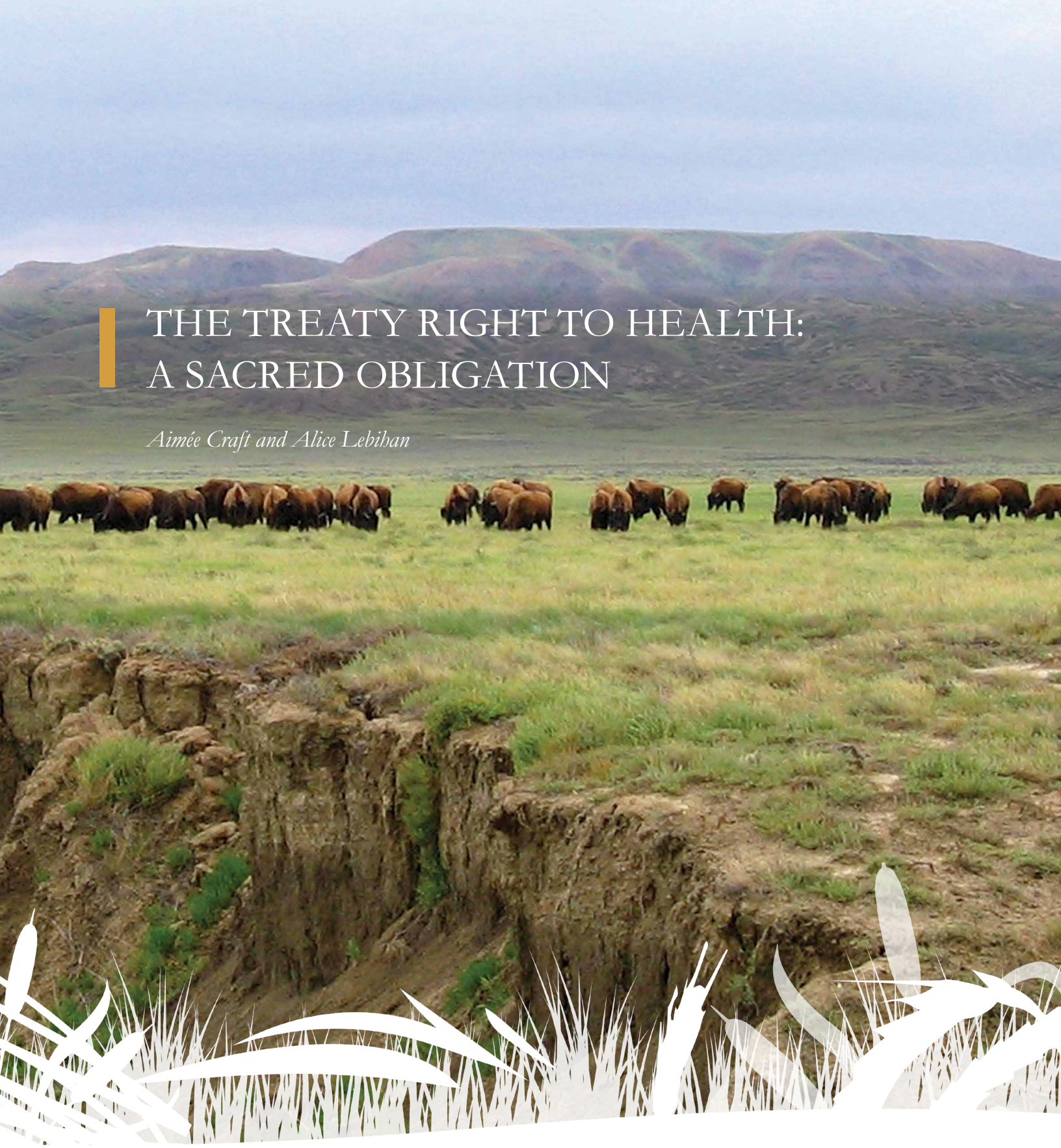

THE TREATY RIGHT TO HEALTH: A SACRED OBLIGATION

Aimée Craft and Alice Lebihan

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

CULTURAL SAFETY AND RESPECTFUL RELATIONSHIPS

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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

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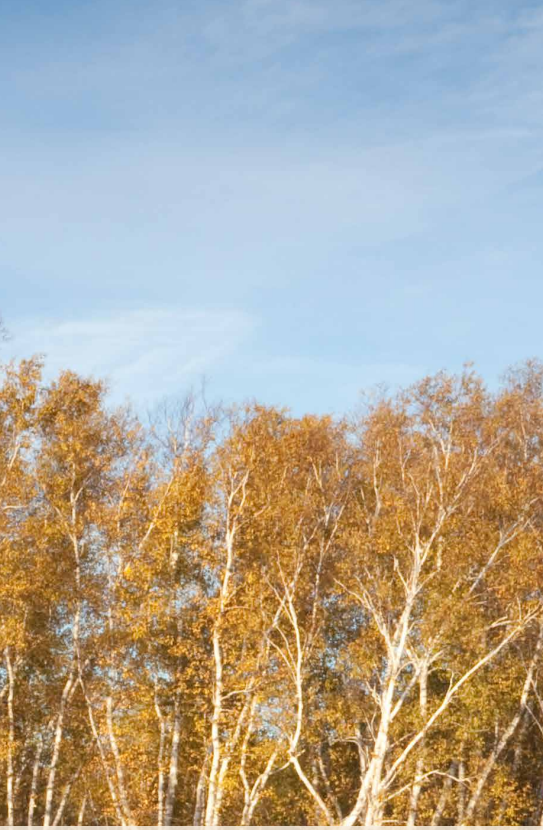

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PART 1: CONTEXT AND BACKGROUND

As we reflect on the 150th anniversary of Treaty No. 1, the first post-confederation historic Treaty made in 1871, and as we collectively battle the global pandemic of COVID-19, which has disproportionately affected First Nations people, the importance of the Treaty right to health is amplified (Ontario Human Rights Commission, n.d.). In addition, the increasingly poor health outcomes faced by First Nations people across Canada and the ongoing jurisdictional battles relating to underfunding of health care services for First Nations people have brought First Nations health to a boiling point. The Truth and Reconciliation Commission of Canada (TRC, 2015a) affirmed that reconciliation requires real societal change. If Canada is truly committed to reconciliation and a Nation-to-Nation relationship, as it says it is, the need to accept and implement the Treaty right to health is imperative. Respecting the sacred obligations that were included in the Treaty promises is an essential aspect of repairing relationships.

The TRC deplored the state of Indigenous[1] health in Canada. It called on various levels of governments to acknowledge the link to previous (and ongoing) policies that have impacted Indigenous health, and called for the implementation of Indigenous rights to health, as provided for in the Treaties, as well as in constitutional and international law. As stated in Call to Action 18:

> We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties (TRC, 2015a, p. 2).

This report seeks to contribute to a deeper understanding of one piece of a much larger puzzle: the Treaty right to health. This discussion is inherently limited to First Nations peoples (those who made Treaties with the Crown) and to historic numbered Treaties, mostly in the Western provinces of Canada and in parts of Ontario and the Northwest Territories. It is also primarily focussed on the obligations of the Federal Government as the primary Treaty representative.[2] However, arguably there are Crown responsibilities by extension to the Provinces. This report focuses specifically on promises related to the health of First Nations people, sometimes also referred to as the "medicine chest clause" (see Section 5.1 at p. 15 of this report), which is a specific written provision that appears in the written text of Treaty 6. Many have argued that the medicine chest clause is also contained in oral versions of other numbered Treaties. This report also touches on the clause respecting pestilence and famine found in the written text of Treaty 6.

This report does not tackle the complexly woven web of duties

[1] A note on terminology: Most of the language surrounding Indigenous identity, especially that of the legally recognized "Indian" under the *Indian Act* is problematic, to say the least; however, it continues to be the legal technical term used for First Nations peoples under the *Indian Act* and in the Canadian Constitution. When referring to Indigenous Peoples today outside of the technical legal context, either First Nations (more restrictive and generally reserved for people with Indian Status under the *Indian Act*) or Indigenous (more inclusive) is used. As well, the term Aboriginal Peoples of Canada may be referenced, pursuant to Section 35 of the *Constitution Act, 1982*, and includes "Indian, Inuit and Métis." However, most Indigenous Peoples and nations prefer to refer to themselves in their particular languages (ex. Anishinaabe).

[2] Although many First Nations see the Treaty as a kinship relationship made with the Queen, the post-confederation Treaties are considered in settler-colonial law as being made with Canada as a state. This was further confirmed by the repatriation of the *Constitution Act, 1982*.

and obligations relating to the delivery of health care services to all three groups that constitute the "Aboriginal Peoples of Canada" (First Nations, Inuit and Métis). It does not attempt to unravel the corresponding obligations of the Federal Government's jurisdiction and responsibility under s.91(24) "Indians and lands reserved for Indians", the *Indian Act*, or its fiduciary obligation and duty to act honourably.

The report is limited in scope to the Treaty right to health in the Canadian context. While there are similarities with the jurisdictional challenges faced by Native Americans in the United States of America and other Indigenous people around the world, the nature of Treaty obligations and the Canadian constitutional and interpretive framework is unique.

Treaty and Aboriginal rights are enshrined into Canada's constitution through Section 35. Aboriginal rights are legal rights to practices, customs and traditions that are collectively held by Indigenous people, which were integral to Indigenous societies prior to European settlement and continue to be today. Treaty rights flow from Treaty promises made between the Crown and Indigenous peoples. The Crown must uphold both Treaty and Aboriginal rights and cannot infringe upon them without showing a pressing and substantial legislative objective, minimal harm, and consultation or consent, as required by the "justification test" established by the Supreme Court of Canada in the *Sparrow* case (*R. vs. Sparrow,* 1990).

Health and wellness are generally synonymous for First Nations people (sometimes understood through a concept of *mino-bimaadiziiwin* or *pimatisiwin of miyo-wîcêhtowin*).[3] This conception of wellness includes mental, physical, emotional, and spiritual health and well-being, all of which are intimately connected to socio-economic and environmental factors, including the health of lands and waters within Indigenous territories.

Defined by First Nation peoples, indicators of wellness include social determinants of health (such as speaking Indigenous languages, access

[3] The Cree term *miyo-wîcêhtowin* is described by Treaty Elders of Saskatchewan as reflecting the imperative to maintain good or positive relations with all our relatives, now and into the future (Starblanket & Hunt, 2020).

Despite strong evidence from the First Nations perspective that the Treaty right to health was promised in the numbered Treaty negotiations, it remains an unfulfilled promise today. The Federal Government's approach is to rely on the written scope of Treaties and Treaty negotiation, and therefore maintains that legal obligations for health care do not flow from the numbered Treaties (Merrick, 2019).

to traditional foods, ability to participate in ceremony) and rights to mainstream medicine and traditional practices and medicines. Well-being is also intimately connected to the rights to clean drinking water and food sovereignty and security.

Despite strong evidence from the First Nations perspective that the Treaty right to health was promised in the numbered Treaty negotiations, it remains an unfulfilled promise today. The Federal Government's approach is to rely on the written scope of Treaties and Treaty negotiation, and therefore maintains that legal obligations for health care do not flow from the numbered Treaties (Merrick, 2019). The culture of denial is in breach of the overall Treaty relationship, and has had a direct consequence on the health and wellness outcomes of First Nations people in the numbered Treaty areas (Starblanket & Hunt, 2020).

The following discussion of the Treaty Right to Health begins by providing a brief review related to the concept of the Treaty right to Health (Part 3). Indigenous health is then situated in relation to wellness and well-being (Part 4). The report then approaches three critically important dimensions of the Treaty right to health: first the promises that were made as part of the treaties (Part 5), second, the constitutional protection of Treaty (and Aboriginal) Rights in the Canadian Constitution (1982) (Part 6) and third, the ongoing denial of the Treaty right to health (Part 7). The report then outlines the importance of the Treaty right to health and the implementation of Treaty promises for reconciliation, the implementation of the United Nations Declaration on the Rights of Indigenous Peoples, Indigenous self-determination and the Nation-to-Nation relationship (Part 8). The conclusion reaffirms the sacredness of the treaty right and the constitutional and moral imperatives that require the respect for the Treaty promises and implementation of Treaty rights.

PART 2: METHODOLOGY

This report was compiled by conducting a review of publicly available sources, both peer-reviewed and non-peer-reviewed, including secondary sources relating to the Treaty right to health and the medicine chest clause, case law relating to the Treaty right to health and, to the extent possible, recorded oral history sources, all in the Canadian context and relating specifically to the historic numbered Treaties. Other sources were considered where they situate the Treaty right to health in a broader political and legal context. Literature relating to Indigenous perspectives of health and First Nations social determinants of health were also considered in order to contextualize the application and understanding of the Treaty right to health in a contemporary First Nations context.

PART 3: WHAT IS A TREATY RIGHT TO HEALTH?

The Treaty right to health stems from oral and written clauses of Treaties. However, the Treaty parties (First Nations and the Crown) do not agree to its full scope of application nor its existence. Where there is recognition, including through the courts' interpretations of the Treaties, the interpretation of the Treaty right to health is contested (Favel-King, 1996). In addition to being contested, it is generally not implemented, contributing to ongoing jurisdictional battles relating to First Nations health and poor health outcomes for individuals.

The differing perspectives range from the limited view that the Treaty right to health exists only in relation to the medicine chest clause in Treaty 6 and that its scope is narrowly defined (the provision of a 'first aid kit'), to the more broad understanding that the numbered Treaties included oral promises related to ensuring health and medical services to First Nations people in ways that capture the continuance of traditional practices of health and healing, contemporary medicine, and other holistic elements of wellness.

Despite the entrenchment of Aboriginal and Treaty rights in Canada's Constitution (through Section 35) in 1982, the Federal Government has yet to acknowledge either a Treaty or Aboriginal right to health (Boyer, 2003). The Federal Government "believes it holds a non-obligatory role in the provision of health benefits" tied to written or oral Treaty provisions on health "exchanged at the time of Treaty making" (Merrick, 2019).

Treaty First Nations, on the other hand, understand that the Treaty right to health exists through the written and oral promises made in the negotiations of the numbered Treaties (Boyer & Spence, 2015). From this perspective, the Treaty right to health, in its broadest sense, involves:

- the provisions or continued health of Treaty First Nations as secured by the Indigenous negotiators of the numbered Treaties (Lavoie et al., 2016; Waldram et al., 2006), and
- the potentially perpetual non-interference on Indigenous ways of life, including traditional means of ensuring health and well-being, however derived by the Indigenous nation in question (Boyer, 2003; Lux, 2016).

The Treaty right to health, negotiated and either written or part of the oral promises of the numbered Treaties, was meant to add to the existing jurisdiction and self-determination of First Nations over their own health and wellness. According to Yvonne Boyer, "their intent in entering into Treaties was to supplement these systems with promises of medical care and medicines that were useful in treating European diseases" (Boyer, 2003, p. 17).

In many cases, interpretive lines have been drawn regarding the written Treaty 6 medicine chest clause and the overall right to health and promises that were made orally to other Treaty First Nations. Table 1, prepared by Lavoie et al. (2016), illustrates the geographical distribution of the Treaties and the types of relationships to health that exist in relation to each Treaty (p. 66-68).

Table 1: Treaties and self-government activities in relation to Indigenous health

Agreement	Signed	YK	NT	NU	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NF	Relationship to Health: Some control over health services	Relationship to Health: Input into policy regulations	Relationship to Health: Commitment for specific services
Treaty No. 1	1871							X									Implied commitments
Treaty No. 2	1871						X	X									
Treaty No. 3	1873							X	X								
Treaty No. 4	1874						X	X									
Treaty No. 5	1875						X	X	X								
Treaty No. 6	1876					X	X										Medicine chest clause
Treaty No. 7	1877					X											Verbal commitments; none included in text of Treaty
Treaty No. 8	1899		X			X	X										
Treaty No. 9	1905-1906								X								
Treaty No. 10	1906						X										
Treaty No. 11	1921	X	X														

This table situates each of the numbered treaties by region (provinces) and classifies each into the following 3 categories:

a. implied commitments
b. verbal commitments (not written into the treaty texts); and
c. the medicine chest clause.

This approach helps to provide a critical understanding of why federal policy has recognized a Treaty right to health in the Treaty 6 context but does not extend beyond that. Having verbal and/or implied treaty promises recognized and implemented (in health and in other areas) has been difficult for many of the Nations that have advocated in these areas.

The conclusion to this report affirms that whether the promise was implied, verbal or explicitly written into the text, the Treaty right to health should be recognized for all of the numbered treaty Nations and all of the descendants of treaty signatories (whether they reside on reserves or not) or have Indian Status or not.

PART 4: SITUATING WELLNESS AND WELL-BEING AS CORNERSTONES OF INDIGENOUS HEALTH?

First Nations indicators of well-being include ensuring continued access to lands and waters, as well as cultural identity (British Columbia Office of the Provincial Health Officer & First Nations Health Authority, 2018). Cultural wellness, including language, medicine/healing, community belonging, and traditional spirituality are important in assessing the overall wellness of First Nations peoples (First Nations Health and Social Secretariat of Manitoba, 2020, p. 25).

From a First Nations perspective, relational connections with all other beings and the environment more generally bring wellness to themselves as individuals, families, nations and to other beings (Craft, 2018). Humans also depend on relationships to live well (*mino-biimaadiiziiwin*). Anishinaabe *inaakonigewin* requires that decision-making and actions be oriented toward *mino-biimaadiiziwin*. *Mino-biimaadiiziwin* is a foundational legal principle aimed at the well-being of all parts of Creation, including future generations (Craft, 2018).

Language is considered essential to the ability to continue to exercise traditional medicines. This, Willie Littlechild argues, is part of what the Treaty right to health is meant to protect:

> Language is critical in terms of the transmission of traditional knowledge, of medicines," adds Littlechild. "We still have elders - in fact my sister is one of them - who practice traditional medicine. She cannot pass that knowledge on to someone in English [.] We have, as you would imagine, specific names for specific herbs and specific use for that herb or medicine in treatment (as cited in Burnham, 2018, para. 17).

In addition, water is seen by many First Nations people as a medicine in the healing process and an important part of holistic health. Therefore, the health of the water has a direct correlation to the health of individuals, their communities and their nations. To many Indigenous people, "[w]ater means health" (Anderson, 2010, p. 7).

In 2005, the Chiefs of Treaties 6, 7 and 8 issued a "Declaration on the Treaty Right to Health" that considered health holistically (encompassing spiritual, mental, emotional and physical health) and included rights to healing and prevention, including traditional health systems. The Declaration stated that Indigenous Peoples' inherent rights to health and healthcare "are recognized by Treaty-making and the Treaties" and include the "traditional health system of Medicine Women and Men, … ceremonies and practices for healing and prevention, … [and] medicines [from] minerals, animals, plants and water, [and] traditional lands and resources" (Treaty No. 6, No. 7 and No. 8 Chiefs, 2005).

Cree scholar Danika Littlechild (2014) explains that health and wellness are integral to the fulfillment of the Treaty as a whole. She reports that the Treaty 6 signatories understood the 'medicine chest' and 'pestilence and famine' clauses to mean that health and wellness "was also tied to the implementation of the rest of the Treaty, respecting lands, territories, waters, resources and continuing our life ways" (pp. 69-70). According to Starblanket and Hunt (2020) in their report *Covid-19, The Numbered Treaties and The Politics of Life*, the understandings of Indigenous signatories to the numbered treaties were based on wellness as interconnected with the rest of life, and that "Indigenous

communities would be able to sustain a high quality of life and an adequate livelihood relative to newcomer populations" (p. 15). Moreover, Indigenous people wished to maintain their pre-existing medical knowledge and practices, whilst learning from newcomer populations.

Health, wellness, and well-being, understood holistically (mind, body, spirit, and emotions), are seen to encompass continued connection with lands and territories, to language and culture, to food sovereignty, and to a continued way of Indigenous life. The Treaty right to health, broadly conceptualized and implemented from a First Nations perspective, would include these multiple dimensions in complement to each other.

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PART 5: TREATY PROMISES RELATING TO HEALTH

The Treaty right to health was confirmed through Treaty negotiations in written and oral form in the following ways: promises of non-interference with an existing way of life, promises of free medicine and medical care, protection against pestilence, famine, sickness and disease, and the more general promise to care for Indigenous people. While the written "medicine chest clause" only appears in the Treaty 6 document, First Nations have long argued that representations and oral promises were made in all of the numbered Treaty negotiations (1871-1912) for the provision of medical services by the Crown to the First Nations citizens (Boyer, 2011; Boyer & Spence, 2015; see also Littlechild, 2014). The Federal Government has acknowledged that "similar verbal undertakings [to the Treaty 6 reference to medicine] were made by treaty commissioners when negotiating Treaties 7, 8, 10, and 11" (Interdepartmental Working Group to the Committee of Deputy Ministers on Justice and Legal Affairs, 1995, p. 13; see also Boyer, 2003). The medicine chest clause only partially reflects the Treaty right to health, but not in the more "fulsome meaning expressed by Indigenous leaders", as implied through oral Treaty commitments (Merrick, 2019).

Courts have recognized that oral versions of the Treaty are equally valid and constitute part of the Treaty. Furthermore, courts have determined that the rights included in the Treaties must adapt and evolve over time. Therefore, the current interpretation of the Treaty right to health must take into account more than the written text of the Treaty and be understood in a modern context of Indigenous health and well-being. Moreover, according to the Assembly of First Nations (AFN, 2006), the Treaty right to health is constitutionally protected and includes health services that are "comprehensive, accessible, fully portable, and provided as

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Courts have recognized that oral versions of the Treaty are equally valid and constitute part of the Treaty. Furthermore, courts have determined that the rights included in the Treaties must adapt and evolve over time. Therefore, the current interpretation of the Treaty right to health must take into account more than the written text of the Treaty and be understood in a modern context of Indigenous health and well-being.

needed on a timely basis without regard to a person's financial status, residence, or the cost of benefit" (p. 1).

At the time of many of the Treaty negotiations, medical care was provided by doctors who accompanied Treaty parties. As many Indigenous knowledge systems are based on demonstration, the demonstrations of providing medical care may have created a reasonable expectation of medical care among First Nations parties, and a connection between medical care and the Treaty (Boyer, 2011). According to Boyer, there were no references in any of the numbered Treaties to First Nations' relinquishment of jurisdiction over health. In Boyer's (2014) view, Treaty protections to medicine, health care and protection continue to exist today.

5.1 The Medicine Chest Clause (Treaty 6)

The medicine chest clause is written into the text of Treaty 6 (1876). It reads:

> That 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.... That in the event hereafter of the Indians comprised within this Treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by Her Indian Agent or Agents, will grant ... assistance of such character or to such extent as the Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians of the calumet that shall have befallen them.

Treaty 6 Nations "have maintained consistently that the medicine chest provision" is a promise for "full medical care … to be provided under their Treaty" (Royal Commission on Aboriginal Peoples, 1996, p. 74). Political columnist Doug Cuthand explains that "This medicine chest clause has been interpreted by our people as universal medical care. The Chiefs who negotiated Treaty 6 told the [Crown's] representatives that they were concerned for the coming influx of settlers and requested that the government provide medical care" (Cuthand, 2017, para. 5).

Lynn Hickey (1976), in her interviews with Treaty Elders of Alberta, stated that "[w]hat was promised is variously referred to as 'doctors', 'medicines', 'hospitals', a 'medicine chest' and

a 'medicine bag', all of which may be translations of the same thing" (p. 12). Hickey continues, "Any elders who discuss the subject, state that Treaty Indians were promised that they would not have to pay for doctors, hospitalization, medical services, however it is stated, and feel this is the other area in which promises were broken" (pp. 12, 14-15). Hickey further stated that the Indigenous interpretation of a medicine chest, as provided for in Treaty 6, "includes everything in the area of medical care [and] medical services" (p. 12), and encompasses access to traditional medicines (Merrick, 2019, p. 16).

The Maskwacis Cree Nation (2018) has submitted to the United Nations Expert Mechanism on the Rights of Indigenous Peoples that the Treaty right to health in the Treaty 6 medicine chest clause is related to services, medicines, and supplies. They also linked the famine and pestilence clause to the right to food security and food sovereignty and the protection against "chronic diseases, outbreaks, epidemics and other similar health matters" (p. 6). Their submission concluded with seven recommendations – the first being that Treaty violations by way of federal policy be remedied. This includes remedying the breach of the Treaty right to health. The Maskwacis Cree stated further that policy changes be "developed in full and equitable partnership with Indigenous Peoples, and through mechanisms that have Indigenous representatives and the capacity to address Treaty matters" (p. 33).

In the 1935 *Dreaver* case, the federal court found that the medicine chest clause in Treaty 6 meant that all medicines, drugs or medical supplies were to be supplied free of charge to "Treaty Indians" (*Dreaver et al v. the King*, 1935). However, the Federal Government continues to deny that it has a responsibility to ensure a Treaty right to health.

In 1997/1998, the Office of Treaty Commissioner brought together the Government of Canada, the Province of Saskatchewan, and the Federation of Saskatchewan Indian Nations "to outline the respective parties'

understandings of [T]reaty rights to health in the modern context and understanding of" Treaties (Boyer, 2014). (Boyer, 2014). According to Boyer (2014), the Federation of Saskatchewan Indian Nations stated that Treaties "provided us [the Treaty signatories] with a shared future, … prevented war and guaranteed peace, … defined and shaped relations between nations through enduring relations of mutual respect, and … guaranteed the shared economic bounty of … lands" (p. 153).

In response, the Federal Government reportedly expressed that Treaties were intended to "endure into the future", are fundamental to the relationship between Canada and Treaty First Nations, and are guides for future relationships between First Nations and other Canadians (Boyer, 2014, p. 153). The Federal Government further recognized "that, by doing justice to the Treaties, it may honour the past and enrich the future" (Boyer, 2014, p. 153).

In 2007, the Federation of Saskatchewan Indian Nations (FSIN) passed a resolution to accept a set of Treaty Implementation Principles, which outline the responsibility of the Crown to implement the Treaty right to health through the medicine chest clause of Treaty 6 (Boyer, 2014). The resolution stated that the Treaty signatories did not agree to give up the land, and the written text of the Treaty relating to ceding and surrendering are contrary to what occurred at the Treaty negotiations (FSIN, 2007). According to Boyer (2014), the resolution adds that the "word *witaskiwin* was used in the negotiations when describing the accord relating to land. *Witaskiwin* means sharing or living together on the land" (FSIN, 2007, p. 152). Therefore, according to the resolution, First Nations intended to share the land, and in exchange, "the Crown undertook to provide assistance in a number of areas including education, health and medicine, economic independence, hunting, fishing, trapping, gathering, annuities, agriculture, prohibition of liquor, exemption from taxes and conscription" (Boyer, 2014, pp. 152-153). According to the Federation of Saskatchewan Indian Nations, the medicine

chest clause is understood in the contemporary contexts of comprehensive health coverage and assistance in emergencies, including pandemics and floods. In the 2007 resolution, the FSIN reportedly stated that the Treaty's spirit and intent necessitates that "the written terms must be interpreted to reflect changes with the progression of time" (Boyer, 2014, p. 153). Moreover, the resolution reportedly stipulates that "the medicine chest clause means a comprehensive type of health and medical coverage to supplement First Nations health and medicine" and the "pestilence and famine clause in the modern-day context would mean assistance in times of extraordinary circumstances such as diseases, pandemic and floods" (Boyer, 2014, p. 153).

In order to achieve self-determination in health and improve health outcomes, Treaty 6 First Nations across Alberta, Saskatchewan, and Manitoba proposed a health system that is autonomous from the Federal Government. In 2008, they proposed a system based on First Nation-run hospitals, where patients could access western and First Nation medicine, based on Treaty promises for full health care coverage (Boyer, 2014).

5.2 The Other Numbered Treaties

Although the Treaty 6 medicine chest clause is the basis of the Treaty right to health (Lux, 2016), it is also derived from the oral negotiations in Treaties 1, 2, 3, 4, 5, 7, 8, 7, 10, 11 (Lavoie et al., 2016; Merrick, 2019). Although a "plain text" reading of these Treaties suggests that the Crown's commitment to medical service and aid is limited to Treaty 6, such commitments were significant aspects of other Treaties, albeit orally. Moreover, commitments by the Crown during Treaty negotiations of the numbered Treaties affirm its promises to ensure that Indigenous people would "live well into the future" (Starblanket & Hunt, 2020). While other Treaties did not have medicine chest clauses explicitly written into their text, many have argued that the Treaty promises made at multiple negotiations effectively confirm a Treaty right to health as part of the oral agreements, either:

a. explicitly or through conduct;

b. linked to the expressed promise to ensure wellness;

c. tied to the non-interference with existing ways of life; and

d. tied to promises to safeguard against disease (see Boyer, 2011).

For example, at the outset of the numbered Treaty negotiations in 1871, Treaty Commissioner Archibald stated that Queen Victoria, the "Great Mother," wanted the Indian people to be "happy and contented … [and] live in comfort ... [and] make them safer from famine and distress" as well as to "live and prosper" (Morris, 1880, p. 28; see also Boyer, 2011).

Lavoie et al. (2016) provide an overview of provisions for continued health of Treaty First Nations as secured by the Indigenous negotiators of the numbered Treaties. They argue that the Treaties "make varying healthcare-related commitments to signatories," with only Treaty 6 having a written medicine chest clause (p. 68). They categorize commitments as: medicine chest clause, implied commitments, or verbal commitments that are not included in the Treaty text.

The Truth and Reconciliation Commission of Canada found that numerous Treaties included obligations relating to health and wellness (TRC, 2015c). For example, the TRC found that the right to medical care is not limited to what was enshrined in Treaties 6, 7, 8, 10, and 11, as the "Treaty negotiations included many references 'to the protection of, and non-interference with,

traditional ways of life,' which encompasses Aboriginal health" (p. 176). The TRC also found that the historic Treaties created international law obligations regarding Aboriginal health and wellness.

In her Master of Laws thesis, *Innovations in First Nations Health: Exploring the Effects of Neoliberal Settler Colonialism on the Treaty Right to Health*, Merrick (2019) takes an even broader view of the medicine chest clause, applying it to all Treaties and equating it with the delivery of programs by Health Canada. She finds that the medicine chest clause comes from the written interpretation of Treaty 6, and from the oral negotiations of Treaties 1, 2, 3, 4, 5, 7, 8, 9, 10, and 11 (see also Lavoie et al., 2016). Merrick states further that the medicine chest clause "has been translated to equate the receipt of health care services by Treaty First Nations from the Federal [G]overnment on behalf of the Crown. For Treaty First Nations this occurs, in part, via the Non-Insured Health Benefits (NIHB) program administered by Health Canada" (p. 2). According to Merrick, the Indian Association of Alberta (IAA) highlights the "principle of equal treatment" amongst all numbered Treaty areas that was applied throughout negotiations (pp. 15-16). The IAA report on Indian Health Care states, "We must derive from this statement that all the numbered Treaties across Canada were actually to be taken in context of each other and to be considered one complete agreement between the Indians of Canada and the Federal Government" (IAA, 1979, p. 5). "Therefore, what is negotiated and written into the textual interpretation of Treaty [6 adheres to the other Treaties], and vice versa, where oral promises were exchanged" (Merrick, 2019).

In addition, many Treaty Elders and Knowledge Keepers' understandings encompass an inherent and Treaty right to livelihood in perpetuity (Merrick, 2019). In this context, livelihood can be understood as "living good reciprocal relations with all living things," which "contributes to a holistic understanding of individual and communal health" (Merrick, 2019). In 2008, a Treaty Conference hosted by the Assembly of First Nations summarized that Treaties were negotiated "... to allow each people to pursue their ways of life in peace and friendship in this land without fear or threat of domination or subjugation by the other" (AFN, 2008, p. 14).

Treaty First Nations emphasize the aspect of relationality stemming from the course of Treaty negotiations. From this perspective, "the Treaty right to health is a lived extension of a relationship with all of [C] reation", and includes "relations with human and non-human parties in Treaty" (Merrick, 2019). The relational aspect of the Treaty stems from the Indigenous legal orders actively invoked in the negotiations. These legal orders base the Treaties on access to "healthy lands, waters, medicines, and food sustenance which substantiates livelihood and are essential for good health" (Merrick, 2019, p. 4).

PART 6: CONSTITUTIONAL PROTECTION OF TREATY AND ABORIGINAL RIGHTS TO HEALTH

Part 5 (above) outlined the promises that were made as part of making treaties. However, the implementation of those promises has been a contentious issue, especially as it relates to natural resources, education and health. This section provides an overview of the constitutional protection of treaty rights, treaty implementation cases, and the legal context for the recognition of a Treaty right to health.

Aboriginal and Treaty rights are constitutionally protected rights under Section 35 of Canada's *Constitution Act, 1982*. According to Boyer (2003), the connection made between medical care and Treaty making engages a fiduciary duty on the part of the Federal Government and affirms both an inherent Aboriginal right to health (stemming from traditional approaches to health) and a Treaty right to health (flowing from the exchange of promises) (pp. 321-322). She argues that the 1935 case of *Dreaver et al v. the King* (elaborated on below) sets a precedent on the federal obligation to provide Treaty First Nations with healthcare. The case stands for the Treaty 6 medicine chest clause to be interpreted as an obligation on the Crown to supply medical supplies to "Treaty Indians" free of charge (*Dreaver et al v. the King*, 1935; Boyer, 2014). The following subsections discuss the legal nature of obligations that flow from the treaty promises (discussed above), provide a review of the relevant cases, and briefly discuss an Aboriginal right to health as a right complimentary to the Treaty right to health.

6.1 Treaty Rights

As discussed in sections above, the Supreme Court of Canada has held that "Treaties entrench a legal relationship between the Crown and Indigenous Nations with the intent to create obligations" (Boyer & Spence, 2015). "These obligations derive from the intent and context of the Treaty negotiations" (Boyer & Spence, 2015). Moreover, the Supreme Court of Canada has ruled that both the written record from the Canadian government perspective and the Indigenous oral account must have equal weight.[4]

According to the Assembly of First Nations (2008), the true meaning, spirit and intent of Treaties are found in the oral history of the Treaties and Treaty commitments. However, full and proper Treaty implementation is barred by representatives to the Crown, who "undermine and distort the original commitments and the true spirit and intent of Treaties reflected in the respective oral histories" (AFN, 2008, p. 14).

The Supreme Court of Canada has recognized this failure to understand Aboriginal-Crown Treaties meaningfully or completely (Craft, 2014). In the case of *Mitchell v. Peguis Indian Band* (1990), the Supreme Court of Canada found that "Canadian society at large … bears the historical burden of the current situation of native peoples and, as a result, the liberal interpretive approach applies to any statute relating to Indians, even if the relationship thereby affected is a private one" (para 99). The Court stated further that there exists "an appreciation of societal responsibility and a concern with remedying disadvantage, if

4 See *R v Marshall*, [1999] 3 SCR 456 para 78; *R v Sundown*, [1999] 1 SCR 393 at para 24; *R v Badger*, [1996] 1 SCR 771 at para 76; *Mikisew Cree First Nation v Canada (Minister of Canadian Heritage)*, [2005] 3 SCR 388 at para 29.

only in the somewhat marginal context of Treaty and statutory interpretation" (*Mitchell v. Peguis Indian Band*, 1990, para 99).

Courts have recognized the importance of looking at Indigenous oral histories when interpreting Treaties. In interpreting the terms of a Treaty, the Supreme Court has recognized that "...verbal promises made on behalf of the Federal Government at the times the Treaties were concluded are of great significance in their interpretation" (*R. v. Badger*, 1996, para 55; see also Starblanket & Hunt, 2020). Furthermore, Treaties are said to represent, "an exchange of solemn promises between the Crown and Aboriginal Peoples," no "sharp dealings" are to be sanctioned, and any ambiguities "must be resolved in favour of [Indigenous parties to Treaty]" (Starblanket & Hunt, 2020, p. 19). "Finally, Treaties must be understood in light of historical and cultural context, and with adequate regard for extrinsic evidence such as oral accounts, and must be interpreted in a way that is consistent with the interests of the parties to the Treaty at the time of negotiation" (Starblanket & Hunt, 2020; *R. v. Marshall*, 1999).

The Supreme Court of Canada issued a list of Treaty interpretation principles in the *Marshall* decision. These principles are:

1. Aboriginal Treaties are unique agreements and attract special interpretation;
2. They must be liberally construed, and ambiguities resolved in favour of Aboriginals;
3. They are meant to best reconcile the interests of both parties at the time the Treaty was signed;
4. Integrity and the honour of the Crown are presumed in Treaty negotiations;
5. Treaty words must be given the meaning that they would naturally have held for the parties at the time;
6. Interpretation must be sensitive to unique cultural and language differences between the parties at the time;
7. Technical or contractual interpretation should be avoided;
8. Courts cannot alter the terms of a Treaty by exceeding what is possible through the language; and
9. Treaty rights must not be interpreted statically. (*R. v. Marshall*, 1999, para 78)

They are not always implemented in practice, however; nor are they always reflected in judgements (*R. v. Marshall*, 1999; Starblanket & Hunt, 2020; Rotman, 1997). Implementing them would allow for an interpretation based in the context of "historical ceremonies and the assurances of friendship and brotherhood and the Queen's concern for her [Indigenous] subjects which were such a prominent feature of the historical Treaty negotiations" (Boyer, 2011, p. 319). Moreover, the interpretation would not be based "only in cultural and historical terms, but within the context of a modern and ever-changing Canada" (Boyer, 2011, p. 319).

6.2 Cases Law and Judicial Interpretation

There are only a handful of cases that have considered the Treaty right to health. Most of them relate to Treaty 6 and the medicine chest clause. The majority were decided prior to the enactment of Section 35 of the *Constitution Act, 1982*, hence prior to the constitutional protection of Treaty and Aboriginal rights and prior to the *Charter of Rights and Freedoms* that requires non-discrimination by all governments.


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The Crown argued that based on the terms of the Treaty, it had discretion over which supplies would be given to the Band free of charge. The Court took a broad approach to Treaty interpretation and found that the medicine chest clause in Treaty 6 meant that all medicines, drugs, or medical supplies were to be supplied free of charge to "Treaty Indians" (Dreaver et al v. the King, 1935).

6.2.1 Treaty 6 and the Medicine Chest

Dreaver et al v. the King (1935), C.N.L.C. Ex. Ct.

Dreaver was the first case to interpret the medicine chest clause. George Dreaver, Chief of the Mistawasis Band on the Mistawasis Reserve, and two others sought to be reimbursed by the Crown for amounts they claimed had been deducted from the Band. These amounts included medicines, medical supplies, and drugs, which Chief Dreaver argued should have been covered by the Crown in light of the medicine chest provision in Treaty 6. The Crown argued that based on the terms of the Treaty, it had discretion over which supplies would be given to the Band free of charge. The Court[5] took a broad approach to Treaty interpretation and found that the medicine chest clause in Treaty 6 meant that all medicines, drugs or medical supplies were to be supplied free of charge to "Treaty Indians" (*Dreaver et al v. the King,* 1935). Moreover, the Court found that the Crown did not have discretion to choose which medicines, drugs and medical supplies it would cover. According to Yvonne Boyer (2014), *Dreaver* sets a precedent on the federal obligation to provide Treaty First Nations with health care.

R v. Johnston (1965 or 1966)[7]

Dreaver was followed in R. *v. Johnston* (*Johnston*), where Mr. Johnston was charged for failing to pay a hospital tax. Mr. Johnston argued that he was exempt from payment pursuant to the *Saskatchewan Hospitalization Act*, *1953*, under which persons were exempted from such payments if they were eligible to receive "general hospital services from the federal government"

[5,6] The Exchequer Court of Canada was the predecessor to the current Federal Court of Canada.
[7] The citation of the lower-level decision is not referred to by the appellate court.

(Saskatchewan Gazette, 1962). The Magistrate was reported to have stated that:

> the "medicine chest" clause and the "pestilence" clause in Treaty No. 6 should properly be interpreted to mean that the Indians are entitled to receive all medical services, including medicines, drugs, medical supplies and hospital care free of charge.
> *(R v Johnston, 1966, para 6, citing the Magistrate's court decision)*

R v. Swimmer (1970)[8]

In R. *v. Swimmer* (*Swimmer*), Mr. Swimmer was charged with failing to pay hospitalization tax pursuant to the *Saskatchewan Hospitalization Act* (similar to *Johnston*) and with failing to pay a medical care premium. Exceptions existed for persons entitled to have payments covered in their entirety by the Federal Government. The Magistrate found Mr. Swimmer to be an Indian within the meaning of the *Indian Act*, and that the medicine chest clause in Treaty 6 applied to Mr. Swimmer. The lower court judge found that the medicine chest clause "should be interpreted to mean that all Indians to whom the said Treaty applies are entitled to receive all medical services, including medicine, drugs, medical supplies and hospital care, free of charge" (R. *v. Swimmer,* 1970, para. 7).

Reversal of Johnston and Swimmer

Both *Johnston* and *Swimmer* were reversed on appeal. The appellate court in *Swimmer* stated that the plain and ordinary meaning of 'medicine chest' meant no more than the words clearly conveyed: "An undertaking by the Crown to keep at the house of the Indian agent a medicine chest for the use and benefit of the Indians at the direction of the agent" (R. *v. Swimmer,* 1970, para 12). The Court stated further that "[t]he clause itself 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]…" (R. *v. Swimmer,* 1970, para 12). This is a more restrictive approach and is contrary to the court's broad interpretation in *Dreaver*. The decisions issued after 1982 by the Federal Court and the Saskatchewan Queen's bench take a more liberal and contemporary approach to the interpretation of the Treaty 6 clauses, confirming the earlier decision in *Dreaver* that applying the principle of contemporary context could require "a full range of contemporary medical services" (*Wuskwi Sipihk Cree Nation v. Canada,* 1999, para 14).


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[8] There is no reference to the citation information for the magistrate's court decision in Swimmer in the appellate court decision.

Wuskwi Sipihk Cree Nation v. Canada (Minister of National Health and Welfare) [1999] F.C.J. No. 82

In *Wuskwi Sipihk Cree Nation v. Canada,* the federal court referred to *Nowegijick v The Queen* as the authority for Treaties being "liberally construed and doubtful expressions resolved in favour of the Indians" (*Wuskwi Sipihk Cree Nation v. Canada*, 1999, para. 13). The court also referred to *Sparrow* as an authority for interpreting rights in a flexible manner "in order to permit the evolution," as opposed to adopting a "frozen rights" approach where the right in issue is interpreted rigidly within the confines of that concept at the time the Treaty was signed (*Wuskwi Sipihk Cree Nation v. Canada* , 1999, para. 12). Moreover, the court upheld *Dreaver* and found that the Saskatchewan Court of Appeal was incorrect in its approach in *Johnston*, stating:

> Mr. Justice Angers took a proper approach in his 1935 decision in *Dreaver*, reading the Treaty No. 6 medicine chest clause in a contemporary manner to mean a supply of all medicines, drugs and medical supplies. Certainly, it is clear that the Saskatchewan Court of Appeal took what is now a wrong approach in its literal and restrictive reading of the medicine chest clause in the 1966 decision in *Johnston*. In a current context, the clause may well require a full range of contemporary medical services *(Wuskwi Sipihk Cree Nation v. Canada,* 1999, para. 14*).*

It could thus be argued that the finding of the Saskatchewan Court of Appeal in *Johnston* is no longer valid law and that *Dreaver* should be followed.

Duke v. Puts, [2001] S.J. No. 156

Duke v. Puts [2001] was a defamation case. The plaintiff brought a claim regarding defamatory statements that had been made alleging that the plaintiff had made excess profits from the 'medicine chest' privileges enjoyed by First Nations people in Treaty 6 territory. Although this case does not engage in the interpretation of the clause, the court does refer to it, and Justice Kyle reflects interpretive principles in the context of the medicine chest clause found in *Dreaver* and *Wuskwi Sipihk Cree Nation v. Canada* . The Justice states that:

> In *Dre[a]ver v. the King* (1935), Ex. Ct. (unreported) Mr. Justice Angers opined that "The Indians were to be provided with all the medicines, drugs or medical supplies which they might need, entirely free of charge." This broad interpretation of the medicine chest clause has drawn adverse comment, notably from the Saskatchewan Court of Appeal in *R. v. Johnston* (1966), 56 D.L.R. (2d) 749 but with the broad interpretation applied by the courts since the 1982 Charter of Rights and Freedoms, generous provision of the medicines, drugs and medical supplies free of charge has been the policy of the governments involved *(Duke v. Puts,* 2001, para. 2).

In sum, the current state of the law indicates that the Treaty 6 right to health means that all medicines, drugs or medical supplies are to be supplied free of charge to "Treaty Indians," as was originally decided in the 1935 *Dreaver* case.

6.2.2 Treaty 5 and the Treaty Right to Health

The Treaty right to health has not been successfully argued outside of the Treaty 6 context. In the context of Treaty 5, the court did not find against the right; it simply found that there were not enough facts to prove the right.

Norway House Cree Nation (Re), [2008] M.L.B.D. No. 30

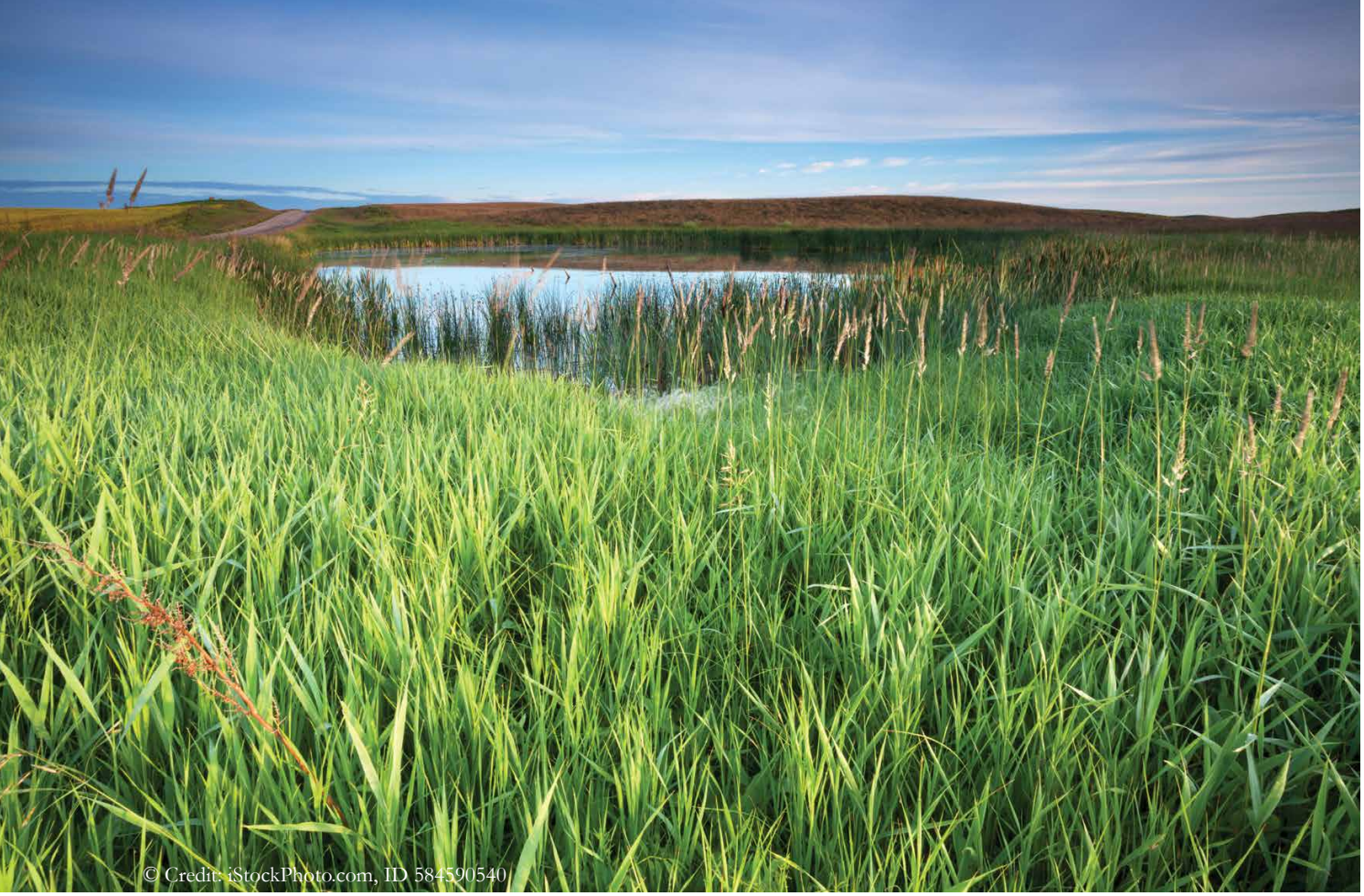
While testifying in this labour case, then Chief Balfour stated that "he felt that the federal government was obligated to provide health services to Norway House Cree Nation pursuant to the Treaty, and that he would consider a failure [by] the federal government to provide funding to constitute a breach of Treaty 5" (*Norway House Cree Nation (Re),* 2008, para. 9). However, the Manitoba Labour Board was not satisfied that a Treaty right to health care was proved, based on the fact that Treaty 5, to which the applicant First Nation was signatory, did not contain any expressed or implied references to health care (*Norway House Cree Nation (Re),* 2008, paras. 31, 105). The court came to this conclusion because of the lack of a comprehensive evidentiary foundation regarding Treaty right to health in Treaty 5 (*Norway House Cree Nation (Re),* 2008, para. 105).[9]

6.3 Aboriginal Rights

Aboriginal rights are another form of constitutionally protected right which reflect the practices, customs, and traditions of Indigenous Peoples. While an Aboriginal right to health, that is the constitutional protection of pre-contact practices relating to health, should be considered in context and connection with Treaty rights, this is not the focus of this report. Section 35 confirms that anyone who possesses Treaty rights also possesses Aboriginal rights, so long as these rights are not extinguished or modified by Treaty. "[W]hen properly understood, [these] constitutional rights impose certain obligations on … federal, provincial, and territorial governments" (Boyer, 2003; Macklem, 2001).

The practices of medicine, healing, and preventative health measures have comprised vital or integral parts of distinctive Aboriginal communities, or are of central significance to that community. They are passed down from generation to generation in various forms, and are still in existence today in modified forms (Macklem, 2001). These practices

[9] It appears that the evidence mostly consisted of Chief Balfour's testimony and academic articles. It is noted at para. 105 that it was not economically feasible to have an expert testify.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may be considered as Aboriginal rights, as they are linked to practices, customs and traditions that are integral to Indigenous groups and date back prior to European contact.

According to Boyer (2011), the application of principles coming from *Sparrow, Van der Peet,* and *Sappier & Gray* may help shape an Aboriginal right to Aboriginal health. In *Sparrow,* the Supreme Court of Canada stated that the interpretation of Aboriginal cultures must be done in a sensitive manner, respecting the way that Aboriginal peoples view their rights (Macklem, 2001; *R v Sparrow*, 1990, para. 1119). Boyer (2011) also argues that in accordance with the test established in the case law, the Aboriginal right to health exists, was never extinguished, and continues to be infringed by governments without justification (pp. 283-284).[10] This issue can be further understood in the literature, including by reading Boyer's 2011 thesis, *First Nations, Métis and Inuit Health and the Law: A Framework for the Future.*

[10] For a deeper analysis of these tests, see Boyer, Y. (2011), Chapter 7.

PART 7: DENYING THE TREATY RIGHT TO HEALTH

The full scope of the Treaty right to health has been the subject of dispute amongst the Treaty parties. As indicated above, the medicine chest clause and oral commitments to medical service and aid translate differently between the Federal Government and Treaty First Nations. Treaty Nations say that health care, medicines, and more are included. The Federal Government's policy is more in line with a "first aid kit" or box of medicines approach. According to Boyer (2011), "[t]his policy disagreement has never been fully resolved, either by court rulings, or by substantive realignment in federal and provincial health policies so a 'Treaty right to health' is given a new, modern meaning in keeping with the original intent" (p. 317).

7.1 The Federal Policy

The following chart indicates how First Nations and the Federal Government maintain different understandings of Treaties (Boyer, 2011, p. 317).

First Nations	Federal Government
Sacred Promises	Contracts
Land sharing agreements between two sovereign nations that established a permantent relationship	Land surrender agreements whereby First Nations ceded their territories to the Crown
The spirit and intent of the treaties are what is most important, including all the oral commitments and not necessarily in the English	Written contractual text is what is most important

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Merrick (2019) argues that the Federal Government's premise is that medical services do not flow from legal obligations from numbered Treaty provisions, but are from "benevolent efforts of early government" (p. 12; see also AFN, 2006; Boyer, 2011; Lavoie et al., 2016; Lux, 2016). This approach is based on a reliance on the written scope of Treaty negotiations. Canada takes the position that only stipulations confirmed by the written version of Treaty contained in documents of the Queen's Printer are considered to be formal "articles of Treaty" (Cardinal & Hildebrandt, 2000; Merrick, 2019). The Federal Government has taken the position that "there is no constitutional obligation or Treaty that requires the Canadian government to offer health programs or services to Aboriginal Peoples" (Commission on the Future of Health Care in Canada, 2002, p. 212).

While both "the federal government and the Saskatchewan First Nations recognized that the Treaties are a foundation for future relations through ongoing Treaty discussions," (Boyer, 2011, p. 315), the Royal Commission on Aboriginal Peoples (1996) report found that it is "indisputable, however, those existing Treaties have been honoured by governments more in the breach than in the observance" (p. 3).

Chief Wilton Littlechild explains that the "government has been woefully, in my view, and I would also say deliberately, violating that Treaty clause" (as cited in Burnham, 2018, para. 6).

Many First Nations continue to advocate for a direct Nation-to-Nation relationship with the federal government. While the Provinces have some role to play in service delivery, this report explores the Treaty right to health, as a legal obligation, which binds the federal government as a representative Treaty partner in the numbered treaties.

7.2 Provinces and the Treaty Right to Health

The Federal Government was the party responsible for the making of the Treaty relationship. It also holds constitutional responsibility for Indians and lands reserved for Indians under the *Constitution Act, 1867*, which confirms the division of powers between the Federal Government and the provinces.

Historically, "Indians and lands reserved for Indians" has been an exclusive federal jurisdictional power. However, the Provinces, as a part of "the Crown," also have obligations to ensure that Treaty and Aboriginal rights are not unjustifiably infringed.

In recent Supreme Court of Canada decisions, specifically with respect to Section 35 on Treaty and Aboriginal rights, the courts have set aside the doctrine of interjurisdictional immunity. The doctrine of interjurisdictional immunity protects certain jurisdictions of the federal government from any provincial interference.

Provinces are responsible for some health services for Indigenous people who do not reside on reserves and/or are non-status or Métis. Because the provinces are responsible for health within the province and are part of the Crown, an argument may thus be made that the provinces have corresponding obligations to implement the Treaty right to health. Some have argued that the Treaty right to health should not exclude those who reside off their home reserves or those who are Treaty descendants, but do not have Indian Status. Issues of jurisdiction and federal/provincial cooperation have been discussed in previous National Collaborating Centre for Indigenous Health reports (see for example, National Collaborating Centre for Aboriginal Health, 2011; Halseth & Murdock, 2020).

PART 8: THE TREATY RIGHT TO HEALTH IN THE CONTEXT OF NATION-TO-NATION RELATIONSHIPS AND RECONCILIATION

According to the Truth and Reconciliation Commission of Canada, reconciliation is rooted in "the establishment and maintenance of mutually respectful relationships" (TRC, 2015b, pp. 11-12). The Legislative Assembly of Manitoba (2016) has adopted this same definition of reconciliation in its *Path to Reconciliation Act*. This requires, amongst other things, the recognition of Indigenous self-determination and Indigenous legal orders (Borrows, 2010). It necessitates the implementation of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which the TRC names as the framework for reconciliation, and calls for real societal change (Legislative Assembly of Manitoba, 2016). All of this requires the recognition and implementation of the Treaty right to health.

8.1 The Truth and Reconciliation Commission of Canada

In its Calls to Action, the TRC (2015a) deplored the state of Aboriginal health in Canada. It called on various levels of governments to acknowledge the link between the state of Indigenous health and previous (and ongoing) policies, and to implement Indigenous rights to health, including in the Treaties as well as in constitutional and international law. The TRC's 10 principles of reconciliation support the full recognition of the Treaty right to health (TRC, 2015d, pp. 3-4). These include five in particular. First, Indigenous people are self-determining and Treaty rights (along with human rights and constitutional rights) must be recognized and respected. Second, UNDRIP is the framework for reconciliation at all levels and across all sectors of Canadian society (this will be discussed further below). Third, addressing the legacy of colonialism, including in health, requires constructive action. Fourth gaps in health outcomes between Indigenous and non-Indigenous peoples is required for reconciliation and a more equitable and inclusive society. Fifth, political will, joint leadership, trust building, accountability, and transparency, as well as a substantial investment of resources, are required.

8.2 The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)

In May 2016, Carolyn Bennett, Minister of Indigenous and Northern Affairs, officially endorsed UNDRIP at the United Nations Permanent Forum on

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Indigenous Issues (Bennett, 2016). This distinguished the government of the day from the previous government's position, which held that UNDRIP was aspirational and not legally binding. Canada declared that it plans to fully implement UNDRIP, and introduced legislation to this effect in December 2020.[11] While the full impact of UNDRIP is somewhat uncertain in domestic law and policy,[12] it is likely to influence the interpretation and implementation of Section 35 of the Constitution, Treaties, and Indigenous laws.[13] At writing, the House of Commons (2020) had passed Bill C-15, *An Act Respecting the United Nations Declaration on the Rights of Indigenous Peoples*.

The TRC recommended UNDRIP as the framework for reconciliation. In its preamble, UNDRIP considers that "Treaties, agreements and other constructive arrangements, and the relationship they represent, are the basis for a strengthened partnership between Indigenous peoples and States" (United Nations General Assembly, 2007). Article 37 provides for the right of Indigenous peoples to "recognition, observance and enforcement of Treaties, agreements and other constructive arrangements concluded with States or their successors and to have States honour and respect such Treaties, agreements and other constructive arrangements." Furthermore, UNDRIP provides for the recognition of rights to health for Indigenous peoples, including the improvement of health (Article 21); the right to develop and administer health programs (Article 23); the right to traditional medicines and health practices, the right to access health services without discrimination, and a right to equal enjoyment of the highest attainable standard of physical and mental health (Article 24). For a more detailed analysis of international obligations and instruments supporting the Treaty right to health, please refer to the Maskwacis Cree Nation's 2018 submission to the Expert Mechanism on the Rights of Indigenous Peoples Study on the Right to Health and Indigenous Peoples.

[11] See Bill C-15: https://parl.ca/DocumentViewer/en/43-2/bill/C-15/first-reading.
[12] See for example Lightfoot (2017).
[13] For an extensive review of perspectives on UNDRIP implementation, see the edited volume by the Centre for International Governance and Innovation edited by Borrows et al. (2019).

PART 9: CONCLUSION

The Treaty right to health has yet to be fully implemented. The Federal Government has accepted responsibility for First Nations people on reserves through policy, but has yet to recognize a Treaty obligation or the sacred nature of the promises made in the treaty negotiations. However, many of the modern Treaties and self-government agreements include health and wellness provisions, as well as Indigenous control over health care services (TRC, 2015c).

The numbered Treaties contain various written and oral promises to the Treaty right to health. Treaty 6 has the medicine chest and pestilence clauses, and from the record we are able to see that other Nations that agreed to make Treaties were promised the same. In other numbered Treaties, implied or verbal commitments included promises of non-interference with an existing way of life, promises of free medicine and medical care, protection against pestilence, famine, sickness and disease, and the more general promise to care for Indigenous people. These promises are still considered by the descendants of Treaty Nations to be sacred obligations made in the context of building relationships.

The Supreme Court of Canada has developed a robust set of Treaty interpretation principles which must guide the understanding of the Treaty right to health. Treaties are solemn promises and any ambiguity must be resolved in favour of First Nations. In a contemporary context, this requires the full recognition and implementation of the Treaty right to health for all descendants of historic numbered Treaties. Some have argued that the Treaty right to health should not exclude those who reside off their home reserves or those who are Treaty descendants but do not have Indian Status. Unfortunately, the current federal policy relating to health services for First Nations often excludes them from obtaining federally funded services.

Health and wellness are integral to the fulfillment of the Treaty as a whole and are "tied to the implementation of the rest of the Treaty, respecting lands, territories, waters, resources and continuing our life ways" (Littlechild, 2014, pp. 69-70).

In addition to the recognition of the Treaty right to health, the implementation of this right requires that Indigenous understandings of health be prioritized. For example, overall frameworks of well-being and the Indigenous determinants of health (including access to language, culture and local foods) must be considered as part of a holistic approach to implementing the right. Ceremonies and practices for health and prevention must be part of the strategies for implementation (as may compliment the western medical practices that are often advocated for as part of the rights implementation agenda). Health and wellness are integral to the fulfillment of the Treaty as a whole and are "tied to the implementation of the rest of the Treaty, respecting lands, territories, waters, resources and continuing our life ways" (Littlechild, 2014, pp. 69-70).

Treaty understandings must evolve and adapt to modern circumstances. In addition, the current twin imperatives of reconciliation and self-determination must inform the recognition of the Treaty right. In its Principles Respecting the Government of Canada's Relationship with Indigenous Peoples, the Federal Government asserted that: "…treaties, agreements, and other constructive arrangements between Indigenous Peoples and the Crown have been and are intended to be acts of reconciliation based on mutual recognition and respect" (Department of Justice, 2018, Sect. 5). In sum, while there are strong arguments to make to support the assertion of the Treaty right to health in Canada, the culture of denial through federal policy means that it remains to be recognized and implemented.

RESOURCES

Reports

Starblanket, G. & Hunt, D. (2020). *Covid-19, the numbered treaties & the politics of life, special report.* Yellowhead Institute. https://yellowheadinstitute.org/wp content/uploads/2020/06/yi-special-report-covid19-and-Treaties.pdf.

Morris, A. (1880). *The Treaties of Canada with the Indians of Manitoba and the Northwest Territories, including the negotiations on which they were based and other information relating thereto.* Belfords, Clarke.

Maskwacis Cree Nation. (2018). S*ubmission of the Maskwacis Cree to the Expert Mechanism on the Rights of Indigenous Peoples Study on the Right to Health and Indigenous Peoples with a focus on children and youth*. https://www.ohchr.org/Documents/Issues/IPeoples/EMRIP/Health/MaskwacisCree.pdf

Articles

Boyer, Y. & Spence, S. (2015). Identifying and advancing the treaty rights to health signed from 1871 and 1906 in Manitoba. *Revue Française D'Études Américaines, 144*(3), 95-108.

Theses

Merrick, R. (2019). *Innovations in First Nations health: Exploring the effects of neoliberal settler colonialism on the treaty right to health* [Unpublished Master's thesis]. University of Victoria.

Boyer, Y. (2011). *First Nations, Métis and Inuit health and the law: A framework for the future* [LLD thesis], University of Ottawa

REFERENCES

Anderson, K. (2010). *Aboriginal women, water and health: Reflections from eleven First Nations, Inuit, and Metis grandmothers.* Atlantic Centre of Excellence for Women's Health & Prairie Women's Health Centre of Excellence.

Assembly of First Nations [AFN]. (2006). *Your health benefits: A First Nations guide to accessing non-insured health benefits*. https://www.ntassembly.ca/sites/assembly/files/10-05-20td59-165.pdf

Assembly of First Nations [AFN]. (2008). *As the sun shines: AFN-Canada treaty implementation conference, Draft conference report*. https://www.afn.ca/uploads/files/aga2013/08-04-30_draft_treaty_conference_report.pdf

Bennett, C. (Hon.) (2016). Announcement of Canada's support for the United Nations Declaration on the Rights of Indigenous Peoples. (Statement delivered at the 15th session of the United Nations Permanent Forum on Indigenous Issues. *Northern Public Affairs*, May 10. www.northernpublicaffairs.ca/index/fully- adopting-undrip-minister-bennetts-speech/

Borrows, J. (2010). *Canada's Indigenous constitution.* University of Toronto Press.

Borrows, J., Chartrand, L., Fitzgerald, O. E., & Schwartz, R. (eds.). (2019). *Braiding legal orders: Implementing the United Nations Declaration on the Rights of Indigenous Peoples.* Centre for International Governance and Innovation.

Boyer, Y. (2003). Aboriginal health: A constitutional rights analysis. *Discussion paper series in Aboriginal health: Legal issues*, 1. National Aboriginal Health Organization. https://senatorboyer.ca/wp-content/uploads/2020/09/Constitutional-Right-No.1.pdf

Boyer, Y. (2011). *First Nations, Métis and Inuit health and the law: A framework for the future* [Unpublished LLD Thesis]. University of Ottawa.

Boyer, Y. (2014). *Moving Aboriginal health forward: Discarding Canada's legal barriers.* Purich Publishing Limited.

Boyer, Y., & Spence, S. (2015). Identifying and advancing the Treaty rights to health signed from 1871 and 1906 in Manitoba. *Revue Française D'Études Américaines, 144*(3), 95-108.

British Columbia Office of the Provincial Health Officer & First Nations Health Authority. (2018). *Indigenous health and well-being: Final update*. https://www.fnha.ca/Documents/FNHA-PHO-Indigenous-Health-and-Well-Being-Report.pdf

Burnham, P. (2018). UN special report: Inside the Medicine Chest. *Indian Country Today,* September 12. https://indiancountrytoday.com/archive/un-special-report-inside-the-medicine-chest

Cardinal, H., & Hildebrandt, W. (2000). *Treaty elders of Saskatchewan: Our dream is that our peoples will one day be clearly recognized as nations.* University of Calgary Press.

Commission on the Future of Health Care in Canada, Commissioner Roy J. Romanow. (2002). *Building on values: The future of health care in Canada* (Final Report). Canadian Government Publishing.

Craft, A. (2014). Living treaties, breathing research. *Canadian Journal of Women and the Law, 26*(1), 1-22.

Craft, A. (2018). Navigating our ongoing sacred legal relationship with nibi (water). In J. Goyder et al. (eds.), *UNDRIP implementation: More reflections on the braiding of international, domestic and Indigenous laws special report.* Centre for International Governance Innovation & Wiyasiwewin Mikiwahp.

Cuthand, D. (2017). Cuthand: Health care must be recognized as a Treaty right. *Saskatoon StarPhoenix,* January 21. https://thestarphoenix.com/opinion/columnists/cuthand-health-care-must-be-recognized-as-Treaty-right

Department of Justice. (2018). *Principles respecting the Government of Canada's relationship with Indigenous Peoples.* Government of Canada. http://www.justice.gc.ca/eng/csj-sjc/principles-principes.html

Dreaver et al v. the King (1935), C.N.L.C. Ex. Ct. (unreported).

Duke v. Puts [2001], S.J. No. 156.

Favel-King. (1996). "The Treaty right to health." In *The Path to Healing: Report of the National Round Table on Aboriginal Health and Social Issues.* Royal Commission on Aboriginal Peoples.

Federation of Saskatchewan Indian Nations [FSIN]. (2007). *Treaty implementation principles:* http://caid.ca/TreImpPri052907.pdf

First Nations Health and Social Secretariat of Manitoba. (2020). *Annual report 2019-2020*. https://d5d8ad59-8391-4802-9f0a-f5f5d600d7e9.filesusr.com/ugd/38252a_833d274892bb446ca53085e2f0e403e4.pdf?index=true

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.

Hickey, L. (1976). *Summary of Elders' interviews: Treaty 6. Office of Specific Claims and Research*. Winterburn.

House of Commons of Canada. (2020). *Bill C-15, An Act respecting the United Nations Declaration on the Rights of Indigenous Peoples*, 2nd Sess, 43rd. https://parl.ca/DocumentViewer/en/43-2/bill/C-15/first-reading

Indian Act, RSC 1985, c I-5.

Indian Association of Alberta [IAA]. (1979). *Indian health care: A Treaty right.*

Interdepartmental Working Group to the Committee of Deputy Ministers on Justice and Legal Affairs. (1995). *Fiduciary relationship of the Crown with Aboriginal Peoples: Implementation and management issues – A guide for managers*. Government of Canada.

Legislative Assembly of Manitoba. (2016). *Bill 18: The path to reconciliation act.* Government of Manitoba. https://web2.gov.mb.ca/bills/40-5/b018e.php

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

Lightfoot, S. (2017). Adopting and implementing the United Nations Declaration on the Rights of Indigenous Peoples: Canada's existential crisis. In K. Ladner & T. Myra (eds.), *Surviving Canada: Indigenous Peoples celebrate 150 years of betrayal* (pp. 440-459). Arbeiter Ring Publishing.

Littlechild, D. (2014). *Transformation and re-Formation: First Nations and water in Canada* [Unpublished Master's Thesis]. University of Victoria.

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

Macklem, P. (2001). *Indigenous difference and the Constitution of Canada.* University Toronto Press.

Maskwacis Cree Nation. (2018). S*ubmission of the Maskwacis Cree to the Expert Mechanism on the Rights of Indigenous Peoples Study on the Right to Health and Indigenous Peoples with a Focus on Children and Youth*. https://www.ohchr.org/Documents/Issues/IPeoples/EMRIP/Health/MaskwacisCree.pdf

Merrick, R. (2019). *Innovations in First Nations health: Exploring the effects of neoliberal settler colonialism on the treaty right to health* [Unpublished Master's thesis]. University of Victoria.

Mikisew Cree First Nation v Canada (Minister of Canadian Heritage) [2005], 3 SCR 388.

Mitchell v. Peguis Indian Band, [1990] 2 SCR 85.

Morris, A. (1880). *The Treaties of Canada with the Indians of Manitoba and the Northwest Territories, including the negotiations on which they were based and other information relating thereto.* Belfords, Clarke.

National Collaborating Centre for Aboriginal Health. (2011). *Looking for Aboriginal health in legislation and policies, 1970-2008: The policy synthesis project*. https://www.nccih.ca/495/Looking_for_Aboriginal_health_in_legislation_and_policies,_1970-2008__The_policy_synthesis_project.nccih?id=28

Norway House Cree Nation (Re) [2008], MLBD No 30, 209 CLRBR (2d) 87.

Nowegijick v. the Queen, [1983] 1 S.C.R. 29.

Ontario Human Rights Commission (n.d.). *Policy statement on a human rights-based approach to managing the COVID-19 pandemic*. http://www.ohrc.on.ca/en/policy-statement-human-rights-based-approach-managing-covid-19-pandemic

Rotman, L. (1997). Taking aim at the canons of treaty interpretation in Canadian Aboriginal rights jurisprudence. *UNB Law Journal, 46(11)*, 11-51.

R v Badger [1996], 1 SCR 771.

R. v. Johnston [1966], SJ No 220.

R v Marshall, [1999], 3 SCR 456.

R v. Sparrow [1990], 1 SCR 1075.

R v Sundown [1999], 1 SCR 393.

R. v. Swimmer (1970), [1971], 1 W.W.R. 756 (Sask. C.A.).

Royal Commission on Aboriginal Peoples. (1996). *Restructuring the relationship* (Volume 2). Canada Communication Group — Publishing. https://data2.archives.ca/e/e448/e011188230-02.pdf

Saskatchewan Hospitalization Act. R.S.S. 1953.

Starblanket, G., & Hunt, D. (2020). *Covid-19, the numbered treaties & the politics of life: Special report*. Yellowhead Institute. https://yellowheadinstitute.org/wp content/uploads/2020/06/yi-special-report-covid19-and-Treaties.pdf

Saskatchewan Gazette. (1962, September 14). The Saskatchewan Hospitalization Act, O.C. 1400/62. *Saskatchewan Gazette, 58*(37).

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.

Treaty No. 6, No. 7 and No. 8 Chiefs. 2005). *Declaration on the treaty right to health, March 16 - 17, 2005*. Adopted by the 31st Anniversary International Indian Treaty Council Conference hosted by the Confederacy of Treaty 6 First Nations, at Ermineskin Cree Nation, Alberta Canada, August 7, 2005.

Truth and Reconciliation Commission of Canada [TRC]. (2015a). *Truth and Reconciliation Commission of Canada: Calls to action*. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

Truth and Reconciliation Commission of Canada [TRC]. (2015b). *Canada's residential schools: Reconciliation* (Volume 6: The Final Report). McGill-Queens University Press.

Truth and Reconciliation Commission of Canada [TRC]. (2015c). *Canada's residential schools: The legacy* (Volume 5: The Final Report). McGill-Queens University Press.

Truth and Reconciliation Commission of Canada [TRC]. (2015d). *What we have learned: Principles of truth and reconciliation*.

United Nations General Assembly. (2007). *United Nations Declaration on the Rights of Indigenous Peoples*. 61/295.

Waldram, J. B., Herring, A. D., & Young, T. K. (2006). *Aboriginal health in Canada: Historical, cultural, and epidemiological perspectives* (2nd ed). University of Toronto Press.

Wuskwi Sipihk Cree Nation v. Canada (Minister of National Health and Welfare) [1999] F.C.J. No. 82.

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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

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