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Chair

Mr. Bruce Stanton

Standing Committee on Aboriginal Affairs and Northern Development

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● (0835)

[*Translation*]

The Chair (Mr. Bruce Stanton (Simcoe North, CPC)): Good day and welcome to the 14th meeting of the Standing Committee on Aboriginal Affairs and Northern Development.

This morning, we are pleased to welcome a delegation from Health Canada. With us are Ms. Michelle Kovacevic, Director General, Strategic Policy, Planning and Analysis Directorate, along with Ms. Kathy Langlois, Director General, Community Programs Directorate. We are also happy to welcome here Mr. Mark Buell, Director of Communications and Research with the National Aboriginal Health Organization.

[*English*]

Members, initially we will be taking our briefing this morning in a reduced quorum. One of the reasons for this is that we will attempt to wrap up the briefing this morning by 9:20. You all know we have the Australian delegation coming for about 9:30. We need about ten minutes or so to do some conversions with the room, as we're going to be meeting in informal session after the break. After we're finished hearing from our esteemed witnesses this morning, we'll be moving the entire Canadian delegation to one side of the room and making room for the Australians.

So without any further delay, let's begin with Ms. Langlois, for ten minutes roughly, and then we'll have time for approximately one question from each party represented here today.

Madame Langlois.

[*Translation*]

Ms. Kathy Langlois (Director General, Community Programs Directorate, Department of Health): Good morning and thank you for inviting us here today. We are very happy to be here and we will try to answer your questions to the best of our ability.

[*English*]

I'm going to speak today about three aspects of aboriginal health. I've provided you with a powerpoint presentation that I will walk through, and I will reference the slides as I move to them.

The first of the three aspects I'm going to talk about is the gap between the health of aboriginal people in Canada and other Canadians, particularly in relation to the social determinants of health. I will talk about the role of Health Canada in improving health, and how the department, along with federal, provincial, and aboriginal partners, is working to improve the health of first nations and Inuit. Thirdly, I would like to also discuss key horizontal steps that we can take toward improving the health of aboriginal people, including recent collaborations that we've had with other countries, including Australia, as well as other federal departments, provincial governments, and of course our first nations and Inuit partners.

On slide two you will see the distribution of the population that is covered through our non-insured health benefits program. These are our registered Indian and recognized Inuit. You will see the distribution of the population there, some 800,000 individuals.

When I present this slide I usually just point out that while the largest number of first nations people covered is about 180,000 in Ontario, you'll note that as a percentage of the population, just taking Saskatchewan for example, the 130,000 individuals there, they are roughly 13% of the population. As a proportion, the first nations population within Saskatchewan is quite significant, even though it's not the largest absolute number of any jurisdiction.

Turning to slide three, describing the health status of first nations and Inuit, you can see that in total the first nations and Inuit population is approximately 3% of the Canadian population. In terms of health status, there have been steady improvements since about 1980. We've seen that first nations life expectancy has increased—and the gap right now is about 6.6 years for males and females—and first nations infant mortality rates have also been declining, but they do remain higher than the Canadian rate, in a range of two to four times in some cases. The challenges that we face in terms of health status have to do with high rates of communicable disease and chronic disease, and high rates of suicide and low socio-economic status.

If I could, I'll just share a few statistics with you. Incidence of tuberculosis is about six times higher for registered Indians, on reserve and off reserve, and it's about 23 times higher for Inuit than for the general population. I've talked about infant mortality rates being two to four times higher. We've just worked in collaboration with Australia, New Zealand, and the United States and found that infant mortality rates are similar among all of the indigenous populations across those four countries in terms of the extent to which they are greater than mainstream populations. The aboriginal peoples account for an estimated 7.5% of all existing HIV infections in Canada, and the prevalence of diabetes is close to four times higher for first nations living on reserve than for the general population.

Many of these statistics are similar across the jurisdictions, and certainly with Australia. You will see that a lot of this comes from socio-economic status and the fact that their low education attainments, low income, high unemployment, and poor infrastructure such as housing and water quality are all factors that contribute to these outcomes in health status. In fact, when we think about the causes of these causes, you can step back and look at the history of colonization, which you will see is very similar to what has occurred in Australia.

In terms of those social determinants of health, Health Canada has been working very closely with the World Health Organisation Commission on Social Determinants of Health. They released their final report, called *Closing the gap in a generation*, in August 2008. The commission's three principles of action are: first, you must improve the conditions of daily life, which are the circumstances in which people are born, grow, live, work, and age; second, tackle the inequitable distribution of power, money, and resources, which are the structural drivers that contribute to the conditions of daily life; and third, it's important to measure the problem, to evaluate action, to expand the knowledge base as well as develop a workforce that's trained in the social determinants of health, including an aboriginal workforce, and to raise public awareness about the determinants of health.

● (0840)

Our view is that this work is significant in terms of improving the health status of indigenous peoples. There are, in fact, some determinants of health, as noted on slide four, specific to aboriginal people, that are different from those for mainstream populations. These are things, as listed here, such as self-determination, the connection to land, language and culture, and a focus on healing and wellness.

Turning to slide five, we've provided you with some examples of programs we have in place that show how we're bringing into play the social determinants lens. We are very focused on the development of children and on a healthy maternity and pre-natal period. So we have programming providing development and support for women and families with infants. Of course, our aboriginal head start program on reserve, which is a program that also exists in the United States, is an important support from birth to six years of age. It is focused on a number of factors, as listed on slide five, including parenting support, which is really a key element.

Our national aboriginal youth suicide prevention strategy is a community-driven program aimed at youth. It builds on the evidence that traditional culture contributes to resilience and is a protective factor against suicide.

Slide six shows a graphic picture of the fact that there is shared responsibility within Canada for the health of first nations and Inuit. The federal government shares this responsibility with provincial and territorial governments, which provide all the hospitals and pay for all the physician services that first nations and Inuit receive. Of course, first nations and Inuit themselves have a huge role to play. Among the 600 first nations communities, many are actively involved in the delivery of their own services, so they are an important jurisdiction that we must consider.

In terms of the federal role, which is on slide seven, just to note, it is based on the Indian health policy of 1979. There is no legislation governing the provision of health services for first nations and Inuit.

Going to slide eight, our mandate for the First Nations Inuit Health Branch is to improve the health outcomes of first nations and Inuit. We do that in two ways: by ensuring availability of and access to quality health services, and by supporting greater control of the health system by first nations and Inuit, which in and of itself has been determined to be a determinant of health. If you are in control of the delivery of your own health services, you have better health status as a result.

Slide nine gives you a pretty good description of all the services offered to first nations and Inuit. There are programs that target all aboriginal people, including the Métis and off-reserve aboriginals, for health promotion and disease prevention programming. The non-insured health benefits program is like a supplementary insurance program that provides vision, dental, drugs, and other services and supplies. There are programs available on all first nations reserves aimed at public health and disease prevention, including alcohol and drug addiction treatment and home and community services. In isolated communities we also provide services such as nurse practitioner and physician services and emergency services, which in many cases is medical evacuation. And we provide primary care, which is health assessment and diagnosis.

First Nations Inuit Health Branch works to develop specific programs and interventions targeted at distinct populations. We have programs aimed at children, programs aimed at those with specific diseases, and programs aimed at those who are healthy so that they may maintain their health. We work in very close partnership with first nations and Inuit. The Assembly of First Nations and the Inuit Tapiriiksat Kanatami are key partners.

We are working to formalize new partnership agreements with provinces and first nations. Most notably, we have agreements in British Columbia and a memorandum of understanding with the Province of Saskatchewan. We're working on flexible funding arrangements that will allow communities that have the capacity to direct their own health services to have the flexibility that comes with that.

We work with other federal departments. An example would be our work with the Department of Indian Affairs on drinking water.

We're very focused on the fact that our system rests squarely on the shoulders of nurses. There are nurses in all the communities, and we're focused on ensuring that we're doing the best job we can to support them. We're looking at innovations in health technology and at the composition of our nurse-based teams as we face the nursing shortage that is being faced throughout the world.

● (0845)

Slides 11 and 12 give you a bit more detail on the programs in two major areas: primary health care, and public health and community programs. You can see the array of services there; I won't go into detail. I've already talked about the non-insured health benefits program.

Slide 13 gives you a sense of the breakdown of our $2.1 billion budget for First Nations and Inuit Health Branch in 2009-10. You'll see there the bulk of the funding goes to community health programs and non-insured health benefits, the two major categories of programs on slides 11 and 12.

In terms of the key challenges, I've talked about some of those. Our population is growing at over twice the rate of the overall Canadian population, so we have a very fast-growing population and a very young population. In many communities, at least half the community members are under the age of 25.

About 17,000 additional clients come onto our services every year because of the population growth, and as I've mentioned, there's poorer socio-economic status and many live in small, isolated communities. So you have a congruence of many challenges coming into play in terms of ensuring adequate health services.

The Chair: We're just about out of time, Madame Langlois, so if you could wrap up, and then we'll....

Ms. Kathy Langlois: Okay.

I think you can see on slide 16 some recent accomplishments around integration, mental wellness, and Indian residential schools that I'll be happy to answer questions on. Then our last slide gives you a sense of how we're collaborating horizontally.

I'll stop there.

The Chair: Thank you very much.

Now we'll go to Mr. Buell from the National Aboriginal Health Organization, for ten minutes.

Mr. Mark Buell (Director, Communications and Research, National Aboriginal Health Organization): Thank you, and good morning.

I would like to extend greetings to the chair and members of the committee, as well as to the other guests of the committee with us today.

I would also like to convey the regrets of the chief executive officer for the National Aboriginal Health Organization, Dr. Paulette Tremblay, because she is unable to attend today.

Thank you for inviting NAHO to participate in this hearing. It is a privilege to have been invited to provide an overview of the health and well-being of aboriginal peoples in Canada.

My name is Mark Buell, and I am the director of communications and research at NAHO, an organization that was founded in 2000 to influence and advance the health and well-being of aboriginal peoples and communities by carrying out knowledge-based strategies.

In Canada, section 35 of the Constitution recognizes the three original peoples in Canada: first nations, Inuit, and Métis. Each of these population groups is distinct from the others and has a unique history. Within each group there is also considerable diversity. There are over 600 individual first nations in Canada.

Recent demographics paint a clear picture of the first nations, Inuit, and Métis populations. According to Statistics Canada's 2006 census, there are almost 1.2 million aboriginal people in Canada, accounting for about 4% of Canada's total population. Of these populations, first nations account for 60%, Inuit for 7%, and Métis for about one-third.

The aboriginal population is the fastest-growing segment of the population, growing nearly six times faster than the non-aboriginal population. The Métis population is growing more than 11 times faster than the non-aboriginal population, and the first nations and Inuit populations are both growing three times as fast as the non-aboriginal population.

Fifty-four percent of aboriginal people live in urban areas, and 48% of the aboriginal population consists of children and youth under the age of 24, compared with 31% for the non-aboriginal population. What this means is that the first nations, Inuit, and Métis populations are young, with half of the Inuit population at 22 years and younger, half of the first nations population at 25 years and younger, and half of the Métis population at 30 years and younger. The median age for the general Canadian population is 40.

Like many of their international indigenous counterparts, aboriginal peoples in Canada suffer from a greater burden of illness than non-aboriginal people. For the first nations population, the following are some examples I've taken from Health Canada's report called “A Statistical Profile of First Nations in Canada”.

In 2000, life expectancy at birth for the first nations population was estimated at almost 69 years for males and just under 77 years for females. This reflects differences of seven and a half years and five years, respectively, from the Canadian population.

The infant mortality rate for first nations in 1999 was eight per 1,000 live births, compared to the Canadian rate of five and a half per 1,000 live births.

For Inuit, the situation is similar. According to a 2003 Health Canada report, life expectancy of Inuit living in the northern territory of Nunavut in 1999 was 67.7 years for men and 70.2 years for women. According to a 2006 Statistics Canada report, the hospital admission rate for lower respiratory tract infections for Inuit children is the highest in the world. Furthermore, the infant mortality rate in Inuit-inhabited regions is four times higher than in the rest of Canada.

Suicide is among the leading causes of death for first nations and Inuit. For Inuit living in Nunavut, this means that the suicide rate for men in 1999 was almost nine times the Canadian rate. As Ms. Langlois indicated, rates for most diseases, including HIV infection, diabetes, measles, and tuberculosis, are much greater than those for the general Canadian population.

Although there is limited information available on the health and well-being of the Métis population in Canada, what we do know paints a similar picture. We do not, however, know the life expectancy for Métis in Canada, nor can I report on the infant mortality rate for Métis.

The health statistics I've reported to you are interesting, but they certainly don't tell us the entire story about indigenous health in Canada. In fact, as many of you are aware, an aboriginal concept of health encompasses much more than these statistics can tell you. Interestingly, though, the World Health Organization's definition of health encompasses a holistic wellness approach that is similar to an indigenous concept of health and well-being: "an integrated approach linking together all the factors related to human well-being, including physical and social surroundings conducive to good health"—in other words, the broader determinants of health, or the causes of the causes.

Health Canada recognizes 12 broader determinants, including such things as housing, income, social supports, and access to services such as health care and education. These broader determinants of health really elucidate the disparities between indigenous peoples in Canada and non-indigenous peoples.

● (0850)

First nations rate lower than the general Canadian population on all educational attainment indicators, including secondary school completion rates, post-secondary education admissions, and completion of university.

Among Inuit children under the age of 15, 40% live in crowded homes, compared to only 7% among all children in Canada. From the 2006 aboriginal peoples survey, we know that 22% of Métis children under the age of six had mothers between the ages of 15 and 24. This is compared to 8% for the non-aboriginal population. And 30% of the Métis children in Canada live in lone-parent households, compared to 13% of their non-aboriginal counterparts.

I won't speak at length about the broader determinants—Ms. Langlois mentioned a few—but it's well known that first nations, Inuit, and Métis score lower on almost every indicator in this regard. In fact the socio-economic conditions of aboriginal peoples are often compared to those of the developing world, but that isn't the case. There are numerous examples of things that work. We also know quite a bit about what doesn't work, and I'd like to bring some of those examples to your attention.

With regard to the prevention of suicide, in a 1998 groundbreaking study by Chandler and Lalonde on suicide in British Columbia first nations communities, they argued that—and I quote from the Policy Research Initiatives journal called *Horizons*:

> ...cultural continuity forms a critical backstop to the routine foibles of identity formation; in the absence of a sense of personal and cultural continuity, studies show that life is easily cheapened, and the possibility of suicide becomes a live option.

It is clear to us that bridging traditional cultures with the mainstream is the key. We would also argue that culture and ethnicity are among the key determinants of health for first nations, Inuit, and Métis in Canada. For example, once western medicine was imposed on Inuit communities, beginning in the 1950s, women were flown out of their home communities to give birth. At a time that should be a great celebration with family, these women would often be alone in southern medical centres. In recent years, however, there's been a resurgence in traditional midwifery in Inuit communities. The Inuulitsivik Health Centre has been operating since 1986 in northern Quebec, and other midwifery centres have followed. Care is provided to women by hybrid teams—Inuit midwives and western medical practitioners. The perinatal outcomes of the Inuulitsivik centre are equivalent to those in obstetric wards in southern Canada.

It is also well known that a top-down approach to the delivery of health care programs and services generally does not work. As I mentioned, there's great diversity among aboriginal peoples. Therefore only a community-driven approach ensures the built-in flexibility to accommodate the diversity of first nations, Inuit, and Métis populations in Canada. Community-based initiatives and control appear to be effective. We have found that community control over resources actually has an amplifying effect on results. When programs and decisions are under the control of an appropriate community authority, outcomes are improved compared to similarly resourced but externally controlled and applied processes.

There is significant research to support the connection between self-determination and health.

In 1988 the Government of Canada approved the health transfer policy framework for transferring resources for health programs to first nations living south of the 60th parallel. By 2005, 78% of communities that were eligible for transfer had done so. The following has been attributed to transferring control over resources for these services to first nations communities: an increased awareness of health issues; the development of services better suited to the unique needs of first nations; improved integration and coordination of health services; and in fact a decline in the use of medical services.

With regard to Métis, NAHO is currently wrapping up a project to evaluate culturally specific health promotion messaging. Mainstream media messages are generally not effective for aboriginal people. We've conducted focus groups across the country with Métis people. Once complete, the information gathered will be used to inform the development of programs and services to address the needs of the Métis population.

I encourage you to visit our site, NAHO.ca, where many resources are available on the health and well-being of first nations, Inuit, and Métis individuals, families, and communities.

Thank you.

I look forward to answering any questions you may have.

● (0855)

[*Translation*]

The Chair: Thank you very much for your presentations.

[*English*]

Right now we're going to go to questions from members.

Members, we really only have time for one question from each party. We'll try to stick to five minutes, and that will have us wrap up at about 9:20.

We'll go to the Liberal Party, Mr. Russell.

Mr. Todd Russell (Labrador, Lib.): Thank you, Mr. Chair. I'll share my time with my colleague Mr. Bélanger.

The Chair: By all means.

Mr. Todd Russell: I want to thank you for the presentations. It's sometimes a bit depressing, you know, to hear all these particular statistics. There seems to be not one health indicator where aboriginal people lead in the country, at least in terms of a "healthy" indicator.

I just have a couple of questions. First, there is no legislation, but what would be the benefits of a legislated mandate as opposed to a policy-driven mandate—from an accountability perspective, from a clarity perspective, even from a meeting-successful-outcomes perspective? I'm wondering if that's not a direction we could move in, and if that wouldn't that help.

Secondly, the non-insured health benefits program is a substantial part of Health Canada's overall health strategy. Are you keeping up? Are the dollars keeping abreast of the population growth and the need, particularly in light of the fact that there are so many other challenges surrounding aboriginal people?

Those are my two particular questions, and then Mr. Bélanger can ask his question.

● (0900)

Ms. Kathy Langlois: I'll take a stab at both those questions. I would ask my colleague to also supplement wherever she might wish to.

In terms of legislation, I think you've pointed out the benefits of legislation—more accountability, more clarity—but I would also note that legislation also can be confining. It's difficult to move more quickly if you have a need to make change. You have to go through a more elaborate process. So there are advantages and disadvantages to legislation. We're now able to move quickly to bring in programs and policies or address issues should there be a need to.

The other thing is that, as Mr. Buell has indicated, community-driven approaches to health are really key. Top-down approaches tend not to be the way to go. If you could build in flexibility and allow community-driven approaches to flourish, that would be key. If legislation could allow that, then I think that would be an important aspect.

In terms of the non-insured health benefits program, there's no doubt that there's a growing cost every year, with growing drug costs and so on. That said, in the last several budgets—in fact, since I've been around, in 2002—we have consistently received resources to cover the costs of the non-insured health benefits program.

The other aspect of the program, though, is that every year we look for efficiencies as well. One example is dispensing fees. When we see that perhaps there are more efficient ways to remunerate pharmacists for the way in which they handle the drugs on our behalf for our clients, then we'll implement those kinds of efficiencies as well.

There is a constant challenge to make sure that the program is as efficient as it possibly can be, given limited resources, but we have been successful in receiving the budget resources to cover those costs.

Mr. Todd Russell: Just as a follow-up, have you done an analysis internally on what the benefits of legislation versus the policy-driven approach have been? And can that be shared?

Mrs. Michelle Kovacevic (Director General, Strategic Policy, Planning and Analysis Directorate, Department of Health): I'm not sure; we'd have to get back to you on that. I suspect we have considered it, certainly for the non-insured health benefits program. As my colleague said, although we do very well, that program is managed at a growth rate of about 5%. That's actually more competitive than most of the provinces and territories, particularly for drugs. As she said, we do come back to cabinet year over year to supplement our actual budget. We've actually entertained whether, if we legislated non-insured, that would help reduce some of the jurisdictional disputes in terms of who pays for what and whatnot.

As for the rest of our programming, I think we'd have to go back and see what we've actually done in terms of analysis.

Mr. Todd Russell: Thank you.

Mr. Bélanger.

The Chair: Go ahead.

Hon. Mauril Bélanger (Ottawa—Vanier, Lib.): Thank you, Mr. Chairman.

Thank you very much for being here. I don't expect to get from you, in the time I have left, detailed answers on this. However, I'd ask you to please send us information on the programs you manage that are directed exclusively to aboriginals not on reserves. We know that more than half of the aboriginal population does not live on reserves. I'd like to know what percentages of your programs that are not exclusively for off-reserve aboriginals are directed to that population.

So I want an overall picture of the programs that are directed at non-reserve aboriginals, and, of the overall programs, what percentages are directed there. I would like to get an overall picture of the department on the health side in terms of what is directed to off-reserve aboriginals.

The Chair: We'll leave that as a question.

Thank you, Monsieur Bélanger.

I will go to the Bloc.

[*Translation*]

Mr. Marc Lemay (Abitibi—Témiscamingue, BQ): First of all, Mr. Chair, I want to apologize for being late. I was tied up with an important conference call with representatives of the Assembly of First Nations of Quebec and Labrador. Therefore, I will let my colleague Yvon Lévesque ask the first questions.

The Chair: Mr. Lévesque.

Mr. Yvon Lévesque (Abitibi—Baie-James—Nunavik—Eeyou, BQ): Welcome to all of you.

With respect to the health of First Nations, are the problems encountered on reserve and off reserve identical?

Ms. Kathy Langlois: Yes, the same problems exist both on and off reserve.

Mr. Yvon Lévesque: Do your statistics have anything to do with overcrowded housing conditions, or do many other factors come into play? Have you been able to identify some of these factors?

● (0905)

Ms. Kathy Langlois: Could you be more specific?

Mr. Yvon Lévesque: We know that houses and residences are overcrowded, owing to a lack of housing for First Nations.

[*English*]

Ms. Kathy Langlois: Okay.

[*Translation*]

Mr. Yvon Lévesque: For example, we know that one way tuberculosis can be transmitted is through close contact with people. The same problem exists among the Inuit population.

Ms. Kathy Langlois: Perhaps my colleague could tell you more about that.

[*English*]

Do you have information on tuberculous on and off reserve?

[*Translation*]

We are responsible for the population on reserve, so our statistics on tuberculosis relate to that population. The provinces are responsible for the problem of tuberculosis and other diseases among the population off reserve.

Perhaps Mr. Buell can tell you more about the situation.

Off reserve, in urban areas, factors such as unemployment and poverty came into play. Therefore, even if overcrowding housing is not as serious a problem, there are other health outcomes to consider.

Mr. Yvon Lévesque: Perhaps Mr. Buell would care to add to that.

[*English*]

Mr. Mark Buell: I would just back up what Ms. Langlois was saying. In cities you're still dealing with overcrowded housing situations and all the difficulties they're in. But we don't know what the rates of tuberculous are off reserve. I have not seen that statistic.

[*Translation*]

Mr. Yvon Lévesque: I'd now like to discuss the financing problems of various hospitals in the regions, for example, hospitals in northern Quebec, Abitibi and James Bay. In Val d'Or in particular, there was a delay at some point in receiving payments for hospital health care. Have these problems been resolved?

Ms. Kathy Langlois: Hospitals are a provincial, not federal, responsibility. Right now, we are responsible for only two hospitals located in Manitoba. We work with the provinces to transfer responsibility for hospitals. Therefore, I cannot answer your question about what happened in the case of the hospitals in the regions you mentioned.

Mr. Yvon Lévesque: I understand, but, aside from transferring responsibility, do you also transfer funds?

Ms. Kathy Langlois: In the case of the two hospitals in Manitoba, yes.

Mr. Yvon Lévesque: I'm talking about hospital under provincial jurisdiction.

Ms. Kathy Langlois: In the case of those hospitals, funds for hospitals are transferred by the Department of Finance through the Canada Health Transfer. Health Canada does not administer these funds.

Mr. Yvon Lévesque: Many departments are involved. I now understand why the provinces have difficulty sorting everything out.

I'll now turn the floor over to my colleague.

Mr. Marc Lemay: Will there be another round of questioning?

The Chair: No, there will only be one round.

Mr. Marc Lemay: There is a higher incidence of diabetes, tuberculosis and HIV AIDS among Canada's aboriginal peoples. When it comes to addressing the problem of crystal meth addiction, diabetes and tuberculosis, are your programs truly geared to aboriginal peoples?

Ms. Kathy Langlois: I can speak about drug treatment programs developed and administered by aboriginals. These programs have had some success, but other factors do come into play, such as housing, income, unemployment and poverty. In terms of health care services, we do everything we can to see to it that programs are managed by aboriginals.

● (0910)

The Chair: I see. Thank you very much.

[*English*]

Now we'll go to Madam Crowder for five minutes.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): Thanks, Mr. Chair.

Thank you for coming before the committee today.

I have a couple of things. Ms. Kovacevic referenced the need to sort out jurisdictional issues. In December 2007 the NDP had a motion before the House on Jordan's principle. The motion had all-party support and passed unanimously in the House. Could you update the committee on the work being done on implementing Jordan's principle?

Ms. Kathy Langlois: Absolutely. We are working right now with the Province of Manitoba and the Province of British Columbia, the first two provinces to say to us that they wanted to adopt Jordan's principle.

The federal government has adopted Jordan's principle. We are working closely with Indian and Northern Affairs Canada. I actually co-chair a director generals steering committee with my counterpart at Indian and Northern Affairs Canada, and we are working to ensure that no child is left without services as the result of a jurisdictional dispute.

Ms. Jean Crowder: I believe a recent case of meningitis on a reserve in Manitoba raised some concerns that perhaps there were jurisdictional issues at play. I think that's just one example of an area where there is some concern. It was certainly a concern in a reserve on northern Vancouver Island, where 40 to 60 children were apprehended recently because of housing conditions. There is this argument between the federal and provincial governments about who is responsible.

Many, many, many cases of children being at risk are still unfolding in Canada because governments can't sort out who is doing what for whom.

You talked about a steering committee. I wonder how quickly, though, we're going to see some results that really do put children first.

Ms. Kathy Langlois: I think it's safe to say that at this point we're focusing our attention on multiple-disability children who have multiple service providers.

Ms. Jean Crowder: Of course you know that the intention was much broader than multiple—

Ms. Kathy Langlois: Yes. I think our view is that we need to walk before we run, and we want to get our dispute resolution mechanism sorted out with straightforward cases in which everyone agrees that a multiple-disability child with multiple service providers should not be left without services because of a jurisdictional dispute. We are working through that in Manitoba. We've agreed to use case conferencing as the approach. We're working with the children at Norway House Cree Nation.

Once we have our dispute resolution mechanism sorted out, we're agreeing to look at the broader issues of children with disabilities. In a B.C. example, our tripartite agreement with the Government of British Columbia and the British Columbia First Nations Leadership Council is an important place to go in terms of looking at the broader issues, such as housing and child apprehension potential.

Ms. Jean Crowder: My understanding is that there wasn't consultation with first nations before the case-conferencing approach was adopted in Manitoba.

Ms. Kathy Langlois: Well, we worked at the table, we four representatives, in the first nations community, and in fact there were discussions with the first nations band councillor about what we were doing. We were going through all the cases, and they were at the table.

Ms. Jean Crowder: Having them at the table and having discussions is much different from having consultations through which they actually have input into the decision-making and the outcome.

Ms. Kathy Langlois: And that's the process we're in right now. We're working with them. There have been no decisions made about those children. We've continued to fund the services until we can work through a process to come to the decisions, and the community is involved in that.

Ms. Jean Crowder: I'm sorry, but I mean the broader issue about using a case-conferencing approach. It's not Norway House Cree Nation, but the broader issue around using a case-conferencing approach. I understand first nations are not happy with it and don't feel they've been appropriately consulted on that approach.

Ms. Kathy Langlois: That would be new information to me. Case conferencing is a way of determining needs. We can call it needs assessment or whatever, but it's best to get the health professionals who know about the needs of the child in the room together. I've not heard that first nations are not happy with the case-conferencing approach.

Ms. Jean Crowder: If I have additional information about that, should I send it to you directly?

Ms. Kathy Langlois: If you wish, please do so, absolutely.

Ms. Jean Crowder: On a broader issue, what we know is that we've got a very young population coming up. I know Mark has identified this as well. We know that this is not new information in terms of the health outcomes. This is not new. We have report after report after report.

We know the social determinants of health are critical. I know that some gaps are closing, but at the rate the gaps are closing, we're going to see another generation suffer the health outcomes that their elders suffered. What is getting in the way of a faster resolution?

● (0915)

The Chair: Give a brief response, please, and then we must move on.

Mrs. Michelle Kovacevic: I think a lot of that is about roles and responsibilities across governments. That won't surprise you.

One of the huge initiatives we have in Health Canada right now is the aboriginal health transition fund, the $200 million over five years, which is project-driven, but provinces, territories, first nations, Inuit, and Métis can draw from that fund to implement services that are integrated or adapted. That forces different parties and different governments to the table. I think more of this kind of initiative, which crosses the boundaries of roles and responsibilities so things are more effectively provided, will go a long way to addressing some of that.

The Chair: Thank you, Ms. Kovacevic and Madam Crowder.

Mr. Duncan, for five minutes. This will be our last question.

Mr. John Duncan (Vancouver Island North, CPC): Good morning.

I noticed an overarching question from Mr. Bélanger on the spending of the department and where it's allocated. I go back to one of the slides where the non-insured health benefit package actually supplements provincial, territorial, and private insurance. If you try to get into that kind of comparison, I think it's going to be very different on reserve, off reserve, by province or territory. I'm not sure you're going to have an easy time sorting that out. I wanted to put that on the record as a comment, not so much as a question, although you can comment if you choose.

We're meeting with the Australians later today. When you read through their *Closing the Gap* document, which is new this year, you can see their statistics are similar to ours in so many ways. One thing they've done is to try to set some measurable targets. I'm wondering if we're headed in that same direction, to set six benchmark targets on things like life expectancy, educational attainment, employment attainment, and so on. That's my first question.

Your last slide talks about letters of intent with Mexico and Australia. I'd like to understand more. Maybe you can round that out a little.

Finally, you talk about a letter of understanding with the U.S. Is that specific to cross-border movement, or is that something different?

Those are my questions. Thank you very much.

Ms. Kathy Langlois: In terms of answering the targets question, setting targets is something we've had some experience in doing in working with first nations, Inuit, and Métis leaders. A number of years back we did set some targets around suicide prevention, diabetes, and some child-based targets, so we do have experience with that. The decision back then was to ensure that the targets were very stretched, such as reducing the rate of diabetes by 50% in five to ten years. They were very, very ambitious targets. I think the key is that we work in partnership with first nations, Inuit, and Métis leaders around those issues in setting targets. So it's not something we would do within Health Canada unilaterally, but we do have experience in setting targets.

In terms of the Australian situation and the letters of intent, we do have letters of intent with Mexico. I am quite familiar with that one, as I've been involved with the Mexicans. What we're doing there is focusing on issues of interest to both countries. So healthy communities are of interest to Canada, whereas health governance and indigenous control of service are of interest to Mexico. So we're having an exchange of information and building our relationships with them. Maternal child health and the work we're doing on midwifery have been of big interest to the Mexicans, and we've had opportunities to exchange information there.

We have an upcoming visit to British Columbia by the Mexicans in May to further deepen the understanding of how the systems work, but also on those specific topics. Then we'll be looking at where we go further with Mexico and whether or not we should actually have longer exchanges, where people would maybe come to work for us and vice versa. So there are things to be thought about there.

In terms of Australia, a letter of intent was signed back in 2007 with the previous government. With the new government taking office, they've said they're interested, but that at this time they're focused on domestic issues. Certainly the closing-the-gap initiative is of importance to them—which you've referenced, and which I'm sure they will be talking about when they're here.

Those are the main things. The memorandum of understanding with the Indian Health Service goes way beyond the border issues. In fact, we had focused on fetal alcohol spectrum disorder and suicide prevention as two key areas, as well as doing extensive work on sharing research agendas.

My colleague may wish to add to that.

● (0920)

The Chair: We're essentially out of time, unless you just have a very brief comment.

Mrs. Michelle Kovacevic: I don't believe so at this time.

The Chair: Okay, very good.

Thank you very much. I appreciate your patience and understanding with our restricted time, and with the earlier than normal start this morning. It's greatly appreciated.

The meeting is adjourned.

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