The International Right to Health and Jordan's Principle: A Comparative Analysis of the Substantive and Procedural differences to Indigenous Children's Right to Health in Canada.

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Abstract

The Jordan's Principle plays a significant role in facilitating Indigenous children's access to healthcare services, resources, and support in Canada. It is designed to prevent delays in federal-provincial jurisdiction disputes, ensuring that Indigenous children receive the care they need. The Principle has evolved from its strict restrictive eligibility criteria towards more open criteria, guided by the concept of substantial equality regarding Indigenous children's health. However, Canada's repeated failure to uphold its duty towards Indigenous children within the domestic legal framework of Jordan's Principle is a matter of urgent concern. This failure extends to the Medicine Chest clause of Treaty 6 and Canada's observance of international human rights treaties, particularly in protecting the right to health.

Canada's international obligations to the right to health fall under several ratified treaties. This paper however, focuses on the following three: *the International Covenant on Economic Social and Cultural Rights* (ESCR), *the Convention on the Rights of the Child* (CRC), and *the United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP). Despite being bound to international human rights mechanisms that mandate Canada to protect, respect, and fulfill the right to health, Canada has yet to guarantee such a right within its domestic legal system. This research will delve into Jordan's Principle to identify the substantive and procedural differences in addressing the right to health for Indigenous children through its legal scope and compare this with Canadian constitutional obligations and Canada's obligations through International Human Rights Law.

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Introduction

In Canada, health care is public and available to Canadians through the *Canada Health Act*. Despite this act, not all Canadians have the same access to healthcare and health-related services. Since the settlement of Europeans within the current Canadian borders, Indigenous Peoples have not been afforded the same rights and privileges as their settler counterparts due to racism and colonialism (Orkin 2003, 461). Colonial legacies continue to affect Indigenous Peoples today, specifically Indigenous children, concerning health and healthcare. Several reports, stemming from national inquiries, have been written in Canada related to uncovering and addressing issues faced by Indigenous Peoples such as: the Royal Commission on Aboriginal Peoples (RCAP) in 1996; the Truth and Reconciliation Commission of Canada (TRC) in 2008 stemming from the Indian Residential School Settlement Agreement (IRSSA) in 2006; and more recently the National Inquiry on Missing and Murdered Indigenous Women and Girls (MMIWG) in 2019. Despite these inquiries, Canada's response to addressing issues faced by Indigenous Peoples has been insufficient to create substantial change. Canada's constitutional protections against systemic and racial discrimination in the *Canadian Charter of Rights and Freedoms* has not resulted in equal access to health services for Indigenous Peoples. Furthermore, it is worth noting that Canada has international commitments to uphold human rights under the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), the *International Convention on the Rights of the Child* (CRC) and the *International Covenant on Economic Social and Cultural Rights* (ICESCR). With that said, these commitments have not resulted in equal access to health services for Indigenous children.

This paper will focus on Canada's implementation of the right to health for Indigenous children. It compares the substantial and procedural obligation to uphold the right to health for

Indigenous children under the *International Covenant on Economic Social and Cultural Rights* (ICESCR) and through Jordan's Principle. The ICESCR operates within the international legal arena, whereas Jordan's Principle is a Canadian legal rule, which means that these two sets of laws operate through different legal mechanisms. Despite the different legal frameworks, both sets of obligations reinforce Canada's responsibilities towards the healthcare of Indigenous children.

The first section of this paper will provide an overview of Canadian domestic health policies, and how the Canadian state has developed its health policies regarding Indigenous Peoples. This section will then discuss how a series of different health policies have had an adverse impact on Indigenous Peoples. The following section will describe Jordan's Principle, in terms of how it came to be and the principle's journey towards its current iteration. The third section will discuss the right to health more broadly under ICESCR, and then analyze how other international declarations such as UNDRIP and CRC protect the right to health for Indigenous children. Finally, the last section will be a comparative analysis of the substantive and procedural obligations towards the right to health under the ICESCR and Jordan's Principle. It will compare how these different frameworks support Indigenous children in exercising their right to health to the highest attainable standards.

Overview of Indigenous Health Policies

Since Confederation, Canada's relationship with Indigenous Peoples has been led by the federal government. Through assimilatory policies, the Canadian government sought to address "the Indian problem" (Erasmus 2003, 190) and respond to settler concerns regarding Indigenous Peoples. The "Indian problem" refers to the biggest hurdle colonial empires faced when

colonizing the Americas through mass immigration despite being the homeland of various Indigenous Nations and Peoples (Craft, Fontaine and the Truth and Reconciliation Commission of Canada 2015, 17). The presence of Indigenous Peoples blocked access to land and in turn the economic opportunities associated with colonized land thus Treaties were negotiated to solve the Indian problem (Craft, Fontaine and the Truth and Reconciliation Commission of Canada 2015, 18). Sadly, treaties were seen as more of a means to an end since settler attitudes towards Indigenous Peoples were that of Eurocentric superiority. Racist attitudes towards Indigenous Peoples extended to healthcare policies, as some historians think that federal engagement in Indigenous healthcare stems from settler concern over the perceived lack of health of Indigenous Peoples and their potential threat to settler health. (Lavoie 2018, 282) The *Constitution Act* of 1867 firmly established the department of Indian Affairs under federal jurisdiction. With that said, the language in that piece of legislation as it relates to health services for Indigenous Peoples is unclear. Section VI Distribution of Legislative Powers states that "Indians and Lands reserved for Indians" are under purview of the House of Commons (The Canadian Encyclopedia, 2007). Separately under Exclusive Powers of Provincial Legislatures is the responsibility of health as it states, "The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals" (The Canadian Encyclopedia, 2007) but no special mention of Indigenous health or the separation of health between Indigenous and non-Indigenous Peoples is explicitly mentioned within the *Constitution Act* of 1867 leaving health services for Indigenous Peoples in a jurisdictional dispute between federal and provincial bodies (Harrold, Lavoie and Marchildon 2021, 564). In 1876, the governor and council attained federal jurisdiction over the *Indian Act.* Section 73 of the *Indian Act* states: "The Superintendent-General in cases where sick, or

disabled, or aged and destitute persons are not provided for by the band of Indians of which they are members, may furnish sufficient aid from the funds of the band for the relief of such sick, disabled, aged or destitute persons" (Indian Act 1876, s.73). This gave the governor and council federal jurisdiction over managing diseases on reserve, as well as providing health and medical services, and ordering mandatory hospitalization. (Harrold, Lavoie and Marchildon 2021, 564) The *Indian Act* established Indigenous Peoples as wards of the state (Browne, Forget and Lavoie 2010, 84) which provided the means for devastating assimilationist policies such as the Indian Residential School System, where Indigenous children were the subjects of nutritional experiments and treacherous treatment which resulted in many deaths (Truth and Reconciliation Commission 2015, 385). In the first volume of the *Final Report*, the Truth and Reconciliation Commission of Canada identified that "As late as 1954, the federal Indian Health Service took the position that it had no statutory responsibility for the provision of either medical or dental care of the Indians. The provision of medical services was initially left in the hands of missionaries, who often had limited medical training." (Truth and Reconciliation Commission 2015, 385) The lack of clear governmental responsibility towards Indigenous health over the last century highlights the historical legacy of Indigenous health services in Canada.

Until 1904, Canadian policy regarding Indigenous Peoples mainly imposed restrictions on traditional practices and sacred protocols (Truth and Reconciliation Commission 2015, 109) while policies supporting Indigenous health were nonexistent (Browne, Forget and Lavoie 2010, 88). At the time, agents of the Crown who were responsible for overseeing Indigenous communities often linked Indigenous health issues to the exercise of traditional practices and ceremony rather than linking such issues to foreign diseases. The lack of regard for Indigenous health and absence of an Indigenous health policy prior to 1904 allowed for a high rate of

tuberculosis in Indigenous communities. In 1898, the Deputy Minister of Indian Affairs, James Smart, commented that "their dances raised dust that spread disease"; they had what he described as high rates of intermarriage within small communities; they failed to take prescribed medicine; and their women married too young and gave birth too soon (Truth and Reconciliation Commission 2015, 388). This quote demonstrates how colonial agents viewed and blamed Indigenous Peoples for their own health problems rather than providing health supports or services. Following the example of the Deputy Minister, other Crown agents followed the dehumanizing attitudes towards Indigenous Peoples which resulted in "tight-fisted governmental policies that actually served to increase hunger and susceptibility to disease" (Truth and Reconciliation Commission 2015, 386). The tight-fisted strategy ultimately fed the spread of disease since Crown agents were instructed to only give relief in extreme cases and to "ensure that aid was not given to those not in need or deserving of it." (Truth and Reconciliation Commission 2015, 387). Given the negative attitude towards Indigenous Peoples that was prevalent at the time, it is unlikely that many Crown agents deemed the sick as deserving of aid.

Indigenous health was further exacerbated during the first half of the twentieth century by another institutionalized form of assimilation, The Indian Residential School system. Indigenous children were forcibly removed from their homes to attend Indian Residential Schools where many suffered institutionalized abuse through scientific experiments such as forced vaccination and nutritional experiments (Truth and Reconciliation Commission 2015, 432). These experiments were conducted without any consultation or appropriate consent from the parents of the children (Truth and Reconciliation Commission 2015, 289). These policies and experiments represent a marked infringement on human rights and also detrimentally impacted the health of Indigenous communities for generations.

In 1904, Canada created the General Medical Superintendent position to oversee Indigenous health across the country. In a 1906 report, Superintended Bryce noted that "the Indian population of Canada has a mortality rate of more than double that of the whole population, and in some provinces more than three times (Truth and Reconciliation Commission 2015, 402). Furthermore, in his 1913 report, Bryce also highlighted that the federal approach to solving Indigenous health issues was not in a manner that is reflective of "the attitude taken towards the presence of disease in civilized societies" (Truth and Reconciliation Commission 2015, 412). Indigenous health policies gradually evolved (Lavoie 2004, 11-13), to the extent that in 1922 Canada implemented the mobile nurse visitor program in order to provide aid to those living in and surrounding the visited reserves. In 1944, Indigenous health was included in the formation of the National Department of Health and Welfare, which resulted in the creation of health facilities built on most Indian reservations (Browne, Forget and Lavoie 2010, 84). In 1968, Indigenous Health Services (IHS) again devised changes to the Indian health plan, such that the IHS would no longer be responsible for subsidizing healthcare in hospitals or for medical care more generally since healthcare was now under provincial jurisdiction. The change in jurisdiction required Indigenous Peoples to access care through their respective provincial plans and bear the same financial burden for healthcare as non-Indigenous settlers. (Lavoie 2018, 284) In 1979, Prime Minister Clark adopted the first Indian Health policy committed to "restoring Indian health through community development, a reaffirmation of the traditional relationship of Indian peoples to the federal government, and by strengthening the relationships within the Canadian healthcare system" (Lavoie 2018, 287) however, the plan was never implemented.

Substantial changes were pushed through the Canadian *Constitution Act* of 1982, which outlined clear jurisdictional division between the federal and provincial governments, including

responsibility for Indigenous health. The *Constitution Act* also reaffirmed and recognized Indigenous Rights and existing Treaty rights, which includes the medicine chest clause and affiliated responsibility towards Indigenous health. Section 35 of the *Constitution Act* states: "The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed" (Constitution Act 1982, s.35). Despite this advancement, colonial legacies nevertheless continue to exist and impact Indigenous People's ability to access healthcare and health services.

Medicine Chest

Prior to the *Constitution Act* of 1982 Canada was an active British colony and the Crown's will was conducted by its ministers within the colony. The country we now know as Canada could not exist without Indigenous Peoples and Crown-Indigenous Treaties outlining relational commitments and obligations between both groups. Despite the treaty making process and commitments made by the Crown to Indigenous Peoples, a whole of government approach to implementing Treaty and Indigenous rights does not exist and the responsibility of overseeing Indigenous affairs lies within department of Indigenous Affairs (Blackburn 2019, 427). Crown-Indigenous treaties are a contractual obligation that outline the Crown-Indigenous relationship, territorial boundaries, and relational responsibilities that go beyond the constraints of land and economics or ministerial jurisdictions. Although treaties link Indigenous Peoples to concepts of place, are seldom extended to issues of health resulting in limited engagement regarding the right to health and the delivery and access to healthcare services despite medical needs being directly expressed within Treaty 6 through the medicine chest clause (Nelson and Wilson 2021, 2). The medicine chest clause states "a medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians at the direction of such agent." (Morris 1880, 357). This means that Indigenous Peoples have the legal right to medical supports provided by the Crown. As the

principle of equal treatment applies to all numbered treaties (Craft and Lebiban 2021, 19), "all the numbered Treaties across Canada were actually to be taken in context of each other and to be considered one complete agreement between the Indians of Canada and the Federal Government" (Craft and Lebiban 2021, 19) the medicine chest clause is a legal obligation towards all treaty peoples.

The right to health is recognized by the federal government through written treaty, in the case of Treaty 6, but has also been recognized through the court's oral versions of treaty. Many Indigenous Peoples have argued that "The medicine chest clause only partially reflects the treaty right to health, but not in the more 'fulsome meaning expressed by Indigenous leaders', as implied through oral treaty commitments" (Craft and Lebiban 2021, 14). The Medicine clause has also been known to have been orally expressed throughout all numbered treaty negotiations (Craft and Lebiban 2021, 14). To further support the claim that verbal promises similar to that of a medicine chest clause had been made, Crown agents brought medical experts to the treaty making negotiations. Providing care throughout the negotiation process implied to Indigenous Peoples that healthcare was part of the negotiated treaty as Indigenous Knowledge Systems are based on physical demonstrations and manifestations (Craft and Lebiban 2021, 15). The physical presence of medical experts created the expectation that the treaty relationship would provide the same level of care for Indigenous Peoples as was present during treaty negotiations (Craft and Lebiban 2021, 15). In the 1935 *Deaver* case, the medicine chest clause was interpreted to mean "all medicines, drugs or medical supplies were to be supplied free of charge to "Treaty Indians" (*Dreaver et al v. the King*, 1935). Despite medical obligations being affirmed from treaties and within the settler legal framework through the *Dreaver* case, the federal government has yet to formally recognize or implement an explicit treaty right to health (Craft and Lebiban 2021, 16).

Denial of the Indigenous treaty right to health upholds colonial legacies which negatively impact Indigenous lives (Nelson and Wilson 2021,2). Additionally, the "separation of Indigenous rights from healthcare is problematic because it is one mechanism by which large-scale injustices, such as colonial practices and policies, come to appear irrelevant to the more intimate, small-scale practice or provision of healthcare – when in fact these broader scale injustices have been repeatedly shown to lead to individual level, intimate experiences of racism and discrimination on the basis of Indigenous identity" (Nelson and Wilson 2021, 7). This paper advances that large scale injustices affect Indigenous children through inadequate healthcare funding, the inappropriate and burdensome demands on Indigenous families to provide information to prove why their child needs supports and the obscene wait for government workers to deem their plea for medical assistance appropriate.

Jordan's Principle

Jordan's Principle is a legal obligation to prioritize Indigenous children's needs for medical treatment, supplies, and all other medical needs over questions of jurisdictional responsibility related to healthcare costs (First Nations Child and Family Caring Society 2021, 19). The Principle itself is the result of the unfortunate case of Jordan River Anderson, a Cree child from Norway House First Nation, who died while in care on February 2, 2005. Jordan was born with complex medical needs and, as a result, lived in the hospital until his second birthday. At that point, the medical team responsible for Jordan's care and the Anderson family devised a plan to move Jordan from the hospital into a home in Winnipeg, where he could receive the care he needed while being surrounded by family. The home was supposed be an intermediate space to receive care outside the hospital (Blackstock 2016, 246) until he could be brought to his community and live with his family. Despite having formally devised plans, Jordan could not

leave the Winnipeg hospital until the government of Manitoba and the federal government resolved their dispute over covering the burden of the at-home care costs. Both parties argued that it was the jurisdiction of the other party to bear the financial burden of Jordan's health costs. The province even insinuated that the Anderson family was responsible for paying the at-home care costs themselves (Blackstock 2016, 246). The jurisdictional dispute ended up lasting years, and Jordan unfortunately passed away prior to its resolution, which means that he lived his entire life in hospital without the opportunity to join his community or his family in their family (Kamran 2020, 279).

The Jordan's Principle Policy

Jordan's Principle was born out of advocacy from First Nations organizations and advocates to put Indigenous children's needs first and jurisdictional disputes over financial burdens of care last (Sinha et al. 2021, 22). In 2007, a motion to ratify Jordan's Principle as a legal obligation was passed unanimously by the House of Commons. Jordan's Principle has no end date (Kamran 2020, 280) ensuring that the child-first practice remains standard in Canadian healthcare systems.

Jordan's Principle, although well-intentioned, did not meet the expectations of Indigenous organizations and Indigenous advocates since the qualification to become beneficiaries of the policy was too narrow and only applied to cases "in which a child was normally resident on reserve, was professionally assessed as having multiple disabilities, and required services from multiple providers. Additionally, the services requested had to be comparable to existing provincial services in a 'similar geographic' location" (Sinha et al. 2021, 23) which resulted in no successful Jordan's Principle claims until 2016 (Sinha et al. 2021, 23). In 2007, the First Nation Family Caring Society (FNFCS) and the Assembly of First Nations filed a human rights

complaint stating that "Canada was racially discriminating against First Nations children by underfunding child welfare services on-reserve and failing to implement Jordan's Principle in a manner consistent with the House of Commons motion" (First Nations Child and Caring Family Society 2023, 1). The Canadian Human Rights Tribunal's (CHRT) ruling ordered the federal government to fulfill the scope and meaning of Jordan's Principle in its entirety (Gerlach, Sangster and Sinha 2020, 22). The legal rule, in the CHRT interpretation, requires the federal government to ensure that "all First Nations children have access to education, social, health services, supports, and products without denials, delays or disruptions" (Gerlach, Sangster and Sinha 2020, 22). This interpretation also includes language needs and supports (First Nations Child and Family Caring Society 2023, 1) implying that Indigenous children's health is interconnected across many aspects of Indigenous life, and not solely limited to healthcare services, healthcare goods and medical prescriptions. The responsibility to uphold the highest attainable well-being of an Indigenous child was later coupled with the concept of substantive equality (First Nations Child and Family Caring Society 2023, 3) however, many court proceedings and advocacy work were required to mandate substantive equality regarding Indigenous children's health under Jordan's Principle.

Jordan's Principle amendments over time

Jordan's Principle has evolved through several CHRT processes brought through human rights complaints by the FNCFCS. In 2016, following the first CHRT ruling on Jordan's Principle, the federal government started the Jordan's Principle Child First Initiative and funded Indigenous led organizations. These organizations provided health, education and social services needs to children who qualified for Jordan's Principle. The Child First initiative fund also

created an Enhanced Service Coordination initiative to maximize access to services and close any existing gaps (Gerlach, Sangster and Sinha 2020, 22).

Despite changes to the scope and implementation of the Principle's legal obligations, Indigenous children in need of health services, support, and attention continue to be denied the support and services they need. Since 2016, the CHRT has processed over 28 non-compliance orders against the federal government over the improper implementation of Jordan's Principle (First Nations Child and Family Caring Society 2024, 1). As of 2016, Jordan's Principle applies to all Indigenous Children, not only those living on reserves and is not only meant to support children with disabilities but to support all Indigenous children with health needs (First Nations Child and Family Caring Society 2023, 2). In 2018 the principle of substantive equality was incorporated into Jordan's Principle, meaning that "services needed to provide First Nations children with the same outcomes as other children, taking into account the disadvantage that First Nations children experience. This means that First Nations children ought to be able to access services, products, and supports that may not be available to other children in order to overcome barriers with inequality and taking into account distinct needs and circumstances of First Nations children and families living on-reserve" (Kamran 2020, 280). Further instructions from the CHRT have resulted in, among others, these core orders:

> "- stop relying on definitions of Jordan's Principle that are not in compliance with the Tribunal's orders; determine individual requests within 48 hours, and within 12 hours for urgent needs. Canada must determine group requests within 1 week, and within 48 hours for group requests for urgent needs.

- A dispute amongst government departments or between governments is not a necessary requirement for a child to be eligible for Jordan’s Principle.

- First Nations children without Indian Act status, who are recognized by their First Nation and who have urgent or life-threatening needs, are eligible for funding through Jordan’s Principle.

- First Nations children who do not have Indian Act status and who are not eligible for Indian Act status, but have a parent/guardian with, or who is eligible for, Indian Act status are eligible for funding through the Jordan’s Principle.

- Jordan’s Principle is not a fixed budget program – it is a legal obligation of the Government of Canada, meaning as more children are eligible the funding pot expands. Recognizing a child for the purposes of Jordan’s Principle does not mean another child gets less.

- Canada cannot interpret the Financial Administration Act (FAA) in a way that hinders its implementation of the Tribunal orders.

- to implement mandatory cultural competency training and performance commitments for all Indigenous Services Canada employees. As well, Canada is ordered to establish an expert advisory committee to develop and oversee the implementation of an evidence-informed work plan to prevent the recurrence of discrimination.

- as part of the commitment to non-discrimination and substantive equality, to assess the resources required to assist families and/or young adults in identifying supports

for needed services for high-needs Jordan's Principle recipients past the age of majority" (First Nations Child and Family Caring Society 2023, 2-3).

Despite these clear directions, Canada continues to burden Indigenous Peoples by forcing them to provide detailed financial and situational information to gain access to Jordan's Principle and the aid promised under its premise.

Current Implementation

The implementation of Jordan's Principle is not straightforward, and measuring the impacts of substantive equality compared to pre-implementation still needs to be fully evaluated. Despite this, Jordan's Principle has been able to support Indigenous children and their families in achieving better health supports to achieve the best interest and health of the child. The current implementation of Jordan's Principle uses a multi-sector approach within the Department of Indigenous Services Canada, such as the First Nations and Inuit Health Branch's (FNIHB) regional operations, Education and Social Development Programs and Partnerships' (ESDPP) regional operations, Child and Family Services (CFSR) and Chief Finances results and delivery officers (CFRDO) (Government of Canada 2019, section 2.2). To receive Jordan's Principle funding, a request must follow a services request and a decision-making process. This process follows the "standing operating procedures" for the Principle, and requires case reviewers to consider health-related aid requests on a case-by-case basis and evaluate how the aid will address the immediate needs of the child (Gerlach, Sangster and Sinha 2020, 24). Through the CHRT ruling, Canada must process and respond to individual Jordan Principle requests within 48 hours and to urgent needs requests in under 12 hours (First Nations Child and Family Caring Society 2021, 15). However, the child's family still holds the burden of writing the requests and providing the correct information sought by government decision makers. The burden put on

families and caregivers to understand and identify the child's unmet needs as well as identify and understand what specialized supports, services, and products are needed to address the child’s needs is unrealistic (Gerlach, Sangster and Sinha 2020, 29). Families and caregivers may not have all the current medical research data or know what kind of care would best suit their child or what medication combinations and treatments would help their child without the assistance of a health professional. This burden, coupled with the hesitancy from Indigenous caregivers and families to request help from the government due to the legacy of care denial and institutionalized racism (Gerlach, Sangster and Sinha 2020, 27) results in fewer Indigenous children accessing the care they need.

The government of Canada’s website surrounding Jordan’s Principle does not provide how federal workers evaluating the requests are trained to understand colonial legacies impacting Indigenous families concerning substantive equality. Regional service coordinator and access workers have identified that time is needed to understand the full scope of the individual situations and “understand the circumstances of a family's life, including their family history, geographical location, housing situation, community infrastructure, and other factors impacting their child's unmet health, social, or educational needs” (Gerlach, Sangster and Sinha 2020, 25). Although a fast-paced request processing system is needed to help alleviate institutional and systemic barriers to Indigenous children's access to care, meaningful relationship creation is missing from the process. Despite being mandated to follow the concept of substantial equality with regards to health, the government of Canada unequally burdens Indigenous families. Asking Indigenous families to support their Jordan’s Principle claim with detailed financial and medical information does not follow substantive equality, since non-Indigenous families are not required to provide such information for their child to receive the care they need. Feedback given by

activists suggests that this burden should be replaced by proactive policies and practices (Sinha et al. 2021,31).

The Right to Health under ICESCR

The right to health is asserted through the *International Covenant on Economic Social and Cultural Rights* (ESCR) which was adopted by the United Nations in 1966 through the language of "the highest attainable of standard of physical and mental health" (Tobin 2012, 18). The right to the highest attainable standard of health is incorporated in other human right treaties and declarations such as the *Convention on the Elimination of All Forms of Racial Discrimination* (CERD), the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW), the *Convention on the Rights of the Child* (CRC), the *Convention on the Protection of the Rights of All Migrant Workers and Members of their Families* (CRMWF), the *Convention on the Rights of Persons with Disabilities*(CRPD) and *the United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP). According to prominent human rights academic John Tobin, the origins of the right to health "was inspired by the perceived need to provide protection for individuals against the unjustified actions of the state" and "the legal recognition of economic and social rights, including the right to health, emerged as a pragmatic and humanitarian response to human suffering and the need for Governments to take measures to alleviate this suffering" (Tobin 2012, 33). Despite the original intention of the right to provide a positive obligation towards guaranteeing the highest attainable standard of physical and mental health for individuals by each state, the right to health does not actually guarantee individual healthcare but does create an obligation for states to work towards the progressive realization of the highest attainable standard of health for its population.

The progressive realization of this human rights obligation, although not fully clear, can be measured by the treaty monitoring body, in this case, the Committee on Economic, Social and Cultural Rights (CESCR), in evaluating if a state is taking sufficient steps to realize the right through all appropriate and available means. Steps to realize the progressive right to health through all available means includes utilizing economic resources or legislative efforts to support realizing the right (Tobin 2012, 178). Similarly, implementing a state's obligation to realizing a progressive right will depend on its social and economic contexts, leaving the evaluation process subject to a margin of appreciation (Tobin 2012, 179). The purpose of treaty monitoring bodies is to provide a link between the legal substantive and procedural requirements of treaties which can be summarized in the committee's general comments on a specific article of the treaty. The CESCR is the treaty monitoring body for the ESCR. In the case of the right to health, the CESCR has used the AAAQ strategy, as identified in General Comments 14 of the CESCR, which identifies evaluation standards based on health availability, accessibility, acceptability, and quality (Hunt 2016, 115). The concept of availability requires the state to take steps progressively to make available healthcare facilities, goods, services, and programs (Barrett and Tobin 2020, 71). Accessibility, has a more complex iteration encompassing four aspects: accessibility without discrimination, physical accessibility, economic accessibility, and information accessibility (Barrett and Tobin 2020, 71). Acceptability references cultural appropriateness and following ethics within the medical sphere, as well as providing some level of confidentiality and overall respect for individual rights to human dignity (Barrett and Tobin 2020, 71). Finally, quality requires medical services to be "scientifically and medically appropriate (Barrett and Tobin 2020, 72). Despite these general guidelines as ascribed by the CESRC's general comment, no concrete legal obligations to respect, protect and fulfill the right

to health are currently in place, however, there are principles to inform resource allocation to reach the positive obligation to the highest attainable standard of health.

In order to respect, fulfill, and protect the right to health according to the AAAQ principle, individual states must provide funding to establish processes that would allow for health services to be available, accessible, acceptable, and of quality. Human rights law has principles that inform the financial allocation process to be followed in order to fulfill the progressive realization of a right. The process requires national policy makers to consider whether resource allocation decisions have been made in accordance with human rights standards. In doing so policy makers need to identify whether the resource allocation decision is evidence-based, that is has been made in consultation with the affected peoples, that the decision is transparent, and what processes have been implemented to support the decision (Barrett and Tobin 2020, 77). According to human rights experts, this approach creates "a substantive burden on the government to justify that it has taken the requisite measures to ensure the allocation of resources to progressively realize the right to health" (Barrett and Tobin 2020, 77).

The Right to Health Under UNDRIP and CRC

The right to the highest attainable standard of health may be predominantly monitored through the ICESR by the CESR monitoring body, but it is also present and commented on through other human rights conventions and declarations. As one example, Article 24 of UNDRIP is specifically relevant to the right to health for Indigenous children. It states that Indigenous peoples: "have an equal right to the enjoyment of the highest attainable standard of physical and mental health" (UNDRIP 2007, art. 24.2). With that said, UNDRIP is not binding on states in the same manner as the CRC or other international conventions, primarily due to the distinction between a human rights convention and a human rights declaration. Human rights

declarations are, in essence, a political position rather than a legal obligation. Despite this limitation, a declaration, also known as soft law, refers to "rules and instruments that do not have legally binding force but at the same time do not completely lack legal significance" (Esterling 2021, 292). However, soft law can eventually become *fons et origo,* meaning, the origins of customary international law (Esterling 2021, 292) and eventually apply as hard law (Esterling 2021, 300). Once a principle becomes international customary law, states are required to abide by its normative obligations as "international law requires that a declaration such as UNDRIP is "characterized by a satisfactory degree of effective compliance by States" (Esterling 2021, 301). An example of this evolution from declaration into hard law is the conception of inherent human dignity, which now has evolved into being present in all human rights legal obligations (Henderson 2018, 11). Under UNDRIP, the normative obligations towards the right to health are much more focused on dismantling systemic issues with regards to accessing the same level of healthcare and health indicators as those of non-Indigenous Peoples. UNDRIP does extend further into Indigenous specific health by adding Indigenous peoples have the right to health access traditional medicines and practices.

Under the CRC, it is stated that special measures may be necessary to achieve the rights indicated in the declaration with regards to Indigenous youth (CRC 2009, 2). In addition, special mention of the child's best interest is present in the Committee of the Rights of the Child's general comment number 2 which focuses on the role of independent national human rights institutions in the promotion and protection of the rights of the child. The Committee requires state parties to recognize Indigenous children's collective and individual rights when implementing rights obligations (CRC 2009, 7). It reiterates that states should use the maximum extent of the available resources to address issues related to poverty and its intersections with

Indigenous children's health (CRC 2009, 8), it also mentions the effect of "inter alia inferior or inaccessible health services" (CRC 2009, 11) on Indigenous children's health. Additionally, general comment 2 of the CRC draws attention to articles in the CRC which delineates the state's obligation: "Article 3 of the Convention requires States parties to ensure that in all actions concerning children, the best interests of the child shall be a primary consideration. Article 4 of the Convention requires States parties to undertake measures to implement the Convention to the maximum extent of their available resources" (CRC 2009, 18). The CRC also provides clarity on ensuring access to adequate facilities and health specialist facilities (Tobin 2012, 159), as well as taking into account children's views on all matters affecting them (CRC 2009, art.12), and ensuring that "expenditure on children's health remains a priority in state budgets at all times" (Tobin 2012, 228). The human rights obligations regarding the right to health, particularly for Indigenous children, are straightforward. However, it's important to note that the right to health is not the same as a specific health outcome (Tobin 2012, 236). It is an obligation to take specific measures to progressively realize health over time (Barrett and Tobin 2020, 72), using all available resources.

Discussion

Comparison of the protections to the right to health offered by the ICESCR and Jordan's Principle in terms of procedural obligations

The right to health ascribed by the ESCR is similar to the obligations under Jordan's Principle legal rule, however, the accountability system of both these health-related obligations differs. The ESCR and the right to health ascribed by Article 12 function within a legal system that predominantly operates under the international legal system, which relies on the voluntary ratification of states on each declaration, treaty, or international convention. Additionally international law originates from a system of law creating inter-state obligations rather than intra-

state humanitarian obligations (Hunt 2016, 85). International human rights treaties are mostly occupied with the wellbeing of all and are "for the benefit of persons within [the state's] jurisdiction" (Hunt 2016, 120). Many conventions and international law articles that are enforceable are mostly quantified as negative rights, meaning they are concentrated on states from infringing on certain individual rights and followed by a positive right requiring the state to respect, protect and fulfill that negative right. In 2018 Canada faced critiques for its treatment of Indigenous children. The 2018 Canadian Universal Periodic Review (UPR) is important as it underscores the need for Canada to uphold its human rights commitments. Following the 2018 UPR Canada indeed responded to the critiques by pledging to fully implement Jordan's Principle in accordance with the CHRT standards (First Nations Child and Family Caring Society 2018, 1). The limitation of the system means Canada is accountable to its own people to implement these commitments and the international monitoring bodies can only issue a measure of non-cooperation should the country continue its maltreatment of Indigenous children (First Nations Child and Family Caring Society 2018, 1).

The right to health falls under obligations of progressive realization through the means of the most available resources. It is hard to evaluate rights of progressive realization by means of the most available resources as other competing rights, intra-state obligations and, budget allocations are hard to quantify. Resource allocations priorities can be justified by any government even those who are criticized over human right failures. The CESCR also recognizes the limitation of the right to the highest attainable mental and physical health as "the right to health is closely related to and dependent upon the realization of other human rights," (Barrett and Tobin 2020, 69) which highlights that fulfillment of human rights within the context of individual aspirations are all inter-connected rather than rigidly separated.

The process for the progressive realization of the right to health, to be the same as other rights under the ESCR, is not labelled nor is there specific instruction on how it should be implemented. The ESCR ascribed the progressive realization of rights without specific end goals. General comments from the ICESCR, however, do provide further direction. On the other hand, these are flexible and are, again, subject to the highest available means within a state to implement. Language under the ESCR Committee repeats the words "to ensure access" however, the level of access is subject to the available means and resources a country has. Through this obligation, Canada does meet the requirements under "a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights" (Tobin 2012, 238), since Canada's *Healthcare Act* ascribes that everyone has coverage and access to essential healthcare services. Moreover, Jordan's Principle created a targeted health policy to try to provide a better standard of healthcare access for Indigenous children.

The right to health for Indigenous children under Jordan's Principle does ascribe more significant details on the procedural aspect of the legal rule which requires putting Indigenous children's care first despite having gone through several CHRT rulings and compliance orders. Jordan's Principle's procedural aspects are apparent; government staff responsible for processing Jordan's Principle requests must do so within 48 hours of individual requests if they are non-urgent and in 12 hours if they are urgent requests (First Nations Child and Family Caring Society 2021, 15). The eligible criteria for Jordan's Principle have been made clear by the CHRT (First Nations Child and Family Caring Society 2021, 12-13) and essentially encompasses all Indigenous children, with or without Indian status, living on or off reserve, insured or non-insured until the age of majority. This goes along with the principle's goal, which is to "ensure all First Nations children have access to education, social, health services, supports, and products

without denials, delays or disruptions" (Gerlach, Sangster and Singha 2020, 22). While the procedural aspects of Jordan's Principle may be apparent, the qualifications of how requests are processed are blurred. The legal requirement per the CHRT requires Canada to utilize substantive equality to ensure equitable and effective implementation of Jordan's Principle but the meaning and implications of this are not clear (Sinha et al. 2021, 24). Both the right to health as ascribed by the ESCR and Jordan's Principle have positive procedural obligations. Yet, the results of these procedural obligations are unclear, meaning the substantive results of each depend on the state's willingness to implement, fund, and interpret the legal obligations.

Substantive Obligation under the Right to Health and Jordan's Principle

When speaking about rights and the law, there is a difference between the interpretation of the black letter of the law and a right's substantive obligations. When it comes to a human right of progressive realization, such as the right to health and the highest attainable standard of mental and physical health, determining the substantive obligations can be difficult. Understanding that each member state is required to realize a right under the most available means, evaluating the substantive obligations to the right to health demands case-by-case inspection and may vary per evaluator. In the case of Canada's obligation to the progressive realization of the right to health for Indigenous children, we can evaluate the obligation through the AAAQ method alongside budgetary availability and allocation.

Through the right to health, Canada is obligated to provide accessibility, availability, acceptability, and quality care and operate under principles of participation, non-discrimination, transparency, and accountability (Hunt 2016, 115). Evaluating this for Indigenous children prior to the meaningful implementation of Jordan's Principle according to its intended purpose and spirit would conclude that Canada lacked to fulfill these obligations. Canada's 2018 Universal

Periodic Review draws this conclusion through member states' concern for Indigenous children, as the review states "Member States urged Canada to end its discrimination against First Nations children by providing adequate and culturally appropriate needs-based funding, and by fully implementing Jordan's Principle, to ensure equitable government services for First Nations children" (First Nations Child and Family Caring Society 2018, 1). The lack of concern from the Canadian government on overall Indigenous wellness is blatant as there are many reports touching on Indigenous lives, the legacy of colonialism, structural racism and inequalities, as well as health gaps between Indigenous and non-Indigenous Peoples. These issues are present within the Royal Commission on Aboriginal Peoples in 1996, the Truth and Reconciliation Commission of Canada reports, as well as numerous Indigenous led advocacy group writings such as the Assembly of First Nations, Native Women's Association of Canada, First Nations Child and Family Caring Society and more. Canada was found to violate its own Human Rights Tribunal ruling and failed to implement the court's will to provide immediate relief of inequalities faced by Indigenous children regarding healthcare several times, which resulted in several non-compliance rulings and human rights complaints (Filipetti 2021, 65).

Regarding the availability of health services, medication, and other healthcare goods, Indigenous children do not have the same access to these services due to geographic variables since many Indigenous communities are far removed from urban settings and hospitals. Indigenous children have not had accessible healthcare due to "the restricted ways in which Indigenous legal rights have been incorporated into healthcare policy, for example, by limiting who has access to healthcare entitlements based on on-reserve/off-reserve geographies as well as federally created identities under the *Indian Act*" (Nelson and Wilson 2021, 7). It is fundamental to note that even when a child may have access to healthcare, it may not be provided to them; just

as in Jordan's case, healthcare services to meet his needs were available but not accessible due to jurisdictional disputes over the cost of the health needs which would have been available to him should he not have been an Indigenous child (Eni 2009, 49).

When it comes to acceptable care of appropriate quality, the CESC outlines that "all health facilities, goods and services must be respectful of medical ethics and culturally appropriate" (Tobin 2012, 171). Historically, Canada has not upheld these principles as inadequate facilities and unethical medical experiments were employed on Indigenous children in Indian Residential Schools. In addition, acceptable care can be extended to facilities and supports outside of healthcare settings that effect attaining the highest physical and mental health standards. The CESCR had identified that acceptable facilities might include "safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel" (Tobin 2012, 159). As of May 2023, Canada still had 31 long-term water boil advisories affecting 27 Indigenous communities (Cameron and Coates 2023, 4). Prior to 2015 there were 139 long term water boil advisories, some who had been in place for over 20 years (Cameron and Coates 2023, 5) in which reinforces the notion that Indigenous children did not have acceptable or appropriate quality healthcare on-reserve or off reserve. Additionally, many instances of micro-aggression and racism felt by Indigenous Peoples when in healthcare settings negatively affect the quality of care they receive. A prevalent example of this is the case of Joyce Echaquan, who died due to racism and medical negligence. In this manner, Canada failed to implement the substantive obligations found under the right to health in ESCR. However, put bluntly by human rights scholars, the reasonability of the right to health and the notion of functioning under the most available means "may strip the right to health of any substantive obligation", arguing that progressive realization has provided

so much government discretion that it has rendered the right to health a vacuous concept with little practical significance (Barrett and Tobin 2020, 77). Nevertheless, international human rights mechanisms impose a substantive obligation on states to explain the steps taken and allocation of resources to realize the right to health progressively.

Under Jordan's Principle, the substantive obligations follow the same narrative as the progressive realization of the right to health regarding the implementation obligation. Jordan's Principle has been led by a series of legal proceedings and issues of non-compliance concerning access to health and the federal government's interpretation of the principle itself. The principle itself sets out the government's obligation to support individual health claims for Indigenous children who would otherwise not have access to health services without financial disputes between governments. The obligation thus remains to support individual claims to health services. Jordan's Principle has indeed expanded the types of aid related to health that would be processed and owned by the government through "a broad range of services, including, but not limited to, "mental health, special education, dental, physical therapy, speech therapy, medical equipment and physiotherapy" (Sinha et al. 2021, 26). It can further be extended to "coverage for items such as clothing and footwear replacements related to a child's condition or air travel for patient family members to attend education workshops on caring for a child with special needs" (Kamran 2020, 281). These factors link Jordan's Principle to the overall wellness of Indigenous children which allows for families to access non-traditional health supports that contribute to the wellness of their child in addition to principles of non-discrimination and substantive equality (Sinha et al. 2021,26).

The obligation to achieve substantive equality is informed by "an obligation not to perpetuate the historical disadvantages endured by Aboriginal peoples" (Sinha et al. 2021, 26).

The CHRT reinforced this view by stating that "If government funding, policy, or conduct "widens the gap between First Nations and the rest of Canadian society rather than narrowing it, the government action is discriminatory and in violation of substantive equality" (Sinha et al. 2021, 26). Substantive equality for individual children's access to healthcare does not fix every problem within attaining healthcare services. Federal government workers are provided with a checklist for determining if Jordan's Principle requests exceed normative standards to provide substantial equality, and the burden of answering these questions is left on the family in need of support (Sinha et al. 2021, 30). Additionally, the concept of substantive equality under Jordan's Principle does not assert that the result must be equitable outcomes or make a connection with the legacy impacts of colonialism or structural inequality for Indigenous Peoples (Sinha et al. 2021, 29). Indigenous advocates insist that the barriers faced by Indigenous families are systemic but that overcoming those barriers is individualized through Jordan's Principle (Sinha et al. 2021, 34). Despite equal outcomes for Indigenous children not being present in principle itself, the final report of the National Inquiry on Missing and Murdered Indigenous Women and Girls asserts that substantive equality needs to be measured in outcomes instead of the current evaluation of Jordan's Principle which is based on equal treatment and access to care (Anadasangaree 2024, 13). The official Jordan's Principle website asserts that: "Substantive equality is both a process and an end goal relating to outcomes that seeks to acknowledge and overcome the barriers that have led to the inequality in the first place. When substantive equality in outcomes does not exist, inequality remains" (Government of Canada 2019, What is substantive equality?). Despite this statement, it is unclear how the federal government is currently implementing substantive equality to the fullest extent. Due to the numerous non-

compliance orders from the CHRT, it is reasonable to conclude that Canada may not be following its commitments in a manner consistent with the quote above.

Conclusion

The right to health is a right of progressive realization, meaning that the burden to realize the right remains under the determination of individual states and their available resources. Canada's obligations to Indigenous children's health, however, is twofold, since the state has commitments to ensure the highest attainable standard of physical and mental health through international legal mechanisms such as UNDRIP, CRC and ICESCR, as well as domestically through Canadian legislation and constitutional obligations such as the *Canadian Charter of Rights and Freedoms*, the Constitution under section 35 in upholding treaty agreements with Indigenous Peoples, and through Jordan's Principle. Despite legal commitments through international and intra-national to respect, protect and fulfill the right to health for Indigenous children, Canada's lack of a holistic approach to tackle structural inequalities resulting in individual barriers to healthcare access negatively impacts Indigenous children's health.

Through the ICESCR, Canada can justifiably state that it is striving to provide Indigenous children with the highest possible attainable standard of mental and physical health through the rolling out of Jordan's Principle and through its current funding of the system. However, the current approach to implementing Jordan's Principle does not fulfill principles of substantive equality as the system is meant to tackle individual red tape of healthcare access rather than systemic changes to better respect, protect and fulfill the right to health. Despite the combination of substantial and procedural obligations under both the ICESCR and Jordan's Principle, Canada continues to uphold colonial legacies negatively impacting Indigenous Children's health.

Nevertheless, there is room to work towards a meaningful implementation of the right and the principle as Jordan's Principle's current iteration is newly determined by the CHRT.

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