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SCIENTIFIC CONTRIBUTION

First Nations health care and the Canadian covenant

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Abstract In this paper I explore the relationship between the Canadian state and Canada's First Nations, in the context of the Canadian health care system. I argue that Canada's provision of health care to its citizens can be best understood morally in terms of a covenant, but that the covenant fails to meet the needs of indigenous peoples. I consider three ways of changing the relationship and obligations linking Canada's First Nations and the Canadian state, with regard to health care- assimilation, accommodation and separation. I argue that all of these options create problems, and at present there is a good argument for working with the status quo, accepting that First Nations are outside the covenant, and securing the state's commitment to their health care on the basis of their citizenship and the liberal principle of equal treatment of citizens by the state.

Keywords First Nations · Health care · Covenant · Assimilation · Accomodation · Separation · Citizenship · Liberal · Equality

Introduction

The focus of this paper is the health care of Canada's First Nations. Though some of the discussion would be relevant also to Canada's other indigenous peoples, I propose to focus mainly on First Nations. This is not intended to minimize the issues affecting the Inuit and Métis people, but rather to maintain coherence, and avoid inappropriate generalization.

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I acknowledge that provisions other than health care have a major effect on the health status of any community. Housing and education are high on the list, though there are others also. Parallels exist between health care and education in the case of Canada's First Nations, but there are also differences, and there is a risk, again, of drawing parallels that I am not competent to draw. Therefore I am choosing to maintain my focus on health care.

Canada's First Nations (traditionally known as Indians) are the largest component group within Canada's indigenous population, which in full comprises First Nations, Inuit and Métis. In the 2011 census there were 851,560 self-identified members of this group constituting 2.6 % of the population. Distribution is uneven. They are <2 % of the population in eastern Canada and the Atlantic seaboard ('Maritime') provinces, around 10 % in the prairie provinces of Saskatchewan and Manitoba, and 31 % in the Northwest Territories (Statistics Canada 2013). Between 2006 and 2011 their population increased by 22.9 %, at a rate over 4 times that of the general population. By mid-century First Nations people may well be a majority in parts of the prairies and the North. There are 614 distinct First Nations communities in Canada (Aboriginal Affairs and Northern Development Canada 2003). Historically their legal status has been distinct from the rest of the population, being regulated by Canada's Indian Act, originally passed in 1876 and much amended since. Under that act they were for long effectively wards of the state, not gaining either full citizenship or the vote until 1960. A significant proportion of people who identity themselves as members of this group- around 214,000—do not in fact have statutory 'status' as First Nation members under the Indian Act (Statistics Canada 2013), a situation which leads to a number of anomalies (Lavoie et al. 2010). The centre of First Nations life has traditionally been the reserve, but

now 50.7 % of the First Nations population with Indian Act status live off-reserve (Statistics Canada 2013).

Canada's First Nations are recognized as having distinctive health needs. On average they have worse health than the rest of the population, with a life-expectancy 5–6 years lower than other Canadians (Statistics Canada 2010); and they are disproportionately afflicted by specific problems. For instance the diabetes rate on-reserve is 17.2 % as against 5 % for the Canadian population as a whole (Public Health Agency of Canada 2011). First Nations people accounted for 16.8 % of Canada's TB cases in 2004 as against 13.3 % for rest of Canada; most cases being accounted for by foreigners (Health Canada 2009). The suicide rate among First Nations youth is 5–6 times that of non-aboriginal youth (Health Canada 2013). First Nations also have distinct needs in terms of health service and service delivery. A significant number live in remote locations with sparse population, where the economics of provision make it very difficult to maintain an equitable level of service. And many First Nations people have distinctive cultural perspectives and priorities with regard to health and health care.

It is clear from reviews of evidence over the past decade that the Canadian health care system has failed to provide care that is satisfactory to First Nations themselves, and it has failed to bring their health up to the level of the population as a whole. (Romanow 2002; Boyer 2004; Health Council of Canada 2005, 2012; Pulver et al. 2010). There is disagreement among commentators as to whether this is a result of under-resourcing, or of misuse of resources that are potentially adequate. Comparisons are often difficult. First Nations are in a different position from other Canadians in that their health care has historically been the direct responsibility of the federal government; whereas for most Canadians, health care is provided predominantly by provincial governments. Over recent decades a transfer of some health care responsibilities from the federal government to individual First Nation authorities has been taking place, together with greater collaboration by those authorities with Provincial health ministries. This 'Health Transfer Policy' has been unevenly and incompletely implemented, and there is some disagreement between First Nation leaders and the government over its implementation and resourcing. However, the potential benefits of this policy are widely recognized in principle, and there is some evidence of actual benefit (Kelm 2004; Smith and Lavoie 2008; Warry 2009) though it is as yet limited.

Health care as a National covenant

The above constitutes an introduction to the background situation. Not surprisingly there has been much discussion in Canada about how this situation might be improved, and various measures have been suggested. I do not intend to propose further practical measures in this paper, but rather to attempt a deeper exploration. I shall do this by considering the fundamental moral basis of First Nations relationship to Canada, and to Canada's health care system; and the implications of this for the structure, funding and implementation of their health care. I hope this will have some relevance to the development of practical measures, particularly to the devolution of health care responsibility to First Nations themselves.

Canada provides a range of health care services to its population free at the point of use, financed by taxes. In some ways it resembles the UK National Health Service, though there are significant differences. The Canadian system represents a strand of welfare collectivism and government activism that is a feature of Canadian history, but this coexists with a strong adherence to liberal individualism in many other areas of Canadian life, and in contemporary Canadian politics. The tensions between liberal and neo-liberal economic policies on the one hand, and the maintenance of collectivist features on the other, is a prominent feature of Canadian politics.

Canada's choice of health care system puts it in something of a minority among advanced nations. Insurance-based health care in which citizens are required to enter into a contractual relationship with a government-regulated health care provider, is more widespread globally (Reid 2010). A useful example of this model would be the Netherlands' system, where health care providers are generally non-profit organizations, and very widespread coverage is offered, though with opt-outs (Rapoport et al. 2009). The essence of this and other insurance-based systems is that the citizen enters into an agreement with a provider, which is time-limited and conditional, under the supervision of the government. Canada has chosen a different path, providing health care to all citizens and established residents, and paying for the bulk of this out of general taxation. We can characterize the moral base of the Dutch system as being contractual, focused on choice and conditionality- with varying health care packages, choice among them and specific conditions of entry. It reflects, I would suggest, a greater emphasis on the liberal values of individual autonomy and responsibility. By contrast we can characterize the Canadian and UK systems as being more collectivist in their orientation, aiming to offer roughly the same health care possibilities to everyone. This universalist approach assumes the existence of an identifiable common model of what constitutes health care; and an aspiration (not always achieved) to provide health care as a universal benefit, universality being one of the fundamental principles of the 1984 Canada Health Act which created the present system. (Government of Canada 2013).

The relationship between state and citizen in this system is different from the equivalent in an insurance-based system. The absence of contract and conditionality in the transfer of resources from those who can pay to those who are in need differs sharply from the conditionality and contingence of the contract, in that the transfer requires a deeper level of trust and commitment than that required by the contract. This element of trust is summed up by Rachlis; 'The Canada Health Act …is built on a foundation of trust and shared values among its three stakeholders: government, providers of care and the citizens of Canada' (Rachlis 2001 p. 54). Going further, Romanow (2012) argues that that system represents a significant expression of Canada's shared identity and national narrative. Its function, for him and many others, is not simply a utilitarian one of maintaining health, but also a symbolic one of expressing part of the nation's identity.

I need a term for this non-contractual relationship that underpins the health care transaction between state and people. Drawing on the writings of several commentators, notably Elezar (1998), Sabetti (2000) and O'Neill (1994), I shall use the term 'covenant', which, I suggest, provides the best fit for the Canadian system. Elazar defines the covenant as 'a morally informed agreement or pact based upon voluntary consent and mutual oaths or promises' (Elezar 1998 p. 8). In his view the covenant involves a deeper level of moral obligation than does the contract, and unlike the contract does not necessarily involve time-limits or means of exit. It requires obligation that, using Coulombe's terminology (2000) is 'historical' and 'moral'; that is, rooted in the specifics of a given society, rather than in universal rights; and based on moral rather than prudential considerations. The concept of the covenant in this context has in fact had a number of proponents in Canada. O'Neill (1994) argued that a covenant model is the best way to understand and sustain Canada's welfare state. He sees intergenerational commitment as a key feature which market liberalism cannot sustain. Subsequently the covenant model was advocated by the Canadian Council of Churches in their evidence to the Commission on the Future of Health Care (The Canadian Council Of Churches 2002); and most importantly this was taken up in the Commission's final report (Romanow 2002), a key document in the recent history of Canadian health care.

Importantly, the nature of the care provided in Canada's health care system, and the version of health that it seeks to achieve in the population, rests on a shared perception of the common good, reflected in what is included, and what is prioritized, in the state health care package. Studies in other western societies have suggested that there is some variation in definitions of good health and health care among the public (e.g. Hughner and Kleine 2004). However, there is an implicit assumption of consensus among those responsible for running health care (Wirtz et al. 2003), which is heavily influenced by the medical profession and other powerful interests. Significantly the 1984 Canada Health Act refers to state provision of what is 'medically necessary' but, as the Commission on the Future of Health Care in Canada acknowledged, it does not define this. Again, consensus is assumed. (Commission on the Future of Health Care in Canada 2002). I would suggest that this implicit assumption of consensus is a characteristic of a covenantal system. Explicit public consultation about health care priorities that has occurred in more contractual systems e.g. Netherlands and Oregon, has not occurred to a comparable extent in Canada (Chafe et al. 2011). The care available in Canada reflects what is assumed to be a shared consensus on health in society. Lomas comments that '…Canadians see [Medicare] as a national program…, and therefore it needs to reflect national values' (Lomas 2000 p. 36). Treatments outside of that consensus area are typically reframed as a consumer good, belonging within the sphere of private provision. For instance Culyer, writing in the Canadian context, states that 'all *needed* healthcare ought to be provided free. Healthcare that is *not needed* must be paid for privately.' (Culyer 2007 p. 23; my italics).

First Nations and the health care covenant

So far I have argued that Canada's health care, as a publicly funded system, is predicated on a set of shared definitions of health and health care need, and a belief in shared priorities with regard to meeting those needs. And I have suggested, in the context of this, that the health care system can best be understood as a covenant between population and government.

However, the covenant does not apply to all residents of Canada. Recent immigrants are not immediately covered by provincial health care plans. Their relationship with the state is essentially contractual, not yet covenantal. They enter the country by choice. They enter into certain agreements when gaining residence. For many immigrants this process could be reversible, given the option (clearly not available to all) of retaining their homeland citizenship and choosing to return. As immigrants become established, and particularly as they acquire citizenship, they evolve into a more covenantal relationship with their adopted country.

And the covenantal relationship has never been effectively applied to Canada's indigenous peoples. As discussed above, their health care has been notably ineffective compared to that provided to the rest of the population. It is arguable that institutional arrangements over the decades have blocked progress- particularly the control of First

Nations health care by the Federal Government where the rest of health care provision is the responsibility of the provinces. That situation is now changing as responsibly for First Nations health care is transferred to First Nations bodies, often in collaboration with Provincial health ministries. Given time, this may change things significantly, but developments so far lack a firm, shared moral and political framework. While new arrangements are taking shape, it seems a propitious time to map out possible politico-moral frameworks that would sustain a new health care framework for First Nations.

Can the health care covenant be brought to properly include the needs of First Nations? And how might this be achieved? I suggested above that the Canadian health care system works to an assumed consensus on what constitutes necessary and appropriate health care, embodied in the Canada Health act as what is 'medically necessary'. Crucial for First Nations in health terms is their position in relation to that assumed consensus. And in that respect I would argue that they are outside it. I am not arguing that their health care needs are dramatically different from those of the rest of the population, but it is clear that there are elements of health care that many First Nations communities would regard as fundamental to their needs, that would not be recognized as necessary, or appropriate, by those who actually define and operationalize that consensus- that is, the professionals, managers and politicians who control the system. A number of papers support this point, but Kelm's account of the Nisga'a nation's health care in British Columbia is particularly instructive (Kelm 2004). Traditional healing methods are often mentioned as legitimate needs for First Nations, and may indeed be justifiable in many cases. But other kinds of extra-consensual health care intervention may be equally legitimate for First Nations, given their situation. Enhanced primary and community care, which are not well-resourced in Canada, may be as relevant as traditional healing. But Canada's health care system defines what is 'medically necessary' quite narrowly. The assumed national consensus about what health care is 'needed', embodied in Culyer's comment ('all needed healthcare ought to be provided free. Healthcare that is not needed must be paid for privately.' Culyer 2007 p. 23) effectively serves to exclude First Nations.

In order to meet First Nations health care needs, Canada needs a firm moral basis to legitimize the provision of health care that is appropriate for First Nations. I propose to consider three possible ways in which such a moral basis may be arrived at. One is for First Nations to conform to the existing consensus, and thus have a better claim to inclusion in the existing covenant. The second is for Canada to broaden its health consensus and review the health care covenant to accommodate First Nations. The third is for First Nations to have a separate health care system with its own legitimizing principles distinct from those of the rest of Canadian health care. These options can be roughly labelled 'assimilation', 'accommodation', and 'separation'. I shall now explore them.

Assimilation

Let us suppose that the best way for First Nations to receive appropriate health care would be to enter the health care consensus that underpins the Canadian health care system; and that to do this they would need to abandon their distinctiveness with regard to health care needs and move toward a more mainstream Canadian health model. In this way they would be able to gain fully from the existing health care system, and effectively come into the covenant.

This view reflects what in a wider context we could term an assimilationist perspective; a view that First Nation membership is a burden, pointlessly excluding its members from benefits enjoyed by their fellow-citizens. This view, historically influential in Canada, lost support since the 1960s but is still advocated by a number of commentators, including Kay (2001) and Flanagan (2008). Also Warry (2009) argues that while assimilation is not overtly advocated by leading members of the federal government, it is favoured within the governing Progressive Conservative party as well as the Canadian press. However, assimilationism is tainted by the history of Canada's destructive and insensitive treatment of indigenous peoples; specifically by the history of coercive assimilation pursued against First Nations. This includes, most recently, the destruction of family relationships and institutionalization of children and young people occurred through Canada's policy of residential schooling for First Nations youngsters.

However, the Canadian situation also includes factors that restrain assimilation; perhaps most importantly the institutional nature of First Nations. Although they are to a considerable degree co-terminous with ethnic and/or cultural groups, First Nations are also corporate entities with formal structures. And, crucially, they pre-existed the Canadian state and the preceding British jurisdiction. As Gover points out 'it is continuity that … distinguishes indigenous communities from other ethnic and cultural minorities' (Gover 2010 p. 4) Canadian courts have given increasing recognition to that continuity, for instance in R. v. Delgamuukw (Penikett 2006). So the state (British, then Canadian) has recognized their continued existence, and the moral, legal and logical space for them to continue to exist has never been lost. The First Nation as recognized in Canadian law is by definition not *constituted* by Canadian law because it had to be there already to be recognized. This means, I would suggest, that the Canadian state cannot legitimately abolish First Nations.

However, a liberal individualist view of this situation would be that each First Nation consists of individuals, and the continued existence of the First Nation must be, morally and politically, a function of the aggregated choices of individual members to remain part of that nation. They could as individuals decide to cease to be members, either freely or under duress, and if they all did that, the First Nation would be no more. Commentators such as Flanagan favour individual cultural assimilation, and while most First Nations have shown no inclination to engage in collective self-dissolution as an intentional act, this could happen nonetheless, as a result of pressures to conform to the wider culture. Direct coercive assimilation is perhaps a thing of the past, but the expectation that First Nations abandon their distinctive health model and assimilate to the national health consensus in order to receiving adequate health care could be seen as indirectly coercive assimilation. As such, it cannot be said to offer an acceptable solution to the problem of First Nations health.

Accommodation

I shall consider two possible alternatives to assimilation. The first of these, accommodation, would involve opening up the health care consensus and re-conceiving the health care covenant in order to accommodate the distinctive needs of First Nations. This is not new. The versions of the covenant being proposed by Romanow and the Canadian council of Churches were intended to properly accommodate indigenous peoples and it would seem reasonable to expect that this could be done. And there are precedents. The basic idea- that Canada should extend its institutions to include indigenous traditions, has been proposed in relation to Canadian law by Borrows (2010), who argues that First Nations legal traditions should become the third component of Canada's legal tradition alongside Common Law and Civil law. In the context of jurisprudence he makes a compelling case, but the health care context presents a number of problems. With regard to the covenant, it is not clear that it is amenable to change. Revisiting the covenant would not be like renegotiating a contract. Elazar's definition of the covenant (Elezar 1998) casts it as historically and politically specific, and it typically constitutes part of the foundation of an institution,—often a state- and is moral as well as legal and political in is foundations. Canada's health care covenant has its roots in the history and politics of the health care system, and reflects a particular set of commitments and relationships that have their roots and development in a specific historical era. The commitments and loyalties that it commands among Canadians cannot be understood outside of those specific historical processes. Attempts at revision run the risk that those loyalties and commitments will unravel, as tacit beliefs and assumptions are thrown into question.

The other problem is that (unlike contracts) the 'glue' of the covenant requires a significant degree of trust and moral commitment on the part of the parties involved. It is questionable whether that exists in the relationship between government and First Nations in Canada at present. Co-operation happens in many areas, but mistrust is often just below the surface, emerging sometimes as a chronic problem- for instance in the failure of treaty negotiations in British Columbia (Penikett 2006); or as a sudden acute manifestation like the Idle No More movement (Indian Country 2012). The problems of addressing the covenant in this way will be difficult in the context of practical politics.

Finally, this process would also require a reconsideration of the health consensus, and a revision of what is agreed to be 'medically necessary'. Earlier on I suggested that this consensus reflects the perspectives of the more powerful professionals and managers who run the health care system. Public views of what constitutes medically necessary care are probably more diverse, and have almost certainly become even more diverse in the years since the Canada Health Act, as alternative and complementary therapies have become popular, and expectations of mainstream medicine have increased. A move to open up a debate on what is medically necessary from the point of view of First Nations (or indigenous peoples generally) could not be contained within that agenda, and would inevitably open out into a much wider debate about what kind of health care the state should pay for- with major implications for costs. Again, the politics of this look very challenging.

So accommodation is an improvement on assimilation in that it offers a more inclusive and respectful response to the problems raised by First Nations health care. But it also presents major challenges.

Separation

The obvious alternative to assimilation and accommodation is separation. In broader political terms the argument for greater separation through political self-determination has been pursued at several levels over several decades, particularly in response to the government's 1969 proposals for assimilation (Russell 2000). A major argument for separation is that the Canadian state has failed to properly recognize and accommodate First Nations within the context of Canada and that, as argued by Asch (2007) among others, indigenous peoples are excluded from Canada's history and identity. Asch argues that Canada's legitimating historical-political discourse excludes First Nations by ignoring their much longer historical discourse, pointing

out that Canada's 'historico-political origin myth to legitimate sovereignty can only begin with European settlement' (Asch 2007 p. 283). So the indigenous narrative is inevitably different, and excluded.

In relation to separation of health care, a well-established set of arguments has been developed over a number of years by bodies such as National Aboriginal Health Organization (see for instance Boyer 2003). These argue for the special and separate status of First Nations, and the special and separate obligations of the Canadian government to them. They draw on such factors as The Indian Act, treaty obligations to First Nations, the resultant fiduciary relationship between the government and First Nations, and the rights of indigenous people under international law. The logic of these arguments clearly places First Nations firmly outside of the health care covenant, requiring separate obligations and a separate agreement between First Nations and the Canadian state.

In the view of many commentators, separatist political arguments have never gained much traction in Canada's government circles, nor have they prevailed in the practical business of achieving better health care, and better health for First Nations. They have never been accepted by the Federal Government (Romanow 2002; Health Canada 2007); and Warry (2009) argues that Canadian politics is moving in a direction that is increasingly inimical to them. Aspects of the treaty-based special status of First Nations are, in the view of some indigenous activists, under threat from the federal government's legislative program, particularly with regard to landholding, and this has provoked protest (Indian Country 2012). In general the neoliberalism implicit in some federal policy is seen as pointing away from the traditional supports of separate status.

However, a different view is put by Slowey (2007), to the effect that neo-liberal governments in Canada may find that it fits their agenda to allow a degree of separation in order to divest themselves of some of their responsibilities toward their First Nation citizens. She argues that the direction of neo-liberal policies in Canada's resource-rich north points toward economic self-sufficiency for those First Nations with sufficient resources; and that a degree of political self-determination is likely to be accepted as part of this development, involving as it would an end to perceived dependency, and a move toward a more contractual, business-oriented relationship between First Nations authorities on one hand and federal and provincial governments on the other. This implies a fundamental change in the moral obligation by governments to seek the well-being of their people- an obligation that underpinned the creation of the health care system, and much else in twentieth century Canada. It implies a move toward a hybrid relationship which combines the principles of small government, (leaving citizens to pursue their own well-being), and devolution (relocating responsibility for the public good to the First Nations own leadership). However, this is fundamentally different from the treaty-based commitments and fiduciary obligations cited by Boyer, and implies a very different relationship.

This trend would not fit with a covenantal relationship as described above. The business-oriented relationship with government might be beneficial to a First Nation endowed with adequate economic resources and political skills to hold its own. But that is not the norm. At present First Nations constitute the most disadvantaged group in the country, and they are likely to be profoundly vulnerable in a 'businesslike' relationship with government. The Canadian state is in a position of enormous resource superiority in any process of negotiations, and as First Nations will still need to draw on the resources of the Canadian state for adequate health care for a good way into the future, they will have very few bargaining chips to match the state's control of those resources. The superior power of the state over its citizens, is normally restrained (in democracies) by the state's obligations toward those citizens- exemplified in this case by the covenantal obligation to provide health care. If these are superseded by a more distanced, contractual relationship First Nations could well be the losers.

So in summary, we have well-established arguments for separate health care for First Nations. But anything that is likely to be acceptable to governments carries risks. It is not the obvious best choice.

Reinterpreting the status quo

I have argued that assimilation is likely to be unacceptable, while accommodation and separation are each problematic in different ways. I now intend to suggest a way forward which unlike these three options, does not require major renegotiations of relationships and obligations, but draws its justification from a reinterpretation of existing relationships. In particular I will draw on the separate status of First Nations, take account of their citizenship, and keep in view the state's obligations to its citizens. I shall consider the citizen relationship to the state in a liberal rather than a collectivist framework, despite the collectivist tradition represented in the health care system. I shall do this for two reasons. First, as I have argued, it is not clear how First Nations can partake of the covenant without entering the health care consensus, which means, in health terms, assimilating. So the collectivist relationship embodied in the covenant needs to be excluded from the argument. And second, despite the strong collectivist strands in Canada's history, it has in recent years been heading in a neo-liberal direction. As a device to clarify my framework I shall use Schwartzmantel's (1994) description of the liberal democratic state. Herein, the state seeks to keep its activities as

limited as is reasonably possible, consonant with the well-being of citizens. In traditional liberalism the most important facilitator of well-being is liberty, which permits citizens to pursue their own well-being to their own specifications. The benefits of liberty are enhanced by the neutrality of the state on what constitutes the good life.

But such a state, committed to protecting the liberty and self-responsibility of citizens, will as a general principle be less willing to protect those citizens from the foreseeable results of their choices, even if those results are harmful. So the crucial question for a liberal-inclined state is: are the distinctive health needs of First Nations members (and the harms resulting from these not being met) incurred by the individual choice to be a First Nation member? To answer this I need to develop two closely related points touched on earlier, as follows:

- First Nations could be abolished by the choice of their members.
- First Nation members choose to live differently from the rest of Canada, and thereby generate different health care needs as part of this differentness.

The implication of these points is that the Canadian state should indeed view First Nation membership as a matter of choice, and treat the resulting needs as incurred by choice. Therefore (given that we cannot invoke the covenant) the state has no obligation to protect members from the impact of those foreseeable needs, since they result from the exercise of liberty. So members must provide for themselves.

As Gover (2010) points out, it is a legal possibility to cease to be a member of a First Nation. This can be done without physical harm or legal sanction. However, despite this I intend to argue that First Nation membership cannot for our purposes be seen as a matter of choice. It is clear that for many First Nation members, membership is fundamental to their identity, and renunciation of this would involve a deeply harmful denial of their essential selves. So, in literal terms they could choose to inflict this harm upon themselves, but it is not reasonable for other Canadians to regard this as a viable option for them, or to expect them to act thus.

What of the second point, that First Nation members are choosing to live differently, and develop different needs? The implication of this is that they *could* choose otherwise; they could choose to assimilate culturally, even if institutional abolition is unacceptable. My argument against this point derives from my argument against self-abolition. Essentially, we cannot have meaningful membership of a First Nation without culture and identity. For First Nation membership to have substance it must include a narrative, a set of shared meanings that defines the content of the particular national identity. A First Nation whose members assimilate fully, so that it has no distinctive lifeworld or identity, is greatly diminished. Even if they retain formal membership and status, their nation is drained of meaning. So the choice of assimilation is formally available, but involves a huge loss and diminution of the individual and the community.

So, First Nation membership creates difficult choices. But that does not in itself establish that the state has a duty to protect these particular citizens from the consequences of those particular choices. After all, in a free society we are sometimes faced with choices of evils. The state may seek to ameliorate the worst of these, particularly to those who are especially vulnerable; but a state operating in the liberal framework, without the covenant, could not justify protecting citizens from all difficult choices. How then can we argue that the unwelcome pressures facing First Nation members (assimilate, or put up with inappropriate health care) justify a different response?

This is the justification. Part of the fundamental function of the liberal state is to treat its citizens equally. This is recognized both in the Kantian tradition and in the utilitarian tradition, as with Bentham's principle that each counts for one and none for more than one (Bentham 1962). As Ellis puts it in describing what she terms classical liberal justice 'the equality of rights holders serves to preserve individual liberty by equalizing relationships among members of civil society' (Ellis 2004 p. 36). That equality of treatment is, I suggest, fundamental, and morally prior to specific measures that the state might take to benefit its citizens; prior also to any contract or covenant with its people. The duty to treat citizens equally precedes and underpins more specific obligations that might be included in the covenant. So access to welfare provision by a liberal democratic state should be provided equally to all citizens according to need, if it is provided at all. In Canada the state has committed itself to providing health care and, as discussed above, the nature of that health care in general reflects the consensus in that society about what health care should be. And this reflects the covenant. But if we accept that First Nations are outside the covenant, what they get in terms of health care needs to be agreed on a different basis from those provisions included in the shared view of health care discussed above and identified specifically by Culyer. The aforementioned requirement for equality must involve provisions of equal worth to its recipients, as compared with other citizens. This does not tell us what kind of provision that should be, and in a real sense I am not in a position to say what it should be. Only First Nations themselves can identify what would be of equivalent value to them.

Nor does my argument tell us how much the Canadian state ought to spend on First Nations health care. There has been argument in recent years as to whether First Nations

are receiving a fair share of Canada's health budget, or less than a fair share, or indeed more than a fair share (e.g. Lavoie and Forget 2006; Romanow 2002). There are reasons why First Nations health care might be legitimately more expensive than that of the average Canadian. Geographical remoteness, the need for cultural appropriateness, poverty, worse health, could all contribute. I am not arguing that the distinctiveness of First Nations and the equality principle justify unlimited resourcing of First Nations health care. Health care of equal value to its recipients as mainstream health care is to other Canadians will probably be more expensive, but it will need to be justified against the criteria I have identified, or something similar. On the other hand we accept that equality of access to health care does not imply equality in the amount that is spent on the health of each individual. Equality of access necessarily involves inequality of expenditure between individuals, as need varies with state of health, and also with factors like age and gender. We accept these differences as legitimate. I suggest that we should treat First Nation membership as equivalent, for this purpose, to those aforementioned characteristics. Like them, it is fundamental to the person and fundamentally shapes health care need. That said, there is no single simple formula which will resolve the question of how much more expenditure First Nations care needs, or ought to be, compared to mainstream care. But I would suggest that the equality principle sustains the notion that First Nations have a legitimate claim to special treatment, and a degree of special resourcing.

Conclusion

If my thesis stands up, basic relationships and obligations need not be renegotiated. They simply need to be properly understood. However, this does not preclude renegotiating institutional arrangements, as with the Health Transfer Policy. In practical terms greater First Nations control of their health care is desirable, but my thesis places the responsibility for resourcing First Nations health care in the same location as for the health care of other Canadians-with the state. This avoids the danger of the state using health transfer to divest itself of resourcing responsibility-the problem of separation. In the future, if First Nations become more economically and politically self-sufficient, separation might be a better choice. Alternatively First Nations and the Canadian state may develop sufficient mutual trust to move to a covenantal relationship with regard to health care. Either of these would involve fundamental renegotiations of relationships and obligations, and either may prove beneficial to First Nations and Canada in the long run. For the present, however, I am suggesting that such fundamental changes can wait for more propitious circumstances.

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