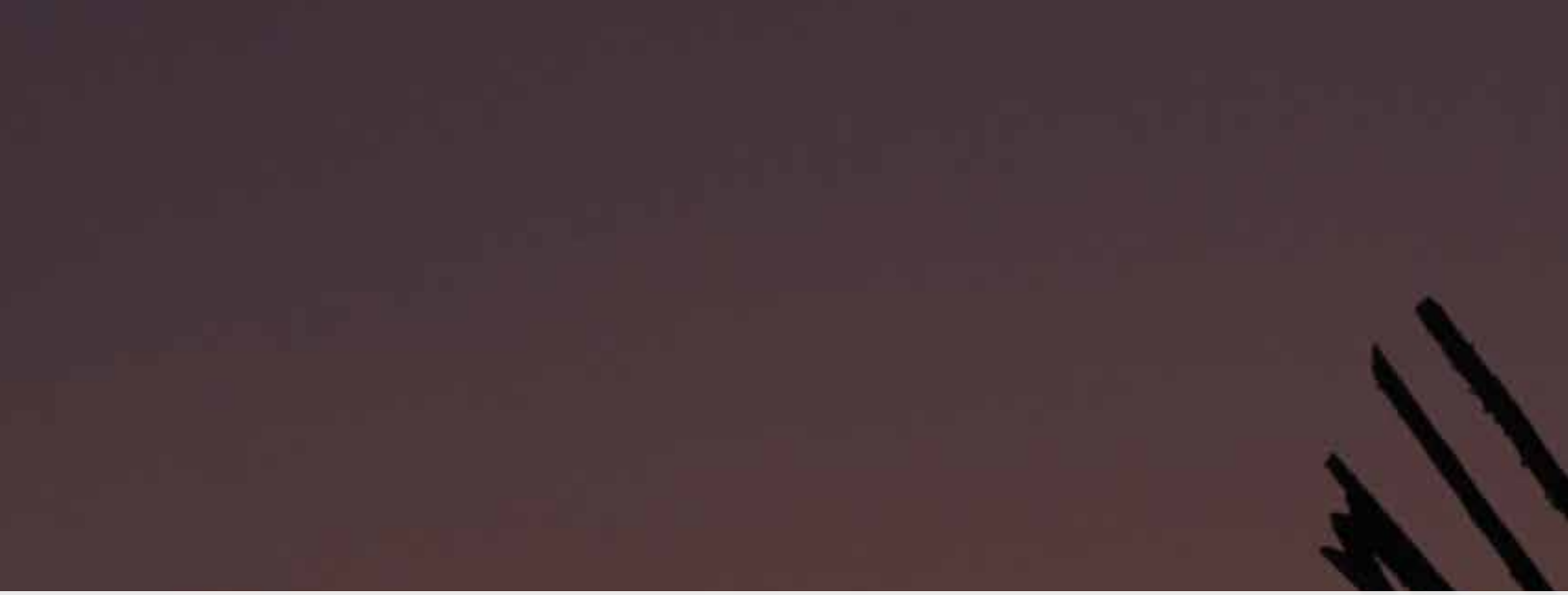
LOOKING FOR ABORIGINAL HEALTH IN LEGISLATION AND POLICIES, 1970 TO 2008

The Policy Synthesis Project

Dr. Josée Lavoie,
Associate Professor, School of Health Sciences,
University of Northern British Columbia: Project Lead

NATIONAL COLLABORATING CENTRE FOR ABORIGINAL HEALTH
CENTRE DE COLLABORATION NATIONALE DE LA SANTÉ AUTOCHTONE



Acknowledgements

This report is the culmination of work undertaken at the National Collaborating Centre for Aboriginal Health (NCCAH) as part of its strategic priority on Aboriginal health policy.

The NCCAH would like to recognize Dr. Josée Lavoie, Associate Professor, School of Health Sciences at the University of Northern British Columbia (UNBC) who provided the scientific direction and leadership on this project.

The NCCAH would also like to thank the members of the team who collected and reviewed information on the health policies that have an impact on the health of First Nations, Inuit and Métis peoples at the federal, provincial and territorial levels, and who supported this project: Lavern Gervais, Research Associate, UNBC; Jessica Toner, Research Assistant, UNBC; Odile Bergeron, Research Assistant from the Unité de santé publique des Autochtones of the Institut national de santé publique du Québec, and Ginette Thomas, Managing Director, NCCAH.

The NCCAH uses an external blind review process for documents that are research based, involve literature reviews or knowledge synthesis, or undertake an assessment of knowledge gaps. We would like to acknowledge our reviewers for the generous contributions of their time and expertise to this manuscript. The authors would also like to thank all of those who contributed insights and comments along the way.

This publication is available for download at: www.nccah.ca

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EXECUTIVE SUMMARY

The objectives of the Policy Synthesis Project were to develop a comparative inventory of federal, provincial and territorial health policies and legislation that make specific mention of Aboriginal, First Nations, Inuit and/or the Métis peoples living in Canada. This project aims to close an important information gap. Despite renewed commitments by governments to the principle of health equity and to making efforts to closing the gap that exists between the health of Aboriginal people and that of their national counterparts, studies documenting legislative and policy responses are lacking.

For this project, information that is publicly available on the worldwide web was gathered over a one year period (April 2007 – April 2008). The decision to focus on internet searches was made because the information is publicly and readily available, and because the internet can be an important tool of policy research and information for policy makers, researchers, users and many government departments.

Overall, this report provides evidence that the Aboriginal health policy in Canada remains very much a patchwork. Considerable diversity exists in all provinces and territories. At the federal level, the policy environment is largely implicit rather than explicit. Some areas of clarity, innovation and gaps have emerged. These are discussed below.

Treaties and self-government activities

A variety of arrangements have emerged as a result of treaties and self-government activities in Canada. In some areas, historic treaties signed between 1870 and

1929 remain current. In others, modern treaties have been signed and have clarified areas of ambiguities embedded in historic treaties. Modern treaties have also been signed in areas where historic treaties had never been negotiated.

Modern treaties have resulted in different arrangements. All four Inuit regions have engaged in self-government activities, resulting in increased autonomy in key areas. The Nunavut Land Claim Agreement resulted in the creation of the territory of Nunavut. In the Inuvialuit and Nunatsiaq regions, Inuit have signed self-government agreements. In Nunavik, the James Bay and Northern Quebec Agreement gave rise to a unique model whereby Inuit-managed structures were created as a result of this agreement (the Health Board and School Boards). An agreement signed in 2007 will lead to the creation of the Regional Government of Nunavik, which will have oversight of all Nunavik structures created as a result of the James Bay and Northern Quebec Agreement, including health services. This new order of government will answer directly to the National Assembly of Quebec. This model is unique in Canada.

The Nisga'a Agreement, the James Bay and Northern Quebec Agreement, and the Labrador Inuit Association Agreement are tripartite agreements that include provisions for self-administration of health services.

To date, most self-government agreements have been signed in the Yukon and in British Columbia. In British Columbia, the Nisga'a Agreement included health services while the Sechelt did not. In the Yukon, most have not.

Legislation and policies

This Policy Synthesis Project maps out:

- the health legislation in place at the federal level, in the territories and in the provinces, and the Aboriginal-specific provisions that are stated in legislation; and
- the health policies in place at the federal level, in the territories and in the provinces, and the Aboriginal-specific provisions that are stated in policies.

As a result, the following pattern emerges.

At the national level, there are only two publicly available national Aboriginal health policies: the 1979 Indian Health Policy and the 1989 Health Transfer Policy. There is ambiguity as to the range of application of the Indian Health Policy because the text of the policy does not specify whether it is inclusive of registered and non-registered Indians. It makes no mention of Inuit. The Health Transfer Policy applies to First Nations on-reserve and to the Inuit of Labrador only.

At the territorial and provincial levels, some legislation contains specific provisions clarifying the responsibilities of the governments of these territories and provinces in Aboriginal health. These are, however, quite limited and focus on jurisdiction. For example, legislation in Alberta are said to apply to Métis settlements. Alberta, Saskatchewan, Ontario and New Brunswick legislation specifically state that the Minister responsible for health may opt to enter into an agreement with Canada and/or First Nations for the delivery of health services, thereby clearly indicating that the provision of services is outside of the province's mandate.

Self-government agreements, where they exist, define areas of jurisdiction for the federal, provincial/territorial and Aboriginal governments. This is reflected in legislation. Health legislation in the Yukon, Quebec and Newfoundland & Labrador contain provisions related to existing self-government agreements, thereby clarifying these territory/provinces' roles and responsibilities in health only in the areas included in these self-government agreements.

Finally, some provinces and territories have embedded provisions related to Aboriginal healing and ceremonial practices. The Yukon is the only jurisdiction where health legislation recognizes the need to respect traditional healing practices.[1] The legislation does not define what is included as traditional healing practices. Quebec, Ontario and Manitoba recognize that Aboriginal midwives should be exempted from control specified under the Code of Professions. Ontario extends this exemption to traditional healers. In addition, British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick and Prince Edward Island have adopted tobacco control legislation that clearly states that the use of tobacco for ceremonial purposes will not be regulated under the terms of this legislation.

Findings also showed the existence of a limited number of Aboriginal-specific legislation and policies. Ontario was the first province to develop an Aboriginal Health and Wellness Strategy in 1990, and to develop an overarching Aboriginal Health Policy in 1994. The Aboriginal Health Policy is intended to act as a governing policy and assist the Ministry of Health in accessing inequities in First Nation/Aboriginal health programming,

[1] The legislation did not define this term.

responding to Aboriginal priorities, adjusting existing programs to respond more effectively to needs, supporting the reallocations of resources to Aboriginal initiatives, and improving interaction and collaboration between ministry branches to support holistic approaches to health. This is the most comprehensive Aboriginal health policy currently in place in Canada.

In British Columbia, the 2005 Transformative Change Accord and the First Nations Health Plan form the Tripartite First Nations policy that aims to close the disparities that exist between First Nations and other British Columbians in the areas of health, education and housing. The policy document also intends to clarify issues surrounding Aboriginal title and jurisdiction. It appears to apply only to First Nations, and not to other Aboriginal groups in British Columbia.

A similar framework was developed in Nova Scotia: the 2005 Providing Health Care, Achieving Health – Mi'kmaq. Again, the framework focuses on the specific needs of the Mi'kmaq people and not to the Métis or other Aboriginal peoples living in Nova Scotia.

Métis self-government and health policy

The Northwest Territories is the only jurisdiction in Canada where Métis have signed a comprehensive land claims agreement. This agreement was signed by Canada, the Northwest Territories, the Sahtu Dene and the Métis. This is the only instance we documented of federal involvement in Métis lands rights. The Northwest Territories is also the only jurisdiction to provide Métis with access to a program that is equivalent to the federal government's Non-Insured Health Benefits.

In Alberta, the 1938 Métis Betterment Act provided land to the Métis. Twelve settlements were established; eight remain today. Some level of local Métis government was established as a result. The extent of their powers has changed over the years, but the Act did not include provisions related to health or healthcare. The 1989 Métis Settlements Accord, which replaced the 1938 Métis Betterment Act, includes a number of health-specific provisions, including the right to: a) make bylaws to promote the health, safety and welfare of the residents of the settlement area; b) invest money in a hospital district or health region under the Regional Health Authorities; and c) make bylaws respecting and controlling the health of the residents of the settlement area and against the spread of diseases. Noteworthy, Alberta's health legislation includes provisions stating that these apply to Métis settlements.

In Manitoba, Métis are in the process of exploring land claim and self-government issues. The Saskatchewan Métis Act 2002 recognized the contribution the Métis Nation has made to the provision of health services to Métis.

Emergence of cross-jurisdictional forums

Cross-jurisdictional forums have emerged in a few provinces. These are committees or working groups that bring together federal, provincial and Aboriginal government representatives to discuss policy and concerns that cross jurisdictional boundaries, and find solutions. These are relatively new developments. Examples include:

- British Columbia's Tripartite First Nations Health Plan which was adopted in 2007 as a result of a partnership between the Government of British Columbia, the Government of Canada, and the Leadership Council Representing the First Nations of British Columbia. The Health Plan provides for a new governance structure for First Nations health services in BC consisting of a First Nations Health Governing Body (to design and oversee implementation of a new governance structure), a First Nations Health Council (serving as an advocacy voice for First Nations on health-related matters), a tripartite First Nations Health Advisory Committee (to review and monitor health plans and health outcomes, and recommend actions on closing health gaps), and an association of health directors and other professionals to create and implement a First Nations capacity development plan.
- The Saskatchewan Northern Health Strategy which brings together First Nations, Métis, northern municipalities, Regional Health Authorities, federal and provincial authorities. Its purpose is to explore areas of collaboration, improve the continuum of care for all northerners, design strategies to better use existing resources, and resolve cross-jurisdictional issues.
- The Manitoba Inter-Governmental Committee on First Nations Health which was set up in 2003 to identify priorities and coordinate approaches to improve First Nations health in Manitoba. The committee's membership includes representatives from Assembly of Manitoba Chiefs, Manitoba Keewatinook Ininew Okimowin, Southern Chiefs Organization Inc., First Nations and Inuit Health Manitoba Region, the Public Health Agency of Canada, Manitoba Health, the Manitoba Department of Aboriginal and Northern Affairs, Family Services and Housing Manitoba, Manitoba Finance, and Indian and Northern Affairs Canada.

Intergovernmental health authorities

Intergovernmental health authorities are formal organizations created through federal-provincial partnerships, Aboriginal partnerships, or self-government agreements. An example of these types of authorities are the health care structures that emerged as a result of the James Bay and Northern Quebec Agreement. These structures are somewhat unique in Canada in that they are co-funded by the federal and provincial governments to serve the health care needs of Nunavik Inuit and the James Bay Cree. Although their governance is distinct, these structures are functionally integrated into the provincial health care system.

The Athabasca Health Authority in Saskatchewan is another example of an Aboriginal health authority that is an extension of a provincial health care system, while co-funded by federal and provincial governments. It provides services to two First Nations and three Métis communities.

Finally, the Northern Intertribal Health Authority (NITHA) is the only organization of its kind in the country. NITHA is a partnership of the Meadow Lake Tribal Council, the Lac LaRonge First Nations, the Peter Ballantyne Cree Nation, and the Prince Albert Grand Council. These Tribal Councils and First Nations collectively represent nearly half of First Nations in Saskatchewan. NITHA provides education and technical support to NITHA partners in the area of communicable disease control, epidemiology and health status monitoring.

Concluding comments

While it should be noted that many developments in Aboriginal health policy have occurred in the past 10 years, and that activities seem to be ever increasing, the result of this analysis shows a patchwork of Aboriginal-specific legislation, policies and provisions, with significant gaps. Most provisions focus on clarifying federal-provincial jurisdictional boundaries or provincial responsibilities in relation to existing self-government agreements.

Jurisdictional complexity has been noted and problematized by many landmark studies, from the 1966 Hawthorn Report (Hawthorn, 1966) to the Royal Commission on Aboriginal Peoples (Royal Commission on Aboriginal Peoples, 1996), the Royal Commission on the Future of Health in Canada (Romanow, 2002), and the Report of the National Advisory Committee on SARS and Public Health (National Advisory Committee on SARS and Public Health, 2003). Despite these concerns, jurisdictional complexity seems to be increasing rather than declining, partially as a result of increased Aboriginal engagement in self-government and a lack of federal/provincial coordination.

While there are always challenges associated with the multiple authorities engaged in healthcare policy, planning and service delivery, there are also international trends in promoting citizen engagement in the pursuit of equity (World Health Organisation & UNICEF, 1978; World Health Organisation, 2008). Given these trends, the findings reported in this report suggest that jurisdictional complexity may be a phenomenon that will persist. Therefore, coordination rather than consolidation may be a more appropriate policy response. Cross-jurisdictional mechanisms therefore should be promoted and supported.

ACRONYMS & ABBREVIATIONS

AFN	Assembly of First Nations
AHA	Athabasca Health Authority
AHWS	Aboriginal Health & Wellness Strategy
ANAC	Aboriginal Nurses Association of Canada
CAP	Congress of Aboriginal Peoples
FHP	Federal Health Partnerships
FNIH[a]	First Nations and Inuit Health
FNIHB[b]	First Nations and Inuit Health Branch of Health Canada
INAC[c]	Indian and Northern Affairs Canada
IPAC	Indigenous Physicians Association of Canada
ITK	Inuit Tapiriit Kanatami
LIA	Labrador and Inuit Association
MFA	Manitoba Framework Agreement
MNC	Métis National Council
MSB[d]	Medical Services Branch
NAFC	National Association of Friendship Centres
NAHO	National Aboriginal Health Organization
NCCAH	National Collaborating Centre for Aboriginal Health
NHS	Northern Health Strategy
NIHB	Non-Insured Health Benefits
NIICHRO	National Indian and Inuit Community Health Representatives Organization
NITHA	Northern Inter-Tribal Health Authority
NWAC	National Women's Association of Canada
PHAC	Public Health Agency of Canada
RHA	Regional Health Authority

[a] Regional offices of the First Nations and Inuit Health Branch of Health Canada. They were known as FNIHB until 2007 which replaced the Medical Service Branch (MSB) in 1997

[b] National office. It replaced the Medical Service Branch (MSB) in 1997.

[c] Indian and Northern Affairs Canada. It was known as the Department of Indian Affairs and Northern Development until 1966. Prior to that (1867-1966) Indian and northern affairs administration was handled by various departments throughout the years, including the Office of the Secretary of State, Citizenship and Immigration, Mines and Resources, and Northern Affairs and National Resources.

[d] The former name of the First Nations and Inuit Health Branch of Health Canada.

LOOKING FOR ABORIGINAL HEALTH IN LEGISLATION AND POLICIES

1. Introduction

The Canadian health system consists of many inter-related elements that are the responsibility of the federal, provincial, or municipal governments, Aboriginal authorities or the private sector (Wigmore & Conn, 2003). Partly as a result of the multiple authorities, the overall system can be best described as a "patchwork" linked together by legislation, policies and relationships. In some cases, this results in a relatively seamless system. In most cases however, the system is, at best, loosely woven resulting in gaps and ambiguities.

For Aboriginal people, jurisdictional issues have created and continue to add complexities that negatively impact access to care and health. This has been highlighted by the Assembly of First Nations' report *First Nations Public Health Framework* (Assembly of First Nations, 2006b), the Métis National Council's (MNC) *Métis Health Research Project* (Canada, 2005), and the Inuit Tapiriit Kanatami (ITK) report, *Backgrounder on Inuit Health* (Inuit Tapiriit Kanatami, 2004). Jurisdictional complexities and ambiguities create challenges in accessing services (Hawthorn, 1966; National Advisory Committee on SARS and Public Health, 2003; Romanow, 2002). These ambiguities and complexities exist for a number of reasons.

The jurisdictional divide: The federal government has primary responsibility for a complement of health services provided to Status Indians living on-reserve and to Inuit living in their traditional territories in Québec and Labrador. Only one

program applies to all Status Indians and Inuit, regardless of where they live: the Non-Insured Health Benefits (NIHB) program. Métis, off-reserve Status Indians, non Status Indians, and Inuit living or accessing care outside of their traditional territories fall under the purview of provincial governments.

Thirteen different healthcare systems: Provincial and territorial governments are responsible for the delivery of a number of health services, as defined by the Canada Health Act 1984. These services are complemented by services designed to meet territorial or provincial priorities. Since services delivered in different provinces and territories may vary, services provided to Aboriginal people as residents across provinces and territories will also vary.

Regionalization: Most provinces have developed regional Health Boards or Authorities to improve citizen participation, set priorities regionally, and coordinate and integrate healthcare delivery (Kouri, 2002). Regionalization has added yet another level of complexity and variation in the complement of services accessible to all residents, including Aboriginal peoples.

Self-government activities: Trends in self-government have provided improved opportunities for Aboriginal participation in service delivery. Agreements between federal and/or provincial health Ministries/Departments/Health Authorities and Aboriginal communities have multiplied. Self-government agreements have their own geographical boundaries that may or may not coincide with provincial Health Authorities' own boundaries. Further, the relationship between Aboriginal nations and Health Authorities vary across the country.

The information gap: Despite renewed commitments by governments to the principle of health equity and to making efforts to close the gap that exists between the health of Aboriginal people and that of their national counterparts, no studies documenting legislative and policy responses were located. A review of literature conducted to inform this project confirmed that most policy research has focused on a single or a limited number of policies that exist within a single jurisdictional context (provincial, territorial or federal) (Lalonde et al., 2009; Lavoie et al., 2005; Lawrence, 2010; Quinonez & Lavoie, 2009; Vukic et al., 2009; Wearmouth & Wielandt, 2009).

The purpose of the Policy Synthesis Project was to fill this information gap. Specifically, the objectives were to:

a) develop a comparative inventory of federal, provincial and territorial health policies and legislation that make specific mention of First Nations, Inuit and the Métis peoples living in Canada;
b) document health related provisions embedded in treaties and self-government agreements;
c) identify emerging trends in terms of jurisdictional fragmentation and coordination; and
d) document opportunities for Aboriginal engagement in shaping health policy, programs and services, as entrenched in institutional arrangements.

1.1 Why focus on legislation and policies

This project focuses on Aboriginal-specific provisions entrenched in national, territorial or provincial legislation and policy documents. The decision to focus on formal documents that shape institutional arrangements was made for a number of reasons. First, legislation and official policies provide documented formal government commitments and generally reflect longer term directions. Although legislation can be amended or repealed and policies replaced, their formality denotes commitment. The second reason was pragmatic. While legislation and policies tell only part of the story and informal arrangements can create opportunities for bridging jurisdictional gaps, the undocumented nature of these types of arrangements means they are vulnerable to quick alterations or dissolution resulting from changes in government directions or priorities, funding cut backs, or changes in staff. Informal arrangements are also difficult to track down.

The relationship between policy and legislation is complex. Public policy is often broadly defined as a process in which strategic actions (or inactions) are articulated by public authorities in order to act upon situations defined as problematic (see for examples Parsons, 1995; Howlett & Ramesh, 2003). Such a definition would include legislation as one form of public policy. Others see laws, regulations and rules as legislative instruments, whereas they see policy determinations as non-binding guidelines and principles. Policy and law are often intertwined, as high level policy directions lead, at times, to the adoption of legislation. Moreover, legislations are often broadly worded documents that may result in the adoption of other legislation and/or policies to provide direction in their implementation. That being said, policy guidelines cannot override, amend or be in conflict with laws (including subordinate legislation). Legislation thus entrench policy objectives into an enforceable format (Legemaate, 2002).

In the context of this report, the term 'health policy' is used to mean "a statement of a decision made by a government to control the healthcare system, to help solve problems within or caused by it" (Walker et al., 2003, p. 6). Policies may focus on establishing jurisdictional responsibilities and accountabilities; financing, funding, and remuneration decisions about support

services; or on what and how services will be delivered and accessed (Lavis et al., 2002). 'Health legislation' may be defined as "the body of rules that regulates the promotion and protection of health, health services, the equitable distribution of available resources and the legal position of all parties concerned, such as patients, health care providers, health care institutions and financing and monitoring bodies" (Leenen, 1998).

1.2 Scope

Two broad areas of delimitation underscore this project. First, this document focuses exclusively on national, territorial and provincial health policies as adopted by Ministries and Departments of Health. It must be acknowledged that every Aboriginal group has its own definition of health which is generally broader and more holistic, including determinants such as self-determination, housing, land, language, etc. (First Nations Regional Health Survey National Committee, 2005; Reading et al., 2007). Nevertheless, this document does not adopt a broad determinants of health approach. Health legislation and policies as designed by federal, territorial and provincial Ministries and Departments of Health are unlikely to reflect First Nations, Inuit and/or Métis' cultural understandings of health. However, a broad determinants of health approach would have meant cataloguing every policy currently in place in Canada. This would have been a daunting task! Nevertheless, the methodology used in this project can be replicated to inform policy analysis in other areas of public policy that have an impact on Aboriginal peoples in Canada.

Second, this document focuses on the text of legislation and policies. It is beyond the scope of this project to document the process adopted in the development of each legislation or policy, or the paths taken in their implementation. However, since documenting implementation pathways has considerable utility, some recommendations will be made in the concluding section of this document on potentially useful studies emerging from the findings of this project.

Given that this document is based on information publicly available on the worldwide web, there are some obvious limitations to this report. The internet is a challenging research tool since information is forever shifting and no consistent method for referencing has been adopted. Accuracy of information is at times difficult to ascertain, and must be checked against numerous sources. When doubts existed, multiple sources were used for confirmation. Further, there is no way to determine whether a record is complete. This report may therefore contain gaps in information.

1.3 Intended use

This report catalogues the evidence gathered by the authors. It is intended to support critical analyses. To facilitate use, large data tables have been placed in Appendices at the end of the report. The report has been structured in the following broad sections.

Section 2, Methodology: This section describes the methodology that was adopted to gather the data presented in this report. It also explains where the information came from, and discusses the strengths and limitations of the sources of information used.

Section 3, Aboriginal peoples in Canada, in the territories, and in the provinces: Nationally, Aboriginal peoples total 3.8 percent of the Canadian population. This percentage varies a great deal when looking at specific territories or provinces. The purpose of this section is to provide the context required for discussion of Aboriginal-specific legislation and policies. This section begins with a socio-demographic profile of Aboriginal peoples in Canada, the territories, and in the provinces. This is followed with a discussion of Aboriginal organizations with a health mandate in Canada, the territories and the provinces.

Section 4, Aboriginal peoples and the Federal government: The federal government plays a very important role nationally in providing broad directions for policies and programs that reflect national values. The leadership of the federal government in the adoption of the Canada Health Act 1984 or in responding to the SARS outbreak are cases in point. The purpose of this section is to outline the role the federal government plays in Aboriginal health, as defined by legislation and policies. The section begins with a review of key historical documents that continue to be of relevance today. This is followed by a discussion of the role key federal departments play in Aboriginal health.

Section 5, The treaties, self-government activities and health: Historic treaties and trends in self-government activities have resulted in a variety of initiatives and arrangements that have created opportunities for Aboriginal engagement in health policy and service delivery. This section discusses how treaties and self-government agreements have framed Aboriginal responsibilities for health services.

Section 6, The legislative and policy environment for Aboriginal health: This section details the findings of this review of territorial and provincial health legislation and policies that contain Aboriginal-specific provisions, highlighting areas of strengths and gaps. Included in this section is a review of opportunities for Aboriginal peoples and communities to participate in regional health authorities. The section concludes with a more detailed discussion of key health legislation and policies that may serve as models for other jurisdictions.

Section 7, Emerging opportunities: Jurisdictional fragmentation has repeatedly been raised as a concern in the provision of health care for Aboriginal peoples. Over the past decades, coordination mechanisms have emerged to bridge jurisdictional gaps. This section highlights emerging models and the opportunities they may provide.

Section 8, Conclusions: This final section summarizes key findings and provides direction for further work.

It is hoped that this report will benefit the ongoing efforts of Aboriginal organizations in addressing community health, supporting Aboriginal health policy research, and informing federal, provincial and territorial decision-makers and Aboriginal communities in their policy discussions.

2. Methodology

The Policy Synthesis Project is based on information that is publicly available on the worldwide web. The decision was made to focus on internet searches for a number of reasons. First, limiting the search to publicly and readily available information was intended to ensure consistency in identifying health policies and legislation between different provincial/territorial/federal governments. Second, the internet is an important and underutilized tool of policy research and information for policy makers, researchers, users, and many government departments. Third, expanding this project to include documents that are not readily available on the internet would have required identifying key collaborators within each government department and training them to ensure consistency in information gathering. This would have required considerably more resources and time to possibly yield little more than what was available on the internet.

The information for this project was compiled over a one year period (April 2007 – April 2008). Internet searches utilized the following terms and combinations of these words: Aboriginal, First Nation(s), Inuit, Metis or Métis, Indian, Amérindiens, Reserve, Health, Medicine and Medical. Lower case was used to avoid problems retrieving information from case sensitive search engines.

The key websites that were explored included the Parliamentary Library; Health Canada; the Public Health Agency of Canada (PHAC); Indian and Northern Affairs Canada (INAC); Department of Justice Canada; Statistics Canada; the Aboriginal Canada Portal; provincial and territorial websites, including any Ministries/Departments responsible for Aboriginal Affairs or health; and Aboriginal organizations.

Specific definition and methodological issues that emerged through this project are detailed below.

2.1 Socio-demographic profile of the Aboriginal population

Census data produced by Statistics Canada was used to provide a socio-demographic profile of First Nations, Inuit and Métis populations at the federal level, and in the territories and provinces.

The 2006 Census captured a larger percentage of Aboriginal people than previous Censuses (Statistics Canada, 2008b). Data collected and presented by Statistics Canada is used by many differing agencies and organizations throughout Canada, yet it must be acknowledged that a number of concerns have been raised over the interpretation of such figures and their impacts on Aboriginal people. For example, the Assembly of First Nations recently expressed concerns regarding the accuracy of the recently released 2006 Census figures (Bailey, 2008). Statistics Canada nevertheless produces the only data set available that reports on all three Aboriginal groups. The Department of Indian and Northern Affairs Canada (INAC) keeps its own data on those registered as Indians under the Indian Act. An Inuit registry is also kept. These resources, however, capture only a portion of the overall Aboriginal population and are not publicly available.

Statistics Canada uses its own identification categories that include North American Indian, Métis, Inuit, single responses and multiple responses. Specifically, the Aboriginal identity population is composed of "those persons who report identifying with at least one Aboriginal group (that is, "North American Indian", "Métis" or "Inuit (Eskimo)", Amérindien), and/or who report being a Treaty Indian or a Registered Indian as defined by the Indian Act of Canada, and/or who were members of an Indian Band or First Nation" (Statistics Canada, 2004). This method is based on self-identification.

2.2 A word on terminology

In Canada, the collective term 'Aboriginal' is used as an umbrella term encompassing Indians, Inuit and Métis, as entrenched in the Canadian Constitution as amended in 1982. We acknowledge that the term glosses over cultural, legislative and administrative complexities.

In this document, the term 'Aboriginal' is used only when statements apply to First Nations living on and off-reserve, Inuit, Métis and non-status individuals of First Nation ancestry. In other cases, self-referents will be used. The term 'Indian' is used when quoting historic documents or when referring to the Indian Act's legal term "Indians" which defines access to certain federal programs and benefits.

2.2.1 First Nations

The term 'First Nations' is the preferred self-referent used by the Indigenous peoples of Canada historically known as "Indians."

The collective term 'First Nations' is inclusive of multiple nations, including Nisga'a, Cree, Ojibway, Salish, Mohawk, Mi'kmaq, and Innu, to name a few. In administrative terms, there are currently more than 600 First Nations recognised by the federal government (Canada, 2006b). These are political and administrative organizations that emerged to satisfy the requirements of the Indian Act.

The federal government distinguishes between registered (or status) and non-registered (or non-status) Indians. The terms 'registered' and 'status' are used interchangeably in this report. A registered Indian is a person registered under the terms of the Indian Act. Registration ensures the right to live on-reserve and have access to treaty and/or policy-defined benefits. Class 24 of section 91 of the "Constitution Act, 1867" recognizes registered Indians as a federal responsibility. Non-registered Indians are a provincial jurisdiction. Generally, these distinctions tend to blur in the territories, as territorial governments have tended to use more inclusive rules of eligibility for their programs.

Eligibility for registration can be lost and, to a limited extent, gained. From the turn of the last century until 1985, an Indian woman who married a man who was not a registered Indian lost her Indian status. Children from this union were not eligible to be registered as Indians. As a result, many lost the right to live on-reserve with their relatives. In contrast, a non-Indian woman (of European or other origin) who married an Indian man gained Indian status. This discriminatory provision was repealed from the Indian Act with the adoption of the 1985 Bill C-31. As the legislation stands, those that have never lost their Indian status are registered as "Indians" under the Indian Act article 6(1). Those who lost status by marriage or other discriminatory means prior to 1985 are eligible for registration under the Indian Act article 6(2). Both 6(1) and 6(2) classification categories imply full status and benefits. Children of parents classified as 6(1) are classified as 6(1). Children of a 6(1) parent and 6(2) parent are classified 6(1). Children of a 6(1) parent and a non-status are considered 6(2). Finally, children of a 6(2) parent and non-status parent are considered non-status. This is a growing, yet largely invisible, group in Canada (Clatworthy & Four Directions Project Consultants, 2001; Clatworthy, 2003). Those who can document eligibility can potentially become registered Indians.

Some First Nations communities have argued that the federal criteria fail to be inclusive of their membership. As a result, some communities have expanded their membership rules to include those of common ancestry that may nevertheless not be eligible for registration as an Indian under the Indian Act. Nevertheless, the federal government understands its responsibility for financing health services and other programs to be limited to those registered as Indians.

Throughout the text, we have utilized the most commonly used First Nations self-referents. These are generally derived from English.

2.2.2 Inuit

Inuit is the collective self-referent of the Arctic peoples. Inuit themselves recognise local groups with different names (Pallurmiut, Inuvialuit, etc.) reflecting the complexity of Arctic history and subtlety in cultural differences that are often glossed over by outsiders. Most Inuit live in one of four Inuit regions: Inuvialuit in the Northwest Territories, Nunavut, Nunavik in Québec, and Nunatsiavut in Newfoundland and Labrador. Inuit in all four regions have been involved in self-government activities.

In the 1939 decision, Re: Eskimos (Re: Eskimos, [1939] S.C.R. 104, [1939] 2 D.L.R. 417), the Supreme Court of Canada settled the issue and determined that the Inuit were "Indians" under the British North America Act, 1867 and thus a federal responsibility. The Indian Act 1951 was amended to include a provision stating, "A reference in this Act to an Indian does not include any person of the race of aborigines commonly referred to as Inuit" (Leslie, 2002). Thus provisions under the Indian Act were never extended to Inuit. A separate Inuit registry exists which defines an Inuk[3] as the child of one Inuk (Ontario Aboriginal Health Advocacy Health Initiative, 1999). Mixed ancestry does not impact "Inuit status".

2.2.3 The Métis

The Red River region, located north of what is now Winnipeg, is often viewed as the geographic birth place of the Métis. According to the Métis National Council, the Métis people emerged out of the relations of Indian women and European men, prior to Canada's crystallization as a nation, in west central North America. While the initial offspring of these Indian and European unions were individuals who possessed mixed ancestry, the gradual establishment of distinct Métis communities, outside of Indian and European cultures and settlements, as well as the subsequent intermarriages between Métis women and Métis men, resulted in the genesis of a new Aboriginal people - the Métis.

Distinct Métis communities emerged as an outgrowth of the fur trade along some parts of the freighting waterways and Great Lakes of Ontario, throughout the Northwest, and as far north as the McKenzie River. The Métis people and their communities were connected through the highly mobile fur trade network, seasonal rounds, extensive kinship connections and a collective

[3] Inuit is the plural form. Inuk is the singular.

identity (i.e. common culture, language, way of life, etc.). They developed their own blended culture and their own language, Michif (or Metchif). After Confederation, the Métis were not entitled to sign treaties. Like non-status Indians, themselves descendents of status Indians and non-Aboriginals, Métis do not benefit from the special provisions made by the federal government for a number of programs, including community-based health services (Métis National Council, 2008).

Increasingly, a number of Métis communities are being recognized both loosely, as in Ontario, and legislatively, as in Alberta. In the latest Census report, Statistics Canada documented communities containing 25 percent or more Métis residents (Statistics Canada, 2008a).

Documents and policies use two variations for the spelling of the word: Métis and Metis. For consistency, throughout this document the spelling 'Métis' has been adopted unless the alternate spelling appears in a direct citation.

2.3 Treaties and self-government activities

The documentation of treaties and self-government activities for this report has focused on four types of documents: historic treaties; modern treaties, also known as land claim agreements; self-government agreements; and agreements that are specific to health, such as those that emerged as a result of the Health Transfer Policy (Health Canada, 2007b). Although not all documents speak directly to health issues, each document was scanned for the words 'health', 'medicine', 'medical' and 'doctor.' We included one or two sentences to briefly describe if and how health is referenced in these documents. For those documents where health may not be specifically mentioned, we included them in this report if they are important in the context of Aboriginal health in Canada.

A number of pre-confederation treaties were signed, first with the French and subsequently with the British settlers' governments. Pre-1867 treaties were generally peace and friendship treaties. Post-confederation treaties were signed between 1870 and 1929. These treaties, called the numbered Treaties (No. 1 to 11), were negotiated with a number of First Nations across Canada. They invariably involved land surrenders associated with the development of Canada as a nation-state. Every historic treaty crossed cultural groups and traditional territorial boundaries.

Since 1974, a number of First Nations and Inuit organizations have been involved in what has been described as the modern treaty negotiation process. Self-government agreements have also been signed. Recently, opportunities to negotiate self-government agreements have been extended to the Métis. Researchers have yet to document the impact self-government activities have had on areas that were jurisdictionally contentious.

2.4 Aboriginal organizations with a health policy mandate in the provinces, territories and Canada

A number of Aboriginal organizations exist at the national, territorial and provincial levels. This project focuses on national, territorial, provincial and regional Aboriginal organizations that are predominantly administered and directed by Aboriginal peoples. Some organizations may extend membership and/or services to all Aboriginal peoples such as Aboriginal women's associations, whereas others may be more specific, as in the case of First Nations, Inuit or Métis organizations. Organizations that may have Aboriginal components/departments (i.e. Registered Nurses Association of the Northwest Territories and Nunavut) were excluded. It is beyond the scope of this document to provide an analysis of the impact these organizations have had on shaping Aboriginal health policy.

Increasingly, regional Aboriginal organizations have been provided opportunities to participate in the administration and delivery of health services to Aboriginal peoples. INAC community profiles[4] and the Canada Aboriginal Portal[5] were used to document the number of groups involved in Aboriginal health. First Nations and Tribal Councils constitute the largest number of Aboriginal organizations.

A Tribal Council is an institution that Indian bands/First Nations voluntarily join based on shared interests in order to deliver programs and services. Tribal Councils can enter into agreements with INAC or other federal government departments and are typically responsible for the administration of economic development, financial management, health services, community planning, technical services and governance (Canada, 2004b). Although this may vary considerably across the country, Tribal Councils are often involved in health policy development. Membership in Tribal Councils is voluntary. In some regions, membership fluctuates as First Nations join, or leave, Tribal Councils. In this document, Tribal Councils and bands existing as of January 2008 have been included in Appendix B.

Where they exist, Inuit regional organizations were documented.

The Métis of the Northwest Territories, Alberta, Saskatchewan and Manitoba are organized around Métis Locals. These are

[4] Available at http://sdiprod2.inac.gc.ca/FNProfiles/

[5] Available at http://www.aboriginalcanada.gc.ca/acp/site.nsf/en/index.html

regional-local Métis organizations that represent regional concerns and interests to the territorial or provincial Métis organizations. Where they exist, these were listed.

Finally, there are a number of groups in the provinces and territories that are funded by both federal and provincial governments, such as the Grand Council of the James Bay Cree in Québec or the Athabasca Health Authority in Saskatchewan. These have been listed with notes about their uniqueness.

2.5 Legislation, policies and Aboriginal health

Federal, territorial and provincial legislation and policies were examined. The federal government funds health services and programs for First Nations on-reserve and Inuit living in their traditional territories, outside of any legislative framework (Lavoie et al., 2005). For this project, mandates were reviewed for the following five departments: the Department of Canadian Heritage, the Federal Healthcare Partnership, Indian and Northern Affairs Canada, the Public Health Agency of Canada, and Health Canada.

The Department of Canadian Heritage, which houses an Aboriginal Affairs Branch, is responsible for 33 Acts. The Department's primary focus is on Aboriginal peoples off-reserve. They do not have a health focus but they do have a policy development mandate. These were considered out of the scope for the purpose of this project.

The Federal Healthcare Partnership (FHP) was established in 1994. This is a voluntary alliance of federal government organizations with responsibilities for ensuring delivery of healthcare services to specific client groups. The partnership includes:

- Citizenship and Immigration Canada which provides health services to certain classes of migrants (primarily refugee claimants and Convention refugees) in need of assistance during their settlement period in Canada;
- Correctional Service Canada which provides health services to federal inmates and some former inmates on parole;
- The Department of National Defence which provides health services to regular Force members and eligible members of the Reserve Force;
- Health Canada, which is responsible for health services to eligible First Nations peoples and Inuit, through the First Nations and Inuit Health Branch;
- The Royal Canadian Mounted Police which provides services to its regular members, eligible civilian members (i.e., civilian members injured during the course of their duties), and eligible retired members (i.e., retired members in receipt of a disability pension where the disability is work-related); and
- Veterans Affairs Canada which provides health services to eligible veterans and others who qualify for its programs.

The Public Works and Government Services Canada, the Treasury Board of Canada Secretariat, and the Public Health Agency of Canada participate in FHP discussions.

The purpose of the FHP is to identify, promote and implement more efficient and effective healthcare programs through collaboration. Specific areas of collaborations include audiology, dental care, federal/provincial/territorial representation, health human resources, health information management, medical supplies and equipment recycling, mental health, pharmacy, and vision care. The adoption of Aboriginal-specific health policies is, however, outside the mandate of the FHP.

The Department of Indian and Northern Affairs Canada has the federal responsibility for Indian Affairs. Indian health was initially included under Indian Affairs. It was moved to the Department of National Health and Welfare (now known as Health Canada) in 1945, a year after its creation, where it has remained ever since. Although some of its programs are arguably health related, the Department of Indian and Northern Affairs Canada's mandate is not health focused. The Department manages the structures and provisions that are linked to the Indian Act.

Of the five departments identified, only Health Canada and the Public Health Agency of Canada (PHAC) have a mandate that is directly related to Aboriginal health. These mandates will be discussed in their own sections.

While more health policies may exist, few were found to be publicly accessible through the Internet, which may result in gaps in information. For example, while sections 73 and 81 of the Indian Act make some reference to health, their scope is quite limited. Further, for those federal Aboriginal health policies that were developed as a result of Cabinet Submissions to the Treasury Board of Canada Secretariat, the publicly available information is largely limited to brief digests of these submissions. Treasury Board Submissions[6] are confidential, not publicly available, and could not be accessed in the context of this report.

There were similar gaps in health policy information at the provincial and territorial level because information was not uniformly available across provinces/territories. In some cases, the websites of provinces and territories provided a list of legislation and regulations by department or ministry. In these

[6] A Treasury Board submission is an official document submitted by a sponsoring minister on behalf of a federal organization seeking approval or authority from the Treasury Board for an initiative that the organization would not otherwise be able to undertake or that is outside its delegated authorities (Canada, 2007a).

cases, the health legislation (Acts) were recorded for each ministry or department. However, in many cases the legislation/regulations were not listed by department or ministry. In these cases, a word search was conducted (using the terms identified earlier) for each government ministry website to identify possible relevant policies/legislation, and these documents were further word searched to confirm relevancy. All successful searches were recorded.

2.6 Decentralization – Regionalization of health services

The purpose of decentralizing health care systems to regional health authorities is in part to increase public participation in decision-making (Kouri, 2002). Theoretically, regionalization should enable greater participation for everyone. Bands and Tribal Councils have been one of the few means of engagement available to First Nations, especially in remote and rural areas. The question remains whether and how First Nations and other Aboriginal peoples are engaged in this process.

This section provides an overview of the current provincial health systems. This includes the degree to which policies provide opportunities for Aboriginal participation in regional health authorities, where they were established. Details are provided in Appendix B. The information for this section was retrieved primarily through the provincial or territorial ministry or department of health website.

3. Aboriginal Peoples in Canada, the Territories and the Provinces

The purpose of this section is to provide the context required for discussion of Aboriginal-specific legislation and policies. This section begins with a socio-demographic profile of Aboriginal peoples in Canada, the territories and the provinces. This is followed with a discussion of Aboriginal organizations with a health mandate in Canada, the territories and the provinces.

3.1 Socio-demographic profile

The 2006 census reported a total of 1,172,790 individuals claiming Aboriginal identity, compared to 976,305 in 2001. A breakdown is provided in Table 1. The Aboriginal population is growing at nearly twice the rate of other Canadians. The First Nations population in Canada continues to grow at a much higher rate than other Canadians. Statistics Canada reported a growth rate of 14.6 percent between 2001 and 2006 (Statistics Canada, 2006a; 2006b). This compares to a growth rate of 15.1 percent from 1996 to 2001. In contrast, the Inuit population continues to grow at a constant rate. Statistics Canada reported a growth rate of 12.0 percent among the Inuit between 2001 and 2006 (Statistics Canada, 2006a; 2006b). Between 1996 and 2001, the growth rate was 12.1 percent. The Métis population is growing faster than the First Nations or Inuit populations. Between 1996 and 2001, Statistics Canada reported a growth rate of 43.2 percent. Between 2001 and 2006, the growth rate was 33.3 percent (Statistics Canada, 2006a; 2006b).

According to Statistics Canada, nearly half the increase in the Aboriginal population can be attributed to demographic factors, such as high birth rate. Other factors include increased awareness of one's Aboriginal roots, increased self-identification for the Métis, and a more complete enumeration of reserves (Statistics Canada, 2008a; 2008b).

This national perspective glosses over the complexity and diversity of the Aboriginal peoples across Canada, in the territories and provinces. Of direct relevance to this project is the proportion of Aboriginal peoples in the territories and provinces. As shown in Figure 1, Aboriginal peoples constitute a significant proportion of the population in the territories, and in Manitoba and Saskatchewan. In contrast, the Aboriginal population is less than 3 percent in Ontario, Quebec, New Brunswick, Nova Scotia and Prince Edward Island.

One key point emerges from the above discussion. At the national level, the Aboriginal population represents 3.8 percent of the overall population and cannot, through the democratic process alone, hope to have its interests represented and protected (Schouls, 1996). Alternative arrangements such as Aboriginal-specific provisions entrenched in legislation and policies are necessary. While the same logic applies to Aboriginal peoples in most provinces, this is not the case in the territories where Aboriginal peoples constitute an important proportion of the voters.

3.2 Aboriginal organizations with a health policy mandate in the provinces, territories and Canada

Since the 1960s, Aboriginal organizations have emerged to meet advocacy needs or as a result of self-government activities. Nationally, there are seven Aboriginal organizations whose mandate is to advocate in health policy-related matters, among others. The following descriptions are excerpts from the websites of these organizations.

The Assembly of First Nations (AFN) was incorporated in 1969. It was previously known as the National Indian Brotherhood. The AFN is the national representative organization of the First Nations in Canada. The AFN Secretariat is designed to present the views of the various First Nations through their leaders in areas such as: Aboriginal and Treaty Rights, economic development, education, languages and literacy, health, housing, social development, justice, taxation, land claims, environment, and a whole array of issues that are of common concern which

Table 1: Aboriginal Identity Population in Canada, 2006

Geographic name	Total Population (A)	Aboriginal Identity Population (B)	North American Indian	Métis	Inuit	Non-Aboriginal Identity Population	% of Canadian Aboriginal Population (Column B ÷ Population of Canada)	Aboriginal Population as % of the P or T Population (Column B ÷ Column A)
Canada	31,241,030	1,172,785	698,025	389,780	50,480	30,068,240	3.8%	
Yukon Territory	30,190	7,580	6,280	800	255	22,615	1%	25.1%
Northwest Territories	41,060	20,635	12,640	3,580	4,160	20,420	2%	50.3%
Nunavut	29,325	24,915	100	130	24,635	4,405	2%	85.0%
British Columbia	4,074,385	196,075	129,580	59,445	795	3,878,310	17%	4.8%
Alberta	3,256,355	188,365	97,275	85,495	1,610	3,067,990	16%	5.8%
Saskatchewan	953,850	141,890	91,400	48,120	215	811,960	12%	14.9%
Manitoba	1,133,515	175,395	100,640	71,805	565	958,115	15%	15.5%
Ontario	12,028,895	242,495	158,395	73,605	2,035	11,786,405	21%	2.0%
Quebec	7,435,905	108,425	65,085	27,980	10,950	7,327,475	9%	1.5%
New Brunswick	719,650	17,650	12,385	4,270	185	701,995	2%	2.5%
Nova Scotia	903,090	24,175	15,240	7,680	325	878,920	2%	2.7%
Prince Edward Island	134,205	1,730	1,225	385	30	132,475	0%	1.3%
Newfoundland and Labrador	500,610	23,455	7,765	6,470	4,715	477,160	2%	4.7%

Statistics Canada, 2007

arise from time to time. More information is available at www.afn.ca/.

The Inuit Tapiriit Kanatami (ITK), formerly Inuit Tapiriit of Canada, is the national voice of Canada's Inuit. Founded in 1971, the organization represents and promotes the interests of Inuit. In its history, ITK has been effective and successful at advancing Inuit interests by forging constructive and co-operative relationships with different levels of government in Canada, notably in the area of comprehensive land claim settlements, and representing Inuit during the constitutional talks of the 1980s. More information is available at www.itk.ca/.

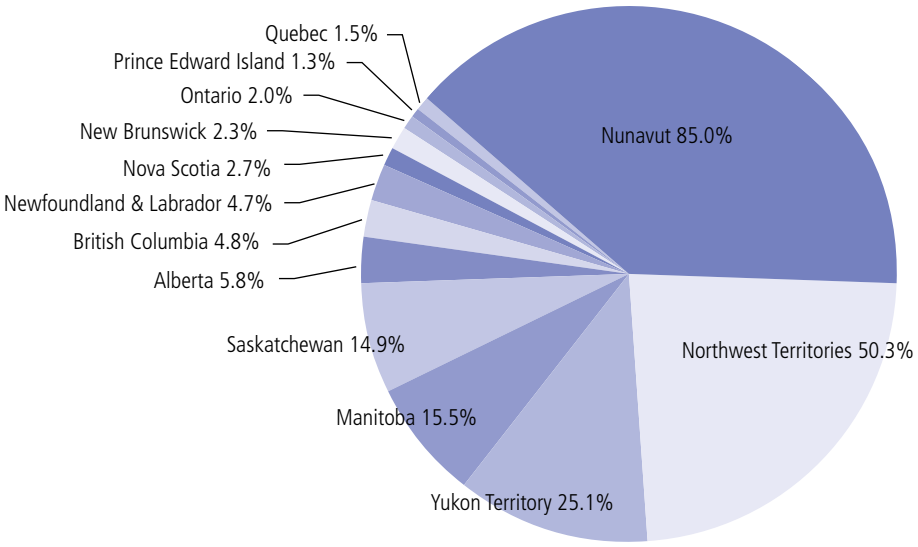

Figure 1: Percentage of the territorial or provincial population that claims Aboriginal identity 2006 (Statistics Canada, 2007)

The Métis National Council (MNC) has been representing the Métis Nation nationally and internationally since 1983. It receives its mandate and direction from the democratically elected leadership of the Métis Nation's governments from Ontario westward. Specifically, the MNC reflects and moves forward on the aspirations of these Métis governments at national and international levels. More information is available at www.metisnation.ca/.

The Congress of Aboriginal Peoples (CAP) represents the interests of Aboriginal peoples living off-reserve. Founded in 1971 as the Native Council of Canada, CAP's goals are to re-establish recognition of non-status and off-reserve Aboriginal people, and to obtain fundamental Aboriginal and human rights for them. More information is available at www.abo-peoples.org/.

The Native Women's Association of Canada (NWAC) was founded to enhance, promote, and foster the social, economic, cultural and political well-being of First Nations and Métis women within First Nation, Métis and Canadian societies. NWAC is an aggregate of thirteen Native women's organizations from across Canada and was incorporated as a non-profit organization in 1974. More information is available at www.nwac-hq.org/.

The National Association of Friendship Centres (NAFC) was established in 1972 to represent the growing number of Friendship Centres at the national level. Friendship Centres are non-profit organizations located in urban centres across Canada to meet specific needs of Aboriginal peoples living in urban areas. More information is available at www.nafc-aboriginal.com/about.htm.

The National Aboriginal Health Organization (NAHO) was incorporated in 2000. NAHO is an Aboriginal-designed and -controlled body committed to influencing and advancing the health and well-being of Aboriginal Peoples by carrying out knowledge-based strategies. More information is available at www.naho.ca/english/.

Aboriginal health professional associations have also emerged over the years, to promote the development of an Aboriginal health workforce and the integration of Aboriginal values in practice. Examples include,

- The Indigenous Physicians Association of Canada (IPAC). More information is available at www.ipac-amic.org
- The Aboriginal Nurses Association of Canada (ANAC) founded in 1975. More information is available at www.anac.on.ca; and
- The National Indian & Inuit Community Health Representatives Organization (NIICHRO) created in 1992. More information is available at www.niichro.com/2004.

At the territorial and provincial levels, numerous organizations have emerged, some as a result of structures created by the Indian Act (Bands, Tribal Councils), some as a result of self-government activities (for example, the Grand Council of the Crees), and some as a result of advocacy needs (Aboriginal women's associations).

Key Aboriginal organizations with a health mandate are listed in Appendix B. A total of 41 separate Aboriginal organizations are documented at the territorial and provincial levels alone. The list may, however, not be complete. Numerous regional and community-based organizations also exist.

3.3 Summary

A key point emerging from these findings is that although the Aboriginal population represents only 3.8 percent of the overall population, it does represent a significant proportion of the territorial population, where it can hope to impact policies through the democratic process alone. Elsewhere, alternative arrangements, such as Aboriginal-specific provisions entrenched in legislation and policies, are necessary.

There are many existing Aboriginal organizations with a health specific mandate. While it is beyond the scope of this project to assess the impact these organizations have had on Aboriginal health policy decisions, there is ground to feel encouraged.

4. Aboriginal Peoples and the Federal Government

This section explores the relationship between Aboriginal peoples and the federal government. The federal government plays a very important role nationally in providing broad directions for policies and programs that reflect national values. The leadership of the federal government in the adoption of the Canada Health Act 1984 or in responding to the SARS outbreak are cases in point. The section begins with a review of key historic documents that continue to be of relevance today. This is followed by a discussion of the role key federal departments play in Aboriginal health.

4.1 Foundational documents

The Royal Proclamation: Canada's relationship with Aboriginal peoples takes root in its unique history. Simply put, the British Crown issued the Royal Proclamation in 1763, following the 1759 conquest of what was known as New France. The Royal Proclamation was an attempt to contain a westward expansion from the American colonies and to create an alliance between the Crown and the Aboriginal populations to ensure the sovereignty of the British Crown (Coates & Morrison, 1986). It essentially stated that the indigenous peoples of Canada were not conquered and retained

title to their ancestral territory. Any encroachment on the part of settlers was to be approved by the Crown, negotiated through the Treaty process, and duly compensated. Aboriginal lands could only be acquired by the Crown (King George, 1763).

The Royal Proclamation has been said to apply to the parts of what is now Canada that were under British rule in 1763 (excluding British Columbia and the lands that had been given to the Hudson's Bay Company). It has, nevertheless, continued to inform the relationship between Canada and Aboriginal peoples, and a concept of Aboriginal rights (Havemann, 1999).

The 1867 British North America Act (also known as the Constitution Act 1867) created the federal dominion. Canada is a highly decentralized federation (Savoie, 1999). The Constitution Act 1867 defined Indian Affairs as an area of federal jurisdiction, and health services as an area of provincial jurisdiction. As shown in Table 2, the language was however broad, leaving considerable room for interpretation.

Section 35 of the Constitutional amendment of 1982 recognizes and affirms existing Aboriginal and treaty rights. The Act goes on to state that Aboriginal peoples include the Indian, Inuit and Métis peoples. The words "Indian," "Inuit," or "Métis' appear nowhere else in the document.

The 1982 Constitutional amendment has clarified issues of Aboriginal rights.

Section 25 guarantees that provisions included under the Charter of Rights cannot abrogate or derogate from Aboriginal rights entrenched in treaties, the Royal Proclamation and land claims.

Aboriginal Rights and Freedoms Not Affected by Charter

25. The guarantee in this Charter of certain rights and freedoms shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada including

a) any rights or freedoms that have been recognized by the Royal Proclamation of October 7, 1763; and
b) any rights or freedoms that now exist by way of land claims agreements or may be so acquired.

Section 35 of the Constitution has affirmed the rights of Aboriginal peoples, and for the first time in Canada's history, recognized Métis as Aboriginal peoples.

Rights of the Aboriginal Peoples of Canada

Recognition of existing aboriginal and treaty rights

35. (1) The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed.

Definition of "aboriginal peoples of Canada"

2) In this Act, "aboriginal peoples of Canada" includes the Indian, Inuit and Métis peoples of Canada.

Land claims agreements

3) For greater certainty, in subsection (1) "treaty rights" includes rights that now exist by way of land claims agreements or may be so acquired.

Aboriginal and treaty rights are guaranteed equally to both sexes

4) Notwithstanding any other provision of this Act, the aboriginal and treaty rights referred to in subsection (1) are guaranteed equally to male and female persons.

Commitment to participation in constitutional conference

35.1 The government of Canada and the provincial governments are committed to the principle that, before any amendment is made to Class 24 of section 91 of the "Constitution Act, 1867", to section 25 of this Act or to this Part,

a) a constitutional conference that includes in its agenda an item relating to the proposed amendment, composed of the Prime Minister of Canada and the first ministers of the provinces, will be convened by the Prime Minister of Canada; and
b) the Prime Minister of Canada will invite representatives of the aboriginal peoples of Canada to participate in the discussions on that item.

Whether the 1982 Constitutional amendment resulted in a redefinition of federal responsibility with regards to Métis and Indians not eligible for registration under the Indian Act is a matter of debate (Métis National Council, 2008). Métis have for a long time argued that they should be included under the category "Indians" as defined in the Indian Act (Jackman, 2000). So far, eligibility for federal health services has not been extended to Métis or to Aboriginal peoples not eligible for registration under the Indian Act.

4.2 The Indian Act

The Indian Act was implemented in 1876. The Act defines the legislative authority for the federal government's obligation for Indian health in Section 73, which gives the Governor in Council the authority to make regulations,

a) to prevent, mitigate and control the spread of diseases on reserves, whether

Table 2: Areas of Exclusive Jurisdiction, 1867

Areas of federal jurisdiction	Areas of provincial jurisdiction
91(24) Indians, and Lands reserved for the Indians.	92(7) The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.

or not the diseases are infectious or communicable;
b) to provide medical treatment and health services for Indians;
c) to provide compulsory hospitalization and treatment for infectious diseases among Indians;
d) to provide for the inspection of premises on reserves and the destruction, alteration or renovation thereof;
e) to prevent overcrowding of premises on reserves used as dwellings;
f) to provide for sanitary conditions in private premises on reserves as well as in public places on reserve (Canada, 1985a).

It should be noted that the Indian Act's regulation-making power does not provide sufficient authority for a comprehensive public health and health services regulatory framework on First Nations reserves. The Act does not extend to Inuit.

4.3 Federal, territorial/provincial and Aboriginal jurisdiction

The relationship between the federal government and territorial or provincial authorities is complex. Territorial and provincial laws that attempt to regulate registered Indians in an area of exclusive federal authority are invalid. However, territorial and provincial laws that do not invade a domain of exclusive federal authority may apply to Indians (British Columbia Ministry of Aboriginal Relations and Reconciliation, 2010).

Some First Nations have argued that Sections 73 and 81 of the Indian Act provide First Nations jurisdiction over public health on-reserve (Assembly of First Nations, 2006a). Section 81, "Powers of the Council," does allow bands to enact health related by-laws. However, section 4, "Application of Act," has historically prevented the enactment of health related by-laws that are inconsistent with territorial and provincial health laws by requiring that First Nations comply with territorial and provincial health laws instead.

This is a debated area and has been problematized. The report of the National Advisory Committee on SARS and Public Health noted:

> A continuing challenge in mounting appropriate [public health] responses [to emerging threats] is a recurring tension between the right and aspirations of Aboriginal peoples to greater self-determination within the Canadian federation, and the uncertain effectiveness and efficiency of reinforcing the extant pattern of separate health systems for First Nations and Inuit communities. (National Advisory Committee on SARS and Public Health, 2003, p. 79)

This debate is likely to continue for some time.

4.4 Strengthening relationships and closing the gap (the Kelowna Accord)[7]

A special meeting of First Ministers and Aboriginal leaders held in September 2004 resulted in a commitment to design an action plan to improve access to health services for all Aboriginal peoples. What followed was months of discussions and consultation by Aboriginal groups to design a blueprint for improving First Nations, Inuit, and Métis health.

The blueprints were tabled and debated at a meeting of the First Ministers in November 2005, in Kelowna, British Columbia. As a result, the First Ministers and First Nations leaders committed, through the document *First Ministers and National Aboriginal Leaders Strengthening Relationships and Closing the Gap* (commonly known as the Kelowna Accord), to a $5.1 billion, long-term plan. The Accord and associated financial commitment was short lived, ending with a shift of government at the federal level. Still, two provinces, British Columbia and Nova Scotia, have adopted policies and strategies that were designed in the context of these discussions. These are discussed in Section 6.

4.5 Current federal departments and mandates

As discussed in the methodology section, we reviewed the mandate of five departments for this project: the Department of Canadian Heritage, the Federal Healthcare Partnership, Indian and Northern Affairs Canada, the Public Health Agency of Canada, and Health Canada. Of these, both Health Canada and the Public Health Agency of Canada play the most important role, and are discussed below.

4.5.1 Health Canada

Health and Welfare Canada was created in 1944. It has changed its name and shifted its organization a number of times. Its latest iteration, the federal Department of Health, was established by the Department of Health Act 1996. The Act states that:

> The powers, duties and functions of the Minister extend to and include all matters over which Parliament has jurisdiction relating to the promotion and preservation of the health of the people of Canada not by law assigned to any other department, board or agency of the Government of Canada (Canada, 1996).

Its mandate focuses on five core roles:

- First, Health Canada administers the Canada Health Act, which embodies the key values and principles of Medicare.
- Second, it provides policy support for the federal government's Canada Health Transfer. As part of that role,

[7] The term "Kelowna Accord" was never used at the First Ministers' Meeting, nor does it appear on either of the documents. The term first appeared in a Toronto Star article in January of 2006.

Health Canada transfers funds to First Nations and Inuit organizations and communities to deliver community health services (see the discussion on the First Nations and Inuit Health Branch, below). The Department also provides grants and contributions to various organizations that reinforce the Department's health objectives.

- Third, Health Canada acts as a regulator for thousands of products, including: biologics, consumer goods, foods, medical devices, natural health products, pesticides, pharmaceuticals, and toxic substances. Health Canada also delivers a range of programs and services in environmental health and protection, and has responsibilities in the areas of substance abuse, tobacco policy, workplace health and the safe use of consumer products. As well, Health Canada monitors and tracks diseases and takes action where required.
- Fourth, Health Canada is a service provider of supplementary health benefits to eligible First Nations and Inuit to cover: pharmaceuticals, dental services, vision services, medical transportation, medical supplies and equipment, and crisis intervention mental health counseling. This program is known as the Non-Insured Health Benefits (NIHB) program, and is discussed below.
- Finally, Health Canada plays an important role as a health information provider (Health Canada, 2007a).

The Act fails to clarify whether the Department has responsibilities in health matters not expressly addressed by provincial legislation, such as on-reserve public health and health service provision.

Health Canada and the Minister of Health are responsible for 13 Acts:

- Assisted Human Reproduction Act
- Canada Health Act
- Canadian Centre on Substance Abuse Act
- Canadian Institutes of Health Research Act
- Controlled Drugs and Substances Act
- Food and Drugs Act
- Hazardous Materials Information Review Act
- Hazardous Products Act
- Pest Control Products Act
- Pesticide Residue Compensation Act
- Radiation Emitting Devices Act
- Tobacco Act
- Canadian Environmental Protection Act (co-administered by Environment Canada).

These Acts do not contain Aboriginal-specific provisions.

The First Nations and Inuit Health Branch (FNIHB) of Health Canada is Health Canada's largest program. Its annual budget is more than two thirds of Health Canada's three billion dollar budget (Treasury Board of Canada Secretariat, 2008). Health Canada's role in First Nations and Inuit health goes back to 1945, when Indian health services were transferred from Indian Affairs and began to provide direct health services to First Nations peoples on-reserve and Inuit in the north.

FNIHB has slowly moved away from direct service delivery to First Nations and Inuit communities (Lavoie et al., 2005). Devolution, a policy that resulted in the establishment of the territorial Departments of Health, was largely completed by the late 1980s.[8] By the mid 1980s, the Federal government began to develop administrative arrangements to provide First Nations and Inuit communities with the opportunity to exercise more control over community-based health services. The mechanisms that emerged are linked to two policies: the 1979 Indian Health Policy and the 1989 Health Transfer Policy.

The Indian Health Policy was adopted on September 19, 1979 (Crombie, 1979). The policy was a two page document with one broad based objective:

> the goal of Federal Indian Health Policy is to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves (Health Canada, 2007c, para. 4).

It listed three pillars from which to improve Indian health:

1. Increase the health status of Indian communities, through mechanisms generated and maintained by the communities themselves;
2. Strengthen traditional and new relationships between Federal, Provincial, and local governments and Indian government organizations by encouraging greater involvement in the planning, budgeting and delivery of health programs; and,
3. Increase the capacity of Indian communities to play a positive and active role within the Canadian health care system and with decisions affecting their health (Health Canada, 2007c).

The Indian Health Policy did not lead to the formulation of an implementation strategy with short, medium and long term objectives. The adoption of the Indian Health Policy was followed three months later with the release of the Indian Health Discussion Paper that presented the results of a study of Indian health services conducted by the Medical Services Branch (MSB). It made four broad recommendations:

1. the achievement of effective communication between Indian people and National Health and Welfare through the development of mutually acceptable communication strategies;
2. sharply increased efforts to reduce

[8] See Dacks (1990) for a detailed history.

environmentally related diseases and to promote a healthy social environment on Indian reserves;
3. the achievement of self-determination in the health field by Indian communities; and
4. the encouragement of community development through the creation of a National Institute of Indian Health and Social Development (National Health and Welfare, 1979).

The paper addressed a number of issues, namely the transfer of existing health services to Indian communities. By 1982, the Community Health Demonstration Program was established to allow First Nations to experiment with different models of community-based service delivery (Garro et al., 1986).

The term "Indian" in the Indian Health Policy has resulted in ambiguities. Clearly excluded from the scope of the policy were Métis communities, non-status Indians and Indians living off-reserve. The policy, however, failed to clarify whether it was intended to include Inuit.

The Health Transfer Policy is the most tangible outcome of the Indian Health Policy. The Health Transfer Policy, initiated in 1989, has provided opportunities to single communities and Tribal Councils for increased local responsibility in the planning and delivery of community-based health services, as well as some regionally-based programs (Lavoie et al., 2005). The objective was to promote community uptake of community-based health services, as well as some regional programs provided by FNIHB. Options are described in Table 3. As of 2003, FNIHB reported that 295 communities had signed a transfer agreement.

An alternative model, the integrated model, was created in 1994. According to the 2005 Evaluation of the Health Transfer Policy report, this model was designed to broaden opportunities for community control to communities that were deemed too small to successfully transfer (see Lavoie et al., 2005 pp. 43-44 for a more detailed discussion). Provisions for the integrated model were approved under separate Treasury Board authorities and differ somewhat from that of transfer, with different criteria for eligibility. As a result, First Nations communities in the Yukon can sign an integrated agreement but are however not eligible to transfer (Lavoie et al., 2005). As of 2003, 176 communities had signed an integrated agreement.

Communities that prefer more flexibility can negotiate a self-government agreement, which brings together INAC and FNIHB programs under a single agreement that allows communities to shift funding from programs previously funded separately (economic development, education, health, social assistance, etc.). As of 2003, only 12 such agreements have been signed. Finally, communities that have opted not to avail themselves of these options are nevertheless involved in the administration of a number of programs,[9] all funded under separate and inflexible agreements (Health Canada, 2003).

Transfer and integrated agreements are defined by policy. These agreements are entrenched in contribution agreements which are, from a legal stand point, contracts. This contrasts with self-government agreements which result in legislation.

With all options, FNIHB may also provide some direct services. FNIHB funds 34 separate programs (Health Canada, 2007b). Approximately 1 in 4 of these programs cannot be included in integrated, transfer or self-government agreements. Communities must access these programs through proposal writing and, if successful, manage the funding through separate contribution agreements. Three separate evaluations have raised administrative issues and concerns over the level of fragmentation associated with this multiplicity of small programs (Gibbons, 1992; Institute for Human Resource Development, 1995; Lavoie et al., 2005).

Current policy developments suggest that FNIHB continues to be committed to promoting First Nations and Inuit self-management of community-based health services (Health Canada, 2008). Other opportunities have emerged as a result of unique processes of negotiations: the James Bay and Northern Quebec Agreement and the Nisga'a Final Agreement are examples. These are discussed in Section 5.

The Non-Insured Health Benefit (NIHB) program, although not a policy, warrants a brief summary. The Canada Health Act defines publicly insured (funded) health services such as hospitalization, access to general practitioners and specialists. Non-insured services are those that individuals must pay for out of pocket or through private insurance. The full complement of insured services varies somewhat from province to province and across the territories. For example, Manitoba fully covers the costs of chiropractic care, whereas British Columbia only partially covers this service.

Registered Indians living on and off-reserve and Inuit living anywhere in Canada are entitled to services included under the NIHB program. This program covers the cost of medication, eye care, dental care, medical equipment

[9] For examples, the Community Health Nursing, Community Health Representatives, Brighter Futures, Building Healthy Communities, Canada Prenatal Nutrition Program. See FNIHB's program compendium for a detailed list (Health Canada, 2007b).

Table 3: Models of Community Control

	Under the purview of FNIHB			Under the purview of INAC
Model	Non-transferred, non integrated	Integrated	Transfer	Self-government
Eligibility	Communities south of the 60th parallel (the provinces)	Communities in the Yukon, Northwest Territories and south of the 60th parallel (the provinces)	Communities south of the 60th parallel (the provinces)	All communities
Duration of agreement	Up to 3 years depending on individual program authority	Phase 1: Up to 1 year Phase 2: Up to 5 years	3 to 5 years	5 years
Description	All transferable and non-transferable programs are funded under separate agreements.	All transferable programs chosen by the community under a single 3 to 5 years agreement. Non-transferable programs under separate contribution agreements.	All transferable programs chosen by the community under a single 3 to 5 years agreement. Non-transferable programs under separate contribution agreements.	All of INAC and most FNIHB programs can be included under a single flexible agreement. Communities can chose the programs to be included.
Budgetary line flexibility	No, unless prior written approval of FNIHB	With written approval of FNIHB	Yes, among transferable programs. Cannot reallocate among targeted programs.	Yes, this is the most flexible model.

and medical transportation. Medical transportation support is limited to Registered Indians living on-reserve and Inuit from Nunavik and Nunatsiavut traveling from their traditional territories to urban centres for health care. The territories have adopted slightly different definitions.

The NIHB is often mentioned by Aboriginal peoples in relation to a treaty right to health (Assembly of First Nations, 2005). This perspective is not shared by the federal government (Boyer, 2004). Historically at least, the federal position has been that services were extended to Indians for humanitarian reasons (see Waldram et al., 2006, p. 178-181 for a more detailed discussion). The federal government has not recently taken an explicit position on this matter.

4.5.2 The Public Health Agency of Canada

The Public Health Agency of Canada (PHAC) was created in 2004 by an Act of Parliament (Canada, 2006a) following the 2003 severe acute respiratory syndrome (SARS) outbreak. The report of the National Advisory Committee on SARS and Public Health (National Advisory Committee on SARS and Public Health, 2003) has highlighted that the federal-provincial jurisdictional fragmentation over Aboriginal peoples' health care is a public health concern that creates barriers to health service access.

PHAC currently offers a number of off-reserve health programs. The programs are specifically designed to meet the needs of marginalized populations, including Aboriginal people living off-reserve. Aboriginal-specific policies, if they exist, could not be located. The Public Health Agency of Canada – Strategic Plan: 2007 to 2012 states that PHAC plans to increase its capacity in Aboriginal health and develop a strong over-arching strategic Aboriginal public health policy. To do this, PHAC proposes to launch and maintain collaborative relationships with national and regional Aboriginal organizations and other federal departments (Canada, 2007b). Provincial and territorial jurisdictions are not mentioned.

4.6 Summary

The Federal government acknowledges a special relationship with Aboriginal peoples. Recognition of this relationship was first limited to First Nations (Indians), but was extended to Inuit in 1939. As a result of the 1982 Constitutional amendment, Métis are now recognized as an Aboriginal people. Whether federal jurisdiction extends to Métis and those not eligible for registration under the Indian Act is a matter of perspective. So far, services have not been extended to them.

Constitutional areas of federal/provincial jurisdiction remain broadly defined, leaving opportunities for confusion, and for gaps to emerge as a result of policy

shifts in one jurisdiction or when new issues emerge. Jurisdiction over public health on-reserves is a case in point.

As can be seen from the discussion above, federal policies informing issues of jurisdiction over Aboriginal health are thin and loosely woven. Federal policies fail to address the Métis or those not eligible for registration as Indians under the Indian Act. These policies do not link to legislation, other than the Indian Act and the Canada Health Act 1984. Provisions under these Acts are broadly worded, and subject to interpretation.

The Public Health Agency of Canada's proposal to develop an over-arching Aboriginal public health policy negotiated with federal departments and Aboriginal organizations may partially address this particular issue. It may, however, not fully succeed in clarifying other jurisdictional issues or provide guidance to the territories and the provinces.

5. The Treaties, Self-Government Activities and Health

Some treaties and many self-government agreements have framed Aboriginal responsibilities for health services. A limited number of treaties were signed before Confederation. Most of these were peace and friendship treaties and did not result in land surrenders. There were, however, some exceptions to this. The Upper Canada and Lower Canada Land Surrender Treaties, the Robinson and Williams Treaties, and the Douglas Treaties were pre-Confederation treaties that resulted in land surrenders.

Treaties signed after Confederation were generally associated with land surrenders. A collection of treaties commonly known as the numbered treaties were signed to facilitate the expansion of settlers westward. The boundaries of these treaties cross vast tracts of land. They did not respect Aboriginal peoples' own understanding of their traditional territories. Finally, many numbered treaties were signed before the creation of western provinces and the territories. It is thus not surprising to find that single treaties cross current provincial and territorial boundaries (Indian and Northern Affairs Canada, 2008). The boundaries of the same treaties ignored traditional boundaries, dividing some nations.

Over the past four decades, some Aboriginal nations have signed modern treaties or land claim agreements. Historic Treaties and trends in self-government activities have resulted in a variety of initiatives and arrangements that have created opportunities for Aboriginal engagement in health policy and service delivery. These are discussed in turn.

5.1 Historic treaties

This section summarizes the findings of our review of the numbered treaties, which is detailed in Appendix C. Only Treaty Six includes specific healthcare provisions, with its so-called "medicine chest clause". This clause charges the federal government with the responsibility of protecting First Nations people from pestilence and famine, and to provide a "medicine chest"[10] in the house of each Indian agent. The First Nations' rationale for requesting this provision is clearly articulated in the records of Alexander Morris, the Treaty Commissioner at the time. Morris writes:

> The Indians were apprehensive of their future. They saw the food supply, the buffalo, passing away, and they were anxious and distressed... They desired to be fed. Smallpox had destroyed them by hundreds a few years before, and they dreaded pestilence and famine (1880, p. 178).

Requests for similar provisions were made in the negotiations of Treaties 8, 10 and 11. Specifics included a request for medicines and for a resident medical man. These requests were, however, not included in the text of these Treaties. Nevertheless, the Treaty Commissioner's notes make clear commitments to provide medicines (Canada, 1899; Canada, 1906; Canada, 1921).

While many First Nations view these provisions as the basis of a federal obligation to provide comprehensive health services, the federal government has adopted the position that the provision of medical care is a matter of policy and not of right (Boyer, 2004). The federal position is based on a ruling of the 1966 Supreme Court of Saskatchewan, known as the Johnston appeal, which states that:

> the [medicine chest] clause itself does not give to the Indians the 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 (Canada, 1966, p. 753).

According to this interpretation, it is up to the federal government to determine the legitimacy of Indians' request for health care and to allocate it free of charge or at a cost.

A broader approach to treaty interpretation has since been supported in Canadian courts. In 1989, the British Columbia Court of Appeal indicated that treaty interpretation should be fair, large and liberal in favour of the Indians, that the treaty be construed in terms which would be naturally understood by the Indians, that the Crown should avoid sharp dealings, and that interpretations of ambiguous wordings should not prejudice the Indians if another interpretation is possible (Claxton & Saanichton Marina Ltd, 1989).

[10] A medicine cabinet containing medications available at the time.

Further, a 1999 ruling on a case brought forth by the Wuskwi Sipihk Cree Nation of Manitoba has criticised the narrow interpretation adopted in the Johnston appeal, stating instead that:

> 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 (Canada, 1999, p. 5).

This ruling has yet to impact the policy position of the government of Canada.

5.2 Self-government activities in the territories and the provinces

Modern treaties have been signed in areas where historic treaties were never negotiated (for examples, the James Bay and Northern Quebec Agreement, Canada, 1974; the Nunavut Lands Claim Agreement, Canada, 1993; and the Agreement with the Nisga'a Nation et al., 1999). Every modern treaty and self-government agreement has resulted in different arrangements. For example, all four Inuit regions have engaged in self-government activities, resulting in increased autonomy in key areas.

- The Nunavut Land Claim Agreement resulted in the creation of the territory of Nunavut.
- In the Inuvialuit and Nunatsiaq regions, Inuit have signed self-government agreements.
- In Nunavik, the James Bay and Northern Quebec Agreement gave rise to a unique model whereby Inuit-managed structures that resulted from this agreement (the Health Board, the School Board) were seen as extensions of the provincial government's own structures. An agreement signed in 2007 will lead to the creation of the Regional Government of Nunavik, which will have oversight of all Nunavik structures created as a result of the James Bay and Northern Quebec Agreement. This new order of government will answer directly to the National Assembly of Quebec (Indian and Northern Affairs Canada, 2007).

Most self-government agreements and modern treaties have established Aboriginal government's jurisdiction in health. Health care structures that emerged as a result of the James Bay and Northern Quebec Agreement are somewhat unique in Canada, in that these structures are co-funded by the federal and provincial governments to serve the health care needs of Nunavik Inuit and the James Bay Cree (Canada, 1974). Although managed by Aboriginal authorities, these structures are also linked to the provincial health care system.

Further, the Nisga'a Agreement, the James Bay and Northern Quebec Agreement, and the Labrador Inuit Association Agreement are tripartite agreements that include provisions for self-administration of health services. The new arrangements include provisions that clarify jurisdiction, roles and responsibilities, as well as mechanisms to address jurisdictional issues as they emerge. Still, each agreement is somewhat unique, thereby creating somewhat different arrangements and obligations. Noteworthy, self-government agreements signed in the territories do not include provisions for health services. Neither does the Sechelt Indian Band Self-Government Act, although this agreement contains a provision authorizing the First Nation to make laws in relation to health services on Sechelt lands (Canada, 1986).

5.3 Summary

Of the historic treaties, only Treaty Six contains health-related provisions. A 1999 court case reversing earlier interpretations of the scope of the Medicine Chest clause has still to impact policy. Self-government agreements signed by the Nisga'a, the Nunatsiaq and Nunavik Inuit, as well as the James Bay Cree include provisions for health services. Not all self-governments do.

These self-government agreements have provided opportunities for Aboriginal engagement in health policy, planning and delivery. This contrasts with opportunities extended to signatories of historic treaties, which have been limited to participating in the planning, management and delivery of community health services, under the Health Transfer Policy.

6. The Legislative and Policy Environment for Aboriginal Health in the Territories and the Provinces

This section details the findings of our review of territorial and provincial legislation and policies that contain Aboriginal-specific provisions, highlighting areas of strengths and gaps. The opportunities for Aboriginal engagement created by the decentralization of provincial healthcare systems are then explored. The section concludes with a more detailed discussion of key legislation and policies that may serve as models for other jurisdictions.

6.1 Aboriginal-specific mandates, legislation and policies

Findings for territorial and provincial health legislative frameworks are summarized in Appendix A, and detailed in Appendix E.

Jurisdictional provisions: Our review of evidence shows that legislation in some territories and provinces contain specific provisions to clarify the responsibilities of these territorial and provincial governments in Aboriginal health. These are, however, quite limited and focus on jurisdiction. Legislation in Alberta are said to apply to Métis settlements. Alberta, Saskatchewan, Ontario and

New Brunswick legislation specifically state that the minister may opt to enter into an agreement with Canada and/or First Nations for the delivery of health services, thereby clearly indicating that the provision of services is outside the province's mandate. Examples are provided in Table 4.

Health legislation in the Yukon, Quebec, and Newfoundland and Labrador contain provisions related to existing self-government agreements and modern treaties, thereby clarifying responsibilities of these territorial and provincial governments in health only in those areas articulated in these agreements. For example, while the Yukon Health Act highlights the importance of partnerships with Aboriginal groups, it also stipulates that the Yukon Land Claim Agreement or the Yukon First Nations Self-Government Agreement shall prevail in a conflict (Yukon, 2002a). The 1991 Loi sur les services de santé et les services sociaux defines a process for handling complaints related to access to services for signatories of the James Bay and Northern Québec Agreement. Similar provisions exist in Newfoundland and Labrador, as shown in Table 5.

Policies and legislation that speak to traditional healing practices: As shown in Table 6, some legislation include provisions related to traditional healing.[11] The Yukon is the only jurisdiction where health legislation recognizes the need to respect traditional healing practices and the importance of establishing partnerships with Aboriginal peoples. Quebec, Manitoba and Ontario recognize that Aboriginal midwives should be exempt from control specified under the Code of Professions. Specific provisions are listed under the Midwifery Act. The same exemptions are extended to traditional healers in Ontario.

[11] The legislation and policies consulted did not specify what was included under this term.

Table 4: Excerpts of legislation provisions that clarify jurisdiction

Act	Provision
The Alberta Public Health Act 2000	"65 (1) When an order is issued under section 62 in respect of patented land as defined in the Métis Settlements Act, the regional health authority may submit a notice of health hazard to the Registrar of the Métis Settlements Land Registry and the Registrar shall record the notice against the Métis title register for the land that is subject to the order. (2) A notice of health hazard recorded under this section does not lapse and shall not be cancelled except on the receipt by the Registrar of the Métis Settlements Land Registry, of a notice in writing from the regional health authority requesting cancellation. (3) On recording a notice of health hazard, the Registrar of the Métis Settlements Land Registry shall notify the person against whose Métis title the notice is recorded and every person who has recorded an interest against the Métis title" (Alberta, 2000e).
The Alberta Hospitals Act 2000	Part 3 - Hospitalization Benefits Plan states that the Minister may on behalf of the Government of Alberta enter into an agreement with the Government of Canada providing for the making of contributions by Canada to Alberta in respect of the costs incurred by Alberta in providing insured services to Indians residing in Indian reserves in Alberta (Alberta, 2000d).
The Saskatchewan Public Health Act 1994	"For the purpose of carrying out this Act according to its intent, the minister may enter into agreements with a local authority, the Government of Canada or its agencies, the government of another province or territory of Canada or its agencies, an Indian band or any other person" (Saskatchewan, 1994).
The Ontario Long-Term Care Act 1994	"(7) The Minister shall designate as a multi-service agency, (a) an approved agency that is an organization operating under the authority of a First Nation, if the Minister has entered into an agreement with the First Nation under clause 9 (1) (a) and the approved agency meets the requirements for designation as a multi-service agency set out in the agreement; (b) an approved agency that is an organization operating under the authority of a group of First Nations, if the Minister has entered into an agreement with the group of First Nations under clause 9 (1) (b) and the approved agency meets the requirements for designation as a multi-service agency set out in the agreement; (c) an approved agency that is an organization operating under the authority of an aboriginal community, if the Minister has entered into an agreement under clause 9 (1) (c) with the approved agency or an aboriginal organization other than the approved agency and the approved agency meets the requirements for designation as a multi-service agency set out in the agreement" (Ontario, 1994a).
The New Brunswick Public Health Act	"58(1) The Minister may, subject to the approval of the Lieutenant-Governor in Council, enter into and amend an agreement with (c) a band council as defined in the Indian Act (Canada, 1985a), a municipality or a rural community…" for the purpose of the organization and delivery of the public health programs and services, the prevention of diseases and injuries and the promotion and protection of the health of the people of New Brunswick or any group of them (New Brunswick, 1998).

Finally, British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, New Brunswick and Prince Edward Island have adopted tobacco control legislation that specifies that the legislation does not apply to the use of tobacco for ceremonial purposes (Alberta, 2005; British Columbia, 1996u; Manitoba, 2004; New Brunswick, 1998; 2004; Ontario, 2006c; Prince Edward Island, 2006; Saskatchewan, 2001b).

Table 5: Excerpts of legislation that clarify responsibilities in relation to self-government agreements

Act	Provision
The Newfoundland and Labrador Health and Community Services Act 1995	"2.1 This Act and regulations made under this Act shall be read and applied in conjunction with the Labrador Inuit Land Claims Agreement Act and, where a provision of this Act or regulations made under this Act is inconsistent or conflicts with a provision, term or condition of the Labrador Inuit Land Claims Agreement Act, the provision, term or condition of the Labrador Inuit Land Claims Agreement Act shall have precedence over the provision of this Act" (Newfoundland and Labrador, 1995).

Table 6: Provisions in legislation that speak to traditional healing practices

Name of the Act, Document	Relevance to Aboriginal Health
The Yukon Health Act 2002	This Act stipulates the importance of partnerships with Aboriginal groups and the respect of traditional Aboriginal healing. It also stipulates that the Yukon Land Claim Agreement or the Yukon First Nation Self-Government Agreement shall prevail in a conflict (Yukon, 2002a).
The Manitoba Midwifery Act 1997	8(5) The council shall establish (a) a standing committee for the purpose of recruiting and selecting public representatives to serve on the council and committees of the college; (b) a standing committee to advise the college on issues related to midwifery care to aboriginal women (Manitoba, 1997b).
The Ontario Midwifery Act 1991	Exception for aboriginal midwives (3) An aboriginal person who provides traditional midwifery services may, (a) use the title "aboriginal midwife", a variation or abbreviation or an equivalent in another language; and (b) hold himself or herself out as a person who is qualified to practise in Ontario as an aboriginal midwife (Ontario, 1991a).
The Ontario Regulated Health Professions Act 1991	Exemption, aboriginal healers and midwives 35. (1) This Act does not apply to, (a) aboriginal healers providing traditional healing services to aboriginal persons or members of an aboriginal community; or (b) aboriginal midwives providing traditional midwifery services to aboriginal persons or members of an aboriginal community. Jurisdictions of Colleges (2) Despite subsection (1), an aboriginal healer or aboriginal midwife who is a member of a College is subject to the jurisdiction of the College. Definitions (3) In this section, "aboriginal healer" means an aboriginal person who provides traditional healing services; ("guérisseur autochtone") "aboriginal midwife" means an aboriginal person who provides traditional midwifery services. ("sage-femme autochtone") (Ontario, 1991b).

Aboriginal-specific policies: There exists a limited number of Aboriginal-specific policies across Canada. Ontario was the first province to develop an Aboriginal Health and Wellness Strategy in 1990, and to develop an overarching Aboriginal Health Policy in 1994 (Ontario Aboriginal Health Advocacy Health Initiative, 1999). The Aboriginal Health Policy is intended to act as a governing policy and assist the Ministry of Health in accessing inequities in Aboriginal health programming, responding to Aboriginal priorities, adjusting existing programs to respond more effectively to needs, supporting the reallocation of resources to Aboriginal initiatives, and improving interactions and collaboration between ministry branches to support holistic approaches to health. This is the most comprehensive policy currently in place in Canada. It is perhaps as a result of this policy of Aboriginal engagement that Ontario is also the only jurisdiction to have developed a comprehensive health plan for an influenza pandemic with a section specific to First Nations communities. The plan outlines emergency pandemic procedures and policies, and identifies the needs of First Nations communities during an influenza pandemic. It also clarifies the roles and responsibilities of the Ontario Ministry of Health and Long-Term Care, First Nations and Inuit Health (FNIH), and First Nations communities in responding to an influenza pandemic (Ontario, 2006b).

In British Columbia, the 2005 Transformative Change Accord and the First Nations Health Plan form a Tripartite First Nations policy that aims to close the disparities that exist between First Nations and other British Columbians in the areas of health, education and housing. The policy also intends to clarify issues of Aboriginal title and jurisdiction. It explicitly applies to First Nations, and does not address the needs of other Aboriginal groups in British Columbia (First Nations Leadership Council et al., 2006).

A similar policy was developed in Nova Scotia. The 2005 Providing Health Care, Achieving Health – Mi'kmaq focuses on the specific needs of the Mi'kmaq people, however, it does not address the needs of the Métis and other Aboriginal peoples living in Nova Scotia (Mi'Kmaq et al., 2005).

Métis-specific policies and legislation: The Northwest Territories is the only jurisdiction in Canada where Métis have signed a comprehensive land claims agreement.[12] This agreement was signed by Canada, the Northwest Territories, the Sahtu Dene and the Métis. This is the only instance of federal involvement in Métis land rights. It is also the only jurisdiction with a Métis Health Policy (Northwest Territories Health and Social Services, 2008). The policy is, however, limited to extending access to Non-Insured Health Benefits as provided to Registered Indians.

In Alberta, the 1938 Métis Betterment Act provided land to the Métis. Twelve settlements were established. Eight remain today. Some level of local Métis government was established as a result. The extent of their powers has changed over the years, but the Act did not include provisions related to health or healthcare. The 1989 Métis Settlements Accord, which replaced the 1938 Métis Betterment Act, includes a number of health-specific provisions, including a) the right to make bylaws to promote the health, safety and welfare of the residents of the settlement area; b) the right to invest money in hospital district or health region under the Regional Health Authorities; and c) make bylaws respecting and controlling the health of the residents of the settlement area and against the spread of diseases. Since then, the Métis of Alberta have focused on securing increased control over issues such as housing, child welfare, health and legal institutions (Métis National Council, 2007). Alberta's health legislation state that they extend to Métis settlements.

In Saskatchewan, the Saskatchewan Métis Act 2002 (Saskatchewan, 2001a) has recognized the contribution the Métis Nation has made to the provision of health services to Métis. This recognition has not resulted in the creation of formal mechanisms to improve opportunities for Métis to participate in priority setting or decision-making over health.

6.2 Decentralization

Most provinces and territories (with the exception of Prince Edward Island, the Northwest Territories, and more recently Alberta) have adopted decentralized models of health care delivery. Decentralization is a transfer of authority from the Department of Health to regional authorities tasked with priority setting and the allocation and management of health resources (Saltman et al., 2007). Decentralization is intended to increase opportunities for citizen engagement in local priority setting.

Our findings show that most decentralized provincial healthcare systems have not entrenched mechanisms to ensure Aboriginal representation. British Columbia and Nova Scotia have provisions that stipulate that the make-up of the Board of Directors must reflect the population that the RHAs are set up to serve. Aboriginal peoples are not specifically mentioned.

Ontario is the only province to have established a council composed of Aboriginal peoples to advise on regional priority setting in healthcare, which is provided through the Local Health Integration Networks. Specific provisions are listed in Table 7. Details of the documents reviewed for this analysis are provided in Appendix F.

6.3 Summary

The data explored above describe the Aboriginal health legislative and policy environment that exists in the provinces and the territories. It shows that although progress has been made in the development of legislation and policies that contain Aboriginal-specific provisions, what remains is very much a patchwork. Legislative frameworks show little evidence of concern for addressing Aboriginal needs; the main focus remains the clarification of jurisdiction, and even that is partial. Policies are few. There is considerable variation from one province/territory to the next, and there are significant gaps.

When taken together, federal and provincial/territorial legislation and

Table 7: Provisions for Aboriginal participation entrenched in decentralized provincial healthcare systems

British Columbia	Article 7.6.4 states that "the membership of public sector boards should reflect the cultural and geographical makeup of the population" (The Board Resourcing and Development Office, 2007).
Ontario	According to the Principles Governing the Appointments Process, the "Persons selected to serve must reflect the true face of Ontario in terms of diversity and regional representation." The Local Health System Integration Act requires the creation of an Aboriginal and First Nations health council to advise the minister about health and health services related issues (Ontario Public Appointment Secretariat, 2007).
Nova Scotia	According to the regulations, "the following are to be considered assets in the consideration of candidates for nomination: population characteristics such as age, gender, ethnicity, geography or membership in a disadvantaged group (Government of Nova Scotia, 2000).

[12] "Comprehensive Land Claims Agreements are negotiated in areas of the country where Aboriginal rights and title have not been addressed by treaty or through other legal means. These agreements are modern-day treaties between Aboriginal claimant groups, Canada and the relevant province or territory" (INAC, 2009, "Comprehensive Claims" accessed from http://www.ainc-inac.gc.ca/al/ldc/ccl/index-eng.asp).

policies fail the test of seamlessness. They also fail to address shifts in jurisdictions related to changes in legislation or resulting from new arrangements such as decentralization or self-government agreements.

Still, some Aboriginal-specific policies are noteworthy. The policies in place in Ontario are the most comprehensive to date. British Columbia and Nova Scotia have recently adopted policies of their own. Also noteworthy are provisions in legislation that exempt Aboriginal midwives and healers from limitations to practice entrenched in codes of profession. These may serve as models for other jurisdictions.

7. Emerging Mechanisms

As noted in the introduction, jurisdictional fragmentation has repeatedly been raised as a concern in national studies and by national Aboriginal organizations. Over the past decades, coordination mechanisms have emerged to bridge jurisdictional gaps. Generally, these fall into two broad areas: cross-jurisdictional coordination forums and intergovernmental health authorities. This section highlights emerging mechanisms and the opportunities they may provide.

7.1 Emergence of cross-jurisdictional coordination forums

Cross-jurisdictional coordination forums have emerged in a few provinces. These forums function as committees, not formal organizations, which bring together stakeholders in Aboriginal health. They generally include Aboriginal organizations, as well as federal and provincial government departments. Their roles vary but can generally be defined as information sharing and coordination. These are relatively new developments. Examples include:

- British Columbia's Tripartite First Nations Health Plan which was adopted in 2007 as a result of a partnership between the Government of British Columbia, Government of Canada, and the Leadership Council Representing the First Nations of British Columbia. The Health Plan provides for a new governance structure for First Nations health services in BC consisting of a First Nations Health Governing Body (to design and oversee implementation of a new governance structure), a First Nations Health Council (serving as an advocacy voice for First Nations no health-related matters), a tripartite First Nations Health Advisory Committee (to review and monitor health plans and health outcomes, and recommend actions on closing health gaps), and an association of health directors and other professionals to create and implement a First Nations capacity development plan (First Nations Leadership Council et al., 2007).
- The Saskatchewan Northern Health Strategy (NHS) which brings together First Nations, Métis, northern municipalities, Regional Health Authorities, and federal and provincial authorities. The NHS was created in 2001 to explore areas of collaboration, improve the continuum of care for all northerners, design strategies to better use existing resources, and resolve cross-jurisdictional issue (Northern Health Strategy, 2008).
- The Manitoba Inter-Governmental Committee on First Nations Health which was set up in 2003 to identify priorities and coordinate approaches to improve First Nations health in Manitoba. The committee's membership includes representatives from the Assembly of Manitoba Chiefs, Manitoba Keewatinook Ininew Okimowin, Southern Chiefs Organization Inc., First Nations and Inuit Health Manitoba Region, the Public Health Agency of Canada, Manitoba Health, the Manitoba Department of Aboriginal and Northern Affairs, Family Services and Housing Manitoba, Manitoba Finance, and Indian and Northern Affairs Canada.

7.2 Intergovernmental health authorities

Intergovernmental health authorities are formal organizations created either through federal-provincial partnerships, Aboriginal partnerships or self-government agreements. An example of this can be found in the health care structures that emerged as a result of the James Bay and Northern Quebec Agreement. These structures are somewhat unique in Canada in that they are co-funded by the federal and provincial governments to serve the health care needs of Nunavik Inuit and the James Bay Cree. These structures are extensions of the provincial health care system.

The Athabasca Health Authority in Saskatchewan is another example of an Aboriginal health authority that is federally and provincially funded. It can also be considered an extension, although informal, of a provincial health care system. The Athabasca Health Authority (AHA) was established under the Non-Profit Corporations Act in 1995 and is not included under the Regional Health Services Act. The AHA has a funding agreement with the provincial and federal governments for the provision of health services for Athabasca Basin residents in four Métis communities: Campbell Portage, Stony Rapids, Wollaston Lake Uranium City, and the First Nations communities of Fond du Lac and Black Lake (Athabasca Health Authority, 2006).

Finally, the Northern Intertribal Health Authority (NITHA) is a partnership of the Meadow Lake Tribal Council, the Lac LaRonge First Nations, the Peter Ballantyne Cree Nation, and the Prince Albert Grand Council. These

Tribal Councils and First Nations collectively represent nearly half of First Nations in Saskatchewan. This makes NITHA the only First Nations health organization of its kind in the country. NITHA provides education and technical support to NITHA partners in the area of communicable disease control, epidemiology and health status monitoring. NITHA is funded through a contribution agreement with FNIHB.

7.3 Summary

Cross-jurisdictional coordination forums and intergovernmental health authorities are recent developments and provide evidence of the increased collaboration across governments to set up local or regional health organizations. Cross-jurisdictional coordination models have been set up to address cross-jurisdictional challenges at a regional (the Northern Health Strategy) or provincial level (as in British Columbia or Manitoba). While encouraging, these mechanisms are not empowered to change legislation and adopt policies. Their effectiveness in addressing cross-jurisdictional issues may nevertheless be constrained by existing legislation, policies and budgets that are decided at the national and provincial levels. Still, these developments are steps in the right direction.

8. Conclusions

The objective of this Policy Synthesis Project was to map existing legislation and policies that contain Aboriginal health-specific provisions. It is important to recognize that significant work related to Aboriginal health occurs outside of any legislative and policy frameworks. This may include the establishment of collaborative processes, the inclusion of Aboriginal peoples on regional health boards, the creation of new programs and new delivery models to ensure responsiveness, and other types of initiatives.

While it could be argued that these initiatives may be in place as a matter of policy, these policies may be unwritten, regional in scope, informal or not publicly available. In the context of this project, we decided not to document these initiatives partly because the task would have been monumental, partly because the work is largely undocumented, and partly because goodwill-based initiatives that exist outside of legislation and formal policies may be short lived. They are the most vulnerable to budget cuts, changes in government and staff, and other pressures.

Legislation and policies are long term commitments, usually supported by funding, and play an important role in maintaining the coherence of health care systems and in working towards objectives of Aboriginal, national, territorial or provincial significance. They also play an important role in entrenching value-based principles such as equity, responsiveness and public participation.

This project shows that over the past 40 years, considerable efforts have been made to include Aboriginal-specific provisions in legislation and in the development of Aboriginal-specific policies. Significant gaps and jurisdictional ambiguities however remain. Further, policies have remained largely silent on the needs of Aboriginal peoples not eligible for registration under the Indian Act and for the Métis.

Our hope is that this report will support critical analyses in Aboriginal health policy research. From our perspective, this project has raised many questions, for example:

1. Acknowledging that the current collection of Aboriginal health policies results in a patchwork begs the question, what should Aboriginal health policies look like? What principles and values should be reflected? What provisions should be entrenched in legislation? What provisions should be entrenched in policies?

2. Are current models of self-government agreements that include provisions for health optimal mechanisms to improve Aboriginal health and support communities to grow, flourish and prosper? Are they simply a transfer of federal, territorial and provincial responsibilities to Aboriginal government?

3. Has the growth in self-government activities across the country affected territorial and provincial health care systems, and policy decisions?

4. The emergence of provincially supported Aboriginal health authorities in Quebec (James Bay Cree and Nunavik Inuit), Saskatchewan (Athabasca Health Authority) and British Columbia (Nisga'a) is relatively recent. Compared to other provincial health authorities, these organizations occupy a slightly different position in their provincial health care system. How do these organizations balance their accountabilities to their communities, the provincial health care system and their funders?

These are just a few examples of questions raised through this project. Readers are likely to have their own.

Although this project identified many gaps and raised many questions, it also documented the considerable changes that have occurred in the past 40 years and, we hope, will generate reflection, research and discussions that will guide the next 40 years.

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APPENDICES

Appendix A

Summary of Findings, Legislative and Policy Patchwork: The Territories and Provinces

Appendix B

Aboriginal Organizations with a Health Policy Mandate in the Territories and Provinces

Appendix C

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Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Appendix F

Health Care Decentralization

Appendix A

Summary of Findings, Legislative and Policy Patchwork: The Territories and Provinces

Summary of Findings, Legislative (L) and Policy (P) Patchwork: The Territories and Provinces													
	YK	NWT	NU[14]	BC	AB	SK	MB	ON	QC	NB	NS	PEI	NFLD &LAB
Specific provisions in health legislation to clarify responsibilities in Aboriginal health.		L[15]			L[16]								
Provisions stating that the minister may opt to enter into an agreement with Canada and/or First Nations for the delivery of health services.					L	L	L[17]	L	L	L			
Health legislation containing provisions related to existing modern treaties.	L								L				L
Health legislation recognizing the need to respect traditional healing practices.	L												
Provisions that recognize that Aboriginal traditional healers should be exempted from control specified under the Code of Professions.							L[18]	L[19]					
Provisions that emphasize the importance of partnerships, information sharing or consultation with Aboriginal groups.	L			P			L	L					
Tobacco control legislation that specifies that the legislation does not apply to the use of tobacco for ceremonial purposes.				L	L	L	L	L		L		L	
Territory/province-wide Aboriginal health policy framework.				P				P			P		

[14]Nunavut was carved out of the Northwest Territories. Its Government was established in 1999, and the responsibilities for the provision of health services to communities now included in Nunavut were transferred to its new government in 2003. Currently, Territorial health services are covered under the 1988 NWT Medical Care Act.

[15]Provision specific to Métis.

[16]Provisions exist stating that the legislation apply to Métis settlement.

[17]For Tuberculosis programs only.

[18]Provisions exist specifically for Aboriginal midwives.

[19]Provisions exist for traditional healers and midwives.

Appendix B

Aboriginal Organizations with a Health Policy Mandate in the Territories and Provinces

Aboriginal Organizations with a Health Policy Mandate in the Territories and Provinces		
Province/ Territory	Territory/Province-wide organization	Regional organizations
Yukon	· The Council of Yukon First Nations · The Yukon Aboriginal Women's Council.	· There are three INAC recognized Tribal Councils (Daak Ka Tlingit Nation, Kaska Tribal Council, Southern Tutchone Tribal Council) representing 18 INAC-recognized Bands.
Northwest Territories	· The Assembly of First Nations Regional Office Northwest Territories · The Native Women's Association of the Northwest Territories	· The Dene Nation of Northwest Territories · The Fort Providence Métis Council · The Fort Resolution Métis Council · The Inuvialuit Regional Corporation · Five Tribal Councils (Deh Cho First Nations, Gwich'in Tribal Council, Akaitcho Territory Government (NWT Treat 8 Tribal Corporation), Dogrib Treaty 11 Council, Sahtu Dene Council) represent 29 federally funded settlements.
Nunavut	· The Innuitit Women's Group	· Three regional organizations exist (the Kitikmeot Inuit Association, the Kivalliq Inuit Association and the Qikiqtani Inuit Association. and together represent all Inuit communities included in the Nunavut Land Claim Agreement. There however do not have a health-specific mandate.
British Columbia	· The British Columbia Assembly of First Nations · The First Nations Summit of British Columbia · The British Columbia First Nations Health Council[20] · The Union of British Columbia Indian Chiefs · Métis Provincial Council of British Columbia · United Native Nations · Red Road HIV/AIDS Network · Healing Our Spirit British Columbia Aboriginal HIV AIDS Society	· Twenty-seven Tribal Councils (Carrier Chilcotin Tribal Council, Carrier Sekani Tribal Council, Fraser Thompson Indian Services Society, Gitksan Local Services Society (also referred to as Gitksan Government Commission), Haida Tribal Society, Ktunaxa Kinbasket Treaty Council,[21] Waikiutl District Council, Lillooet Tribal Council, Lower Stl'atl'imx Tribal Council, Musgamagw Tswawtaineuk Tribal Council, Naut'sa mawt Tribal Council, Nicola Tribal Council, Northern Shuswap Tribal Council, Nuu-chah-nulth Tribal Council, Okanagan Nation Alliance, Oweekeno-Kitasoo-Nuxalk Tribal Council, Shuswap Nation Tribal Council, Squamish Nation Network, Sto:lo Nation, Sto:lo Tribal Council, Treaty 8 Tribal Association, Tsilhgot'in National Government) together represent 198 BC first Nations. · Other regional organizations include the Gitxsan Chiefs' Office, the Heiltsuk Nation, the Nisga'a Lisims Government, the Office of the Wet'suwet'en, the Squamish Nation Network and the Nisga'a Valley Health Authority. · Two Rivers Métis Society · Vancouver Métis Community Association
Alberta	· The Grand Council of Treaty No. 8, the Treaty No. 7 Management Corporation and the Confederacy of Treaty No. 6 First Nations collectively represent the interests of treaty signatories. · Métis Settlements General Council · The Métis Nation of Alberta	· Eight Tribal Councils (Athabasca Tribal Council Limited, Kee Tas Kee Now Tribal Council, Lesser Slave Lake Indian Regional Council, North Peace Tribal Council, Treaty 7 Management Corporation, Tribal Chiefs Ventures Incorporated, Western Cree Tribal Council, Yellowhead Tribal Development Foundation) collectively represent 35 First Nations. Alberta counts 11 independent (not affiliated with a Tribal Council) First Nations. · Métis Regional Councils[22] · Aseniwuche Winewak Nation (the Rocky Mountain Cree People) represents six Settlements whose members are non-registered Indians of Cree, Beaver, Stoney and Iroquois descent.

[20]The British Columbia First Nations Chiefs' Health Committee (CHC) was formed by a resolution of the First Nations Summit in October, 1997. The CHC was established to provide leadership direction and on-going political support for the development of First Nations' health policy, programs and services. The CHC is the recognized mechanism to work with federal, provincial and First Nations governments on policy and priority setting (First Nations Chiefs Health Committee, 2007). It was renamed the First Nations Health Council in 2007.

[21]Ktunaxa Kinbasket Treaty Council includes 5 bands in British Columbia and two in the US. The five in British Columbia are: ?Akisq'nuk First Nation, Lower Kootenay, St. Mary's, Tobacco Plains.

[22]We were unable to ascertain the exact number of these settlements.

Aboriginal Organizations with a Health Policy Mandate in the Territories and Provinces

Province/ Territory	Territory/Province-wide organization	Regional organizations
Saskatchewan	· Federation of Saskatchewan Indian Nations · Saskatchewan Native Council · Métis Nation – Saskatchewan	· Nine INAC recognized Tribal Councils (Agency Chiefs Tribal Council, Battlefords Agency Tribal Chiefs Inc, Northwest Professional Services Corp, File Hills Qu'appelle Tribal Council Inc., Meadow Lake Tribal Council Program Services Inc., Prince Albert - PADC Management Company Ltd., Saskatoon Tribal Council, Touchwood Agency Tribal Council Inc., Yorkton Tribal Administration Inc.) represent 63 First Nations. · Saskatchewan also counts 9 independent First Nations (not affiliated to a Tribal Council). · Fort Carlton Agency Council and the Southeast Treaty #4 Tribal Council are not INAC recognized Tribal Councils. Each represents 2 First Nations listed by INAC as independent. · Northern Intertribal Health Authority is a regional organization that brings together the Meadow Lake Tribal Council, Prince Albert Grand Council, La LaRonge First Nation, Peter Ballantyne Cree Nation · 130 Métis locals in 12 regions
Manitoba	· Assembly of Manitoba Chiefs · Manitoba Métis Federation · Métis Women of Manitoba · Mother of Red Nations Women's Council of Manitoba	· Seven Tribal councils (Dakota Ojibway Tribal Council, Interlake Reserves Tribal Council, Island Lake Tribal Council, Keewatin Tribal Council, Southeast Resource Development Council, Swampy Cree Tribal Council, West Region Tribal Council) represent 54 First Nations. An additional 9 first Nations are independent (not affiliated to a Tribal Council). · 27 northern First Nations are affiliated with the Manitoba Keewatinook Ininew Okimowin Inc., and 33 southern First Nations are affiliated with the Southern Chiefs Organization. · The Aboriginal Council of Winnipeg, Inc. is a community-based, membership-driven Aboriginal organization which serves as a political and advocacy voice for the Aboriginal community of Winnipeg (Aboriginal Council of Winnipeg, 2007).
Ontario	· Chiefs of Ontario · Union of Ontario Indians · Métis Nation of Ontario · Ontario Native Women's Association	· Nishnawbe Aski Nation (NAN) represents 49 First Nation communities within the territory of James Bay Treaty 9 and the Ontario portions of Treaty 5. · Sixteen Tribal Councils (Anishinaabeg of Kabapikotawangag Resource Council Inc., Bimose Tribal Council, Independent First Nations Alliance, Keewaytinook Okimakanak/ Northern Chiefs Council, Matawa First Nations Management Inc., Mushkegowuk Tribal Council, Nokiiwin Tribal Council Inc., North Shore Tribal Council, Ogemawahj Tribal Council, Pwi-di-goo-zing-ne-yaa-zhing Advisory, Shibogama First Nations Council, Southern First Nation Secretariat, United Chiefs & Councils of Manitoulin Island, Waabnoong Bemjiwang Association of First Nations, Wabun Tribal Council and Windigo First Nations Council) represents 99 First Nations. An additional 40 First Nations are independent (not affiliated to a Tribal Council). · 30 Chartered Community Councils represent the interests of Métis at the regional level.
Quebec	· The First Nations of Quebec and Labrador, and its health arm, the First Nations of Quebec and Labrador Commission of Health and Social Services · Quebec Native Women Inc. · Native Alliance of Quebec	· Seven Tribal councils (Algonquin Anishinabeg Nation Tribal Council, Algonquins Nations Programs & Services Secretariat, Atikamekw Sipi Conseil Nation, Conseil tribal Mamuitun, Grand Conseil Waban-Aki Inc., Mi'gmawei Mawiomi Secretariat, Regroupement Mamit Innuat Inc.) represent 26 First Nations. An additional 5 communities are considered independent (not affiliated to a Tribal Council). · The Grand Council of the Cree and the Makivik Corporation are two organizations that emerged from the James Bay and Northern Quebec Agreement. The Grand Council of the Cree represents ten communities, whereas the Makivik Corporation represents 14 communities.
Pan-Atlantic coalition	· Atlantic Policy Congress of First Nations Chiefs Secretariat (headquarters located in Nova Scotia)	
New Brunswick	· The Union of New Brunswick Indians · New Brunswick Aboriginal Peoples Council	· Three Tribal council (Mawiw Council, North Shore Micmac District Council, Saint John River Valley Tribal Council) represent 14 First Nations. Only one First Nation is considered independent (no Tribal Council Affiliation).
Nova Scotia	· Union of Nova Scotia Indians · Confederacy of Nova Scotia Métis · Nova Scotia Women's Association	· Two Tribal councils (Union of Nova Scotia Indians - Advisory Services and the Confederacy of Mainland Micmacs) represent thirteen First Nations.

Aboriginal Organizations with a Health Policy Mandate in the Territories and Provinces

Province/ Territory	Territory/Province-wide organization	Regional organizations
Prince Edward Island	· Native Council of Prince Edward Island	· There is no INAC-recognized Tribal council in PEI. The Mi'kmaq Confederacy of Prince Edward Island Inc. however represents the two PEI First Nations.
Newfoundland and Labrador	· Federation of Newfoundland Indians · Ktaqamkuk Mi'kmaq Alliance · Labrador Inuit Association · Newfoundland Aboriginal Women's Network	· There are three First Nation communities, none of which are represented by a Tribal Council. The two Labrador Innu communities are however affiliated with the First Nations of Quebec and Labrador Health and Social Services Commission. · In addition, one First Nation is currently attempting to achieve recognition by INAC.

Appendix C

Treaties and Self-Government Activities in Relation to Aboriginal Health

Treaties and Self-Government Activities in Relation to Aboriginal Health

Agreement	Signed	Description	By	Relationship to health
Robinson Treaties	1850, 1853	The Robinson Treaties are land surrenders or land purchases. The Treaties guaranteed continued access to the First Nations signatory for the purpose of hunting and fishing, until the Crown sells the land to private interests.	Ontario: Her Majesty The Queen, and Joseph Peandechat, John Iuinway, Mishe-Muckqua, Totomencie, Chiefs, and Jacob Warpela, Ahmutchiwagabou, Michel Shelageshick, Manitshainse, and Chiginans, Principal Men of the Ojibewa Indians Inhabiting The Northern Shore Of Lake Superior.	The Robinson Treaties contain no health-specific provision (Surtees, 1986).
Douglas Treaties	1850, 1854	Land on the island of Vancouver.	British Columbia: Representatives of Her Majesty Queen Victoria, and the Teechamitsa Tribe	The Douglas Treaties contain no health-specific provision Canada, 2006c).
Treaty No. 1	1871	Treaty No. 1 covers a small portion south of Lake Winnipeg and Lake Manitoba, Manitoba.	Manitoba: Her Majesty the Queen and the Chippewa and Swampy Cree Tribes of Indians of Manitoba and Country Adjacent with Adhesions	Treaty No.1 contains no health-specific provision (Canada, 1871).
Treaty No. 2	1871	Treaty No. 2 covers a small southeast portion of Saskatchewan, and according to the Government of Saskatchewan, no First Nation from Treaty 2 lives in Saskatchewan (Saskatchewan, 2007).	Manitoba: Her Majesty the Queen and the Chippewa Tribe of Indians, inhabitants of the country within the limits, mostly Ojibway Saskatchewan: Her Majesty the Queen and the Chippewa Tribe of Indians	Treaty No. 2 contains no health or medical-specific provision (Canada, 1871).
Treaty No. 3	1873	Treaty No. 3 is a land surrender of 14,245,000 hectares of land so Canada could use it for agriculture, settlement and mineral discovery.	Manitoba: Her Majesty the Queen and the Saulteaux Tribe of the Ojibbeway [historical spelling] Indians at the Northwest Angle on the Lake of the Woods with Adhesions Ontario: Her Majesty the Queen and the Saulteaux Tribe of the Ojibbeway Indians at the Northwest Angle on the Lake of the Woods	Treaty No. 3 contains no health-specific provision (Canada, 1873).

Treaties and Self-Government Activities in Relation to Aboriginal Health

Agreement	Signed	Description	By	Relationship to health
Treaty No. 4	1874	Treaty No. 4 encompasses southern Saskatchewan as well as a small western portion of Manitoba and south eastern Alberta.	Saskatchewan: Her Majesty the Queen and the Cree and Saulteaux First Nations Manitoba: Her Majesty the Queen and the Cree and Saulteaux First Nations	Treaties No.4 (Canada, 1874) and No. 5 (Canada, 1875)contains no health-specific provision. A Medical Officer associated with the Department of Indian Affairs was however present at the time the Treaty was signed to provide medical treatment to Indians assembled for the signature.
Treaty No. 5	1875	Treaty No. 5 was signed September 20th and 25th, 1875. This treaty was signed in two separate phases: northern and southern. In 1875, the southern part of the treaty was negotiated. The northern part of Treaty 5 was negotiated in 1908.	Ontario: Her Majesty the Queen and the Saulteaux and Swampy Cree Tribes of Indians at Beren's River and Norway House. Saskatchewan: Her Majesty the Queen and the Saulteaux and Swampy Cree Tribes of Indians at Beren's River and Norway House with Adhesions. Manitoba: Her Majesty the Queen and the Saulteaux and Swampy Cree Tribes of Indians at Beren's River and Norway House with Adhesions	Treaty No. 5 contains no health-specific provision. A Medical Officer associated with the Department of Indian Affairs was however present at the time the Treaty was signed to provide medical treatment to Indians assembled for the signature (Canada, 1875).
Treaty No. 6	1876	Treaty No. 6 was signed in 1876 at Fort Carlton, Fort Pitt and Battle River with Adhesions by representatives of Her Majesty Queen Victoria, the Plain and Wood Cree Indians and other Tribes of Indians.	Alberta: Representatives of Her Majesty Queen Victoria, the Plain and Wood Cree Indians and other Tribes of Indians. Saskatchewan: Representatives of Her Majesty Queen Victoria, the Plain and Wood Cree Indians and other Tribes of Indians.	Treaty No. 6 includes a medicine chest clause which promises access to a medicine chest (medication cabinet), relief from pestilence or general famine as well. This clause is the foundation of the Treaty right to health (Canada, 1876).
Treaty No. 7	1877	Treaty No. 7 is located in the Southern portion of Alberta and was signed on September 22nd and December 4th, 1877. Treaty 7 encompasses the southern portion of Alberta. The Treaty supplied one square mile of land for each Indian family which included a limited supply of cattle, some farm equipment.	Alberta: Her Majesty the Queen and the Blackfeet and other Indian Tribes at the Blackfoot Crossing of Bow River and Fort Macleod	Treaty No. 7 contains no health or medical-specific provision (Canada, 1877).
Treaty No. 8	1899	Treaty No. 8 was signed in June 1899 between Her Majesty the Queen and various First Nations at Lesser Slave Lake. The area of Treaty 8 consists of 840,000 square kilometers located in the north western part of Canada which encompasses the northern half of Alberta, the northwest corner of Saskatchewan, and the north of British Columbia. Treaty No. 8 was the first treaty to recognize the co-existence of Indians and Métis peoples.	Alberta: Queen Victoria and various First Nations at Lesser Slave Lake (Cree, Chippewyan, Beaver). Saskatchewan: Her Majesty the Queen and various First Nations at Lesser Slave Lake. Northwest Territories: Queen Victoria and various First Nations at Lesser Slave Lake (Cree, Chippewyan, Beaver).	Treaty No. 8 contains no health-specific provision. Requests were made for such provisions in Treaty negotiations. Specifics included a request for medicines and a request for a resident medical man. These requests were not included in the text of the Treaty. However, the Treaty Commissioner's notes make clear commitments to the provision of medicines (Canada, 1899).
Treaty No. 9	1905-06	Treaty No. 9, also known as the James Bay Treaty, covers almost two-thirds of northern Ontario and was the first treaty to have a provincial involvement in negotiations.	Ontario: The federal government of Canada signed Treaty 9 with the Cree and Ojibway First Nations of Northern Ontario	It appears that while signatories believed that medical assistance would be provided every year at the time of annuity, the report of the Commissioners and the text of the Treaty are silent on medical assistance (Canada, 1929).

Treaties and Self-Government Activities in Relation to Aboriginal Health

Agreement	Signed	Description	By	Relationship to health
Treaty No. 10	1906	Treaty No. 10 covers 220,000 square kilometres of northern Saskatchewan and Alberta, mostly lands deemed unsuitable for agriculture. The text of Treaty 10 recognizes the co-existence of Indians and Métis peoples.	Saskatchewan: His Majesty the King of Great Britain and Ireland and the Chipewyan, Cree and other Indians inhabitants of the territory covered by the Treaty	Treaty No.10 (Canada, 1906) contain no health or medical-specific provisions. Requests were received for such provisions in Treaty negotiations. Specifics included a request for medicines and a request for a resident medical man. These requests were not included in the text of the Treaty. However, the Treaty Commissioner's notes make clear commitments to the provision of medicines.
Treaty No. 11	1921	Treaty No. 11 includes the western half of the Northwest Territories, including the southeast part of the Yukon Territory. The Treaty was signed July 26, 1921 at Arctic Red River and at Fort McPherson on July 28, 1921.	Yukon: The Slave, Dogrid, Loucheux and Hare Tribes and Her Majesty the Queen in right of Canada. Northwest Territories: King George V and 21 First Nations in what is known today as the Northwest Territories.	The text of Treaty No. 11 contains no health or medical-specific provision. Requests were made for such provisions in Treaty negotiations, including a request for medicines and a request for a resident medical man. However, the Treaty Commissioner's notes make clear commitments to the provision of medicines (Canada, 1921).
Williams Treaties	1923	The Williams Treaties were land surrenders. Specifically, three parcels of land totaling over 20,000 square miles.	Ontario: The government of Canada and the Mississauga Indians of Rice Lake, Mud Lake, Scugog Lake and Alderville; and the Chippewa Indians of Christian Island, Georgina Island and Rama	The Williams Treaties contain no health or medical-specific provisions (King George & The Mississauga Indians of Rice Lake, 1923; King George & Chippewa Indians of Christian Island, 1923)
Métis Betterment Act[23]	1939	The Métis Population Betterment Act, later changed to Métis Betterment Act, was enacted by the Province of Alberta in 1938. A joint Métis and government committee identified the lands for Métis settlement. Twelve Métis settlements were set aside: Big Prairie (Peavine), Caslan (south of Lac La Biche), Cold Lake, East Prairie (south of Lesser Slave Lake), Elizabeth (east of Elk Point), Fishing Lake, Gift Lake (or Utikuma), Kikino (originally called Beaver River or Goldfish Lake), Paddle Prairie (or Keg River), Touchwood, Marlboro and Wolf Lake (north of Bonnyville).	Alberta: Government of Alberta and the Métis of Alberta	This act did not pertain to health or health services.

[23] This information was garnered from the Alberta online encyclopedia (http://www.albertasource.ca/metis/eng/people_and_communities/issues_betterment.htm). An original copy of the Act was not secured.

Appendix D

Self-Government Activities in Relation to Aboriginal Health

Self-Government Activities in Relation to Aboriginal Health				
Agreement	Signed	Description	By	Relationship to health
James Bay and Northern Quebec Agreement	1975	This agreement is known as the first modern treaty signed in Canada. It defined the rights of Cree and of the Inuit in relation to land and resources (Canada, 2004a).	Quebec: James Bay Cree and Nunavik Inuit, the governments of Quebec and Canada	The Cree Board of Health and Social Services of James Bay and the Nunavik Regional Board of Health and Social Services were created in 1978 as a result of the James Bay and Northern Quebec Agreement, and tasked with the administration and delivery of health and social services delivered to all Quebecers through provincial programs, as well as those services provided to First Nations and Inuit by the federal government.
Northeastern Quebec Agreement	1978	This agreement provides a mechanism to define the rights of Naskapi with regards to land and resources (Canada, 2004a).	Quebec: the Naskapi, the governments of Quebec and Canada	As a result of the Northeastern Quebec Agreement, an advisory committee of health and social services was set up to represent the interests of the Naskapis. According to the Agreement, the services are provided by the Quebec health care system.
Inuvialuit Final Agreement	1984	The purpose of this agreement is to provide rights, benefits and compensation in exchange for the interest of the Inuvialuit in the Northwest Territories and Yukon Territory.	Yukon: The Inuvialuit and the federal and territorial governments. Northwest Territories: The Committee for Original People's Entitlement, representing the Inuvialuit of the Inuvialuit Settlement Region and the Government of Canada.	The agreement established the Inuvialuit Social Development Program, mandated to improve health, education, housing and standards of living of the Inuvialuit. Specific areas of concern include housing, health, welfare, mental health education, elders and the maintenance of traditional practices and perspectives within the Inuvialuit Settlement Region. Canada agrees to provide special funding to contribute to the accomplishment of these social goals by the Inuvialuit. Under this agreement, public health remains an area of Territorial jurisdiction (Canada, 1984).
Sechelt Indian Band Self-Government Act	1986	The Act granted authority to the Sechelt band to exercise delegated powers and negotiate agreements about specific issues. The Sechelt Indian band has municipal status under provincial legislation.	British Columbia: Her Majesty in right of Canada, the Province of British Columbia and the Sechelt Indian Band	Article 14 states that the Council has, to the extent that it is authorized by the constitution of the Band to do so, the power to make laws in relation to (i) health services on Sechelt lands (Canada, 1986).

Self-Government Activities in Relation to Aboriginal Health

Agreement	Signed	Description	By	Relationship to health
Métis Settlements Accord	1989	The Alberta-Métis Settlement Accord originated on July 1, 1989 by Premier Getty and Randy Harder, the president of the Federation of Métis Settlements. The Accord helped resolve litigation problems between the province and the Federation. In 1990, the Alberta government placed into action the Métis Settlements Land Protection Act, Métis Settlements Act (MSA), Métis Settlement Accord Act and the Constitution of Alberta Amendment Act. During the signing of this Accord in 1990, the Alberta Federation of Métis Settlements was renamed Métis Settlements General Council.	Alberta: Government of Alberta and the Métis of Alberta	The Accord includes a number of health-specific provisions, including a) the right to make bylaws to promote the health, safety and welfare of the residents of the settlement area; b) the right to invest money in hospital district or health region under the Regional Health Authorities; c) make bylaws to promote the health, safety and welfare of the residents of the settlement area; and d) make bylaws respecting and controlling the health of the residents of the settlement area and against the spread of diseases (Alberta & Alberta Federation of Métis Settlements Association, 1990).
Gwich'in Comprehensive Land Claim Agreement	1992	The Gwich'in Comprehensive Land Claim Agreement grants ownership to the Gwich'in Tribal Council of 16,264 square kilometres of land throughout the Gwich'in Settlement Area and the Yukon Territory. The Agreements attempt to clarify rights regarding land and resources.	Northwest Territories: Government of Canada, the Gwich'in (as represented by the Gwich'in Tribal Council) at Fort McPherson, Northwest Territories. Yukon: Gwich'in Tribal Council, Her Majesty the Queen in right of Canada	This agreement provides a framework to inform program-specific self-government discussions. It clarified rights outlined in Treaty No. 11. Health services are one area cited for further self-government discussions (Indian and Northern Affairs Canada, 1992).
The Umbrella Final Agreement	1993	Recognize the significant contributions of Yukon Indian People and Yukon First Nations to the history and culture of the Yukon and Canada; and enhance the ability of Yukon First Nations and Yukon Indian People to participate fully in all aspects of the economy of the Yukon.	Yukon: Yukon First Nations, Government of Canada and the Government of the Yukon Territory	The Umbrella Agreement includes a provision entrenching the right of signatory First Nations to negotiate individual self-government agreements. The Agreement also stipulates that provisions included in the Agreement shall be mindful of public health and public safety. Furthermore, most references to health pertain primarily to social services. All self-government agreements were examined for health-specific provisions. All include provisions allowing the First Nations to negotiate a Self-Government Financial Transfer Agreement that may include health services. To date, it appears that the Carcross/Tagish First Nations Agreement (see below) is the only agreement to include health services (Canada et al., 1993).

Self-Government Activities in Relation to Aboriginal Health

Agreement	Signed	Description	By	Relationship to health
Sahtu Dene & Métis Comprehensive Land Claim Agreement	1993	The agreement includes recognizing Sahtu Dene and Métis ownership of land in the Mackenzie River Valley. The Government of Canada agreed to negotiate self-government agreements on a community by community basis with the five Sahtu communities of Colville Lake, Fort Good Hope, Tulita, Deline and Norman Wells.	Northwest Territories: This Agreement was signed September 6, 1993 between the Government of Canada and the Métis of Fort Good Hope, Fort Norman and Norman Wells in the Sahtu Region of the Mackenzie Valley as represented by the Sahtu Tribal Council.	The Umbrella Agreement includes a provision entrenching the right of signatory First Nations to negotiate individual self-government agreements that include health services. The Agreement also stipulates that provisions included in the Agreement shall be mindful of public health and public safety. Furthermore, most references to health pertain primarily to social services (Canada, 1994).
Nunavut Land Claim Agreement	1993	The agreement was the preliminary step to the establishment of the new Territory of Nunavut. The terms of the agreement include jurisdiction over territorial matters: wildlife management, land use planning and development, property taxation, and natural resource management – were transferred to the new government (Inuit of Nunavut Settlement Area & Canada, 1993).	Nunavut: Inuit of the Nunavut Settlement Area and the Government of Canada	The Agreement led to the establishment of the new territory of Nunavut, which is headed by a public government. The responsibilities of the Nunavut government are similar to those of the Northwest Territories and its powers include socio-economic programs such as health, social services, language, culture, sustainable development and finances.
Manitoba Framework Agreement	1994 for 10 years, extended by 3 years	The Manitoba Framework Agreement (MFA) Initiative on self-government was signed in December 1994 as part of a long-term commitment to develop self-government in Manitoba. The agreement committed the Assembly of Manitoba Chiefs and the federal government to a 10-year process, ending December 2004, aimed at dismantling INAC's regional operations in Manitoba, recognizing and developing Manitoba First Nation governments and restoring jurisdiction to First Nations in Manitoba.	Manitoba: Assembly of Manitoba Chiefs and the federal government	Although little information is available on the details of current discussions, it does not appear that health is being included in discussions (Manitoba, 1997a).

Self-Government Activities in Relation to Aboriginal Health

Agreement	Signed	Description	By	Relationship to health
Indian Self-Government Enabling Act	1996	The purpose of the Act is to assist bands, municipalities and the government to participate in the implementation of systems of concurrent real property taxation under both Indian land taxation laws and Provincial law.	British Columbia: Act of Parliament, Government of British Columbia	The Act contains no health-specific provisions. It does however begin a process for addressing Aboriginal self-government in British Columbia (British Columbia, 1996o).
Indian Advisory Act	1996	This Act states that the Lieutenant Governor in Council may establish a committee to be known as the British Columbia Indian Advisory Committee, to advise the minister on all matters regarding the status and rights of Indians.	British Columbia: Act of Parliament, Government of British Columbia	The Act contains no health-specific provisions. It does however begin a process for addressing Aboriginal rights in British Columbia (British Columbia, 1996n).
The Nisga'a Final Agreement	1999	The Act granted authority to the Nisga'a Nation to exercise delegated powers and negotiate agreements about specific issues.	British Columbia: Her Majesty in right of Canada, the Province of British Columbia and the Nisga'a Nation	Sections 82 to 86 of the Agreement pertains specifically to health services, and provide the Nisga'a Lisims Government the authority to make laws in respect of health services on Nisga'a Lands. At the request of any Party, the Parties will negotiate and attempt to reach agreements for Nisga'a Lisims Government delivery and administration of federal and provincial health services and programs for all individuals residing within Nisga'a Lands. Those agreements will include a requirement that Nisga'a citizens and individuals who are not Nisga'a citizens be treated equally in the provision of those health services and programs. The Agreement also provides the Nisga'a Lisims Government with the authority to may make laws in respect of the authorization or licensing of individuals who practice as aboriginal healers on Nisga'a Lands, but, this authority to make laws does not include the authority to regulate products or substances that are regulated under federal or provincial laws of general application (Nisga'a Nation et al., 1999).

Self-Government Activities in Relation to Aboriginal Health

Agreement	Signed	Description	By	Relationship to health
The Métis Act	2001	The Act aims to recognize contributions of the Métis and to deal with certain Métis institutions.	Saskatchewan: Act of the Government of Saskatchewan	This Act states that the Government of Saskatchewan and the Métis Nation - Saskatchewan will work together through a bilateral process to address issues that are important to the Métis people, including the following: (a) capacity building; (b) land; (c) harvesting; (d) governance. The purpose of this Part is to recognize the contributions of the Métis people to the development and prosperity of Canada, including: (h) the leadership role of Métis institutions in providing educational, social and health services to Métis people, and the contribution of those institutions to the delivery of those services. The Act does not commit to specifics with regards to Governance and health (Saskatchewan, 2001a).
Tlicho Agreement	2003	The agreement provides certain rights and benefits respecting land and resources for the Tlicho and self-government to Tlicho Citizens as well as governmental powers and authorities.	Northwest Territories: Dogrib Treaty No. 11 Council, the Government of Canada and the Government of the Northwest Territories.	With regards to services, the Agreement stipulates that Intergovernmental Agreements must be negotiated between the Dogribs and the Territorial Government before this Agreement comes into effect. Health services are explicitly cited Canada et al., 2003)
Carcross/ Tagish First Nations Programs and Services Agreement Respecting the Indian and Inuit Affairs Program and the First Nations and Inuit Health Branch of the Government of Canada	2003	This Agreement transfers the responsibility for health and other services to the First Nation.	Yukon: Carcross/ Tagish First Nations, Indian and Inuit Affairs and the First Nations and Inuit Health Branch of the Government of Canada	This agreement acknowledges that Canada – First Nations and Inuit Health Branch – shall no longer manage, administer or deliver the Initial Accessed Programs and Services. After the effective date of this agreement, responsibility is assumed by the First Nation pursuant to this Agreement (Carcross/Tagish First Nation et al., 2003).
Nunavik Inuit Land Claims Agreement (NILCA)	2007	This is an agreement in principle, leading to the creation of the Regional Government of Nunavik. This future regional institution, which will be created by legislation and answer to the National Assembly, will bring together three main organizations created by the James Bay and Northern Quebec Agreement, namely: the Kativik Corporation, the Kativik School Board and the Nunavik Regional Board of Health and Social Services (Indian and Northern Affairs Canada, 2007). This is a unique model of self-government in Canada.	Quebec: Nunavik Inuit (Makivik Corporation, the Government of Quebec, the Government of Canada	This agreement consolidates the powers of the Inuit of Nunavik over institutions created under the 1975 James Bay and Northern Quebec Agreement.

Appendix E

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
Yukon	The Yukon Act	1898	This Act does not contain provisions pertaining specifically to health or Aboriginal peoples (Canada, 1898).
Yukon	Health Care Insurance Plan Act	1971	This Act does not contain provisions pertaining specifically to Aboriginal peoples (Yukon, 1971).
Yukon	Extended Health Care Benefits Regulation	1994	This Regulation does not contain content pertaining specifically to Aboriginal peoples (Yukon, 1994).
Yukon	Bill C-39, The Yukon Act	2002	This legislation replaced the Yukon Act (See 2002 Yukon Act below) (Canada, 2002).
Yukon	Health Act	2002	This Act stipulates the importance of partnerships with Aboriginal groups and the respect of traditional Aboriginal healing. It also stipulates that the Yukon Land Claim Agreement or the Yukon First Nation Self-Government Agreement shall prevail in a conflict (Yukon, 2002a).
Yukon	Health Care Insurance Plan Act	2002	This Act does not contain content pertaining specifically to health or Aboriginal peoples (Yukon, 2002b).
Yukon	Yukon Act	2002	There is reference made to Aboriginal rights however, nothing in relation to health (Canada, 2002).
Northwest Territories	The Western Arctic Claim	1984	The Inuvialuit Final Agreement. The Agreement did not result in a transfer of responsibility for health services from the Government of the NWT to the Inuvialuit (Canada, 1984).
Northwest Territories	Northwest Territories Act	1985	There are references made to Inuit and Indian hunting rights and laws applicable specifically to Inuit. There are no references to health (Canada, 1985b).
Northwest Territories	Hospital Insurance and Health and Social Services Administration Act (formerly Territorial Hospital Insurance Services Act)	1988	There are no Aboriginal specific provisions (Northwest Territories, 1988a).
Northwest Territories	Public Health Act	1988	There are no Aboriginal specific provisions (Northwest Territories, 1988d).
Northwest Territories	Medical Care Act	1988	There are no Aboriginal specific provisions (Northwest Territories, 1988b).
Northwest Territories	Medical Travel	1998	In this policy Métis peoples are distinguished from the general population (Northwest Territories, 1988c).
Northwest Territories	Extended Health Benefits	1998	As in the above policy Métis peoples are distinguished from the general population (Northwest Territories, 1998).
Northwest Territories	Sahtu Dene and Métis Land Claim Settlement Act	1994	There is no mention of health (Northwest Territories, 1994).
Northwest Territories	Health and Social Services Establishment Policy	1999	There are no Aboriginal specific provisions (Northwest Territories, 1999).
Northwest Territories	Métis Health Benefits	2003	To be eligible for the Métis Health Benefits Program, clients must be: · a resident of the NWT and registered under the NWT Health Care Plan; · a descendent of the Chipewyan, Slavey, Gwich'in, Dogrib, Hare or Cree people; and · resided in or used and occupied the Mackenzie Basin on or before January 1, 1921, or is a Community Acceptance Member, or was adopted as a minor (Northwest Territories, 2003).

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
British Columbia	Health Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996a).
British Columbia	Health Authorities Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996b).
British Columbia	Health Care (Consent) and Care Facility (Admission) Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996c).
British Columbia	Health Emergency Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996d).
British Columbia	Health Professions Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996e).
British Columbia	Health Research Foundation Act [Repealed]	1996	There is no Aboriginal-specific provision (British Columbia, 1996f).
British Columbia	Health Special Account Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996g).
British Columbia	Hearing Aid Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996h).
British Columbia	Hospital Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996j).
British Columbia	Hospital (Auxiliary) Act [Repealed]	1996	There is no Aboriginal-specific provision (British Columbia, 1996i).
British Columbia	Hospital District Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996k).
British Columbia	Hospital District Finance Act [Repealed]	1996	There is no Aboriginal-specific provision (British Columbia, 1996l).
British Columbia	Hospital Insurance Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996m).
British Columbia	Medical and Health Care Services Special Account Act [Repealed]	1996	There is no Aboriginal-specific provision (British Columbia, 1996p).
British Columbia	Medical Practitioners Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996q).
British Columbia	Medicare Protection Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996r).
British Columbia	Mental Health Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996s).
British Columbia	Ministry of Health Act	1996	There is no Aboriginal-specific provision (British Columbia, 1996t).

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
British Columbia	Health and Social Services Delivery Improvement Act	2002	There is no Aboriginal-specific provision (British Columbia, 2002).
British Columbia	Health Sector Partnerships Agreement Act	2003	There is no Aboriginal-specific provision (British Columbia, 2003).
British Columbia	The Transformative Change Accord	2005	The accord was signed in 2005 between the Government of British Columbia and Government of Canada and the Leadership Council Representing the First Nations of British Columbia. This Accord is a commitment to close the gap that exists between British Columbia First Nations and other British Columbia residents in health, education, housing and to settle issue of Aboriginal rights and title (Government of British Columbia et al., 2005). The Accord resulted in a 10 year First Nations Health Plan (First Nations Leadership Council et al., 2006).
British Columbia	Tobacco Control Act	1996	(3) Subsection (2) does not apply to the ceremonial use of tobacco in or on school property if the ceremonial use of tobacco is approved by the board and it is performed (a) in relation to a traditional aboriginal cultural activity, or (b) by a prescribed group for a prescribed purpose (Assembly of First Nations, 2006a; British Columbia, 1996u).
Alberta	Ambulance Services Act	1990	The Act explicitly states that the services included under this Act extend to municipalities, including Métis settlements (Alberta, 2000a).
Alberta	Government Organization Act	1994	Schedule 6 - Intergovernmental and Aboriginal Matters of the Act is explicit that the General powers and duties of the Minister extend to Métis settlements. The Act is silent on Indian reserves (Alberta, 2000b).
Alberta	Health Professions Act	1999	Part 5 - Business Arrangements - Conducting a Practice clarifies that municipalities, including Métis settlements, do not have the powers to require a municipal license from regulated health professions (Alberta, 2000c).
Alberta	Hospitals Act	1980	Part 3 - Hospitalization Benefits Plan states that the Minister may on behalf of the Government of Alberta enter into an agreement with the Government of Canada providing for the making of contributions by Canada to Alberta in respect of the costs incurred by Alberta in providing insured services to Indians residing in Indian reserves in Alberta (Alberta, 2000d).
Alberta	Public Health Act	1984	The Act clarifies its relationship with and responsibility towards Métis settlements. The Act extends to these settlements. It also clarifies process with regards to notification of health hazard: Notice of health hazard – Métis patented land 65 (1) When an order is issued under section 62 in respect of patented land as defined in the Métis Settlements Act, the regional health authority may submit a notice of health hazard to the Registrar of the Métis Settlements Land Registry and the Registrar shall record the notice against the Métis title register for the land that is subject to the order. (2) A notice of health hazard recorded under this section does not lapse and shall not be cancelled except on the receipt by the Registrar of the Métis Settlements Land Registry, of a notice in writing from the regional health authority requesting cancellation. (3) On recording a notice of health hazard, the Registrar of the Métis Settlements Land Registry shall notify the person against whose Métis title the notice is recorded and every person who has recorded an interest against the Métis title. The Act is silent on application on Indian reserves (Alberta, 2000e).

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
Alberta	Regional Health Authorities Act	2000	Under the Regional Health Authority Act the relationship between Aboriginal people and health is not addressed though the Act does define Métis Settlements as a municipality (Alberta, 2000f).
Alberta	Tobacco Reduction Act	2005	Nothing in this Act affects the rights of aboriginal people respecting traditional aboriginal spiritual or cultural practices or ceremonies (Alberta, 2005).
Saskatchewan	The Health Districts Act	1993	This Act contains no Aboriginal-specific provisions (Saskatchewan, 1993).
Saskatchewan	The Public Health Act	1994	For the purpose of carrying out this Act according to its intent, the minister may enter into agreements with a local authority, the Government of Canada or its agencies, the government of another province or territory of Canada or its agencies, an Indian band or any other person (Saskatchewan, 1994).
Saskatchewan	Vital Statistics Act	1995	Registration divisions: 35(3) Every Indian agency in Saskatchewan is a registration division. Division Registrars: 36 (2) Every Indian superintendent in Saskatchewan is authorized to as division registrar of the registration division formed by the Indian agency under his or her jurisdiction. Registrations – remuneration: 40 Division registrars and Indian superintendents are to be remunerated by municipalities and other persons in the manner and in accordance with the amounts prescribed in the regulations. Regulations: 60 The Lieutenant Governor in Council may make regulations: (e.1) prescribing the fees for each registration including a maximum or minimum annual amount to be paid by a municipality or other person to division registrars and Indian superintendents with respect to registrations; (Saskatchewan, 1995).
Saskatchewan	The Regional Health Services Act	2002	Administrative powers: (5) A regional health authority may, for the purpose of carrying out its responsibilities pursuant to subsection 27(1): (a) enter into agreements with the Government of Canada or its agencies, the Government of Saskatchewan or its agencies, the government of any other province or territory of Canada or its agencies, municipalities, any other government organization, Indian bands or any other persons; (6) The cancer agency may, for the purpose of carrying out its responsibilities pursuant to the agreement to this Act and The Cancer Agency Act: (a) enter into agreements with the Government of Canada or its agencies, the Government of Saskatchewan or its agencies, the government of any other province or territory of Canada or its agencies, municipalities, any other government organization, Indian bands or any other persons; (Saskatchewan, 2002).
Saskatchewan	Tobacco Control Act	2001	Furnishing tobacco to young persons prohibited (5) Nothing in this section prevents a person from giving tobacco or a tobacco-related product to a young person if the gift is made solely for use in traditional Aboriginal spiritual or cultural practices or ceremonies. 11 (2) Subject to subsection (3), no person shall smoke or hold lighted tobacco in an enclosed public place. (3) Subsection (2) does not apply to: (c) and enclosed public place while it is being used with the consent of the proprietor, for traditional Aboriginal spiritual or cultural practices or ceremonies, if the use of tobacco or tobacco-related products is an integral part of the traditional Aboriginal spiritual or cultural practices or ceremonies being carried out in the enclosed public place; (Saskatchewan, 2001b).

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
Manitoba	The Sanatorium Board of Manitoba Act	1987	Powers of board: 3(2) With a view to attaining the aims and objectives of the board and without restricting the generality of subsection (1), the board may (v) co-operate with the appropriate department of the Government of Canada, in endeavouring to establish a satisfactory tuberculosis control program for the Indian population of Manitoba; (Manitoba, 1987b).
Manitoba	The Public Health Act	1987	12.2(1) For the purpose of preventing, controlling or dealing with a threat to public health, the minister, a person designated by the minister or the chief medical officer of health may provide information to and obtain information from any of the following: (c) a band as defined in the Indian Act; (Manitoba, 1987a).
Manitoba	The Regional Health Authorities Act	1996	24(2) In the course of preparing a proposed regional health plan, the regional health authority shall consult with such persons, including municipalities, Indian Bands, and government departments and agencies, as the regional health authority considers appropriate (Manitoba, 1996).
Manitoba	The Midwifery Act	1997	8(5) The council shall establish (a) a standing committee for the purpose of recruiting and selecting public representatives to serve on the council and committees of the college; (b) a standing committee to advise the college on issues related to midwifery care to aboriginal women (Manitoba, 1997b).
Manitoba	The Non-Smokers Health Protection Act	2004	Section 5.1 of the act states that nothing in this Act prohibits (a) an Aboriginal person from using tobacco; or (b) a non-Aboriginal person from using tobacco with an Aboriginal person; if the activity is carried out for a traditional Aboriginal spiritual or cultural practice or ceremony (Manitoba, 2004).
Ontario	Health Protection and Promotion Act	1990	Part VI – Health Units and Boards of health 50. (1) A board of health for a health unit and the council of the band on a reserve within the health unit may enter into an agreement in writing under which, (a) the board agrees to provide health programs and services to the members of the band; and (b) the council of the band agrees to accept the responsibilities of the council of a municipality within the health unit. Appointment of member by council of band (2) The council of the band that has entered into the agreement has the right to appoint a member of the band to be one of the members of the board of health for the health unit. Joint appointment (3) The councils of the bands of two or more bands that have entered into agreements under subsection (1) have the right to jointly appoint a person to be one of the members of the board of health for the health unit instead of each appointing a member under subsection (Ontario, 1990a).
Ontario	Indian Welfare Services Act	1990	Indians eligible for social assistance benefits Every Indian resident in Ontario is entitled to the benefits of the Family Benefits Act or the Ontario Disability Support Program Act, 1997 to the same extent as any other person. Canada-Ontario agreements authorized 3. The Minister, with the approval of the Lieutenant Governor in Council, may make agreements with the Crown in right of Canada, or an agency thereof, (a) to provide compensation to any children's aid society that extends its facilities and services to Indians; (b) to provide compensation to any authority operating a home for the aged that provides accommodation and care for Indians; (c) respecting the payment of the cost of providing assistance under the General Welfare Assistance Act or assistance under the Ontario Works Act, 1997 for Indians; (d) respecting the payment of the cost of providing rehabilitation services for Indians; and (e) respecting the provision and payment of such other services as will promote the well-being of Indians (Ontario, 1990b).

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
Ontario	Midwifery Act	1991	Exception for aboriginal midwives (3) An aboriginal person who provides traditional midwifery services may, (a) use the title "aboriginal midwife", a variation or abbreviation or an equivalent in another language; and (b) hold himself or herself out as a person who is qualified to practise in Ontario as an aboriginal midwife (Ontario, 1991a).
Ontario	Regulated Health Professions Act	1991	Exemption, aboriginal healers and midwives 35. (1) This Act does not apply to, (a) aboriginal healers providing traditional healing services to aboriginal persons or members of an aboriginal community; or (b) aboriginal midwives providing traditional midwifery services to aboriginal persons or members of an aboriginal community. Jurisdictions of Colleges (2) Despite subsection (1), an aboriginal healer or aboriginal midwife who is a member of a College is subject to the jurisdiction of the College. Definitions (3) In this section, "aboriginal healer" means an aboriginal person who provides traditional healing services; ("guérisseur autochtone") "aboriginal midwife" means an aboriginal person who provides traditional midwifery services. ("sage-femme autochtone") (Ontario, 1991b).
Ontario	New Directions: Aboriginal Health Policy for Ontario	1994	This was developed between representative First Nation/Aboriginal organizations and the Ministry of Health. This led to the development of the Ontario Aboriginal Health Advocacy Initiative manual (Ontario, 1994b).
Ontario	Long-Term Care Act	1994	Approval of agencies 5. (1) The Minister, (b) shall approve, (i) an agency that is an organization operating under the authority of a First Nation to provide a community service, if the Minister has entered into an agreement with the First Nation under clause 9 (1) (a) and the agency meets the requirements for approval set out in the agreement, (ii) an agency that is an organization operating under the authority of a group of First Nations to provide a community service, if the Minister has entered into an agreement with the group of First Nations under clause 9 (1) (b) and the agency meets the requirements for approval set out in the agreement, (iii) an agency that is an organization operating under the authority of an aboriginal community to provide a community service, if the Minister has entered into an agreement under clause 9 (1) (c) with the agency or an aboriginal organization other than the agency and the agency meets the requirements for approval set out in the agreement. Part V - Agreements with First Nations or Aboriginal Organizations 9. Agreements with First Nations or Aboriginal Organizations 9. (1) The Minister may, (a) enter into an agreement with a First Nation to provide for community services for the people of the First Nation; (b) enter into an agreement with a group of First Nations to provide for community services for the people of those First Nations; (c) enter into an agreement with an aboriginal organization to provide for community services for the members of one or more aboriginal communities. Same (2) An agreement under subsection (1) may provide for matters in addition to or in substitution for matters provided for in this Act or the regulations and it may also provide that one or more provisions of this Act or the regulations do not apply in respect of a First Nation, an aboriginal community or an organization referred to in clause (e) of the definition of "agency" in subsection 2 (1).

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
Ontario	Long-Term Care Act (cont'd)	1994	Part VI - Multi-Service Agencies First Nations and aboriginal communities (7) The Minister shall designate as a multi-service agency, (a) an approved agency that is an organization operating under the authority of a First Nation, if the Minister has entered into an agreement with the First Nation under clause 9 (1) (a) and the approved agency meets the requirements for designation as a multi-service agency set out in the agreement; (b) an approved agency that is an organization operating under the authority of a group of First Nations, if the Minister has entered into an agreement with the group of First Nations under clause 9 (1) (b) and the approved agency meets the requirements for designation as a multi-service agency set out in the agreement; (c) an approved agency that is an organization operating under the authority of an aboriginal community, if the Minister has entered into an agreement under clause 9 (1) (c) with the approved agency or an aboriginal organization other than the approved agency and the approved agency meets the requirements for designation as a multi-service agency set out in the agreement (Ontario, 1994a).
Ontario	Ontario Aboriginal Health Policy for Ontario Manual (OAHAI)	1999	This policy manual was designed and distributed to assist various Aboriginal organizations in informing their clientele. It is the result of New Directions. It is very difficult to find an online copy of the OAHAI. However, it is linked to the AHWS (Ontario Aboriginal Health Advocacy Health Initiative, 1999).
Ontario	Ontario Health Plan for an Influenza Pandemic	2006	Section 20 is specific to First Nations communities. It outlines emergency pandemic procedures and policies, and identifies the needs of First Nations communities during an influenza pandemic. It also clarifies the roles and responsibilities of the Ontario Ministry of Health and Long-Term Care, First Nations and Inuit Health (FNIH), and First Nations communities in responding to an influenza pandemic (Ontario, 2006b).
Ontario	Smoke-Free Ontario Act	2006	13. (1) The purpose of this section is to acknowledge the traditional use of tobacco that forms part of Aboriginal culture and spirituality. Non-application of s. 3 (2) Section 3 does not prohibit a person from giving tobacco to an Aboriginal person who is or appears to be less than 19 years of age or 25 years of age, as the case may be, if the gift is made for traditional Aboriginal cultural or spiritual purposes. Non-application of smoking prohibitions (3) No provision of an Act, regulation or municipal by-law that prohibits smoking in a place, including section 9 of this Act, (a) prohibits an Aboriginal person from smoking tobacco or holding lighted tobacco there, if the activity is carried out for traditional Aboriginal cultural or spiritual purposes; (b) prohibits a non-Aboriginal person from smoking tobacco or holding lighted tobacco there, if the activity is carried out with an Aboriginal person and for traditional Aboriginal cultural or spiritual purposes. Place for traditional use of tobacco (4) At the request of an Aboriginal resident, the operator of a hospital, facility, home or other place set out below shall set aside an indoor area, separate from any area where smoking is otherwise permitted, for the use of tobacco for traditional Aboriginal cultural or spiritual purposes: 1. A hospital as defined in the Public Hospitals Act. 2. A private hospital as defined in the Private Hospitals Act. 3. A designated psychiatric facility. 4. A nursing home as defined in the Nursing Homes Act. 5. A home for special care under the Homes for Special Care Act. 6. An approved charitable home for the aged under the Charitable Institutions Act. 7. A home as defined in the Homes for the Aged and Rest Homes Act. 8. A place that belongs to a prescribed class (Ontario, 2006c).

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
Ontario	Local Health System Integration Act	2006	Preamble, The people of Ontario and their government, (g) recognize the role of First Nations and Aboriginal peoples in the planning and delivery of health services in their communities; Reports, 13. (1) Each local health integration network shall submit to the Minister an annual report, within the time period that the Minister specifies, on its affairs and operations during its immediately preceding fiscal year. Contents, (3) The annual report shall include, (b) data relating specifically to Aboriginal health issues addressed by the local health integration network. Part III - Planning and Community Engagement, Provincial strategic plan 14. (1) The Minister shall develop a provincial strategic plan for the health system that includes a vision, priorities and strategic directions for the health system and make copies of it available to the public at the offices of the Ministry. Councils, (2) The Minister shall establish the following councils: 1. An Aboriginal and First Nations health council to advise the Minister about health and service delivery issues related to Aboriginal and First Nations peoples and priorities and strategies for the provincial strategic plan related to those peoples. Community engagement, 16. (1) A local health integration network shall engage the community of diverse persons and entities involved with the local health system about that system on an ongoing basis, including about the integrated health service plan and while setting priorities. 2006, c. 4, s. 16 (1). Duties, (4) In carrying out community engagement under subsection (1), the local health integration network shall engage, (a) the Aboriginal and First Nations health planning entity for the geographic area of the network that is prescribed (Ontario, 2006a).
Quebec	Youth Protection Act	1977	37.5. In order to better adapt the application of this Act to the realities of Native life, the Government is authorized, subject to the applicable legislative provisions, to enter into an agreement with a first nation represented by all the band councils of the communities making up that nation, with a Native community represented by its band council or by the council of a northern village, with a group of communities so represented or, in the absence of such councils, with any other Native group, for the establishment of a special youth protection program applicable to any child whose security or development is or may be considered to be in danger within the meaning of this Act (Quebec, 2008c).
Quebec	An Act Respecting Cree, Inuit and Naskapi Native persons	1978	The Act does not contain a reference to health services. The Act defines Cree, Inuit and Naskapi beneficiaries (Quebec, 2008a).
Quebec	Loi sur les villages cris et le village naskapi	1978	The Act does not contain a reference to health services. The Act creates municipalities in Cree and Naskapi reserves.
Quebec	Loi sur le ministère de la santé et des services sociaux	1985	The Act makes no reference to Aboriginal, Amérindian, Indian, Inuit or Métis.
Quebec	Loi sur les services de santé et les services sociaux	1991	The Act makes no reference to Aboriginal, Amérindian, Indian, Inuit or Métis. For signatories of the James Bay and Northern Québec Agreement, the Act specifies a process for handling complaints related to access to services.

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
Quebec	Politique de la santé et du bien-être	1992	This policy defines the global health objectives. Aboriginal groups are mentioned in the context of vulnerable populations. The policy states that, to be effective, interventions must be adapted to the needs of vulnerable groups (Québec, 1998).
Quebec	An Act Respecting Prescription drug insurance	1996	The Act makes no reference to Aboriginal, Amérindian, Indian, Inuit or Métis (Quebec, 2008b).
Quebec	Loi sur la santé publique	2001	The Act makes no reference to Aboriginal, Amérindian, Indian, Inuit or Métis (Québec, 2001).
Quebec	Loi sur les services préhospitaliers d'urgence	2002	The Act makes no reference to Aboriginal, Amérindian, Indian, Inuit or Métis (Québec, 2002).
Quebec	Loi sur les agences de développement de réseaux locaux de services de santé et de services sociaux	2003	The Act makes no reference to Aboriginal, Amérindian, Indian, Inuit or Métis (Québec, 2005).
Quebec	L'intégration des services de santé et des services sociaux - Le projet organisationnel et clinique et les balises associées à la mise en œuvre des réseaux locaux de services de santé et de services sociaux	2004	Aboriginal groups are mentioned in the context of vulnerable populations (Québec, 2004).
New Brunswick	Health Act	1973	The Act does not contain provisions pertaining specifically to Aboriginal peoples.
New Brunswick	Hospital Services Act	1973	The Act does not contain provisions pertaining specifically to Aboriginal peoples.
New Brunswick	Medical Services Payment Act	1973	The Act does not contain provisions pertaining specifically to Aboriginal peoples.
New Brunswick	Hospital Services Act	1973	The Act does not contain provisions pertaining specifically to Aboriginal peoples.
New Brunswick	Health Services Act	1973	The Act does not contain provisions pertaining specifically to Aboriginal peoples.
New Brunswick	Mental Health Act	1973	The Act does not contain provisions pertaining specifically to Aboriginal peoples.
New Brunswick	Ambulance Services Act	1990	The Act does not contain provisions pertaining specifically to Aboriginal peoples.
New Brunswick	Mental Health Services Act	1997	The Act does not contain provisions pertaining specifically to Aboriginal peoples.

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
New Brunswick	Public Health Act	1998	Part V – Administration Minister may enter into agreements 58(1) The Minister may, subject to the approval of the Lieutenant-Governor in Council, enter into and amend an agreement with (c) a band council as defined in the Indian Act (Canada), a municipality or a rural community, For the purpose of the organization and delivery of the public health programs and services, the prevention of diseases and injuries and the promotion and protection of the health of the people of New Brunswick or any group of them (New Brunswick, 1998).
New Brunswick	Regional Health Authorities Act	2002	Part II – Powers and Duties of the Minister Agreements by Minister 13The Minister may enter into, and amend, agreements for the purposes of this Act with (c) a band council as defined in the Indian Act (Canada), Division C – Power, Duties and Responsibilities of Regional Health Authorities Agreements by regional health authority 37A regional health authority may enter into, and amend, an agreement for the purposes of this Act and the regulations with (d)a band council as defined in the Indian Act (Canada), (New Brunswick, 2002b).
New Brunswick	Smoke-free Places Act	2004	Application of Act 2(2) Nothing in this Act affects the rights of aboriginal people respecting traditional aboriginal spiritual or cultural practices or ceremonies (New Brunswick, 2004).
Nova Scotia	Health Act	1989	The Act does not contain provisions pertaining specifically to Aboriginal peoples (Nova Scotia, 1989a).
Nova Scotia	Health Services and Insurance Act	1989	The Act does not contain provisions pertaining specifically to Aboriginal peoples (Nova Scotia, 1989b).
Nova Scotia	Hospitals Act	1989	The Act does not contain provisions pertaining specifically to Aboriginal peoples (Nova Scotia, 1989c).
Nova Scotia	Health Authorities Act	2000	4 (1) The selection process established pursuant to subsection 3(2), shall be open, public and transparent in all respects, including: (d) the opportunity for applicants to self-identify as members of minority groups, such as disabled, First Nations, visible and cultural minorities, etc.; (Nova Scotia, 2000)
Prince Edward Island	Tobacco Sales and Access	2006	(6) Nothing in this section prevents a person from giving tobacco to a person who is or appears to be under the age of 19 years if the gift is made solely for use in traditional Aboriginal spiritual or cultural practices or ceremonies (Prince Edward Island, 2006)
Newfoundland and Labrador	Neglected Adults Welfare Act	1990	Labrador Inuit rights 2.1 This Act shall be read and applied in conjunction with the Labrador Inuit Land Claims Agreement Act and, where a provision of this Act is inconsistent or conflicts with a provision, term or condition of the Labrador Inuit Land Claims Agreement Act, the provision, term or condition of the Labrador Inuit Land Claims Agreement Act shall have precedence over the provision of this Act (Newfoundland and Labrador, 1990).
Newfoundland and Labrador	Health and Community Services Act	1997	Labrador Inuit rights 2.1 This Act and regulations made under this Act shall be read and applied in conjunction with the Labrador Inuit Land Claims Agreement Act and, where a provision of this Act or regulations made under this Act is inconsistent or conflicts with a provision, term or condition of the Labrador Inuit Land Claims Agreement Act, the provision, term or condition of the Labrador Inuit Land Claims Agreement Act shall have precedence over the provision of this Act (Newfoundland and Labrador, 1995).

Territorial and Provincial Legislation and Documents of Relevance to Aboriginal Health

Province/ Territory	Name of the Act, Document	Year ratified	Relevance to Aboriginal Health
Newfoundland and Labrador	Child Care Services Act	1998	Labrador Inuit rights 3.1 (1) This Act and regulations made under this Act shall be read and applied in conjunction with the Labrador Inuit Land Claims Agreement Act and, where a provision of this Act or regulations made under this Act is inconsistent or conflicts with a provision, term or condition of the Labrador Inuit Land Claims Agreement Act , the provision, term or condition of the Labrador Inuit Land Claims Agreement Act shall have precedence over the provision of this Act or a regulation made under this Act. (2) Where, under this Act or regulations made under this Act, a director issues a licence he or she may add to that licence terms and conditions that the licensee must comply with in order to ensure compliance with the terms and conditions of the Labrador Inuit Land Claims Agreement Act (Newfoundland and Labrador, 1998a).
Newfoundland and Labrador	Child, Youth and Family Services Act	1998	Labrador Inuit rights 2.1 This Act and regulations made under this Act shall be read and applied in conjunction with the Labrador Inuit Land Claims Agreement Act and, where a provision of this Act or regulations made under this Act is inconsistent or conflicts with a provision, term or condition of the Labrador Inuit Land Claims Agreement Act, the provision, term or condition of the Labrador Inuit Land Claims Agreement Act shall have precedence over the provision of this Act or a regulation made under this Act (Newfoundland and Labrador, 1998b).
Newfoundland and Labrador	Adoption Act	1999	Best interest principles 3. (3) Notwithstanding subsections (1) and (2), this Act and regulations made under this Act shall be read and applied in conjunction with the Labrador Inuit Land Claims Agreement Act and, where a provision of this Act or regulations made under this Act is inconsistent or conflicts with a provision, term or condition of the Labrador Inuit Land Claims Agreement Act, the provision, term or condition of the Labrador Inuit Land Claims Agreement Act shall have precedence over the provision of this Act or a regulation made under this Act (Newfoundland and Labrador, 1999).
Newfoundland and Labrador	Labrador and Inuit Land Claims Agreement	2004	38. The Health and Community Services Act is amended by adding immediately after section 2 the following: Labrador Inuit rights 2.1 This Act and regulations made under this Act shall be read and applied in conjunction with the Labrador Inuit Land Claims Agreement Act and, where a provision of this Act or regulations made under this Act is inconsistent or conflicts with a provision, term or condition of the Labrador Inuit Land Claims Agreement Act, the provision, term or condition of the Labrador Inuit Land Claims Agreement Act shall have precedence over the provision of this Act (Newfoundland and Labrador, 2008).

Appendix F

Health Care Decentralization

Health Care Decentralization				
Province/ territory	Regional structure	Established	Members are	Provisions entrenching Aboriginal participation
Yukon	Not regionalized			
Northwest Territories	8 Health and Social Services Authorities, 5 are regional health boards, 2 are community boards, and 1 serves the entire territory	1997-1998, restructured in 2002	Appointed	No specific provision to ensure Aboriginal representation (Government of the Northwest Territories, 1988).
Nunavut	Not regionalized			
British Columbia	5 Regional Health Authorities and 1 PHSA	1997, restructured in 2001	Appointed	Article 7.6.4 states that "the membership of public sector boards should reflect the cultural and geographical makeup of the population"(The Board Resourcing and Development Office, 2007).
Alberta	9 Regional Health Authorities, each RHA includes Community Health Councils	1994, restructured in 2003	Appointed	No specific provision to ensure Aboriginal representation (Government of Alberta, 2008).
Saskatchewan	13 Regional Health Authorities, each RHA includes Community Advisory Networks	1992, restructured in 2001-2002	Appointed	No specific provision to ensure Aboriginal representation (Saskatchewan Health, 2008).
Manitoba	11 Regional Health Authorities, each RHA includes District Health Advisory Councils	1997-1998, restructured in 2002	Appointed	No specific provision to ensure Aboriginal representation (Manitoba, 2008).
Ontario	14 local health integration networks	District Health Boards in 1973, LHINs in 2005	Appointed	According to the Principles Governing the Appointments Process, the "Persons selected to serve must reflect the true face of Ontario in terms of diversity and regional representation" The Local Health system Integration Act requires the creation of an Aboriginal and First Nations health council to advise the minister about health and health services related issues (Ontario Public Appointment Secretariat, 2007).
Quebec	18 Agences de développement de réseaux locaux de services de santé et de services sociaux	1989-1992, restructured in 2003, on-going in 2005	Appointed	No specific provision to ensure Aboriginal representation (Gouvernement du Québec, 2005).
New Brunswick	8 Regional Health Authorities	1993-1994, restructured in 2002	Elected/ Appointed	No specific provision to ensure Aboriginal representation (New Brunswick, 2002a).

Health Care Decentralization

Province/ territory	Regional structure	Established	Members are	Provisions entrenching Aboriginal participation
Nova Scotia	9 District Health Authorities	1996, restructured in 2001	Appointed	According to the regulations, "the following are to be considered assets in the consideration of candidates for nomination: population characteristics such as age, gender, ethnicity, geography or membership in a disadvantaged group (Government of Nova Scotia, 2000).
Prince Edward Island	Not regionalized	1993-1994, restructured in 2003, abolished in 2005		
Newfoundland & Labrador	4 Regional Integrated Health Authorities	1994, restructured in 2003-2004, 2005.	Appointed	No specific provision to ensure Aboriginal representation (Government of Newfoundland and Labrador, 2005).

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

1 250 960 5250
NCCAH@UNBC.CA
WWW.NCCAH.CA