

Cultural Rights and First Nations Health Care in Canada

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Abstract

In this paper, I apply Kymlicka's theory of cultural rights to the health care of Canada's First Nations, within the framework of human rights and the rights of indigenous peoples, as formulated by the United Nations. I extend Kymlicka's concept of cultural rights into a specific right to culturally appropriate health care, and I consider how this right can be categorized. I also explore how far the Canadian state recognizes a right to health care in general and to culturally appropriate health care in particular; and whether it has instituted a statutory or constitutional right in these areas. Finally, I consider the same questions with regard to First Nations health care in British Columbia. My conclusions are that the right to culturally appropriate health care is not recognized nationally, or in British Columbia, and that the potential exists to establish such a right politically.

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Indigenous cultural rights

This paper focuses on the health care rights of indigenous peoples, and in particular on the bases for a right to culturally appropriate health care for indigenous peoples in Canada. It identifies conceptual scaffolding to support this particular subset of the broader human right to culture, and explores its application in Canada. To that end, it draws on arguments for the right to culture as a human right, and for the right to health care as a statutory or constitutional right.

The UN Universal Declaration of Human Rights states that everyone has the right to participate freely in the cultural life of the community.¹

The International Covenant on Economic, Social and Cultural Rights (ICESCR) identifies a right to take part in cultural life and notes the obligation of governments to promote this.² This is elaborated in General Comment 14 and 21, where indigenous peoples right to culturally appropriate health care and to their specific cultural heritage, respectively, are identified.³ Also in the UN Declaration of the Rights of Indigenous Peoples (DRIPS), 15 of the 45 articles assert the right to retention, protection, and continued practice of indigenous cultures.⁴ Canada is a party to all these documents.

International agreements and treaties can be regarded as bases of human rights, but there is a case for looking behind these and seeking underpinning moral and political arguments to support them, as suggested by Nickel.⁵ My agenda is to identify a robust moral argument that can provide support additional to the human rights agenda established by the above instruments, using a different starting point that falls within my competence. Therefore, I aim to identify first principles that are politically sustainable in the Canadian context, to support these rights, and to achieve this, I propose to draw on Will Kymlicka's theory of indigenous cultural rights.⁶ Kymlicka is a Canadian political philosopher who over 30 years has developed theoretical analyses of both multiculturalism and the politics of indigenous-colonial relationships. His work is especially relevant to my inquiry in two ways. First, his starting point in terms of political theory is liberalism, with its basic premise in the

value of individual liberty. Liberalism is influential in Canada, and has often been hostile to the idea of collective rights and collective obligations relevant to indigenous rights. Nonetheless, Kymlicka justifies such rights and obligations from first (liberal) principles, providing a parsimonious argument for their existence. He argues that in order for the individual to exercise the autonomy at the heart of liberalism, they need to have an internalized system of values giving meaning to their interests, enabling them to evaluate their available choices. In his view, a "societal culture," with constituent ideas and assumptions encompassing the whole of the daily life of a society, is necessary to facilitate this. Otherwise, individuals cannot be properly autonomous or rational.

Institutions that purport to support individual autonomy (which in liberal democracies would include many state institutions, from law and order to education), should therefore, by virtue of that function, support a societal culture for every individual, and not contribute to the destruction of cultures. Kymlicka argues that it is sometimes justifiable for governments to make specific provision to help minority cultures to survive. Though this may apparently depart from the liberal principle of equality, he argues that the important equality to be pursued is equality of concern (that everyone is equally important), not equality of treatment. If we view everyone as equally important, and their cultural needs are not all the same, it is justified not to treat everyone the same.

His second point of particular relevance is that he views culture as dynamic and interactive with the wider world; he sees cultural communities as capable of choosing to change their cultural values and practices in major ways without losing cultural identity. This dynamic view of culture fits with some other contemporary perspectives in this field, accommodating as it does the cultural significance of colonialism.⁷

Culture is, in Kymlicka's view, a group right; that is, a right that can only be held by a group, not by an individual alone, as a culture must be a group rather than an individual good. Kymlicka sees this right as universal, but threatened in the case of

indigenous minorities who are under pressure to assimilate into dominant settler societies. Involuntary loss of their own culture would be disabling for the exercise of agency by individuals of these communities. The right to culture also has ramifications into the wider political status of indigenous peoples. Kymlicka argues that self-determination is a necessary concomitant to this right, as it is necessary for indigenous peoples to have political freedom to ensure their continued existence as cultural communities.⁸

Canada's First Nations

In 2016, Canada had a total indigenous population of 1,673,785 (4.9% of the total population), including Inuit, Metis, and First Nations.⁹ My paper focuses on First Nations (population 977,230 in 2016). This population, divided into 634 identifiable First Nation communities, has a distinct legal status, reflecting a colonizing agenda first of Britain, then of Canada; this status is embodied in legislation (the "Indian Act"), and in treaties with some individual nations.¹⁰

First Nations provide an example of an indigenous people whose right to a culture has been compromised, in that they have suffered punishment at various times for living according to their cultures, and the Canadian authorities have attempted to coerce them into cultural assimilation. Canada offers a high level of welfare provision to its citizens, including education and health care, and these provisions have the potential to inflict cultural damage.¹¹ Notably, residential schools have had a particularly negative effect on many First Nations people over more than a century.¹² However, my concern is health care, where decisions impact on many aspects of living and, according to Kymlicka's principle, should be made within the culture of those affected by the decisions. Where alien cultural values are imposed by the health care system, the cultural rights of indigenous service-users are compromised, and where this harm is imposed consistently, the ability of those affected to live within their culture, and indeed the viability of their culture, are compromised. On this basis, I

am arguing that it is a reasonable extension of the right to culture as argued by Kymlicka, to derive from it a right to cultural appropriateness in those interventions that are an essential part of living. Health care is one of these. My argument seems to be consistent with General Comment 14 (ICSECR) and Article 24 of DRIPS, as they assert a right to cultural appropriateness (paragraph 27 of General Comment 14) and to traditional medicines and social and health services (DRIPS).¹³

Canada's First Nations have cultural perspectives on health and health care that are distinct from Western health perspectives including, among other differences, a framing of health as environmental and communal rather than individual, and a greater emphasis on spirituality in health and health care compared with Western health traditions.¹⁴ So culturally appropriate health care for First Nations is likely to be somewhat different from mainstream health care in Canada. Its content is ultimately for First Nations to decide, but a minimum expectation (in the context of rights I shall argue below) could include, first, personal health care employing the full resources of Western medicine but adapted to the priorities of First Nations; second, investment in public and environmental health reflecting First Nation priorities; and third, support for traditional medicine, accepting that traditional norms concerning the healer's role may require an "arm's length" approach by a publicly funded health care system.¹⁵ There is extensive evidence that health care provided by the Canadian state to First Nations has been experienced as culturally inappropriate.¹⁶ There is also evidence that it is ineffective and inadequate. First Nations have significantly worse health outcomes than other Canadians and though other health determinants probably contribute to this (inferior housing, education, and environmental conditions, as well as poverty and social exclusion), the state's health care provision has failed to counterbalance these problems.¹⁷

Categories of rights

I am arguing for a right to culturally appropriate health care for First Nations on the basis of

Kymlicka's argument for cultural rights. But before I consider whether there is any evidence that such a right is recognized or implemented in Canada, I need to clarify the kind of rights involved in this enquiry. Influential definitions of rights, such as those offered by Raz and Dworkin, identify a right as an interest of a person or persons, which is so important to the interest holder(s) that it places a duty on others to accommodate that interest.¹⁸ The claim on the other's duty can be defined as a right, and it overrules competing claims of utility or interest. Rights have been categorized in several ways, but I shall distinguish them on two axes. First, a distinction can be made between human rights and statutory or constitutional rights. Human rights can be judged to exist on the basis of a moral judgment, irrespective of whether that right is recognized by relevant persons or organizations. Indeed, where it is not so recognized, the existence of the human right, declared in a source such as Article 8 of DRIPS, can justify arguing that an equivalent statutory or constitutional right should be created in that state—a principle that can be traced back to Locke.¹⁹ I would argue that Kymlicka's cultural right is a human right, derived from ethico-political argument and not dependent on recognition or provision by any existing persons, organizations, or states. My question is, does Canada translate Kymlicka's human right into an equivalent statutory or constitutional right?

The second distinction is between positive rights and negative rights. A negative right is a right to be left alone, not to be molested. It implies a duty on the part of others to refrain from interfering. A positive right is a right to be provided with something, and usually such a right implies a duty on the part of a specific other to make that provision.

Initially, a positive right to a culture does not seem to make sense. Culture is generated by communities, not normally claimed from a specific other as of right. It seems more appropriate to see the right to culture as a negative right not to have one's culture destroyed or eroded. However, given the close involvement of modern states with the lives of their citizens, including indigenous peoples, and given the centuries of encroachment by

those states upon the lives of indigenous peoples, it is not enough to leave them alone. The right to a culture needs more than benign neglect if it is to be respected in the modern context.

So what is the implication of the right asserted by Kymlicka on the provision of health care in Canada? Does it entail that First Nations have a positive right to culturally appropriate health care provided as a duty by the state, or does it simply entail that nobody should impose culturally inappropriate health care on First Nations; a negative right? If cultural right is negative, it may provide the basis for a right of First Nations to run their own health care, but it does not provide any right to resourcing for this. Canada could respect that negative right by leaving it to First Nations to provide their own private health insurance. But if it is a positive right then this places the Canadian state under a duty to resource culturally appropriate health care.

The key to the negative-positive right distinction is the principle that is the basis of Kymlicka's theory: equality of concern entails different needs justifying different treatment. Kymlicka's argument for the right of indigenous people to have their cultures respected by the state is a liberal argument—that every individual should be equally important to the state, and their interests equally valued; not that every individual should receive identical treatment from the state, as equal importance might involve different treatment. Equality of concern entails that the state, where it provides health care for its citizens, provides equally appropriate health care for all its citizens.²⁰ So for indigenous peoples, group-based cultural appropriateness is required. And in accordance with the equality principle, the cultural right in the Canadian context looks like a positive right involving a claim on the government to provide culturally appropriate health care. The only exception to this is where cultural appropriateness precludes direct government provision, as in some areas of traditional medicine, requiring a more background level of government support.

I should add here that providing something to which the recipient *has* a right does not in itself constitute providing it *as a right*. The Canadian

state may provide culturally appropriate health care to First Nations as a matter of policy but still not recognize or be bound by the relevant human right, and may not institute any statutory or constitutional right to that same care.

Existing rights

We return now to my earlier question; is there any evidence that a statutory or constitutional right to culturally appropriate health care is recognized and implemented in Canada? To identify this, we need to look at legislation and official communications expressing the government's commitments and obligations.

Canada has externally recognized the aforementioned right through ratifying the ICESCR, which obliges governments to facilitate culturally appropriate health care. But internally, with regard to implementation, the picture is rather different. Canada's publicly-funded health care system is defined and regulated by the 1984 Canada Health Act, a federal law that allocates functions to the federal government (mostly supervisory and financial) and the provincial governments (managing and delivering). On examination, there seems to be no evidence of a right to culturally appropriate health care in the Act. Nor does the Indian Act contain anything that identifies such a right.²¹ Some government documents have actually denied the existence of a legal responsibility on the federal government to provide health care to First Nations at all, at least in terms of treaty obligations. This seems to have been last explicitly stated at government level by the Minister of National Health and Welfare in 1974, but it has never been explicitly reversed.²² The confusion around this area is described elsewhere, but suffice it to say here that there does not seem to be a firm basis for ascribing a right to culturally appropriate health care to First Nations on the basis of any internal statutory or constitutional obligation acknowledged at the federal level.²³ This disparity with Canada's ICESCR commitment has been noted by several parties, including Amnesty International, which in 2017 presented evidence to the UN Committee on Economic, Social and

Cultural Rights that was strongly critical of Canada's failure to adhere to its obligations under the Convention, with regard to (among other things) indigenous health care.²⁴ That said, the situation may be changing. Canada voted against DRIPS at the time of its adoption (together with Aotearoa New Zealand, Australia, and the US) and it has been argued that this represents a defensive reaction by colonial states to a questioning of their legitimacy and a potential threat to their economic interests.²⁵ But federal policy has shifted recently toward implementation of DRIPS, a development that may open the door for recognition of the right to culturally appropriate health care. However, that is as yet unclear.

Looking at other sources of government information, it is written in several places on the Health Canada website that the government intends to provide more appropriate care for First Nations.²⁶ However, despite several mentions of Canada's accession to the ICESCR on the federal government website, there seems to be nothing in Health Canada's online information that constitutes or implies the acknowledgement of a right to culturally appropriate care, or a duty to provide it. A more explicit commitment to provide culturally appropriate health care to cultural minorities is expressed by the British Columbia government, which stated in 2017, with reference to British Columbian health care regulators that "23 health regulatory bodies declared their commitment to making the health system more culturally safe for First Nations and Aboriginal People". However, that undertaking likewise includes no mention of a right to such care.²⁷

It is worth asking at this point whether the Canadian state recognizes and implements a right to health care for citizens and residents in general. If it did, and combined this with recognition and implementation of Kymlicka's equality of concern principle in some form, we might take this as implying a right to culturally appropriate health care. And recognition of this general right seems to be indicated by the fact that Canada is a signatory to the Universal Declaration of Human Rights, which includes the right to health—a right that the ICE-

SCR interprets as requiring significant government obligation.²⁸ However, internally, in terms of implementation of such a right into statute, there is no consensus as to whether a statutory right to health care exists for Canadians. It is true that for many years health care has been widely regarded as a right of Canadian citizenship, a view echoed in the Romanow Report, but this has not translated clearly into a statutory right; Bhatia argues that since the 1990s, governments have recoiled from the idea of a social right to health care.²⁹ The Canada Health Act is ambiguous on the question of rights, stating that each province's health care insurance plan "must entitle" all insured persons in the province to health services provided on uniform terms.³⁰ The use of the term "entitle" is the nearest the Act comes to acknowledging rights, and in its 2002 report, the Standing Senate Committee on Social Affairs, Science, and Technology argued that the existence of a statutory right cannot be read into this or into any other statute or constitutional provision.³¹ Court-recognized legal rights relating to health care have generally been limited to negative rights to particular courses of action, such as purchasing private health care.³²

What about the above-mentioned principle of equal concern? This accords with Canada's liberal tradition and is echoed in the Charter of Rights and Freedoms, which states that citizens hold their rights equally, and ordains equality under the law.³³ However, equality in relation to state welfare provision (including health care) seems to have been interpreted in a limited way by the courts. For instance, although section 15 of the charter has been interpreted as being anti-discriminatory in preventing the exclusion of particular disadvantaged groups from state provision, the courts have not as yet interpreted it as warranting redistributive resourcing of the kind that would be needed for culturally appropriate health care for First Nations.³⁴ And although the Canada Health Act refers to "uniform terms" in relation to the principle of universality, this uniformity is ambiguous, perhaps requiring only the same kind of health care to be available to everyone, not necessarily the same

quality of health care (which would require cultural appropriateness).³⁵

Finally, in this section, I shall look for rights derivable from duties. There is a tradition in moral philosophy that certain kinds of rights and duties correlate. Duties are often inferred from rights, but it has been argued by a number of writers that in some cases, rights can be inferred from duties.³⁶ The idea of welfare rights as a subcategory of positive rights rests upon this argument, in that a state that accepts a formal duty to specific others to make a specific provision to them (typically through legislation) is effectively conferring a right on those recipients. A statutory or constitutional duty on the part of the Canadian state to its citizens to provide them with health care could be taken as creating this kind of right, on the part of those citizens, to that health care provision. But again, that duty, though referred to at the political and administrative level, does not appear to have been instituted in statute, or in the constitution, despite the duties that are identified in the ICESCR.³⁷

So, my conclusion is that though the Canadian state has externally recognized a human right to culturally appropriate health care, it has not clearly instituted such a right at a statutory or constitutional level.

British Columbia's Tripartite Initiative

The second part of my inquiry concerns the degree to which a specific development in First Nations health care might change the situation with regard to cultural rights in Canada. Historically, First Nations health care has been provided by the federal government, but there has been movement since the 1980s toward giving First Nations more control over their own health care. Under the health transfer policy, various health services in different parts of Canada have been given to First Nation organizations.³⁸ This has been a piecemeal and uneven process, but substantial progress has been made in some areas. I propose to consider one of these initiatives, and ask whether it constitutes implementation of the right to culturally appropriate

health care.

2005 saw the inception of the Tripartite Initiative, a collaboration by the federal government, the British Columbia government, and British Columbia's First Nations, intended to develop a comprehensive First Nations health care system. This consists of a network of First Nation-based organizations, including the First Nations Health Authority (hereinafter the FNHA) as First Nations health care provider and, in some cases, funder.³⁹ In 2013, as part of this initiative, the FNHA began to take over specific health care provisions from the federal agency which had hitherto been the main provider, a process that is ongoing.⁴⁰ The FNHA has varying degrees of accountability to First Nation representative bodies and to the provincial and federal governments, the latter two being the paymasters of the system. It was created in part to provide culturally appropriate health care, so I want to consider specifically whether its creation realizes First Nation cultural rights.

The founding document of the Tripartite Initiative is the Tripartite Framework Agreement, and a number of documents including further agreements, annual reports, updates and plans have followed.⁴¹ These give an evidently authoritative account of the intentions, commitments, and principles that the participants are working toward, so any positive statutory or constitutional right to culturally appropriate health care is likely referenced here. And there is in fact no mention of such a right by any of the parties, jointly or separately. Other rights are mentioned in several places, including patients rights, First Nations rights to self-determination, and DRIPS. The possibility of a charter of rights for First Nations health is mentioned. But the right to health care, and the right to culturally appropriate health care, are absent.

As already discussed, rights might also be identified in the existence and acknowledgement of duties. The federal government has not acknowledged any formal duty to provide health care to First Nations, arguing that its provision over the decades has been motivated by humanitarian considerations. However, the FNHA's takeover of these

provisions is an opportunity for it to accept that previously denied duty. But how might a duty ascribable to the FNHA create a corresponding right for its First Nations service users? For a FNHA duty to entail a First Nations right, the FNHA would need to owe its duty to First Nation users themselves, directly or through some other body. It is not enough for First Nations to be beneficiaries of a duty owed to someone else. The duty must be to them. The relationship needs to be such that the FNHA's purpose, as an organization, is to act in accordance with First Nation choices, and this requires that the FNHA exists and acts for the benefit of First Nation users. Insofar as that requirement is met, First Nations could be said to have a positive right to the FNHA's provision.

The FNHA has no representative structure of its own through which such a relationship with its First Nation service users could be structured. The body that aims to represent British Columbia First Nations in the Tripartite Initiative is the First Nations Health Council, one of the partners in the tripartite agreement. This body was instrumental in the negotiations with the federal and provincial governments in 2008–11, before the creation of the FNHA. It has a partly political, partly representative role and includes representatives of First Nation communities across British Columbia, with a remit that centers on representation and negotiation. It is the obvious candidate to enable British Columbia First Nations to hold the FNHA accountable for its provision. Given appropriate powers, it could act on the behalf of the First Nations it represents, to oversee the FNHA and hold it accountable on their behalf.

The documentation produced by the bodies involved in the Tripartite Initiative does not discuss in any detail questions of duty or responsibility in the relationships between the participating bodies. But they do discuss accountability, so it is worth noting the relationship between the concepts of duty and accountability. Duty is generally understood to involve an obligation to act in a certain way, either generally or toward certain others to whom the duty is owed. Where that action involves some kind of provision, those to whom the duty

is owed may or may not also be recipients of the provision. Where the duty is owed to the recipient, this could be seen as conferring a right on that recipient, as discussed above. Accountability, the requirement to account for one's actions (usually to another specified party), is logically distinct from duty, but in many situations the two relationships reinforce one another.

The FNHA's relationships of accountability connect it to the First Nations Health Council (FNHC) and also to the provincial and federal governments. But a close study of the documents defining these relationships makes it clear that explicit acknowledgement of a conventional chain of accountability and obligation have been avoided, and instead an alternative model has been used to define the relationships between these bodies. The concept of "reciprocal accountability" is presented in the documents as an important principle defining their organizational relationships, through which bodies can hold one another accountable for specific activities, in a negotiated way.⁴² The emphasis here is clearly on what we may call "transactional" relationships, created between parties on the basis of agreements; as against what might be termed "structural" relationships, which fix organizations in a one-way chain of accountability ending formally (in the case of democratic government) with the electorate. The transactional emphasis clearly has advantages, but it creates difficulty in finding clear lines of accountability, a difficulty identified by Dwyer et al in their overview of health care contracting for indigenous peoples.⁴³ The relationships are not specified precisely enough to connect the FNHA, the FNHC, and the user population in a way that permits ascription of duty.

If the FNHA is anyone's agent within the tripartite system, it is probably that of the federal and provincial governments. They finance the FNHA.⁴⁴ It is spending money for which the governments are accountable to their electorates, so in real terms, the FNHA is answerable to these governments for that expenditure. Again, the language of reciprocal accountability softens this, but in the absence of other clear indices of accountability, it

generally tends to revert to the paymasters. It begins to look as if the rights that are being implemented by the creation of the FNHA are those of the federal and provincial governments, not First Nations.

Rights at the political level

A further possibility remains. As mentioned previously, rights exist at several levels, and statutory and constitutional rights are not the only ones that are relevant. Clearly, in many cases human rights are not enforceable in the same way as rights codified in the statutes or constitutions of individual states, but nonetheless have some legal and/or political force. Those codified by the UN have force insofar as the UN has leverage through its own agencies and through international law.⁴⁵ And there are other kinds of leverage that can commit governments to respect rights that are not codified in statute or constitution. Agreements between governments and other bodies can do this, and the degree of commitment to the rights involved will depend on how binding those agreements are.

Moving to the political level allows us to look again at the relationships between the FNHA and the other bodies in the Tripartite Framework Agreement. If we leave aside their documented definitions of accountability and focus on the general relations of governance, we see collaboration of governments and non-governmental bodies, operating as partners, and committed to an enterprise that could span several decades. As a framework for this particular kind of enterprise, I propose to introduce an additional concept, that of multi-level governance. Multi-level governance was developed in the 2000s as a model of governance less bound by traditional political and administrative structures, focusing on negotiated collaboration by bodies at different levels in the formal structure.⁴⁶ It has been applied to governance involving indigenous peoples in several countries, not least because it circumvents political dominance of indigenous bodies by settler states.⁴⁷ Inequality of power is de-emphasized in favor of cooperation and negotiation. What I termed above "transactional" accountability, based prag-

matically on negotiation, better characterizes this situation than the “structural” accountability (my term again) of traditional government structures.

One of the virtues of multi-level governance is that it allows flexibility and mutuality in dealings between agencies at different levels. The lack of formal, exclusive lines of accountability opens the way for political relationships of de facto accountability and duty, which are mutually reinforcing, and allow a shared perception of duties that are not legally codified but command political acceptance. On past performance, federal and provincial governments preferred to avoid codification of health care rights for First Nations, but they may be persuaded to tacitly accept a de facto duty, which the FNHA owes to First Nation service-users. But by what arrangement might such a duty be established at the political level, in such a way that it establishes a right on the part of First Nations to culturally appropriate care? As stated above, there is no mechanism for First Nations people to directly hold the FNHA accountable, even less to bind it to a duty to them. There is no representative mechanism, in particular, in the running of the FNHA. However, the FNHC, a partly representative body, has a relationship with the FNHA that already includes elements of accountability in the “reciprocal accountability” format. Those could be firmed up and extended, at a negotiated political level, to create a stronger relationship of obligation. This relationship could allow the FNHC to hold the FNHA not only accountable to itself, but duty-bound to the population which it represents. The ability of the federal and provincial governments to tolerate this development would need to be stretched short of breaking point, and that would require very fine political judgment on the part of the FNHC and the FNHA, particularly in establishing the delicate phrasing that would establish the FNHA duty in practice, but not explicitly enough to evoke resistance from the governments. If this proves politically feasible in practice, and the FNHA and the First Nation population can accept their respective ends of the chain of accountability passing through the FNHC, then we have the structural components necessary for the establishment

of a political right to culturally appropriate health care on the part of British Columbia’s First Nations.

Conclusion

The Tripartite Framework Agreement on First Nations health care provision in British Columbia was created partly in response to a perceived need for culturally appropriate health care. I have argued that a right to such health care was not built into the agreement. This is partly because Canada’s health care system does not clearly provide for health care as a right in general, and partly because the tripartite system (probably as a consequence of the general Canadian situation) does not offer culturally appropriate health care as a right, in particular. So Kymlicka’s argument for indigenous cultural rights has not been realized in this case; nor has my argued human right to culturally appropriate health care. However, I have suggested that by mobilizing the flexibility of multi-level governance, and aligning rights and duties, the right to culturally appropriate health care can be realized at a political level. It is clear that the establishment of that right in rules, practice, and discourse, against the established habits of Canada’s political class, will take time, and it will involve the application of political arts over that time. But if First Nations leaders in British Columbia are willing and able to pursue this, a major precedent could be set for Canada in the advancement of indigenous rights.

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