"Colonial Legacies and Fiduciary Law:
A Conceptual Framework for Addressing Aboriginal Health"

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Part I: Introduction

Canada's universal health care system attempts to provide comprehensive, needs based health care coverage to all of Canada's residents. There is one group however, whose needs are clearly not being met by this system: Aboriginal people[1]. Epidemiological data indicate that Aboriginal people have significantly worse health outcomes compared to their non-Aboriginal counterparts in many areas of comparison including infant mortality, rate of HIV, rate of tuberculosis and rate of bronchitis, to name a few. The terms "deplorable", "a national disgrace", in a state of "crisis" and "simply unacceptable," have all been used to describe the health situation of many of Canada's First Nations communities.[2]

The reasons for these abhorrent outcomes stem largely from colonial policies of assimilation that systematically destroyed indigenous cultures, families and ways of life, and disrupted their economic, political and legal orders. However the current disparity between Aboriginal and non-Aboriginal health outcomes is, as Constance MacIntosh notes in *Canadian Health Law and Policy*, "indicative of what can only be a continuing failure of Canadian law and policy to enable and support a systemic remedy."[3] Yvonne Boyer however, in *Moving Aboriginal Health Forward,* notes that while law certainly has played a negative role in shaping the social and structural factors that affect health,[4] it can also be used as a tool for change: "the law can also provide the teeth for enforcing public health standards and changing existing patterns that damage health."[5] In light of the law's ability to influence health outcomes, this paper will consider whether the law of fiduciary duty could be the conceptual framework needed

[1] This paper is directed primarily to issues pertaining to First Nations and Inuit communities, but the author has no reason to believe that all aboriginal peoples are not affected by diminished health resources, in all senses of the word.
[2] Constance MacIntosh, "Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations" in Downie et al, eds, *Canadian Health law and Policy,* 4th ed (Canada: Lexis Nexis, 2011) 575 at pp 583-584
[3] *Ibid* at 596
[4] Yvonne Boyer, *Moving Aboriginal Health Forward* (Canada: Purich Publishing, 2014) at 92
[5] *Ibid* at 92.

to enforce those health standards and change existing health patterns as they relate to Aboriginal peoples. More specifically, this paper will consider whether Canada's Aboriginal people could argue that the Crown's fiduciary obligations to them extend to the protection of their health interests.

I begin by looking at the way colonialism has adversely impacted the health status of Aboriginal people. I then briefly overview how Aboriginal health is currently governed and administered, in light of Canada's constitutional division of powers, and will consider some of the problems that have arisen as a result of this administration. I will then outline the law of fiduciary duty as it applies in the Aboriginal context, and consider how this law might be applied in relation to Aboriginal heath interests. I conclude however, by arguing that even if the law of fiduciary duty were to apply in this context, it would not create a remedy for the health disparities arising from colonial legacies both past and present; rather, it would simply reinforce the paternalistic, colonial and confusing model of governance that currently plagues the administration and provision of Aboriginal health care services. I therefore maintain that the only way to address poor aboriginal health outcomes is to dismantle the underlying colonial structures that caused and continues to perpetuate them. It is only through an ethic of decolonization and the promotion of aboriginal self-determination that we can begin to address Aboriginal wellbeing, both in the health care context and beyond.

Part II: Aboriginal Health in Context

Words such as "in crisis", "a national disgrace" and "deplorable" have all been used to describe Aboriginal health outcomes[6] and the health statistics for Aboriginal peoples living in Canada paint a very grim picture.[7] Aboriginal people die at higher rates and at younger ages than

[6] MacIntosh, *supra* note 2 at 575.
[7] Boyer, *supra* note 4 at 24

the general Canadian population. The infant mortality rate for Aboriginal people is seven times higher than the national average.[8] The rate of suicide is twice that of the general population. Aboriginal people experience HIV rates at around 3.6 times higher than other Canadians.[9] And the rate of diabetes among Aboriginal people is three to five times higher than the rest of the population. Given these statistics, it is clear that Aboriginal peoples suffer from a disproportionate burden of ill health.[10]

Many of the health problems that Aboriginal peoples face today, and their underlying social determinants, are linked to historic policies of colonialism and assimilation.[11] The *Report of the Royal Commission on Aboriginal Peoples* ("*RRCAP*") states that:

> The transformation of Aboriginal people from the state of good health that had impressed travellers from Europe to one of ill health, for which Aboriginal people were (and still are) often held responsible, grew worse as sources of food and clothing from the land declined and traditional economies collapsed […] it worsened yet again, as long-standing norms, values, social systems and spiritual practices were undermined or outlawed.[12]

Systemic attempts to destroy Aboriginal cultures, families and connections with the land, the loss of sovereignty, the disruption of political, economic, and legal orders, the imposition of the reserve and the residential schooling systems, and colonialist notions of European superiority and Aboriginal inferiority have adversely impacted the health status of Aboriginal peoples for over a century.[13] Conversely, those communities that were less exposed to assimilationist policies appear to have better health outcomes, as indicated by a recent study on the incidence of diabetes in Alberta First Nations. The authors of the study write that: "Our quantitative results […] suggest that some First Nations in Alberta have been better able to preserve their culture (as

[8] Boyer, *supra* note 4 at 24
[9] Boyer, *supra* note 4 at 24
[10] Miranda D Kelly, "Towards a New Era of Health Policy" (2011) 2 The International Indigenous Policy Journal 1 at 1
[11] Boyer, *supra* note 4 at 22
[12] Canada, Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples,* Vol III Gathering Strength at 113
[13] Alexandra Kent, "Restructuring First Nations Health Governance: A Multilevel Solution to a Multifaceted Problem" (2014) 5 The Arbutus Review 131 at 133

measured by Indigenous language knowledge) and consequently are relatively protected from diabetes."[14] Colonialism has therefore created, as MacIntosh explains "a social determinant of health that is unique to the Indigenous population within the Canadian context."[15]

Part III: The Administration of Aboriginal Health

The effects of colonialism have also impacted the administration and delivery of Aboriginal health care. Under the *Constitution Act 1867,* jurisdictional authority was divided between the provincial and federal governments.[16] While the administration of health care does not explicitly fall under either federal or provincial ambits of power, the Supreme Court of Canada ("SCC" or "the Court") has held that jurisdiction over health is primarily provincial with federal power limited to what is ancillary to their express powers under section 91.[17] Section 91(24) of the *Constitution Act 1867* however, places "*Indians and lands reserved for Indians*" under federal jurisdiction.[18] As a result, whether Aboriginal health falls under provincial or federal jurisdiction is unclear, and the question has yet to be settled by the courts.[19] This jurisdictional confusion is a product of a colonial legacy that, through the *Constitution Act 1867*, divided power between the federal and provincial governments with no regard to the Aboriginal systems of governance already in place, and treated Aboriginal peoples as an area of public policy that needed regulating.

Jurisdictional uncertainty has led to disagreement between the federal and provincial governments over the administration and funding of Aboriginal health care. This in turn has

[14] Richard T Oster et al, "Cultural Continuity, traditional indigenous language, and diabetes in Alberta First Nations: a mixed methodology study" (2014) International Journal for Equity in Health, 13:92, at 8
[15] MacIntosh, *supra* note 2 at 578
[16] *Constitution Act*, *1867* (UK), 30 & 31 Vict, c 3, ss 91-92, reprinted in RSC 1985, App II, No 5
[17] *Schneider v The Queen*, [1982] 2 S.C.R. 112 at 137
[18] *Constitution Act 1867*, *supra* note 16 at s 91(24)
[19] MacIntosh, *supra* note 2 at 584-585

created a "complex and convoluted" health care delivery system for Aboriginal people.[20] Even Health Canada acknowledges the complexity of the system, holding that Aboriginal peoples are provided with health care services through a "complex, dynamic and interdependent" combination of federal, provincial, and First Nation's run programs.[21]

According to Health Canada, the province delivers hospital, physician and public health services to all residents, including Aboriginal peoples, but that they generally do not operate direct health services on reserve.[22] The federal government, through the First Nations and Inuit Health Branch ("FNIHB") finances and provides most health services to on-reserve First Nation and Inuit communities. The FNIHB administer a number of programs including:[23]

- Primary care centers and nursing stations in remote or isolated communities;
- Public health programs focused on the prevention of communicable disease, safe drinking water, and other public health issues;
- Home and community care services to on-reserve First Nations and Inuit communities; and
- Non-insured health services (eg. prescription drugs and dental care) to "Status Indians,"[24] both on and off reserve.

However, because the federal government limits most of its service delivery to on-reserve communities, Métis and off-reserve Aboriginal groups are necessarily excluded from receiving these services.[25] Finally, most on-reserve First Nations also play an active role in the delivery and administration of health care within their communities. Through "contribution agreements"

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[20] Boyer, *supra* note 4 at 102
[21] Health Canada, First Nations and Inuit Health Strategic Plan: A Shared Path to Improved Health, (Ottawa: Health Canada 2012) at 7
[22] *Ibid,* at 6
[23] *Ibid, at 7*
[24] ""Indian Status" refers to a specific legal identify of an Aboriginal person in Canada. With the creation of the Indian Act in 1867, the Canadian government developed criteria for who would be legally considered to be an Indian. This criteria continues to be outlined in Section 6 of the Indian Act, thus defining who qualifies for Indian status." –Indigenous Foundations, "Indian Status", http://indigenousfoundations.arts.ubc.ca/home/government-policy/the-Indian-act/Indian-status.html
[25] MacIntosh, *supra* note 2 at 600

made with the federal government, certain First Nations have assumed control over federally funded health services. Contribution agreements vary based on the nature of programs and administrative capacity of the communities,[26] so the extent to which a First Nation is responsible for the delivery of its health services varies from community to community. Furthermore, the role of the First Nation appears to be limited to the administration and delivery of care, with ultimate responsibility for determining what services will be funded resting with the federal government.[27]

While the above description provides a cursory overview of the administration of Aboriginal health care services in Canada, it does not consider a multitude of other factors that impact how health services are delivered in practice.[28] A detailed overview of the administration of Aboriginal health care is beyond the scope of this paper. However the complexity of the system, and its impact on Aboriginal health, cannot be overstated. Boyer notes that the gaps created by jurisdictional conflicts constitute a major determinant of ill health for Aboriginal peoples in Canada.[29] Similarly, Alexandra Kent notes that lack of intergovernmental coordination often leads to overlaps and duplication of services.[30] Finally, the National Collaborating Centre for Aboriginal Health notes that in some cases "the gaps and ambiguities created by a complicated policy environment and jurisdictional confusions have created barriers to equitable access to

[26] Health Canada, "Contribution Agreements" Online: Health Canada <http://www.hc-sc.gc.ca/fniah-spnia/finance/agree-accord/index-eng.php>
[27] This does not reflect the situation in BC where Health Canada has recently transferred its role in the design, management and delivery of First Nations health programming to the First Nation's health authority. This was a result of the British Columbia Tripartite Framework Agreement on First Nation Health Governance. – Health Canada, "British Columbia Tripartite Framework Agreement on First Nations Health Governance", online: Health Canada <http://www.hc-sc.gc.ca/fniah-spnia/pubs/services/tripartite/framework-accord-cadre-eng.php>
[28] For example, this review does not consider the effect that negotiated self-government agreements have had on shaping the role that specific First Nations play in the administration of their health care, nor does it consider the role of regional health authorities.
[29] Boyer, *supra* note 4 at 102
[30] Kent, *supra* note 13 at 137

health care and services."[31] Aboriginal peoples in some communities face further barriers when trying to access the health care system because of language difficulties, cultural inappropriateness of service, scarcity of Aboriginal service providers and discrimination and institutional racism within the mainstream system.[32] As such, while it is clear that historical policies of colonization and assimilation are in large part to blame for the poor Aboriginal health outcomes, jurisdictional confusion and debate between the different levels of government have created a complex delivery system that is doing little to solve the problem, if not making it worse.

In spite of the federal government having accepted responsibility for providing certain Aboriginal health services as outlined above, they consistently deny that this is based on any legal obligation.[33] Rather, they contend that any medical assistance that they do provide to Aboriginal peoples is simply a discretionary exercise of their section 91(24) jurisdiction.[34] Conversely, many Aboriginal groups view the federal government's provision of health services to be part of Canada's fiduciary obligation to Aboriginal peoples.[35] In the next section, I therefore consider the strengths and weaknesses of this argument.

Part IV: Fiduciary Duty in the Aboriginal Context

Fiduciary law is an equitable doctrine that originates from the law of trust. When a fiduciary relationship is held to exist, the fiduciary is required to act in the best interest of the beneficiary (the person or group on whose behalf the fiduciary is acting), to avoid all conflicts of interest,

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[31] National Collaborating Centre for Aboriginal Health, "An Overview of Aboriginal Health in Canada" National Collaborating Centre for Aboriginal Health, (18 July 2013) Online: http://www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/101/abororiginal_health_web.pdf at 6
[32] Kent, *supra* note 13 at 137
[33] Jack Woodward, Native Law, loose-leaf (consulted on 22 Oct 2014), (Canada: Carswell, 1994) ch 19 at 19-20.1
[34] MacIntosh, *supra* note 2 at 588
[35] *Ibid*

and to act with absolute loyalty in managing the affairs of the beneficiary.[36]

In the 1984 case *Guerin v The Queen ("Guerin"),* the SCC for the first time recognized that the Crown-Aboriginal relationship is fiduciary in nature, with the Crown owing a fiduciary duty to Aboriginal peoples. The issue in *Guerin* was whether the federal government had acted inappropriately when it leased Musqueam reserve land to a private third party on conditions less favourable than what it had lead the Musqueam band to believe. The Court found that in doing so, the Crown had breached its fiduciary obligation to the Musqueam band.[37]

While prior to *Guerin*, the courts had recognized that the Crown was in a trust-like relationship with Aboriginal peoples, it was unclear as to whether this relationship was legally enforceable, or if it was merely a political obligation that did not attract legal protection.[38] The Court's recognition of a fiduciary relationship is therefore significant.[39]

The SCC held that the basis for the relationship arises from the Crown's assumption of control over the unique, pre-existing rights of Aboriginal peoples, and its commitments through the Royal Proclamation of 1763 to the *Constitution Act 1982*, to protect those rights.[40] In *Wewaykum Indian Band v Canada ("Wewaykum")*, the court explained that while the historic Aboriginal-Crown relationship had some positive aspects, "the degree of economic, social and proprietary control and the discretion asserted by the Crown also left the Aboriginal population vulnerable to the risks of government misconduct and ineptitude."[41] The concept of fiduciary duty is thus used as a mechanism to supervise the high degree of discretionary control that the

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[36] *Manitoba Métis Federation Inc v Canada ("Manitoba Métis"),* 2013 SCC 14, at para 47
[37] *Guerin v The Queen*, [1984] 2 SCR 335, at 389
[38] James Reynolds, *A Breach of Duty: Fiduciary Obligations and Aboriginal Peoples*, (Canada: Purich Publishing 2005) at 1-2
[39] Yvonne Boyer, "First Nations, Mets and Inuit Health Care: The Crowns Fiduciary Obligation" (2004) National Aboriginal Health Organization, Discussion Paper Series in Aboriginal Health, Native Law Centre University of Saskatchewan at 21
[40] Jack Woodward, *supra* note 33, at 3-42
[41] *Wewaykum Indian Band v Canada*, 2002 SCC 79, para 80

Crown gradually assumed over the lives of Aboriginal people.[42]

Post *Guerin*, some uncertainty existed as to how far the Crown's fiduciary obligations to Aboriginal peoples would extend. The SCC has since clarified that these obligations do not exist at large, in relation to all aspects of the Crown-Aboriginal relationship, but rather, they apply to "specific Indian interests".[43] Thus, the fiduciary relationship is limited to situations in which the Crown has assumed discretionary control over a "cognizable Indian interest.[44] In *Wewaykum*, the court also noted that the Crown's undertaking of discretionary control must be done in such a way so as to invoke responsibility in "the nature of a private law duty".[45]

The concept of the Crown's fiduciary obligation to Aboriginal peoples has typically been applied to "Crown actions affecting Aboriginal property rights, or the ability to carry out traditional practices."[46] After the decision in *Guerin*, the Crown's fiduciary duty to Aboriginal peoples was affirmed in relation to reserve creation, treaty interpretation, and s. 35 Aboriginal rights.[47] Doctrinally, however, no difficulty arises as a result of extending the obligation to other interests.[48] One may conclude from this that the full gamut of interests protected by this relationship is by no means settled.[49] The Court in *Wewaykum* has affirmed this notion: "potential relief by way of fiduciary remedies is not limited to the s. 35 rights (*Sparrow*) or existing reserves (*Guerin*)."[50]

Canadian courts have further held that the Aboriginal-Crown fiduciary relationship is *sui generis* (meaning of its own kind or class), and thus differs from the traditional fiduciary

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[42] *Ibid*, at para 79
[43] *Ibid at* para 81
[44] *Manitoba Métis, supra* note 36, at para 51
[45] *Wewaykum*, *supra* note 41 at para 85
[46] Erika Chamberlain, "The Crown's Fiduciary Duties to Aboriginal Peoples as an Aspect of Climate Justice" (2012) 30 Windsor Y.B. Access Just. 289 at 302-303
[47] Ibid 304.
[48] John Borrows and Leonard Rotman, *Aboriginal Legal Issues*, 4th ed, (Canada: LexisNexis, 2012) at 463
[49] Jack Woodward, *supra* note 33, at 3-43
[50] *Wewaykum supra* note 41 at para 79

relationship. The reasons for this are two-fold: i) the traditional fiduciary relationship is confined to the private law context whereas the Crown-Aboriginal fiduciary relationship arises outside of this context; and ii) the *sui generis* fiduciary relationship is more flexible in its requirements compared to the traditional duty: depending on the circumstances of the case the content of the duty may vary and the duty may tolerate conflicts of interests;[51] and there is room for the application of a limited duty rather than "the full menu of obligations imposed on a classic private law duty."[52] The *sui generis* nature of this relationship thus gives the doctrine a degree of flexibility not found within the traditional private law fiduciary duty.[53]

Part X: Health Care as a Fiduciary Obligation

The Crown may be found to owe a fiduciary duty to an Aboriginal person or group if i) the claim is in relation to a "cognizable Indian interest"; ii) the Crown has assumed discretionary control over that interest; and iii) this discretion invokes responsibility "in the nature of a private law duty". These discrete aspects of the doctrine will be considered sequentially.

i. "cognizable Indian interest"

While "cognizable Indian interests" giving rise to fiduciary obligations have so far only been found to exist in relation to land interests, treaty interpretation or s. 35 Aboriginal rights, courts recognize that other interests may also attract fiduciary protection. For example, in 2011 the Newfoundland and Labrador Court of Appeal in *Anderson v Canada (Attorney General)* ("*Anderson*") explicitly noted that the door remains open for other interests to be found subject to the Crown fiduciary obligation.[54]

Indeed, Canadian courts appear open to hearing arguments as to why other interests ought

[51] *Squamish Indian Band v R*, 2001 FCT 480 at para 473
[52] *Ibid* at para 475.
[53] J Timothy S McCabe, *The Honour of the Crown and its Fiduciary Duties to Aboriginal Peoples,* (Canada: LexisNexis, 2008), at 159-160
[54] *Anderson v Canada (Attorney General),* 2011 NLCA 82, at para 53

to be subject to fiduciary protection. In the 2013 case of *Brown v Canada* ("*Brown")* for example, the Ontario Superior Court of Justice (OSCJ) certified a class action law-suit in which the plaintiffs were alleging that the federal government had breached its fiduciary duty by failing to stop the provincial government from removing Aboriginal children from their homes and placing them in foster care between 1965-1984. In *Brown*, the "cognizable Indian interest" asserted was that of Aboriginal culture and identity. While the OSCJ did not go so far as to say that Aboriginal culture and identity was a "cognizable Indian interest", in certifying the class-action suit, they did find that given that " the law in this area is "rapidly evolving," it is at least arguable that a fiduciary duty arose on the facts herein."[55] Likewise, in another case regarding the certification of a class action lawsuit, the Newfoundland and Labrador Court of Appeal upheld the lower court's decision to certify the class given that there was "some basis in fact for the proposition that Canada had an over-arching responsibility for the health and welfare of Aboriginal persons attending residential schools."[56] From this, it may reasonably be inferred that, while "cognizable Indian interests" have generally only been found to exist in relation to Indian lands or s. 35 Aboriginal rights, this limitation is imposed neither doctrinally, nor by the SCC, and Canadian courts appear open to entertaining arguments for its expansion. The inherent importance of one's health, the related disparities that exist between Aboriginal and non Aboriginal peoples, and the fact that colonization has produced a social determinant of health unique to Aboriginal peoples,[57] creates a strong foundational basis upon which to argue that Aboriginal health ought indeed to be recognized as a "cognizable Indian interest."

That being said, the SCC's most recent application of this test, in *Manitoba Métis Federation Inc v Canada ("Manitoba Métis"),* set a very high threshold for proving a

[55] *Brown v Canada (Attorney General)* 2013 ONSC 5637, 2013 at para 44
[56] *Anderson*, *supra* note 54 at para 63
[57] MacIntsoh, *supra* note 2, at 578

"cognizable Indian interest" in relation to land. It appears to equate the test for a "cognizable Indian interest" in land to the test for proving s. 35 Aboriginal rights. Albeit, *Manitoba Métis* is specifically concerned with land interests, it nonetheless establishes a strict standard upon which to assess "cognizable Indian interests, " which may suggest that the Court is wary of extending the doctrine of fiduciary duty and may be moving towards limiting its application. In regards to Aboriginal health, this may thus prove problematic.

ii. Crown Discretionary Control

A finding of a Crown fiduciary duty will also depend on whether the Crown assumed discretionary control over the "cognizable Indian interest". A review of Crown conduct over the course of the 19th and 20th centuries illustrates the way in which the federal Crown has gradually assumed discretionary control over Aboriginal health.

According to the *RRCAP*, between the end of the 19th century and the middle of the 20th, "health care was provided by an assortment of semi-trained RCMP agents, missionaries and officers, and later by a growing number of nurses and doctors in the full or part time employ of the federal government."[58] The number of organized medical services available to Aboriginal peoples increased after the First World War.[59] And in 1946, the Superintendent of Indian Health Services publicly asserted that they were accepting responsibility for Aboriginal health services: "Although neither law nor treaty imposes such a duty, the Federal Government has, for humanitarian reasons, for self-protection, and to prevent the spread of disease to the white population, accepted responsibility for health services to the native populations."[60]

By the 1950s, the Department of National Health and Welfare was operating a network of 33 nursing stations, 65 health centers and 18 small regional hospitals for registered Indians and

[58] *RRCAP*, *supra* note 12 at 114
[59] Boyer, *supra* note 39 at 14
[60] MacIntosh, *supra* note 2 at 592

Inuit, with these numbers growing by 1960.[61] The *RRCAP* explains that while this new western style health system that was imposed on Aboriginal peoples appears to have had some benefits (infant mortality began to decline, life expectancy began to increase, and where infectious disease was still rampant, it began to slow), those benefits came at a price:[62]

- Aboriginal people in their own communities were offered health care "with no foundation in local values, traditions or conditions;"[63]
- "Virtually all" health and social service providers were non-Aboriginal which lead to misunderstandings, resentment and racism;[64] and
- Aboriginal healing skills, herbal medicinal knowledge and other traditional practices were "devalued by medical personnel" eventually leading to the loss of much of this knowledge. [65]

This led the majority of traditional healers to abandon or hide their practices for fear of being persecuted by the Canadian government or Christian churches.[66] Finally, as a result of these practices "Aboriginal people learned that they were not in charge; non Aboriginal people learned that they were. This legacy is difficult for both sides to put behind them."[67]

In 1979, the Federal government appears to have changed course with the release of its Indian health policy, the goal of which was to "achieve an increasing level of health in Indian communities, *generated and maintained by the Indian communities themselves*."[68] This was the first time the Government acknowledged the role indigenous peoples might play in ameliorating conditions leading to poor health outcomes.[69] This eventually lead to the 1988 Health Transfer policy whereby Aboriginal communities, through the contribution agreements described in Part

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[61] *RRCAP*, *supra* note 12 at 114
[62] *Ibid*
[63] *Ibid*
[64] *Ibid*
[65] *Ibid*
[66] MacIntosh, *supra* note 2 at 595
[67] *RRCAP*, *supra* note 12 at 114
[68] Health Canada, "Indian Health Policy 1979, online: Health Canada http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php [emphasis added]
[69] MacIntosh, *Supra* note 2 at 598

III above, started to assume administrative control over specific health services. While these contribution agreements do empower Aboriginal communities to administer their own health care services, the agreements are subject to a number of restrictions and fiscal complications that hinder a community's ability to take meaningful control over their health.[70]

Some observations will serve to illustrate this concern. First, federal funding for health care programs is tied to the number of registered Indians on the reserve, not the actual number of people on reserve. So, for those communities in which Aboriginal identify is more broadly defined, the community itself must make up for the discrepancy in funding.[71] Second, the federal government has allocated funds for certain health care services, such as primary care, but not others, such as mental health care. As such, a First Nation either has to make up for the shortfall, or offer reduced services limited to those that fall within Canada's vision of Aboriginal health care.[72] Finally, those communities that do overspend in order to meet their service demands are at risk of the federal government imposing third party management.[73]

The practices outlined above illustrate the extent to which, over the course of the 19th and 20th centuries, the Federal Crown has asserted its control over the health of Aboriginal peoples and has assumed more and more responsibility for the delivery of their health care. They also demonstrate the way in which federal discretion over health care decisions have deeply affected, and continues to affect, the lives of Aboriginal peoples. While the federal government appears to be relinquishing some of that control and putting it back into the hands of Aboriginal communities through the use of contribution agreements, government funding restrictions and program requirements are undermining any amount of meaningful control that might otherwise be possible. As a result, the discretion to determine who gets health care, when, and why, is still

[70] *Ibid* at 600
[71] *Ibid* at 602
[72] *Ibid*
[73] *Ibid*

very much in the hands of the federal government. Given that the doctrine of fiduciary duty is meant to be used as a check on the high degree of discretion assumed by the Crown over the lives of Aboriginal people, it seems particularly appropriate for it to apply in this context.

iii. In the nature of a private law duty

Whether or not the federal government's discretion invokes a responsibility in the nature of a private law duty is perhaps the factor that poses the biggest challenge to this analysis. In *Wewaykum* the Court exemplified the difference between public law duties that would not attract fiduciary protection, and public law duties that, in their nature as private law duties, would attract fiduciary protection: "a quasi proprietary interest (eg. reserve land) could not be put on the same footing as a government benefit program. The latter will generally give rise to public law remedies only. The former raises considerations "in the nature of a private law duty.""[74] Given that the provision of health care is much more comparable to a benefits program than it is to a proprietary interest, this distinction may prove to be problematic.

That being said, the *sui generis* nature of the Crown Aboriginal fiduciary relationship allows for it to be applied in a more flexible manner. Timothy S McCabe in *The Honour of the Crown and its Fiduciary Duty to Aboriginal Peoples* writes that "[…] notwithstanding the several statements of the Supreme Court alluding to the finitude of the fiduciary duties of the Crown to Aboriginal peoples, it remains manifest that as *sui generis* duties they are capable of expansion and mutation to meet the needs of justice revealed in future cases."[75] As such, given the injustices that Aboriginal people have endured in relation to their health at the hands of the federal government, the *sui generis* nature of the government's fiduciary duties means that it may still prove applicable. On the other hand, Dwight Newman in *Revisiting the Duty to Consult*

[74] *Wewaykum*, *supra* note 41 at para 74
[75] McCabe, *supra* note 53 at 159-160

Aboriginal Peoples notes that while at one point it appeared that the court would make widespread use of the concept of fiduciary duty, this has since been "definitely rejected" by recent case law.[76] Given the limited application the courts have made of this doctrine, it may prove more challenging after all.

One way around this problem may be to tie the Aboriginal health interests to other interests over which the courts have already determined the fiduciary relationship governs. This strategy is currently being tested by four Alberta First Nations (the Tsuu T'ina, Ermineskin, Sucker Creek and Blood First Nation) who have recently filed a notice of civil claim against the federal government over the state of their on-reserve drinking water. The First Nations are claiming that Canada is in breach of its fiduciary duty to manage reserves under treaties 6, 7 and 8 by creating and sustaining unsafe drinking water conditions.[77] Given that these First Nations have grounded their health related claim to drinking water, in their quasi-proprietary interest in reserve land, it may have a higher prospect of success. While such a strategy will obviously limit the scope of the Crown's duty, it may nonetheless achieve important protection for the specific health interest at issue.

iv. Crown Conduct as Fiduciary

Finally, assuming the Crown's fiduciary obligations do extend to Aboriginal health interest, what would this duty entail? According to McCabe, even when fiduciary duties are found to exist, there is a "marked variability" in the content of those duties.[78] Erika Chamberlain in *The Crown's Fiduciary Duties to Aboriginal Peoples as an Aspect of Climate Justice,* also notes that fiduciary duties tend to be proscriptive rather than prescriptive: fiduciary law tends to focus on what would constitute a breach of that duty, and does not typically indicate what would be

[76] Dwight Newman, *Revisiting the Duty to Consult Aboriginal People*, (Canada: Purich Publishing, 2014) at 27
[77] Stephanie Hewson, "Drinking Water in First Nations Communities: Has Canada Breached its Fiduciary Duty?" McGill Journal of Law and Health, (23 Oct 2014) Online: http://mjlh.mcgill.ca/blog.php?blog_id=126
[78] McCAbe, *supra* note 53, at 159

required of the fiduciary to meet that duty.[79]

MacIntosh surmises that a Crown fiduciary duty over Aboriginal health interests would mean that federal decisions to reduce or deny program funding would become actionable,[80] and that the federal government would be required to make programming decisions based on what is in the best interest of the community or group in question, with less emphasis on financial constraints.[81] However, John Borrows and Leonard Rotman in *Aboriginal Legal Issues,* explain that when the Crown's fiduciary obligations to Aboriginal peoples conflict with its other responsibilities, such as those to the public at large,[82] "the Crown cannot ignore one interest in favour of the other. Rather, it must attempt to balance its competing responsibilities."[83] Likewise, the court has also noted that because the Crown-Aboriginal fiduciary relationship is *sui generis* it allows for "fiduciary duties that "tolerate conflicts of interest" and that are limited in obligation."[84] Given that health care decision-making often requires balancing a number of different interests, including the interests of the public at large, it is unlikely that the government would be required to completely dispense with those other interests in order to meet its obligations to Aboriginal peoples. Likewise, financial constraints are an unfortunate reality of health care decision-making, and courts have tended to accept financial considerations as a valid reason for governments not being able to provide certain health care services.[85] As such, while the Federal government may be required to place less emphasis on financial constraints in its fiduciary capacity, it is unlikely that a court would require them to dispense with those considerations all together. Finally, given the proscriptive nature of fiduciary law, it is unclear

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[79] Chamberlain, *supra* note 46 at 311
[80] MacIntosh, *supra* note 2 at 601
[81] *Ibid* at 596
[82] Borrows and Rotman, *supra* note 48, at 466
[83] *Ibid*
[84] McCabe, *supra* note 53 at 159
[85] Nola M Ries, "Charter Challenges" in Downie et al, eds, *Canadian Health law and Policy,* 4th ed (Canada: Lexis Nexis, 2011) 615 at 632

whether it would place any sort of positive obligation on the government to provide Aboriginal peoples with a certain level of care.

Part XI: Beyond Legal Considerations

As outlined in Part I, colonial policies of assimilation, and attitudes of colonial superiority, are the reasons that Aboriginal peoples and communities suffer the brunt of bad health. Jurisdictional squabbling between the federal and provincial governments has only exacerbated the problem by creating gaps in service and systemic barriers to accessibility. In light of this, a finding that the federal government owes a fiduciary obligation to Aboriginal peoples in relation to their health interests may hold some benefits. Notably: it would hold the federal government legally accountable to the task; it would provide Aboriginal peoples with an enforceable and compensable remedy when the government breaches its duties; and, by placing the fiduciary obligation on the federal government, it may help clear up some of the jurisdictional confusions that has lead to gaps in service and confusing administrative models. Unfortunately, however, this legal avenue is unlikely to address the root causes of the issue - colonialism and its manifestation in poor health outcomes – and may in fact entrench these causes even further.

According to MacIntosh, the health disparities resulting from colonial policies of forced dislocation, cultural suppression, political marginalization and assimilation "can likely only be addressed through measures that are informed and shaped by an ethic of decolonization."[86] Imposing a fiduciary obligation on the federal government to look after Aboriginal health interests does not create a relationship based on decolonization; rather, it perpetuates the colonial power imbalances already at play by giving the federal government the power to determine what is in the best interest of Aboriginal peoples. And while clearing up the jurisdictional uncertainty does seem like a worthy goal, it fails to situate the problem within its colonial context: the very

[86] MacIntosh, *supra* note 2 at 610

issue of jurisdictional confusion stems from the imposition of a colonial constitutional regime that only imagines two jurisdictions, and divides power accordingly. Framing the problem as jurisdictional distills the issue into which head of power controls which aspect of Aboriginal life, and fails to address the very matter of state control itself.[87]

The federal government has attempted to hand over administrative control of various health services to Aboriginal communities through contribution agreements. On a conceptual level, this move is clearly consonant with a de-colonizing approach to health care.[88] However given the way the federal government specifies funding levels based on their conceptions of who is 'Indian' and decides exactly what programs to fund, these agreements mean that power still ultimately rests with the federal government. As Andreas Krebs notes:

> AANDC [Aboriginal Affairs and Northern Development Canada] and Health Canada simply expect First Nations to reproduce the health system found in mainstream Canada, but with Indigenous people administering it. So long as AANDC and Health Canada control the purse strings, there is no room for First Nations to take control of their health in any meaningful way. Doctors and traditional healers will remain at odds; communities will be expected to suffer through the imposition of a cookie cutter approach to their well being; and chronic diseases associated with colonialism -- from diabetes to depression to substance abuse -- will continue to plague Indigenous people.[89]

Much of the literature and empirical data has demonstrated a correlation between aboriginal self-determination, self-governance, and improved health.[90] As such, there needs to be a fundamental shift that will support and promote Aboriginal self-determination both in the health care context and beyond. And while transferring meaningful control to Aboriginal peoples will by no means create a panacea, and will likely generate its own set of complex problems, at least those problems will arise, and can be solved, with Aboriginal peoples at the helm. As such,

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[87] Mary Ellen Turpel, "Home/Land" (1991) 10 Can. J. Fam. L. 17 at 30
[88] MacIntosh, *supra* note 2 at 599
[89] Andreas Krebs, "Colonialism Causes Diabetes and Other Things I learned at the Indigenous Health Conference" 26 November 2014, Huffington Post, Online: <http://www.huffingtonpost.ca/andreas-krebs/colonialism-and-health-problems_b_6220272.html>
[90] MacIntosh, *supra* note 2 at 605

while extending the Crown's fiduciary obligations to include Aboriginal health interests may provide Aboriginal peoples with a legal mechanism to address the symptoms of colonialism, igniting Aboriginal agency and supporting Aboriginal self governance will likely create a more positive outcome that extends well beyond the confines of health care.

Part VII: Conclusion

In this paper I have considered whether the Crown's fiduciary duty to Aboriginal peoples extends to Aboriginal health interests. I have demonstrated that while this argument does have a strong basis, it also faces some challenges. While there are strong arguments that Aboriginal health should be recognized as a "cognizable Indian interest" and courts appear amenable to hearing these arguments, the Supreme Court of Canada's most recent articulation of how to prove a "cognizable Indian interest" may have created an unattainable standard. However, the law of fiduciary duty, particularly in relation to aboriginal interests, is a flexible principle whose reach is by no means settled. Likewise, the law more generally, is a powerful and creative tool and the affect of a well-presented and well-argued law suit, regardless of outcome, ought not to be underestimated. Legal action may well influence the continuing dialogue on how best to protect and serve aboriginal peoples health interests. However, rather than focusing on whether or not the law of fiduciary duty could be used to obtain better health services for aboriginal peoples, the focus should be on how the law can be used to dismantle the underlying colonialist structures and power imbalances that created, and are perpetuating poor aboriginal health outcomes in the first place; because supporting Aboriginal self-determination and self-governance through an ethic of decolonization is the only way to achieve positive results in both the health care context and beyond.

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