

The Failure of Federal Indigenous Healthcare Policy in Canada

By Mike Gouldhawke

LATE LAST MONTH, the federal government held two days of meetings on developing Indigenous health care legislation. These virtual meetings included some, **but not all** provincial and territorial health ministers, along with First Nations, Inuit and Métis Nation **representatives**, including Indigenous doctors, and was partly in response to the racist treatment and death of Joyce Echaquan of the Atikamekw Nation in a Quebec hospital in September of last year.

If and when this legislation materializes, it will be a first in Canadian history. This country has never developed a law around Indigenous health care.

As the process of development goes on, there are a variety of challenges, historically and contemporary, as well as previous calls for reform and for Canada to live up to its obligations, that should be addressed. This Brief outlines the compounding crises, and the resistance, that have constituted Indigenous healthcare in this country.

Re-Prioritizing Health Policy in Canada

Despite these recent meetings on developing Indigenous health legislation, and the First Ministers' meeting in December of 2020 which prioritized the COVID-19 pandemic, federal Indigenous health policy has fallen by the wayside for decades.

The 2004 Health Accord between the federal government and provinces and territories included a 10-Year **Plan** on improving Indigenous health, co-developed with Indigenous representative organizations, but it expired in 2014 and has yet to be replaced, despite repeated **promises** from the Liberal government. The Canadian Health Coalition, in a 2017 **report**, called the “lack of progress on closing the health gap for Aboriginal people” the most egregious of the 2004 Health Accord's failings.

Meanwhile, Indigenous people continue to face what some call “syndemic” conditions¹, meaning multiple interacting and mutually aggravating epidemics, themselves worsened by **already existing** negative determinants of health, in this case due to colonialism. Added to this is ongoing and deadly systemic racism within health care, which has been the cause of street demonstrations across the country.

Who Delivers Indigenous Healthcare?

Canada's public health care system operates under a jurisdictional **patchwork**, divided between the provinces, territories, the federally-funded Non-Insured Health Benefits (NIHB) program for First Nations and Inuit, and finally, limited Métis programs via Indigenous Services Canada.

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This complexity means that there are effectively 15 different healthcare systems in the country.

Although medicare, since the 1960s, has been considered a major point of Canadian **pride** and identity, health care in general has never appeared in the country's Constitution, the highest of Canadian law, either in 1867 or 1982. Instead, the Constitution merely **delegates** jurisdiction for hospitals to the provinces. There is no mention of Indigenous peoples or our jurisdiction.

The **Canada Health Act** of 1984, similarly, does not mention Indigenous peoples, despite the emergence of constitutional Aboriginal rights just a few years earlier. The Health Act itself is conspicuously minimalist, coming in at only 14 pages, staying short and to the point of reaffirming provincial jurisdiction and mostly limiting the federal government's role to the realm of funding.

Indigenous health services long predate the public medicare system initiated in the 1960s, but have also been, and continue to be characterized by oppressive treatment.

Life expectancy for Inuit is a decade less than the Canadian average, for instance, and institutional racism is so **severe** that Indigenous people **strategically avoid** public hospitals, when possible, in favour of clinics managed and staffed by Indigenous people.

Ongoing jurisdictional misalignment between the federal and provincial governments has had critical consequences, necessitating measures such as **Jordan's Principle**, the broad application of which Canada continues to fight against in **court**, as part of its long legal battle against equal funding for Indigenous child welfare.

It speaks volumes of Canadian approaches to Indigenous healthcare that where Indigenous people have created change or opportunities for change, the federal government often only responds with hesitation or fights against it "in the form of legal orders", as Cindy Blackstock recently **explained** to APTN News.

Indeed, Canada has always maintained that it has no legal or constitutional obligations to provide health services to Indigenous people and does so simply as a matter of **policy** or "**benevolence**."²

International Obligations

While Canada has crafted Indigenous-specific health policies in the past, until now it has never enacted Indigenous health care legislation. Instead it has merely delegated power for the creation of certain rules around public health on reserve to Chief and Council through the *Indian Act* and its precursor, the *Gradual Enfranchisement Act*.

However, Canada has made itself a party to applicable international law, such as the Numbered Treaties between the Crown and Indigenous Nations, and the binding international Treaty found in the United Nation's 1966 **International Covenant on Economic, Social and Cultural Rights** (ICESCR).

As the Maskwacis Cree pointed out in their 2016 **submission** to the UN's Expert Mechanism on the Rights of Indigenous Peoples, Article 12(1) of the Covenant outlines a holistic guarantee of well-being, "not for the absence of disease – but rather to ensure certain preconditions for health," in other words, not just health care after we've fallen ill..

They called for Indigenous law, Treaty 6, Canadian law and international law to be read and understood together, in an equitable manner, to allow for a more complete provision "for all aspects of the health of Indigenous Peoples...The Treaty right to health is not a financial burden that is realized through policy decisions," the Maskwacis Cree reaffirmed, "but rather a legal obligation under Treaty, Canadian law and international law."

In **response**, the UN's Expert Mechanism acknowledged Treaty 6 and the Covenant of 1966, and also called for member states to ratify and incorporate into their domestic law the **Indigenous and Tribal Peoples Convention of 1989** (No. 169), a legally binding Treaty of the UN's International Labour Organization.

Article 25 of the Convention of 1989 is meant to ensure adequate health services are made available to Indigenous peoples, but Canada has yet to ratify it, unlike 23 other countries.

This from Canada despite the country's recent moves to implement the 2007 United Nations *Declaration on the Rights of Indigenous Peoples* (UNDRIP), which as a set of international standards, rather than binding law in itself, is meant in part to reaffirm already existing and applicable international laws such as the UN Treaties of 1966 and 1989.

As a signatory to the 1966 Covenant, Canada must file periodic reports to the UN Committee on Economic, Social and Cultural Rights. Canada's most recent **report** was filed in 2013 and claimed that the agreement in the 2004 Health Accord to close the Indigenous health gap was being implemented. The evidence provided was strictly limited to funding.

In **response**, the UN Committee asked Canada for information on the causes of ongoing health disparities affecting Indigenous people and what measures were being taken to address them.

Canada **replied** in 2016, placing the blame on various social conditions Indigenous people are forced to live with, but dodging any mention of its own responsibility for creating and maintaining those conditions, instead implying they are naturally occurring. Canada even went so far as to claim that all levels of government assist Native communities "in addressing health inequalities and disease threats and attaining a level of health comparable to other Canadians."

In another 2016 **statement** to the UN Committee, Canada's representative claimed that a new Health Accord was being negotiated, something recent developments make clear was also false.

A Brief History of Indigenous Healthcare Activism

At present, when Indigenous people engage with the health care system, we are racialized in multiple ways, **according to Dr. Mary Jane Logan McCallum** of the **Munsee Delaware Nation** in her 2017 overview of health and medicine in Canadian colonialism. This can be based on appearance, legal status or where we live, and results in ill-treatment, negative assumptions and differential coverage.

The history of Canada's Indian hospitals and Indian Health Services is one of stark oppression in McCallum's recounting, but as she maintains, colonialism continues in the present and remains a negative determinant of health.

It is important to say here that Indigenous people have never been just passive recipients of Canada's services, neglect or oppression.

As early as 1872, the Chief and Council of the Peguis First Nation (then also known as the St. Peter's band) sent an **affidavit** to the government disputing a lack of health care provision, which they said was promised in the negotiations for Treaty 1. It's **believed** that Peguis First Nation in 1930 became the first reserve in the country to have a nursing station established by the federal government.

In 1935, Chief George Dreaver and two councillors of the Mistawasis band in Saskatchewan took the Crown to **court** because they were being wrongly charged for medical supplies that should have been paid for under the Treaty 6 medicine chest clause. Chief Dreaver had been personally present as a young man at the signing of Treaty 6 in 1876.

The Attorney General for the Crown unsuccessfully tried to use a statute of limitations defense against the Mistawasis band in the 1935 case and the trial judge ordered that the band be financially compensated for medicines in light of the Treaty.

The medicine chest clause was then disputed in several court cases over the decades³, some of which resulted in losses and backtracks, but culminating in the 1999 Wuskwi Sipihk Cree Nation [decision](#) which reaffirmed Dreaver, indicating that the Treaty should be understood liberally and may include full health care, not just medicines, in a contemporary context.

In 1969, Cree political leader Harold Cardinal responded to Canada's new Health Plan for Indian Health Services, saying it was a violation of Treaty rights to pass jurisdiction to the provinces and make Native people pay health premiums to them.⁴

In the 1970 “Red Paper” (also known as “Citizens Plus”), Alberta Chiefs, including Cardinal, responded to the Canadian government’s 1969 “White Paper”, explaining that all Treaties were meant to include a free supply of medicines, and since medical care had evolved over a 100 years, the intent was that Native peoples should receive “whatever medical care could be made available.”

Soon after, Cree activist [Jean Cuthand Goodwill](#), the first Native registered nurse in Saskatchewan, worked for decades to increase Native people’s involvement in health care, co-founding the Canadian Indigenous Nurses Association in 1974, co-developing the National Native Access to Nursing Program at the University of Saskatchewan, as special advisor to the minister of National Health and Welfare, and as department head of Indigenous Health Studies at the First Nations University of Canada.

This activism spanned regions and has been a regular feature of Canadian-Indigenous relations. For those who seek to uphold the medicine chest clause, it has been rooted in Treaties. But the calls for a new model of Indigenous healthcare have taken on many angles, right up to the present.

From Joyce’s Principle to “In Plain Sight”

More recently, resistance has manifested through the actions of Joyce Echaquan of the Manawan community and Atikamekw Nation, who used her phone to record and post online the racist treatment and remarks she was subjected to just before her death on September 28, 2020, at a Joliette, Quebec hospital. Echaquan’s act of resistance in turn sparked solidarity demonstrations by Native people across Canada.

Yet, in November of 2020, the Quebec government’s National Assembly refused to adopt [Joyce’s Principle](#), a set of proposals made by the councils of the Atikamekw Nation and Manawan, because one of those proposals called for recognition of systemic anti-Indigenous racism in Quebec’s health care system.

Quebec’s [refusal](#) was despite a call from Echaquan’s husband and the father of her children, Carol Dubé, for his wife’s death not to be in vain, and for Quebec and Canada to [adopt](#) Joyce’s Principle as “the beginning of real change for all Indigenous people so no one ever again falls victim to systemic racism.”

On the other side of the country, also in November of 2020, the government of British Columbia acknowledged and [apologized](#) for systemic Indigenous-specific racism within BC’s health care system, in response to the findings of a report and review it had initiated in June, itself caused by claims that health care workers were playing racist games, guessing the blood alcohol levels of Indigenous patients.

The report, titled “[In Plain Sight](#)”, states the review did not find evidence for those specific claims, but did make calls for changes to governance, legislation and policy in order to “shift” racist behaviours, beliefs and systems with regard to health care in the province.

While conceding that implementation has been an issue, “In Plain Sight” took a more optimistic look at how Canada has engaged with international norms, mentioning the UN’s 1966 Covenant and its Article 12 regarding the right to health. The report claimed that “Canada has long been supportive of all these international institutions and legal instruments, including as a State Party to the ICESCR.” However, this side steps Canada’s flimsy 2013 and 2016 excuses for failing to implement Article 12.

“In Plain Sight” describes UNDRIP and its adoption by BC in 2019 as being a particularly important “framework for understanding the work that must be done today to address systemic discrimination in B.C.’s health care system.” Yet, “In Plain Sight” doesn’t mention the UN’s 1965 [International Convention on the Elimination of All Forms of Racial Discrimination](#), to which Canada is a signatory, and Article 5(e)(iv) of which prohibits racial discrimination in “public health, medical care, social security and social services.”

Are we Ready for Indigenous Healthcare Legislation?

According to the “In Plain Sight” report, between 2011 to 2017 the life expectancy for the First Nations population in BC actually decreased by two and half years, in part due to the overdose epidemic (this in the only province with a First Nations Health Authority meant to take on health services and responsibilities from the federal government).

Over the past year, the response by all levels of government to the overdose epidemic, but also the COVID-19 pandemic, has aggravated the longer crisis in Indigenous health, provincially and across the country.

An increased recognition of certain rights seemingly doesn’t automatically translate into improved social conditions and Indigenous people will have to continue to fight every step of the way, as we’ve always done, both to better those conditions ourselves and to hold governments accountable to their legal obligations.

As we apparently move towards developing Indigenous healthcare legislation, it remains to be seen if the federal government will finally accept its responsibilities, listen to what Indigenous healthcare leaders and activists have been saying for years, and finally address opportunities for change with commitment, instead of delay, negligence and court challenges.

ENDNOTES

¹Aboriginal Health in Canada, by Waldram, Herring and Young (2006) / Syndemics and Public Health: Reconceptualizing Disease in Bio-Social Context, by Merrill Singer and Scott Clair

²Moving Aboriginal Health Forward, by Yvonne Boyer (2015) / “Your Health Benefits...”, Health Canada (2012); COVID-19, the Numbered Treaties & the Politics of Life, by Gina Starblanket & Dallas Hunt

³Aboriginal Health in Canada, by Waldram, Herring and Young (2006); Moving Aboriginal Health Forward, by Yvonne Boyer (2015); Separate Beds, by Maureen Lux (2016)

⁴Separate Beds, by Maureen Lux (2016)

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