).
	Public Health Act, C.C.S.M. 2006, c. P210.	2006	Provides direction for the province in matters of public health. *Does not include Indigenous-specific provisions.*
	Regulated Health Professions Act, S.M. 2009, c. 15.	2009	Exempts Aboriginal Healers from restricted activities as outlined in the Act, stating exemptions to "treating an aboriginal person or member of an aboriginal community in accordance with traditional healing services that are provided by an aboriginal healer" (s. 5(3)(f)).
	Bill 10, *Regional Health Authorities Amendment Act*, 4th Session, 41st Legislature of Manitoba, 2019.	2019	Initiates reform and establishes the centralized, provincial health care system. *Does not include Indigenous-specific provisions.*

Jurisdiction	Document	Year	Relevance to Indigenous Health
Ontario	*Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26	1990	In carrying out the Act, states the minister may "enter into agreements with Indigenous organizations to provide for home and community care services for Indigenous communities" (s. 6(1)(4.1)), establishing communities as outside the Act. States Indigenous health councils are to advise the Ministry on issues related to health and service delivery for Indigenous Peoples (s. 8.1(1)).
	Health Protection and Promotion Act, R.S.O. 1990, c. H.7	1990	Provides direction for the province in matters of public health. States a health authority may enter into an agreement with a First Nations band council to provide health programs and services to the members of the First Nations band; thereby establishing responsibility for First Nations communities as outside the Act and its regulations.
	Regulated Health Professions Act, S.O. 1991, c. 18	1991	Exempts Aboriginal Healers providing traditional healing services, as well as Aboriginal Midwives providing traditional midwifery services to Aboriginal persons or members of an Aboriginal community, from provisions of the Act. However, if an Aboriginal Healer or Midwife is member of a health profession College, their practice is subject to the jurisdiction of the College (section 35).
	Midwifery Act, S.O. 1991, c. 31.	1991	States an "exception for aboriginal midwives" to restricted titles in midwifery in Ontario, explaining "an aboriginal person who provides traditional midwifery services may… use the title 'aboriginal midwife', a variation or abbreviation or an equivalent in another language; and… hold himself or herself out as a person who is qualified to practice in Ontario as an aboriginal midwife" (s. 8(3)(a)(b)).
	Aboriginal Health Policy	1994	Aims to improve Indigenous health in Ontario through strengthening community involvement in the planning, design, implementation, and evaluation of health programs and services. Led to the establishment of Aboriginal Health Access Centres.
	Commitment to the Future of Medicare Act, S.O. 2004, c. 5.	2004	Describes Ontario's Medicare health coverage system. *Does not include Indigenous-specific provisions.*
	Local Health System Integration Act, S.O. 2006, c. 4.	2006	States responsibility of the local health integration networks (LHINs) to collect and measure health-related data pertinent to Indigenous health issues, stating each LHIN must "include in the annual report ... data relating specifically to Aboriginal health issues addressed by the [LHIN]" (s. 13.1(3)(a)).
	Smoke-Free Ontario Act, S.O. 2017, c. 26, s. 3.	2017	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act and its regulations.
	Connecting Care Act, S.O. 2019, c. 5, s. 1.	2019	Establishes the centralized, provincial health care system. States the provincial health authority must engage with Indigenous communities to establish Indigenous health planning entities to then work "in a manner that recognizes the role of Indigenous peoples in the planning and delivery of health services in their communities" (s. 44(2)(a)).

Jurisdiction	Document	Year	Relevance to Indigenous Health
Quebec	*Act Respecting Health Services and Social Services,* R.S.Q. 1991, c. S-4.2	1991	Describes Quebec's health care system. Respects the autonomy of the Cree Board of Health and Social Services of James Bay (established under the James Bay and Northern Quebec agreement) as a separate entity of which the Act does not apply. Establishes the Nunavik Regional Board of Health and Social Services to respect the autonomy of the Kativik Regional Government on matters of health and social services. The provisions of the Act still apply to the Nunavik Regional Board of Health and Social Services; however, are subject "to the special provisions enacted by [the] Act" (s. 530.2).
	Act Respecting Health Services and Social Services for Cree Native Person, R.S.Q. 1991, c. S-5	1991	Establishes the Cree Board of Health and Social Services of James Bay (resultant of the James Bay and Northern Quebec Agreement).
	Midwives Act, R.S.Q. 1999, c. S-0.1.	1999	Does not exempt Indigenous midwifery from the Act; rather, it allows Indigenous communities to enter into agreements with the provincial government to regulate midwifery practices, particularly with regards to services delivered in their communities.
	Public Health Act, R.S.Q. 2001, c. S-2.2	2001	Provides direction for the province in matters of public health. States the Cree Board of Health and Social Services of James Bay may intervene during public health crises.
	Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing Regional Agencies, S.Q. 2015, c. O-7.2.	2015	Establishes the centralized, provincial health care system. Respects autonomy of the Cree Board of Health and Social Services of James Bay (established under the James Bay and Northern Quebec agreement) as a separate entity of which the Act does not apply.
New Brunswick	*Public Health Act*, S.N.B. 1998, c. P-22.4	1998	Provides direction for the province in matters of public health. States the minister may enter into an agreement with First Nation band councils for the purpose of this Act, establishing First Nation communities as outside the Act.
	Smoke-Free Places Act, R.S.N.B. 2011, c. 222.	2011	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act and its regulations.
	Regional Health Authorities Act, R.S.N.B. 2011, c. 217.	2011	Establishes two regional health authorities for the province. States there must be Indigenous representation in appointments to a Regional Health Authority Board. States the minister may enter into an agreement with First Nation band councils for the purpose of this Act, establishing First Nation communities as outside the Act.

Jurisdiction	Document	Year	Relevance to Indigenous Health
Nova Scotia	*Smoke-Free Places Act,* S.N.S. 2002, c. 12.	2002	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act and its regulations.
	Health Protection Act, S.N.S. 2004, c. 4.	2004	Provides direction for the province in matters of public health. States the minister may enter into agreements with First Nation band councils in the event of a health crisis, to respond and take action; thereby establishing responsibility to First Nation communities as outside the Act.
	Health Authorities Act, S.N.S. 2014, c. 32.	2014	Establishes the centralized, provincial health care system. *Does not include Indigenous-specific provisions.* Regulations of the Act state community health boards must have cultural representation reflective of the community being served. Does not require Indigenous representation; rather, states Indigenous Peoples must have the opportunity to self-identify in their application to join the board.
Prince Edward Island	*Public Health Act*, R.S.P.E.I. 1988, c. P-30.1.	1988	Provides direction for the province in matters of public health. Mandates information sharing with First Nation communities as separate entities, stating: "for the purpose of assessing the impact of, and planning for and dealing with, a threat to public health, the Minister and the Chief Public Health Officer may disclose information to…a band as defined in the Indian Act" (s. 57(1)(f)).
	Regulated Health Professions Act, R.S.P.E.I. 1988, c R-10.1	1988	Exempts "traditional healing services… provided by an "Aboriginal Healer" from restrictions on activities of health professionals, as outlined in the Act (s. 86(4)(e)).
	Tobacco and Electronic Smoking Device Sales and Access Act, R.S.P.E.I. 1988, c. T-3.1.	1988	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act.
	Health Services Act, R.S.P.E.I. 1988, c. H-1.6.	1988	Establishes the centralized, provincial health care system. *Does not include Indigenous-specific provisions.*
Newfound-land and Labrador	*Health and Community Services Act*, S.N.L. 1996, c. P-37.1.	1996	Describes the functions of the provincial health care system. Respects autonomy and rights of Labrador Inuit, stating: "this Act and regulations… shall be read and applied in conjunction with the *Labrador Inuit Land Claims Agreement Act* and, where a provision of this Act or regulations made under this Act is inconsistent or conflicts with a provision, term or condition of the *Labrador Inuit Land Claims Agreement Act*, the provision, term or condition of the *Labrador Inuit Land Claims Agreement Act* shall have precedence over the provision of this Act" (s. 2.1).
	Regional Health Authorities Act, S.N.L. 2006, c. R-7.1.	2006	Establishes the provincial health care system and the four Regional Health Authorities. *Does not include Indigenous-specific provisions.*
	Public Health Protection and Promotion Act, S.N.L. 2018, c. P-37.3.	2018	Provides direction for the province in matters of public health. Respects autonomy and rights of Labrador Inuit, stating provisions of the *Labrador Inuit Land Claims Agreement Act* take precedence in times of conflict.

Jurisdiction	Document	Year	Relevance to Indigenous Health
Yukon	*Health Act,* R.S.Y. 2002, c.106.	2002	Establishes and describes the functions of the territorial health care system. States that in the planning, evaluation, and implementation of health and social services policy, "the Minister all other public officials… should be guided by the importance of the following principles… the partnership of… aboriginal groups, and… the cultural sensitivity and responsiveness of policies and systems" (s. 2(4)(c)(e)). Recognizes and protects "Aboriginal control over traditional Aboriginal nutritional and healing practices… for seekers of health and healing services" (s. 5(1)) and states the Minister must "promote mutual understanding, knowledge, and respect between the providers of health and social services offered in the health and social service system and the providers of traditional Aboriginal nutrition and healing" (s. 5(2)).
	Public Health and Safety Act, R.S.Y. 2002, c. 176.	2002	Provides direction for the territory in matters of public health. *Does not include Indigenous-specific provisions.*
	Hospital Act, R.S.Y. 2002, c. 111	2002	Establishes and describes functions of the Yukon Hospital Corporation. Mandates First Nations representation on the board of trustees appointed by the Commissioner in Executive Council for the Corporation (s. 5(1)(a)(i-ii)). Establishes the First Nations Health Committee to function in Yukon hospitals and offers a variety of First Nation Health Services (types of services outlined in the Act) (s. 6). Mandates the First Nations Health Committee to develop a First Nations Employment Equity and Training Policy and a policy implementation plan. The policy must aim to remedy the under-representation of First Nations in the delivery of health care services and improve the quality of care (s. 6).
	Tobacco and Vaping Products Control and Regulation Act, S.Y. 2019, c. 14.	2019	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act.

Jurisdiction	Document	Year	Relevance to Indigenous Health
Northwest Territories	*Hospital Insurance and Health and Social Services Administration Act*, R.S.N.W.T. 1988, c. T-3.	1988	Describes the territorial health care system. Respects the autonomy of the Tłįchǫ Community Services Agency established under the *Tłįchǫ Community Services Agency Act* and Tłįchǫ Land Claims and Self-Government Agreement. States a chairperson from the Tłįchǫ Community Services Agency must sit on the board of management for the Northwest Territories Health and Social Services Authority to inform decision-making practices.
	Medical Care Act, R.S.N.W.T. 1988, c. M-8.	1988	Establishes the territorial Medical Care Plan for health programs and services. *Does not include Indigenous-specific provisions.*
	Métis Health Benefits Policy	1995	Provides a supplementary health coverage program designed for Métis Peoples living in the Northwest Territories. Program is modeled after the federal Non-Insured Health Benefits program.
	Public Health Act, S.N.W.T. 2007, c. 17.	2007	Provides direction for the territory in matters of public health. *Does not include Indigenous-specific provisions.*
	Medical and Professional Staff Bylaws	2018	States responsibility of the Area and Territorial Medical Directors, Territorial Clinical Leads, and the Territorial Practitioner Executive Committee to provide leadership on the provision of high quality and culturally safe care within the territorial health care system.
	Tobacco and Vapour Products Control Act, S.N.W.T. 2019, c. 31.	2019	Exempts the use of tobacco products for Indigenous-specific ceremonial, cultural, or spiritual purposes from the Act.
	Cultural Safety Declaration of Commitment	2019	Commits the territorial health care system to embed Indigenous cultural safety and relationship-based care throughout its organization and health delivery practices.

Jurisdiction	Document	Year	Relevance to Indigenous Health
Nunavut	*Hospital Insurance and Health and Social Services Administration Act*, R.S.N.W.T. 1988, c. T-3.	1988	Describes administration of health and social services in the territory. *Does not include Indigenous-specific provisions.*
	Medical Care Act, R.S.N.W.T. 1988, c. M-8.	1988	Establishes the territorial Medical Care Plan for health programs and services. *Does not include Indigenous-specific provisions.*
	Mental Health Act, R.S.N.W.T. 1988, c. M-10.	1988	Section 7 states medical practitioners may consult with an Elder to provide involuntary psychiatric assessments for patients who speak an Inuit language fluently and do not speak English or French. The patient and Elder must know each other and be from the same community and cultural background. The Elder may assess whether the patient is suffering from a mental disorder that may result in bodily harm to themselves or others.
	Midwifery Profession Act, S.Nu. 2008, c. 18.	2008	Recognizes and protects the practice of traditional Inuit midwifery, stating "the Minister shall develop instructional content based on traditional Inuit midwifery knowledge, skills and judgment" for all types of midwifery training and professional development programs (s. 6.1(1)). Programs must also ensure persons with "experience in the practice of traditional Inuit midwifery are invited to instruct students and share their knowledge" (s. 6.1(2)). States the Midwifery Registration Committee must "promote the incorporation of traditional Inuit midwifery knowledge, skills and judgment" in all types of midwifery training and professional development programs, as well as the practice of midwifery (s. 8(e)).
	Public Health Act, S.Nu. 2016, c. 13.	2016	Provides direction for the territory in matters of public health. Section 6 asserts Inuit societal values to be the foundation on which the Nunavut public health system operates. States the Minister and the Chief Public Health Officer are responsible to ensure full integration throughout the public health system and describes specific values such as: Inuuqatigiitsiarniq, Tunnganarniq, Pijitsirniq, Aajiiqatigiinniq, Pilimmaksarniq or Pijariuqsarniq, Piliriqatigiinniq or Ikajuqtigiinniq, Qanuqtuurniq, Avatittinnik Kamatsiarniq.

sharing knowledge · making a difference
partager les connaissances · faire une différence
ᖃᐅᔨᒃᑲᐃᖃᑎᒌᓃᖅ · ᐱᕚᓪᓕᖅᑎᑦᑎᓂᖅ

National Collaborating Centre
for Indigenous Health
Centre de collaboration nationale
de la santé autochtone

FOR MORE INFORMATION:
UNIVERSITY OF NORTHERN BRITISH COLUMBIA
3333 UNIVERSITY WAY, PRINCE GEORGE, BC, V2N 4Z9

1 250 960-5250
NCCIH@UNBC.CA
NCCIH.CA

SOCIAL DETERMINANTS