HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

# Standing Committee on Indigenous and Northern Affairs

INAN • NUMBER 013 • 1st SESSION • 42nd PARLIAMENT

**EVIDENCE**

## Tuesday, May 10, 2016

## Chair

**Mr. Andy Fillmore**

# Standing Committee on Indigenous and Northern Affairs

**Tuesday, May 10, 2016**

● (1530)

[*English*]

**The Chair (Mr. Andy Fillmore (Halifax, Lib.)):** Seeing that everyone seems to be here, we'll come to order, even though we're a few minutes early. We can fit more in that way.

Welcome everyone. Thanks for being here today. We are going to be hearing from the first nations and Inuit health branch in the first hour of our meeting. On behalf of the committee, I'd like to welcome Sony Perron, senior assistant deputy minister; Keith Conn, ADM, regional operations; Scott Doidge, director general, non-insured health benefits; Tom Wong, executive director, office of population and public health; and Leila Gillis, director, primary health care systems division. Thank you all for making time for us today.

We're having our meeting today on unceded Algonquin territory, as we always acknowledge.

I'm happy to give you 10 minutes to present your remarks, and you're free to divide that among yourselves, as you like. Is there more than one speaker this morning?

**Mr. Sony Perron (Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health):** There will be one.

**The Chair:** There's just one. Okay.

Without further delay, let's get started, please. You have the floor. Thank you.

**Mr. Sony Perron:** Mr. Chair, members of the committee, thank you for inviting Health Canada's first nations and Inuit health branch for this briefing on first nations and Inuit health programs.

Health Canada is committed to ensuring that first nations and Inuit communities and individuals are receiving a range of health programs and services that are responsive to their needs. The overall objective is to improve health status.

[*Translation*]

As you may know, first nations and Inuit communities are facing major health challenges. Compared to Canadians as a whole, they have shorter life expectancies, higher rates of chronic illness and infectious disease, and higher mortality and suicide rates.

They are also faced with greater challenges in relation to the social determinants of health, such as high unemployment rates, lower education levels and higher rates of overcrowding in homes.

[*English*]

In addition, first nations and Inuit face historical legacies, such as colonialism, the disconnection of culture, and the intergenerational impacts of Indian residential schools.

The health care system for first nations and Inuit is complex. Provinces and territories deliver hospital, physician, and public health programs to all Canadians, including first nations and Inuit, but do not operate health systems on reserve for most. In order to support first nations and Inuit in reaching an overall level of health that is comparable to that of other Canadians, Health Canada funds or provides a range of health programs and services in first nations and Inuit communities.

Within this context, Health Canada works with first nations, Inuit, provincial, and territorial partners to provide effective, sustainable, and culturally appropriate programs and services to improve health outcomes and support greater control of the health system by first nations and Inuit.

As part of this effort, Health Canada invests more than $2.5 billion annually in first nations and Inuit health to supplement programs and services provided by provinces and territories. This includes over $840 million for primary health care and public health on reserve, and $1 billion for health benefits. It also includes over $440 million this year for the British Columbia tripartite initiative, an innovative, precedent-setting development in first nations health, which took effect in October 2011, when B.C. first nations, the Province of British Columbia, and Health Canada signed the British Columbia tripartite framework agreement on first nation health governance.

Spending also includes $240 million for health infrastructure support, which promotes first nations and Inuit capacity to design, manage, and deliver their health programs and services, while supporting health service innovation, integration, and partnerships.

There are five key elements funded by Health Canada to support first nations and Inuit health: health promotion and disease prevention programs, public protection programs, primary care services, supplemental health benefits, and health infrastructure support.

In the area of health promotion and disease prevention, Health Canada provides funding to support community-based health promotion and disease prevention programs to support mental wellness, healthy child development, and healthy living.

Services related to mental health promotion, addiction support, suicide prevention, and counselling are funded under a range of programs, such as the national native alcohol and drug abuse program, Brighter Futures, Building Healthy Communities, and the national aboriginal youth suicide prevention strategy. In the area of healthy child development, it supports children to have the best start in life through programs such as aboriginal head start, the Canada prenatal nutrition program, and maternal child health.

As part of the Indian residential school settlement agreement, Health Canada also funds and provides health support services to former Indian residential school students and their families so that they can safely address a broad spectrum of wellness issues related to the impacts of these schools.

In the area of health protection, the department delivers public health protection programs, including communicable disease control, monitoring of drinking water and waste water, and environmental public health inspections of facilities and housing on reserve. In this area, services are provided by a combination of Health Canada and first nations-employed workers.

In the area of primary health care, Health Canada supports access to primary health care services in 80 remote and isolated first nations communities where access to provincial services is limited. Efforts are ongoing to enhance the inter-professional team approach, increase the number of Health Canada nurses, including nurse practitioners, and increase access to physician services.

Health Canada delivers primary care in 52 first nations communities, while in the remaining locations these services are totally under the control of first nations.

Through home and community care programs, Health Canada supports home care nursing, respite care, client assessments, and personal care or home support in over 500 first nations and Inuit communities. Most of these services are delivered by first nations community-employed health workers.

● (1535)

As indicated before, Health Canada also provides supplemental health benefits. Health Canada supports one of the largest health benefit programs in the country and provides coverage for medically necessary goods and services to over 824,000 eligible first nations and Inuit.

NIHB provides program coverage in different benefit areas to supplement those that are usually available through provinces, territories, and private insurers. This includes coverage for prescription and over-the-counter drugs, dental services, medical transportation, medical supplies and equipment, vision care, and mental health counselling.

The NIHB program does not require co-payments or deductibles and encourages health service providers to bill the program directly so that clients do not face out-of-pocket expenses.

The NIHB program provides important coverage for medical transportation to health care services. Approximately 125,000 clients accessed medical transportation benefits in 2014-15, accounting for over 300,000 medical-related trips. Medical transportation coverage includes emergency transportation and transportation to access medical care, such as appointments with physicians; hospital care; diagnostic tests; medical treatments; alcohol, solvent, drug abuse, and detox treatments; traditional healers; vision and dental appointments; and mental health counselling.

Specific to dental care, the NIHB program provides eligible first nations and Inuit with coverage for diagnostic, preventive, restorative, endodontic, periodontal, removable prosthodontics, oral surgery, and orthodontic services.

[*Translation*]

Health Canada also provides support for the infrastructure of 700 health care institutions across Canada. This supports the delivery of services and helps first nations with health services accreditation, the adoption of cyber health technologies, human resources in Aboriginal health care, and service integration.

Health Canada does not do this alone. First nations and Inuit also take on various degrees of responsibility for directing, managing and providing a multitude of health services funded by the federal government.

Efforts to assist first nations and Inuit in their desire to influence, manage and control health programs and services that affect them continue to be essential for improving health outcomes and expanding access to the health services and programs they need. This approach has been motivated not only by the desire to give first nations and Inuit greater autonomy in matters that could improve their health, but also by the evidence that better control can improve health outcomes and make public health activities more effective and respectful of the culture.

A majority of health programs have been transferred to over 400 first nations communities, to varying degrees. Some first nations communities receive funding to design and deliver autonomous health services that meet their needs, while others work with Health Canada to develop community health plans in order to model the programs to their health services needs. And in some communities, Health Canada personnel deliver health services jointly with local health teams.

We have made significant progress in health services integration in the last ten years. In many regions, we see examples where there are more doctors in the communities or the continuum of health services provided within and outside the community has improved through collaboration agreements. These efforts have resulted in better outcomes and made it possible to implement a more patient-focused approach, in spite of the complexity of the system.

The national organizations are consulted regularly and the two main national organizations representing first nations and Inuit sit at the management table of the First Nations and Inuit Health Branch. There are co-management tables and tripartite tables in most regions of Canada for holding official discussions with the provincial and territorial partners and the first nations and Inuit partners, in order to advance common priorities and resolve systemic issues.

I would like to speak briefly about some of the priorities with which we are concerned.

[*English*]

As you know, first nations and Inuit are more likely to experience complex mental health and substance abuse issues. We have been working with the Assembly of First Nations over the last few years to develop the first nations mental wellness continuum framework. This framework was endorsed and released by the Assembly of First Nations in January 2015, and implementation is under way with first nations partners at the regional and national levels.

Health Canada will also participate in the whole-of-government approach to address the call for action of the Truth and Reconciliation Commission. We are also working jointly with the Assembly of First Nations on a joint review of the non-insured health benefit program. This is a benefit-by-benefit review with the AFN to discuss improvement of the health programs and services.

I want to thank this committee for giving us an opportunity to be with you today, and we will be pleased to answer your questions.

● (1540)

**The Chair:** Thank you very much, Monsieur Perron, and to your colleagues as well. I know that 10 minutes goes fast, and if there's more that you want to share with us today, we'll find a way to fit that into the questions as they come up.

We'll move into a round of seven-minute questions, and Michael McLeod first, please.

**Mr. Michael McLeod (Northwest Territories, Lib.):** Thank you to you all for coming to present to us today. This is an area that I think concerns all of us throughout Canada, the area of health care. I'm from the Northwest Territories, and we certainly have our share of issues across the north. We are a large area with 33 communities, struggling to have the services provided in our communities. It's very rare that you'll see a doctor twice in the communities. Even the nurses are locums, for the most part, who come in for a short stint and then leave.

About 70% of the Government of the Northwest Territories budget is spent in the area of the social envelope. A lot of it is being spent on health. When it comes to our aboriginal population, we have first nations people who are covered through non-insured health benefits, and we have the Métis people who are covered through a program funded by the Government of the Northwest Territories. So they are carrying a huge burden of costs. It's really causing a lot of challenges for them to provide health care for aboriginal peoples.

I'm very curious to know how the non-insured health benefits are calculated. In the Northwest Territories a set amount of money is provided on an annual basis. I'm not sure if it has increased over time, but I know the government is spending roughly three times what is provided, because the federal government hasn't, up till now, been willing to cover the actual costs. There seems to be a formula that is used and it is not really measuring the health needs of the first nations people.

My first question is on that area, then, the real needs of aboriginal peoples in the Northwest Territories. We don't have treatment centres either, so addictions is an issue. Health is an issue. Off-loading to the territorial government is an issue.

Maybe you could just talk about that a little bit, and then I'll ask my next question.

**Mr. Sony Perron:** To give a little bit of context, around 20 years ago there was an agreement between the federal government and the territorial government about the transfer of primary health care services responsibility to the Northwest Territory government. Health Canada's first nations and Inuit health branch doesn't provide community-based health services in this territory. We do have an agreement with the territorial government to provide them, over a multi-year agreement, funding for public health programming—for example, home care services, maternal and child health, and these kinds of programs. We have a master agreement with the territorial government to fund these programs. Some of these resources flow directly to the community from the territorial government, but the main responsibility of the territorial government for primary care would ensure that health services in the territory is with the territorial government. It's not with Health Canada.

Where we also intervene is that first nation or Inuit people living in NWT are covered by the non-insured health benefits program. For medication, dental care, medical supply and equipment, and vision care, these benefits are totally administered by Health Canada and funded by Health Canada. We pay the full cost of these benefits for a client living in Northwest Territories like anywhere in Canada.

For medical transportation, we work with the territorial government to pay our share of the transportation costs for a first nation client. You referred to the Métis. Métis are not eligible clients under the non-insurable benefit. The policy for this program is for Inuit and first nation at this time.

We also have a territorial funding arrangement to supplement funding to territorial government to assist with costs of the health system. In there, there is an envelope—I cannot remember the exact amount, sorry—for medical transportation. The territorial government is receiving an additional envelope to support the cost of medical transportation in the territory, because it's known that the cost of transportation there for client to access needed care is pretty high.

So in addition to the main transfer, there is that envelope provided annually to the territorial government to assist with the cost of medical transportation.

● (1545)

**Mr. Michael McLeod:** I'm quite familiar with the arrangement with the territorial government. I spent 12 years in cabinet with the Government of the Northwest Territories.

Maybe we can get into the specifics. I'm certainly familiar with the fact that the Métis are not included. The Government of the Northwest Territories has taken that responsibility on itself.

I have two questions, given the short period of time. First, given the results of the Supreme Court ruling in the Daniels case now, would you be able to give us some insight on the plans for including the Métis in the non-insured health benefits?

The second question is regarding the Truth and Reconciliation Commission's call to action, which states that we should:

> ...provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

I'm very eager to learn what that means and what that will to translate to.

**Mr. Sony Perron:** Regarding the coverage for Métis, at this time the policy coverage we have for the program at Health Canada is about providing service for first nations and Inuit. Since the court decision, there has not been a change in terms of the eligibility for these programs. The responsibility for providing health care remains with the territorial government or the provinces and territories in general for the rest of the population.

As for the TRC call for action, there are seven recommendations that are directly related to health care or health services. We are in the process of working with the Assembly of First Nations, the Inuit Tapiriit Kanatami, and also the Métis National Council to engage them to support and get their views in the context of the health accord process.

We do expect that during that process we will be able to get the perspectives of these three groups about how we implement these seven recommendations that are directly related to health care. Some of them, as you probably know, are in the range of the responsibilities of the provinces and territories, so we do expect that this process will give an opportunity to learn about how we could best implement these measures.

**The Chair:** With that question and others, there's a lot of subject matter here. If you would like to provide any further information in writing, we'd happily receive that as well. Thank you.

The next question comes from Cathy McLeod, please.

**Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC):** I'm sure you're aware of some recent testimony by a doctor who was here at committee. Also, the APTN did a bit of a series on the non-insured health benefits.

What strikes me, if you look perhaps at the federal service plan, is that it's pretty seamless. For orthodontic work, the dentist might flip a picture in, and the approval comes very quickly. To my knowledge, I don't know of any declines in orthodontic services for people under, say, the public sector plan. So it seems that there are plans out there that are seamless and very burden-free in terms of their paperwork and process. In comparison to the stories that we've heard, that is an issue. You talked about working with the AFN in a review of non-insured health benefits. Are you looking at your systems and processes for a more seamless provision of service, which is the norm? That's the first question.

The second part of that—and then I hope to talk about primary care—is that we heard that the formulary is very restricted. I would like to know if your formulary compares to what is routinely available, for example, in the province of Ontario.

**Mr. Sony Perron:** I will start with the non-insured health benefits joint review process and ask my colleague Scott Doidge to share a few more details.

● (1550)

**Mrs. Cathy McLeod:** Could you let me know when I have two minutes left, Chair, for primary care? Thanks.

**Mr. Sony Perron:** The joint review will allow us to go benefit by benefit and look at the irritants in the system. One of the things we know is that we are running a plan that has coverage in 13 jurisdictions across the country, and most of the health system is driven by provincial and territorial considerations. Formularies are different, program coverage is different, and physicians' practices in terms of prescribing are different. We have to learn about where the irritants are to be able to fix that.

**Mrs. Cathy McLeod:** Can I just interject? Sun Life covers federal government employees across the country, and they don't worry about all of that.

**Mr. Sony Perron:** I think that during the review process we will have to examine this with the AFN, because the design of this program is pretty important. I mentioned earlier that there is is no copayment and there is no deductible. I should have mentioned that there is no maximum amount either. We do have clients who receive hundreds of thousands of dollars in coverage annually because that amount is what they need.

However, in order to balance the plan, plans that have no limits, like that one, will have some criteria for coverage, which is that it's for something is medically necessary. For example, in the area of drugs where we ask for predetermination, it's mostly around drugs that have an addiction issue built in that needs to be controlled. This program has been recognized as one of the most sophisticated in terms of preventing over-prescribing, but it does bring with it some rules, and this is what we want to discuss with the AFN.

On dental care, you referred to public service employee plan. Again, there is a maximum. If you go above this maximum in a given year, you're on your own. For orthodontic treatment, you have a maximum amount. I think it's around $2,000. The rest of the bill is for the family to pay.

In the case of non-insured health benefits, if a client receives coverage we will pay in full. We pay the full cost. There won't be a copayment and there won't be a deductible. However, the medically necessary criteria will be applied, so some of the opportunities to get orthodontic treatment or even dental treatment that is not medically necessary will not be covered like it would be covered under a private plan that only covers a portion of the cost. It's a choice. Public plans usually will have more elements of predetermination in them in order to be able to cover more and to offer more coverage for the clients.

In terms of the administrative process, maybe Scott can give us a sense in terms of the percentage of claims that receive approval without any prior approval or predetermination. It's pretty important.

**Mr. Scott Doidge (Director General, Non-Insured Health Benefits, First Nations and Inuit Health Branch, Department of Health):** Maybe I'll tackle your comparability question after that.

About 99% of pharmacy claims are ultimately approved through NIHB and the majority of those claims—over 90%—are approved on the spot through our electronic claims processing system. There's no out-of-pocket cost for the client, and the provider is subsequently reimbursed for that.

There are some claims for which we do require further information, as Sony mentioned. Many of those drugs are ones that are subject to abuse and are part of something we call our prescription drug abuse strategy, so we do seek further information through our drug exception centre here in—

**Mrs. Cathy McLeod:** I'm sorry, I'm going to cut off you because I've two minutes left and I have to get to the question of primary care.

We heard that you run 52 of the primary care services across Canada. My first question is that in every one of those settings, is Internet service such that there is a good opportunity for telemedicine?

The second is that we hear about the lack of resources and of services.... Having run a number of rural community centres, I know that communities have huge challenges with physician services, nurse practitioners, and mental health counsellors, so I appreciate the recruitment challenges. Do you run those services at a comparable level to a non-indigenous remote community in terms of the service level? Have you studied it? Can you table any studies?

That will use the minute.

**Mr. Sony Perron:** The objective is to run at the same standard. There are some challenges from geography, and distance, and recruitment of nurses, but also in the availability of the physician services that are provided by the province. We have, over the last year, been able to increase the presence of physicians in the communities and when the physicians are not present, the nurses have access on call to a physician to get some direction in terms of service.

Maybe, Leila, you want to comment on the level of care and the recent assessment we performed following the 2015 OAG report.

**Ms. Leila Gillis (Director, Primary Health Care Systems Division, Department of Health):** We're certainly challenged by geographic location and we do have models that are similar to those in other geographic locations. We are about to do a comparative descriptive analysis where there are comparable locations where provincial services are provided. However, we do have, and have increased, nurse practitioners in many of our nursing stations, and part of our analysis of each nursing station and their essential services is the plan to enhance the mix of skills, collaborative practice arrangements for physician coverage, and also to increase the number of nurse practitioners in our current nursing teams within the nursing stations.

● (1555)

**The Chair:** The next question is from Charlie Angus.

**Mr. Charlie Angus (Timmins—James Bay, NDP):** Thank you very much for being here and, Mr. Conn, it's nice to see you here. We're both in our suits today. The last time we were in Attawapiskat, we were in our rubber boots.

I only have seven minutes and I have so many questions. I wish we could do this all day, but I only have seven minutes. I don't want to sound rude, but I have a bunch of short questions and, hopefully, will get short answers.

Can you confirm that the Conservative government set aside money to implement Jordan's principle between 2008 and 2012?

**Mr. Sony Perron:** There was actually an active fund that was created at the time, yes.

**Mr. Charlie Angus:** I didn't see it in this budget. Is that fund there now to implement Jordan's principle?

**Mr. Sony Perron:** The fund has been eliminated in the context of the deficit reduction action plan.

**Mr. Charlie Angus:** Okay. Today is a deadline for implementing Jordan's principle, so there's no fund to respond to the Human Rights Tribunal, but there was under the Conservatives?

**Mr. Sony Perron:** I would say....

I cannot really answer your question the way you're presenting it. Today is the date for—

**Mr. Charlie Angus:** Today is the deadline—

**Mr. Sony Perron:** To answer, we have taken some measures to be in a position to acknowledge the decision of the tribunal. Our staff have been directed to move away from the old definition, because the tribunal has been really clear about what the approach should be going forward.

**Mr. Charlie Angus:** Okay. But there's no fund set aside to implement?

**Mr. Sony Perron:** The envelope that was set aside up to 2012 is not there any more.

**Mr. Charlie Angus:** Looking at the Human Rights Tribunal ruling, a lot of the evidence was from child welfare, but a lot of it was also from your department. Looking at the evidence that was put forward by your own officials, there are some pretty disturbing statements. Tab 78 on gaps in service delivery to first nations children says that the denial of prescriptions that have been ordered by pediatricians is common. Who would make a decision to deny a child's prescription, or on what basis would such a decision be made, if a doctor has ordered it?

**Mr. Sony Perron:** I cannot really comment on the specific case that was behind the evidence that the person or witness brought to the attention of the tribunal. But I can probably ask Scott to give us a sense of what our rate of approval is.

**Mr. Charlie Angus:** These these aren't individual cases; this is systemic. That's what they're saying. These are systemic issues, that children are routinely being denied prescriptions that have been ordered by pediatricians.

Tab 302, which Health Canada supplied to the Human Rights Tribunal, says that if a child with multiple disabilities requires a wheelchair, lift device, or tracking device, they're only allowed one of those items. If they opt for a wheelchair, they don't get a motorized wheelchair; it has to be an adult push chair. Is that policy, or is that what a bureaucrat decides?

**Mr. Sony Perron:** The level of coverage and the criteria for coverage depends on the nature of the handicap faced by the child. Each case is assessed case by case. If the service or the supply of medical equipment is required, it will be paid in full by the program.

There was some issue raised in the tribunal related to medical beds. We have resolved that issue.

**Mr. Charlie Angus:** That was the one where the child was going to die and Health Canada said absolutely not, and the doctor paid out of his pocket.

I want to ask about one of the allegations that has come forward from testimony at our hearings—some very disturbing hearings. It's said that Health Canada is telling doctors to use only one catheter bag a day, which means they have to reuse them. I'm not a doctor and I don't know much about this, but the doctors say this causes recurrent infections, kidney disease.

Is that a decision made by a doctor at your office, or is that just because someone is crunching pennies here?

**Mr. Sony Perron:** I'm not aware of any directive about this.

Scott, I don't know if there is such a directive under medical supplies and equipment. I've never seen that, and I've been in this position for a number of years.

**Mr. Charlie Angus:** That's a pretty serious allegation. Dr. Kirlew says that children are dying from childhood illnesses that are unknown elsewhere, such as rheumatic fever, because they're being prescribed Tylenol. When a child dies at a nurses' station from a lack of medical supplies, are there investigations done to find out why that child died?

**Mr. Sony Perron:** Yes, it's done whenever there is an incident, and not only in the case of death. When there is an incident, there is a protocol to review the incident, to review the charts, and to involve external parties in the review if needed. The objective is to understand the cause and to see if there is any responsibility on the part of the health provider in this context, and also to improve the process.

● (1600)

**Mr. Charlie Angus:** Dr. Kirlew stated yesterday in the newspaper that he's concerned, as a doctor, about the Hippocratic oath under non-insured health benefits, because he says that “I know the system is actually harming people”. I would think you'd want to look into that.

I'm running out of time here. The department states that Health Canada spent $300 million on mental wellness last year. This year's RPPs state that it's $270 million, so does that mean there's a $30 million drop in mental health programs, and what program would that come from?

**Mr. Sony Perron:** No, there is no reduction of spending on mental health. This is probably related to programs that are being renewed and will appear when we get to the supplementary estimates process.

**Mr. Charlie Angus:** I'm told there are only 10 mental wellness teams for indigenous mental health teams across the country. First nations are saying they need 80. Can you confirm that there are 10 mental wellness teams?

**Mr. Sony Perron:** Based on the mental wellness continuum framework, we started to invest a couple of years ago in building mental wellness teams. This is a model that has proven to be effective. At this time there are 10 or 11 being funded throughout the country. This is in addition to local mental health services.

**Mr. Charlie Angus:** We've been told that only $350,000 has been put into that first nations mental wellness continuum framework. Is that true?

**Mr. Sony Perron:** Last year we spent around $300 million on mental health.

**Mr. Charlie Angus:** I know, but within that framework, I've been told that up to date, there has only been $350,000 put into that.

**Mr. Sony Perron:** I cannot comment. Part of the framework is also to manage the funding that is already in place for these programs and to realign them under the framework. This was the intent of that framework, but also to inform future investment.

**Mr. Charlie Angus:** Finally, going back to the issues that we're seeing from the doctors, the testimony at our committee about children left at a nurses' station for 13 hours crying in pain because they don't have pain killers, or children starting to suffocate because they don't have Ventolin, is pretty disturbing to me. If that is a common practice, wouldn't that be kind of like institutional malpractice?

How is that allowed to happen in a medical system in 2016?

**The Chair:** We're out of time, I'm afraid. Maybe you can get the answer in another question, if it's appropriate. Thanks.

The next question is from Rémi Massé.

[*Translation*]

**Mr. Rémi Massé (Avignon—La Mitis—Matane—Matapédia, Lib.):** Thank you, Mr. Chair.

I would like to thank the witnesses for taking part in the committee's work. Your presence is greatly appreciated. Thanks also to your respective teams, who have worked very hard to enable you to participate in this exercise.

In 2013-2014, the annual budget of the Non-Insured Health Benefits Program was a little over $1 billion, a 7% decrease from the previous fiscal year. What are the reasons for these budget reductions, given that the needs are growing year over year?

**Mr. Sony Perron:** Actually, we are seeing constant growth in that budget, but I do not have the details with me today. With the transfer of health responsibilities to the British Columbia First Nations Health Authority, funding for the various components of the program was consolidated in a $140 million envelope that was transferred in its entirety to that agency. As a result, the program budgets you see in the estimates or the annual reports have changed because the funds for British Columbia have been segregated and put in a separate envelope. I can confirm that on an annual basis, the Non-Insured Health Benefits Program is growing on the basis of 5%, while spending continues to increase, probably at a faster pace. To answer your basic question, the budget has not been reduced.

**Mr. Rémi Massé:** Thank you.

What are the three major challenges you are facing in delivering services, and, more specifically, what solutions have you identified to improve the Non-Insured Health Benefits Program?

**Mr. Sony Perron:** One of the major issues is the availability of nursing resources. In remote and rural areas, recruitment and retention are challenges. The workload at the nursing stations is very heavy, and this makes it difficult to keep people in those positions for very long. Of course, there are people who make this their career, but it is difficult to attract new workers. Our workers also have to have solid experience, because they have to be able to offer a range of services, to meet the demand, which is very considerable. There is also the challenge of supporting these workers and connecting with the rest of the health care system. The fact that this is an enclave of health services funded by the federal government, surrounded by services for activities that are under provincial jurisdiction, is also a challenge. We have made a lot of progress in terms of integration, but this is still a major challenge.

For example, doctors come under the provincial program. Those are insured services. Our major challenge is to maintain the coherence and integration of these services. That is why the British Columbia model that I referred to is so important. That model puts all resources, responsibilities and authorities under an entity controlled by the first nations, and so the problems of jurisdiction, service integration and collaboration among the various services are eliminated. With this process, we have given the first nations full control of their services, while the province has committed to working with first nations and the federal government to act as a financial partner and a partner for resolving the issues that the system faces. Service integration is probably the second major issue.

The third major issue is mental health. Your colleague referred to this earlier. It is a challenge. The need is growing, and is largely a result of historical situations that have affected the communities. There are also new needs, such as those related to the abuse of prescription drugs. These kinds of challenges have an enormous impact on the communities, and, more specifically, on the most vulnerable communities. There are very urgent situations. This becomes a problem for health services, in that additional pressure is put on those services. It can have the effect of creating demands that did not exist before. In these circumstances, we have to provide additional services and we have programs that enable us to do that. The work with first nations and Inuit on defining strategies is extremely important. We do have to do that, and we have to do it from a culturally responsible perspective. We have to rebuild what was destroyed by the colonization model that was applied for over a century. We have to make culture central to our actions and respect the autonomy of the first nations, but that must be done one step at a time. Another challenge is building capacity in the organizations and communities.

Some communities have very sophisticated plans that enable them to take charge of programs and adapt them to meet their needs. We have to look after human resources and attract workers to these communities who want to stay and contribute to those plans. In some communities, we are seeing extremely important situations and major progress being made. What we often see in the media are the challenges, and we have to pay attention and work in the places where there are special challenges. There really are places where extraordinary progress has been made, where there is creativity and the first nations have taken control of their health services and are designing intervention plans and models that very much merit attention.

● (1605)

**Mr. Rémi Massé:** Thank you.

In his 2015 report, his audit, the Auditor General identified specific issues. You have talked about committees composed of representatives of Health Canada and various bodies. We have talked about jurisdictional issues. I would like to hear what you can tell us about what the Auditor General meant by jurisdictional issues. What are they? What solutions to this particular problem have been explored?

**Mr. Sony Perron:** The big challenge is to ensure that we can function with the national programs at a provincial level. Some provinces offer services to first nations on the reserves and in their communities, while others offer them no services or exclude them from their systems. Still other provinces provide primary health care to the communities. The model is therefore very different from province to province.

As a result, our programs have to be adapted to the situation in each province. That is why we have created trilateral tables, where services can be coordinated and integrated, and we can discuss problems, not only with the communities, but also with the provincial and territorial partners. I can tell you that we are making progress. We are taking small steps forward on each subject, in order to create models that work.

For example, we participate in a trilateral table with Ontario and the first nations. We are making progress on common subjects and issues. The same is true in the western and Atlantic provinces. These tables are needed, to solve service integration problems.

**Mr. Rémi Massé:** Thank you.

[*English*]

**The Chair:** We're moving now to the five-minute round, and the first question is from Todd Doherty, please.

● (1610)

**Mr. Todd Doherty (Cariboo—Prince George, CPC):** Mr. Perron, I want to deal with the emergencies that we have in La Loche and Attawapiskat. Can you tell me why there is a delay in getting these communities the critical help they need? La Loche is still waiting for some critical support. Even to this point, our honourable colleague was taking it easy on the panel today. Clearly he had an opportunity to ask these questions. We have a crisis. We've all talked about it. There's been a considerable amount of media attention. This is not new. These are crises we're seeing in many first nations communities, not just these two that we've mentioned. Specifically, why is there a delay in getting that critical help to these communities?

**Mr. Sony Perron:** I'm going to share my time with my colleague, Keith, who can talk about the situation at Attawapiskat. He just visited the community, and is quite familiar with the file. I will talk about the La Loche situation.

There is a reserve nearby, the Clearwater River Dene First Nation. This is where Health Canada's first nations and Inuit health branch mandate is. We have worked with the community and with the Meadow Lake Tribal Council. They have a mental wellness team to provides additional support to the first nation Dene community. Two weeks ago, I had my regional executive reaching the chief to make sure that what we have done and the services that were provided by the Meadow Lake Tribal Council were satisfactory. We got the signal that things were working well, and they were working with the province.

If you're referring to the La Loche community, this is not a place where our mandate is operating. We were on reserve in the first nation Dene community. I would say that for that portion, the assessment is that we have been responsive. Now we are looking at the long-term needs of this community. Fortunately, the Meadow Lake Tribal Council, which is the authority that provides service to the first nations in this area, has one mental wellness team, which we referred to earlier today. It has been the instrument that has been used to leverage some capacity. There was also help from other first nation organizations in Saskatchewan that were directed toward the community to assist with that tragic situation.

Maybe I will ask Keith to talk a bit about the situation at Attawapiskat.

**Mr. Keith Conn (Assistant Deputy Minister, Regional Operations, Department of Health):** In terms of Attawapiskat, we did have a sense from our communications with the chief and council and the community members that there were issues percolating, so we were able to deploy some mental health resources through the Nishnawbe Aski Nation organization, which has a crisis response. Even before the declaration, some surge capacity was deployed to the community with our assistance.

Once the declaration of emergency was made, about two and a half days later a crisis response team was deployed to the community through our NAN partnership. That included mental health crisis counsellors and a youth coordinator.

This is a crisis kind of environment, so there's a bit of a rotation. I think we need to look, at as the Chief has said, the more medium- and long-term work in terms of a transition from crisis to stability to mental health supports for youth in the community writ large.

I think we were responsive. We now have our provincial partners. I won't speak for them, but I know I can say they are physically there at present. That's the emergency medical assistance team who were deployed I think a week after the call. Minister Hoskins was responsive in terms of making that happen.

They are there. They are continuing. They have nurse practitioners, mental health workers, and psychologists who were hired through NAN who are in and out on rotation. There are people who need some respite care, of course, given the volumes of work and the intensity of the work in that community.

We were looking at a more sustainable model in terms of medium-term planning. We'll be deploying some federal presence at an executive level this week to look at the more medium- and long-term planning processes.

**Mr. Todd Doherty:** I really appreciate your comments, but I think if you asked our honourable colleagues from both La Loche and Timmins—James Bay, they might have a different opinion on what is really happening and the critical need in the medium to long term. There are challenges we face today. The suicide epidemic is still taking place. We have children who are still choosing to take that avenue or seeing that as the only way out.

I'm going to switch. Hopefully, my colleague from Timmins—James Bay will follow up on that.

Thank you for your time.

**The Chair:** The next question is from Don Rusnak.

● (1615)

**Mr. Don Rusnak (Thunder Bay—Rainy River, Lib.):** I've worked a little bit in health in northern Manitoba. I forget the year, but if you know the “64 agreement” through which there was a divvying up.... We often called it “doctors in the middle of the north with a bottle of rye deciding who was going to do what for which community”. Some communities, Norway House, for example, had a federal hospital. I don't know if it still has a federal hospital. The provincial nursing stations were providing care for communities like Easterville. That was many years ago, so my memory fails me. It was an agreement that probably worked at the time but perhaps doesn't work today. I don't know the status of the agreement. I was with Manitoba Health at the time and was in discussions with Health Canada and the provincial government and the first nations to come up with something better. I know that's what needs to happen across the country. There are successful models that work and that provide good care and continuous care for people in first nations communities and indigenous communities across the country.

I'm going to shift a little bit, because I want to clarify a remark my friend Mr. Angus made when he asked you a question about the fund set up by the previous government regarding Jordan's principle. You started to answer the question by saying that the fund was no longer there, and that it was removed as a result of deficit cutbacks. What year was that in?

**Mr. Sony Perron:** That was in 2012.

**Mr. Don Rusnak:** Okay, so it was put in by the previous government and cut by the previous government. I just want to make that clear, because I like the facts, and I think the facts are important.

**Mr. Sony Perron:** I think the fund was created in 2008, but it was cut in 2012.

**Mr. Don Rusnak:** I'm going to switch gears again on you, and I know I have only five minutes. The Auditor General's 2015 audit found that only one in forty-five nurses examined had completed all five of Health Canada's mandatory training courses. The audit recommended that Canada should ensure that its nurses working in remote first nations communities successfully complete the mandatory training courses as specified by the department.

In its response to the recommendation, Health Canada notes that significant vacancies and turnover rates for nurses had made it a challenge to meet the training course requirements.

Why are the mandatory training courses not provided prior to the assignment of nurses to first nations communities?

**Mr. Sony Perron:** That's an excellent question. Since the OAG report we have made some progress. Leila can give you some progress for each of the courses. These are the five mandatory courses that were identified by Health Canada in order to make sure that we prepare the nurses properly for the work they will have to perform in a remote and isolated community. The plan is to train nurses when they come in, and this is what we do. Before we send nurses into the field, there is a week or two of intensive training—onboarding—to prepare them for the work to make sure that they meet the mandatory requirements. One of the challenges, and it's related to the vacancies, is the renewal of the training. After two years the nurse needs to go through the training for recertification. When we were facing a certain level of vacancy in some areas—and we still are—it was difficult to take a nurse out from where there's a need for nurses and send them for two weeks of training at a time. This is where we got behind in terms of training. Our vacancy rate in the last two years went from around 35% down to 16% now, so we have made some progress. All these nurses coming in need to be trained. Whether they work part-time or full-time, they are trained the same way.

Maybe, Leila, you can give us some results in terms of training compliance for each of the programs.

**Ms. Leila Gillis:** Sure. We have five mandatory courses that are identified, and they are provided as part of the on-boarding program. It is the recertification that affects statistics in that regard. We have improved the rates to 55% of all nurses who are working in the field. Our goal by the end of this fiscal year is still 100%. That is the goal that we have set for our employees. I don't know if you wanted specifics, but the courses are advanced cardiac life support, pediatric advanced life support, international trauma life support, handling controlled drugs and substances, and immunization. It's the combination of all of those being active certifications that we are monitoring with all employees.

● (1620)

**The Chair:** The next question is from Kevin Sorenson, please.

**Hon. Kevin Sorenson (Battle River—Crowfoot, CPC):** I'm not a regular on this committee, but I certainly appreciated your testimony today. I'm a member of Parliament from Alberta. Right now, obviously, we are watching our north very closely. In Alberta, we're watching the Fort McMurray area. We've talked about emergencies in Attawapiskat. That's obviously a massive issue and emergency that we need to deal with—and also at La Loche.

I'm just wondering how Health Canada is involved in the evacuation, if they are. In previous years, when there were fires at La Ronge in northern Saskatchewan, I was at an evacuation site in Saskatoon and I was impressed by the way it was set up. I think it was Health Canada that was there, diagnosing and looking at people, especially aboriginal and first nations people, making certain they were in good health and checking for other health issues as well.

Are you involved in this Alberta evacuation?

**Mr. Sony Perron:** We are working on this with partners, including first nations. This is a tragic situation, and we have a responsibility in that context. As soon as first nations living on reserves are impacted, we have a role. I mentioned initially that we have a role in terms of providing health benefit services, health protection services, and nursing services. Our team in the Alberta region have been working with Alberta Health and the emergency authorities to try to organize services. We have provided some surge capacity to our regional office with additional nurses. We have reached out to other regions to bring additional environmental health officers. We have also organized services for people who have to move from their place of living. For example, when you leave your community to go into a different place, you may have left your medications behind, so Scott's team have issued communications to pharmacists, to clients, to facilitate them in refilling their drugs. We have sent more staff there. So in various fashions we are working with first nations. We are working provincial and federal partners to respond and support first nations communities that are affected by this.

The environmental health issue is a challenge, so we will have our HO inspecting if there are concerns for first nations to make sure that their place of living is safe. We are doing these things.

There was one thing I wanted mention, and it's just slipped out of my mind. It was very important.

Sorry, it was about Fort McMurray. Several first nation communities get their services from Fort McMurray. Community members leave their communities to go to Fort McMurray to see a doctor, to go to the hospital, to get the needed services. One thing we did in the first few hours of this crisis was to start working with all these first nation communities to redirect clients toward other points of service. Therefore, they will still be able to see a physician, they will still get access to care, but not in Fort McMurray. Because we manage medical transportation, there were some logistics involved. But this was probably one of the first tasks that our Alberta regional office started to work on, to redirect clients toward other points of service.

**Hon. Kevin Sorenson:** Mr. Rusnak asked part of my question, because the Auditor General's report in 2015 did speak of the need for nurses. My wife's a nurse, my daughter's a nurse, and we know the good work they do.

He also mentioned one fund that was cut in 2012 by the former government, but the estimates show there was a 5% increase in funding even through those years.

**Mr. Sony Perron:** The 5% increase is for the non-insured health benefits program, which is for drugs, dental care, medical supplies, vision care, etc. There's a 5% escalator in that budget of around $1 billion. However, some programs have no escalator. This one has a 5% escalator—

**Hon. Kevin Sorenson:** Some programs, as they are deemed not needed, may be cut or they may be held at the same level. For other programs, there is an increase in funding. Is that correct?

**Mr. Sony Perron:** Exactly.

**Hon. Kevin Sorenson:** We all like those facts laid out. We like them all on the table.

Could you also give us the current proportion of Health Canada nurses who have completed the mandatory training courses. Is it back where it should be?

● (1625)

**Ms. Leila Gillis:** As I indicated 55% of all the nurses have met the mandatory requirements—and our goal is 100%.

**Hon. Kevin Sorenson:** Do you have a timeline to get it to 100%?

**Ms. Leila Gillis:** Our goal is by the end of this fiscal year.

**The Chair:** Thank you. That'll be good. We appreciate that.

The final questioner we have time for is Mike Bossio, please.

**Mr. Mike Bossio (Hastings—Lennox and Addington, Lib.):** Thank you all once again for being here today and providing this very valuable information. As Charlie said, we have so many questions.

What per cent of Health Canada employees are indigenous?

**Mr. Sony Perron:** This is an interesting question.

I cannot answer for Health Canada as a whole, but in our branch there are 2,400 employees across the country. I think our rate is around 26%. We have an objective to reach around 30% in the next four years.

**Mr. Mike Bossio:** What about in the executive branch of your department?

**Mr. Sony Perron:** I don't have that ratio. We have an aboriginal management development program to increase the number of indigenous people in the executive level.

**Mr. Mike Bossio:** What per cent of nurses and doctors are of indigenous backgrounds?

**Ms. Leila Gillis:** Currently 24% of nurses self-identify as indigenous.

**Mr. Mike Bossio:** I assume that resources are dedicated very specifically toward recruiting and training indigenous nurses to work in their communities?

**Mr. Keith Conn:** To supplement Mr. Perron's response on your question about the executives, I know there are five senior indigenous executives in the branch.

**Mr. Mike Bossio:** Of how many?

**Mr. Keith Conn:** About 20.

**Mr. Mike Bossio:** Is there a program dedicated to recruitment and training of indigenous nurses and health staff?

**Ms. Leila Gillis:** It is not as specific, as we will take any and all nurses within the organization. It's very broad recruitment and retention. We do work with the Aboriginal Nurses Association of Canada in the promotion of indigenous individuals entering nursing, regardless of the employers.

**Mr. Mike Bossio:** From an educational standpoint, is there any specific program trying to steer indigenous youth to either health programs or skilled trades on the health side?

**Mr. Sony Perron:** There are a number of specialized programs, but in the health sector several universities or colleges have identified this as one of the segments of the population they want to bring in. We have a program, the aboriginal health human resources initiative, that provides $3 million a year in bursaries through the Indspire Foundation.

**Mr. Mike Bossio:** Part of the problem with that is the fact that you take them out of their communities and they become integrated into other communities or they don't go back.

Given the technology that's available today to deliver programs online, are there online programs that can be utilized to train nurses? Yes, you need to bring them to the centres to do practicums, but most of the training can occur within their own communities today.

**Mr. Sony Perron:** Even for the mandatory training that my colleague Leila was talking about, we have to bring them out to do the practice side. Nursing is a practice-oriented learning process. Technology can be used for some theory, but it's usually done in the universities and colleges.

We are using telehealth for training, but it's more like specific time-limited training activities to update their skills on some subject —

**Mr. Mike Bossio:** Given where things are today with MOOCs and other online courses, there are certainly more options. I think we need to start thinking outside the box in order to start trying to deliver programs that will get indigenous people trained.

How is the funding for health determined in communities? Is it by need per capita, by comparison to provincial standards? How is that derived?

**Mr. Sony Perron:** Most communities have a community health plan, and they have been funded to develop those plans. The basic factor is population size, and there is an adjustment for remoteness. There is an adjustment depending on the type of program, whether they are delivering it themselves or whether it's delivered by Health Canada.

Each case is unique. There was a formula developed years ago that takes into account population size and location, but over time we have added programs based on capacity and—

● (1630)

**Mr. Mike Bossio:** I'm sorry, but I have just one more question that I need to ask. You mentioned that the Inuit in Northwest Territories and B.C. have now started to take greater control—self determination, self government—over health delivery. Have you compared the results of these efforts with those of non-indigenous communities, and with other indigenous communities that don't have that self-determination?

**Mr. Sony Perron:** It's too early in B.C. to measure the health outcome, because the transfer occurred in 2013, operationally. However, we have seen evidence from self-governing arrangements in other parts of the country where increased control has led to better results.

**Mr. Mike Bossio:** Thank you. I apologize for cutting you off so much, but I only had a small window.

**The Chair:** My thanks to Messrs. Doidge, Conn, Perron, and Wong, as well as Ms. Gillis for your time and your words today.

We know the work you do is very hard and that you work very hard to get it done.

We're going to take a short break and then we'll reconvene in about two minutes. Thanks.

[*Proceedings continue in camera*]