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Chair

The Honourable MaryAnn Mihychuk

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● (1530)

[*English*]

The Chair (Hon. MaryAnn Mihychuk (Kildonan—St. Paul, Lib.)): Welcome, everybody, to the indigenous and northern affairs committee of the 42nd Parliament, first session. Today is meeting number 109, and pursuant to Standing Order 108(2), we're in the study of long-term care on reserve.

Before we get started we always recognize that we're on the unceded territory of the Algonquin people here in Ottawa. It's an important step for us to reflect on that even if it's momentary, as we're in a process of understanding the truth and moving towards reconciliation.

The committee is thrilled to have you. You're at the beginning of a new study on long-term care. We hope it's a short study and very effective on long-term care, which we need in many communities. We will be receiving presentations. You have 10 minutes to present, after which we'll go through questions from the members of Parliament, and that will conclude this session. After that, I understand there's the will to have an in camera session on committee business. That's what we're doing at this meeting.

We'll get started with the Department of Indian Affairs and Northern Development. That's a bit confusing, isn't it? Are you the Department of Indigenous Services? They're nodding yes, but you're not officially a separated department until the bill comes. Is that why we have this issue?

Mr. Keith Conn (Acting Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Indian Affairs and Northern Development): I think so, yes. It's a technicality.

The Chair: Welcome, and I'll turn it over to you, Keith. Do you want to lead us through?

Mr. Keith Conn: Thank you, Madam Chair. Good afternoon.

Thank you for the opportunity to appear before the committee regarding long-term care on reserves. It's obviously an important subject for all communities, Canadians and indigenous peoples alike, in terms of the need for long-term care.

Obviously, elders or seniors are an important aspect in indigenous cultures in terms of knowledge keepers. They also play an integral role in terms of the vitality and well-being of communities writ large, as part of families, in guiding young people and young families, and for the strength of communities and nations. Indigenous peoples turn to their elders as key sources of traditional knowledge, wisdom, and cultural continuity.

I've been told quite clearly, in my travels and in other business meetings with communities and leadership, that first nations individuals and families want to be able to live at home as long as possible, and if and when they require additional supports, to stay in their own communities close to their loved ones. We've heard this time and time again as a common thematic message.

Many first nations individuals, of course, who are no longer able to live at home safely due to complex illnesses or disabilities, must leave their communities to access appropriate housing and care. For those who were previously forced to leave their communities to attend residential schools, in some instances this can be a re-traumatizing experience. That's something we need to think about.

In terms of needs for services, it's important for all of us to keep in mind that the demand for long-term care facility beds is affected by both the number of seniors in a population as well as their overall health status. While the percentage of the on-reserve first nations population over 65 is relatively small, it is growing quickly. By 2016 the proportion had risen to about 28,000 individuals. According to projections, the number of seniors could be more than double by 2036, to almost 75,000 first nations seniors on reserve likely requiring some level of support in terms of housing or assisted living, home and community care, and/or long-term care.

In addition to the increasing numbers of first nations seniors, it is important for us to consider the nature and complexity of the health conditions they face. Compounding the rising size of first nations senior populations, as I mentioned, is the fact that first nations often have more chronic health conditions—as we've all heard, probably, in previous submissions—than non-first nations seniors. By age 60 approximately half of the first nations adults on reserve have been diagnosed with four or more chronic health conditions. My friend and colleague Robin will get into some of that detail.

Our short-term remarks this afternoon will provide you with an overview of the current existing services, along with the continuum of continuing care, the situation in terms of long-term care, and the future opportunities, including current policy development work being led by Indigenous Services Canada.

Before we get deeper into the subject matter, I'd like to clarify for the purpose of the presentation that we're looking at the term “long-term care” to mean “facility-based long-term care”, actually a structure or facility with a team of expertise. It's a term that is used differently across the country, as we can imagine you'll probably hear from different jurisdictions, and territories and provinces. However, we'll use the Canadian Healthcare Association's definition:

> Care is provided for people with complex health needs who are unable to remain at home or in a supportive living environment. Health service is typically delivered over an extended period of time to individuals with moderate to extensive functional deficits and/or chronic conditions.

That's the classical, Canadian Health Care Association's definition that's guiding some of our discussions.

The association itself uses the term “continuing care” to define a system comprised of four elements: home care, which is a big area of interest and investment from Indigenous Services Canada's perspective that we are currently in, and Robin could get into some of that detail; community support services; supportive and assisted living; and long-term facility-based care. Continuing care is a system, in our minds, of service delivery encompassing a range of health and social services that address the holistic health, social, and personal care needs of individuals who do not have or who have lost some capacity for self-care.

● (1535)

These integrated services are designed to improve individual functioning and to provide culturally sensitive support and care in the community where possible, through different stages of aging and illness, up to and including palliative and end-of-life care.

Also, for clarity, I think it's important that since the study is on long-term care on reserve, our response will be focused on needs and programs specific to first nations.

Now I will turn this over to my colleague, Nurse Robin Buckland, to provide you with a brief overview on the home and community care program and the assisted living program, which are two major instruments or initiatives that are funded in terms of first nations on reserve.

Robin.

Ms. Robin Buckland (Executive Director, Office of Primary Health Care, First Nations and Inuit Health Branch, Department of Indian Affairs and Northern Development): Great. Thank you, Keith. I'd like to thank the committee for the opportunity to come here to speak about long-term care. We're quite excited about the fact that the committee is studying this issue, so we are hoping that we are going to be helpful in the remarks that we offer today.

I'll jump right into our home and community care program.

The first nations and Inuit home and community care program was launched in 1999. It's delivered in first nation and Inuit communities right across the country. In terms of first nation communities, it's actually available in 96% of the communities. The services are delivered based on a needs assessment that is done, and there's a range of services that are offered through the home care program to help people who are living with acute, chronic, and complex health issues, so that they can remain in their homes.

The program has a number of key elements that must be delivered in the communities. It's delivered predominantly by RNs, licenced practical nurses, and home health workers. In 2013-14, over two million hours of service were provided to approximately 35,000 clients across 686 first nation and Inuit communities.

While the home care program is to be universal and accessible, there are gaps. The gaps include only being available from Monday to Friday from 9:00 to 5:00. You can imagine a senior living at home requiring services. They might need something after 5:00 at night. That is certainly a demand and a gap.

Like provincial programs, the home and community care program does place limits on the amount of service and the number of hours that are provided to clients. Another gap that we saw prior to budget 2017 was in terms of what were previously called “allied services”, such as physiotherapy and occupational therapy. Typically, communities did not have funding to provide those services. Fortunately, with budget 2017, we saw an investment of $184.6 million over five years in the program. This is quite significant. Communities will work hard to use these dollars to increase the services that they're offering in their communities, increase the number of hours, and offer some of those additional services such as physiotherapy and palliative care.

Brenda is going to talk to us quickly about the assisted living program that she is responsible for.

● (1540)

Ms. Brenda Shestowsky (Senior Director, Social Policy and Programs Branch, Education and Social Development Programs and Partnerships Sector, Department of Indian Affairs and Northern Development): Thanks, Robin.

Thank you, committee members, for inviting me to provide comments here as well.

In addition to the services provided through the department's home and community care program, there are also services available through the assisted living program. These services fall within the range of non-medical supports, things such as housekeeping, homemaking, etc. This is a $110 million per year program that has three components: in-home care, adult foster care, and institutional care.

Eligible individuals may receive in-home care services—as I mentioned, light housekeeping, homemaking etc.—and other activities to help them maintain their functional independence within their home. In 2016-17 about 9,600 individuals benefited from the in-home care program component of the the assisted living program.

Adult foster care is a type of service that is also available. It provides supervision and care to individuals who are unable to live independently because of either physical or cognitive disabilities. These are individuals who do not require 24-hour continuous nursing or medical care. In 2016-17, 118 individuals participated in the adult foster care component of the assisted living program.

The institutional care component of the program helps to subsidize the facility copayment fees related to room and board for those within an institutional environment, long-term care facility, or personal care home, either on or off reserve. In 2016-17, some 830 individuals benefited from the institutional care component of this program.

It's important to note that this program really functions like an income support program, in that it is available to those individuals who cannot pay for institutional care or in-home care supports themselves. It very much mirrors what provinces and territories do with respect to in-home care and institutional services.

As well as not having the financial means, individuals must also not have any available family members who can provide the service to them. It's thus very limited in the scope of its application.

Robin.

Ms. Robin Buckland: Recognizing the time, I will just very quickly speak about some work that we're doing in long-term care.

We're currently exploring the issue of long-term care as well. With the home care program and the assisted living program we cover a number of things, but long-term care has been identified as a gap. We too are therefore going to be looking at it and considering what the potential policy options could be.

The Chair: Good. Thank you.

Questioning first moves to MP Will Amos.

Mr. William Amos (Pontiac, Lib.): Thank you to our hard-working civil servants who come before us today to introduce what is for many but not all of us a new topic, and not something that we all know a lot about. I represent indigenous communities and I must confess that I don't know what the nature of long-term care is in, for example, the community of Kitigan Zibi. It makes me reflect also upon the nature of local consultations that I need to have in relation to this study.

Could you spend a bit of time describing for us the variability of the various long-term care services? You've gone into a couple of areas. I think most of us would expect that it can vary significantly community by community. I don't have a sense of how the variation occurs. For a community of 300 people it might look one way. For a community of 1,000 or 1,500, it might look another way.

If you could flesh that out a bit, I'd appreciate it.

● (1545)

Ms. Robin Buckland: Sure. Thanks for the question.

Long-term care is a new issue for us at ISC to be looking at. We probably will not have all the answers. We're just exploring long-term care ourselves. Recognizing that this is a gap in the services available to first nations on reserve, we're beginning to explore the issue as well.

What I might say, and I suspect some of the committee members may know this, is that long-term care varies quite significantly right across the country. It's not an insured service under the Canada Health Act, so provinces deliver it in different ways in different provinces. Even within provinces there are variations.

When it comes to long-term care facilities on reserve, we have—and this is more the purview of Brenda—very few facilities. I think the number of facilities across the country is....

Ms. Brenda Shestowsky: There are 29 facilities across the country that actually receive funding through the assisted living program, but there are many more facilities that are own-sourced through first nation communities themselves. I believe there is a total of 53 that we are aware of, and there are more and more demands for development of communities on the reserves.

Mr. William Amos: What is the perspective of indigenous services, of the department, around the federal government's jurisdiction and role in the provision of long-term services? Is it debated? To the extent that there are debates, where are those discussion points or debate points to be found?

Mr. Keith Conn: Recently I've been fortunate enough to participate in a tripartite discussion with the Chiefs of Ontario, with leadership from across the province of Ontario, and the Ministry of Health and Long-Term Care to develop some ideas and options around partnering and the monetization of long-term care facilities.

As we know, for example, in Ontario they are responsible for the licensing of long-term care bed spaces and the operations of the facilities, but they are not there for the capitalization process. I wouldn't call it a debate but more of a spirit of co-operation to look at various strategies and options. In Ontario, for example, there are 30,000 people on waiting lists in the province alone. A chunk of that is probably related to first nations looking for long-term care spaces.

In other jurisdictions I'm not aware of any debate. It rests, in my mind, largely on the provincial or territorial government's mandate for the administration of long-term care facilities.

In some cases there has been some modelling and partnership development and co-funding facilities. I could say that we have some research in that area, but I wouldn't necessarily categorize it as a debate. It's just where we can partner, where we can collaborate, which is part of the energy I'm sensing in British Columbia, Nova Scotia, and Ontario. Other jurisdictions may vary.

Mr. William Amos: When I speak to Chief Jean Guy Whiteduck, in Kitigan Zibi, he regularly comments to me that what he and his community are really hoping for is a much greater degree of autonomy in terms of lump sum transfers over to this community so that programming, whether it's health or education, policing, what have you, can be taken care of by them without getting the okay from the department. Is that same kind of discussion going to repeat itself if the federal government engages and takes a hard look at long-term care?

Is this something that should be community-driven as opposed to department-driven?

Mr. Keith Conn: That's a great question. The larger discussion on new fiscal relationships with indigenous communities, first nation communities across the country is opportune in terms of looking, for example, at a 10-year grant in terms of a funding relationship. The grant would provide a certain level of flexibility, I must say, in terms of planning, monetization of partnerships with the private sector or the province around looking at the facility needs that the community would define as a priority.

I think we are at the early days of that discussion, but we're certainly looking forward to our target, as was publicly announced, to have at least 100 recipients in a grant-like arrangement for a 10-year period. That would definitely look at responding to community needs based on what their priorities are as defined by the community and the leadership.

Optimistically I could say that this creates a window to actually do some innovation in terms of partnership development or securing funding from other sources that could build actual infrastructure. We're limited at this time. We have a policy constraint, as we speak. We will also, of course, work with what we have in terms of capital funding for health facilities, nursing stations, treatment facilities, etc.

● (1550)

The Chair: Thank you.

Mr. Keith Conn: There's a large need.

The Chair: Questioning now goes to Cathy McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

I was surprised to hear that 50 long-term care facilities have been established. I'm wondering whether you could provide to our analysts a couple of the names, because I think that to hear from them directly would be important to understanding what their challenges and opportunities are. That would be, I think, a great help.

Ms. Brenda Shestowsky: Definitely we can provide that information.

Mrs. Cathy McLeod: Thank you.

Having lived and worked in rural communities, I have witnessed the difficulties of people in their last years—husbands and wives being separated as one has to go to a home and the other has to manage that. I can remember one gentleman taking a train once a week to visit his wife of 50-some years. It is really difficult, because often of distance.

I think a lot of effort was put into adaptation of the home to keep people home as long as possible. What kind of budget is distributed to communities to support such things as wheelchair ramps and bars? Do you have formal programs and processes in place to support that work in communities?

Ms. Brenda Shestowsky: Some of the funding comes through other areas within the department. Infrastructure programming makes available some funding for home renovation.

Within the assisted living program itself, what we provide funding for is related to the services that individuals can access, such as homemaking services, etc. There really is no renovation portion of the program.

Through the non-insured health benefit program there are also supports that can be accessed. Wheelchairs, for example, and other devices can be made available to support individuals' independence.

Mrs. Cathy McLeod: If someone's mother is coming home and is now wheelchair-bound, how are they going to get the wheelchair ramp or get the bars in? The band office may or may not have the funding to do those things.

Mr. Keith Conn: The individuals who are wheelchair-bound would be provided a discharge plan for accessing appropriate equipment and supplies.

Ramp access is usually left to the local government, to determine how it can address accessibility to the home. Ramps are usually built with band funds in the community. When there's a shortage of band funds, then a request is provided to the first nations infrastructure fund plan at Indigenous Services Canada to support some of that work.

Mrs. Cathy McLeod: If, for example, someone has to relocate outside the community into a provincially licensed facility, to what degree does your branch cover the costs of that program?

● (1555)

Mr. Keith Conn: We do not cover costs for relocation.

Mrs. Cathy McLeod: I don't mean relocation, but if they were moved into, let's say, a home outside their community....

Mr. Keith Conn: We would cover that under our medical transportation framework for costs of transportation.

Mrs. Cathy McLeod: Do you cover it at the same level, typically, across the country as the provinces and territories?

Mr. Keith Conn: I couldn't answer that question clearly in terms of comparability with what the provinces and territories do. I didn't realize the provinces and territories paid for transportation.

Mrs. Cathy McLeod: No, I wasn't talking about transportation, but the actual cost of living in a long-term care facility. It's however many hundred dollars a month.

Mr. Keith Conn: Those rates and costs per bed would vary from jurisdiction to jurisdiction.

Mrs. Cathy McLeod: But if the person cannot cover it themselves, does your branch cover the going rate in each province?

Mr. Keith Conn: Brenda, can you take a stab at that?

Ms. Brenda Shestowsky: Yes, I can jump in on that one.

If an on-reserve resident is moved or has to relocate to access a long-term care facility or chronic care facility off reserve, then yes, our program, the assisted living program, would cover the costs for the living expenses of the individual as well as the cost of care, except for specialized nursing and medical care. That is the cost that would be borne by the provincial government.

Mrs. Cathy McLeod: I know that typically a good support for many is having an adult day program through which a number of people gather. Do you have many of those sorts of programs, or do the communities have those sorts of programs operating?

Again, if you can think of some good examples of communities that run a solid day program in their communities, it would be good to have names for possible witnesses.

Ms. Brenda Shestowsky: We can certainly look to identify whether there are communities that run such programs. The participation of individuals at day care programs is certainly an eligible expense under the assisted living program. Whether it be on or off reserve, those individuals can access such programming.

Mrs. Cathy McLeod: You talked about the $184 million new dollars. How is that money being distributed?

Ms. Robin Buckland: As I mentioned, there's a different breakdown, over the next five years, in terms of those monies. A portion will be going to palliative care. Most of it will be going just to further enhancements in the home and community care program. The services I mentioned that we don't normally have the funds to cover, such as the allied health services, will be part of the additional investment.

Mrs. Cathy McLeod: Let's say you were Tk'emlups, which already has a program. Are they just looking at a certain jump to the base, and is that going to be consistent across the country as a jump to the base rate of what they're getting?

Ms. Robin Buckland: Yes, exactly.

Mrs. Cathy McLeod: What percentage does it work out to be?

Ms. Robin Buckland: I don't have the percentage in front of me, but I think it's a significant investment. Our budget had been $90 million a year. The $185 million is an additional investment over five years. It's a significant investment that's going to be divided across communities.

Mrs. Cathy McLeod: It might, then, be 5% by the time you split it into per-year...?

Ms. Robin Buckland: Yes.

The Chair: The questioning now moves to MP Romeo Saganash.

Mr. Romeo Saganash (Abitibi—Baie-James—Nunavik—Eeyou, NDP): Thank you, Madam Chair.

It's a great pleasure to be back to this committee, however briefly.

The Chair: We miss you already.

Mr. Romeo Saganash: Welcome to our guests this afternoon. There are a couple of questions I would like to ask you.

One thing you say in your presentation, at page 10, is:

> Currently, the department of Indigenous Services Canada does not have the program authority to deliver long-term facility-based care services. The department recognizes that long-term care is a gap for First Nations on reserve.

I'm glad you recognized that, because many of us also have observed it over the years.

Given the fact that the percentage of population of indigenous people living on reserve who are over 65 is quickly growing—I think those are the words you used—to close that gap, is the department considering extending Jordan's principle to senior indigenous citizens?

● (1600)

Ms. Robin Buckland: Thank you for that question.

Jordan's principle definitely applies to first nations children living on or off reserve. We've worked quite hard, as I'm sure you're aware, to increase access for children to services and to fill gaps when we see gaps.

For the time being, Jordan's principle applies to kids, but I think we can think of it in a similar way, in terms of there being a gap and our wanting to close the gap. We're working very hard to improve the outcomes, for example, for first nations seniors living on reserve, so that health outcomes are similar to those for other Canadians.

In my mind, Jordan's principle is a useful way of looking at it—let's look to fill the gaps and reduce the gaps—but Jordan's principle per se applies to kids. We are, however, definitely working hard to look at the issue and to figure out what the potential solutions could be so that we can close the gap.

Mr. Romeo Saganash: One of the important considerations for these types of services relates to rural and remote communities. Services there are lacking, definitely. Is there a plan to that effect as well?

I'll give you an example. The nutrition north program applies to communities that are isolated and not accessible by road. That program specifically applied to those communities. Are we thinking along the same lines in terms of the services you're talking about?

Mr. Keith Conn: I'll take a crack at that. Thank you for the question.

From my experience in listening and working with a number of communities across the country around the issue of long-term seniors care, I think it's safe to say, and a number of them have also said, that depending on the size of the communities and the location, it's not feasible to have a long-term care facility in each and every community, obviously. Where there is critical mass, it might make sense.

For example, in Ontario—and I hate to use Ontario as an example continually, but it's my experience—Wikwemikong is a large community on Manitoulin Island. Also, Six Nations obviously has a sizeable population. Oneida has a really wonderful facility, with both indigenous and non-indigenous patients, as does Akwesasne, of course. They have the critical mass to have the business case to have a facility in those communities. There might be others.

From what I'm gathering, people want to look at different options and modalities—a hub and spoke model, for example.

Think of Sioux Lookout, for example. There is a high population of northern indigenous Oji-Cree community members in and out of Sioux Lookout, or living there. At least they would have more accessibility if they had a long-term care facility, which is what they're promoting right now. The Town of Sioux Lookout, the Sioux Lookout First Nations Health Authority, and a number of the chiefs have been looking at a model that could serve northwestern Ontario.

I think it will have to be nimble and will have to be innovative in terms of different approaches for rural and remote communities. It's the issue of accessibility, however. We have many fly-in communities and not everybody can afford the air flight.

Mr. Romeo Saganash: I asked the question because when you spoke about the gap that needs to be filled, you mentioned in your presentation some of the barriers that exist. What are you doing to address those barriers at the moment? That's why I used the word "plan".

Ms. Robin Buckland: What are we doing to address the barriers? Probably the first thing I'd like to say is that one thing we're trying to do in terms of the continuum of care is to make sure that we're investing to allow community members to stay in their homes as long as they can and as long as they want to—in their homes and their communities—but in instances when that is no longer possible, we're trying to make it a little bit closer to home.

Through the work we're going to be doing looking at long-term care over the next couple of months ourselves, we're hoping to be able to better articulate what the barriers are, and with our partners and community members, identify what the solutions are. That's the approach we're taking: trying to find out from community members what the issues are—some of them are known and some of them we may not know—and then identify the best solutions to meet them.

My hope is that over the next couple of months we'll be able to better answer that question and better determine, with our partners and with first nations, how to address these issues.

● (1605)

The Chair: Questioning now moves to MP Gary Anandasangaree.

Mr. Gary Anandasangaree (Scarborough—Rouge Park, Lib.): I'll defer to MP Harvey.

The Chair: We will switch up and move to Mr. T. J. Harvey.

Mr. T.J. Harvey (Tobique—Mactaquac, Lib.): Thank you, Madam Chair.

Thank you, witnesses, for being here.

I want to start with talking a bit about this idea of institutional care in terms of level 3 or level 4 long-term care. What has been the determined threshold for the size of a community, numbers wise, that it would take to sustain a facility like that?

Normally, I know in New Brunswick, which is where I'm from, you need to have a population centre of 4,000 to 5,000 people with an outlying population to support a facility of that size. What is that number that you think will work, and then how does that look? Is it a combined facility that takes into account assisted living and then level 3 care and level 4 care as a total overarching approach to end-of-life care, or is it different conceptual models that will work within a community or group of communities? How do you see that?

I'm really concerned about the viability of building facilities. It's great if communities can afford to build the facilities on their own. I know there are some communities that have chosen to do so, but just because they've chosen to do so doesn't mean it's necessarily a viable option. Of course, in New Brunswick, we have the exact opposite problem. Except for indigenous communities, we have a declining population. We're building for the top of the bell curve knowing full well that 15 to 20 years from now, the older of our long-term care facilities are actually going to be decommissioned or turned into something else because we just won't have the population we need to sustain them. Could you just speak on that?

Mr. Keith Conn: I'll do a quick thing, and then Robin can do it. That's very interesting.

The viability in my humble estimation.... For example, the long-term care facility in Oneida in southwestern Ontario has a mixed model, i.e., it is long-term care living, assisted living, and level 3 and 4 institutional care. They have a mixed portfolio, if you will use that term, to make it viable and sustainable.

I think the same principle applies to the other facilities I mentioned earlier. It's mixed. It's not all level 3 or 4. That just doesn't make sense for that population locally, but there is also a catchment area that they're trying to serve. Obviously they'll need to look at the diverse needs within that catchment area to make it viable and sustainable, and it has worked obviously for a number of years. But again, those are exceptional, high-population communities. I think we need to look at some variations in approaches for sure.

Robin.

Ms. Robin Buckland: I don't think I have a lot to add to that. I think that it really makes sense. Certainly we've heard from some first nation communities who are thinking about the opportunities in building long-term care facilities where they're not just serving first nations. So there's a business opportunity too for first nation communities. I think that the models are from A to Z. I think we can look at the possibilities. Again, the most important thing is first nations determining what's best to meet their community's needs. I think there are lots of opportunities.

Ms. Brenda Shestowsky: Yes, I would agree with that. I think we have seen already a number of different models across the country ranging from those that are really built on a business model where communities serve off-reserve populations as well, and mainstream populations, so I think there are different models. As my colleagues have said, it really depends on the communities and how they see their populations projecting out and growing and what their needs are.

● (1610)

Mr. T.J. Harvey: I wanted to touch on something quickly that MP McLeod had mentioned earlier around accessibility and the idea of keeping people in their homes as long as they so choose.

I know my family had that opportunity. My grandmother wished to stay in her own home as long as possible, and she was able to do that for about five additional years by making a few simple upgrades to her home. One thing that we've talked a lot about in this committee is housing on reserve and how we should be building housing on reserve with accessibility in mind, so at the very least a minimum of visitable housing. This is the idea that every home that's constructed meets the criteria to have zero-barrier access, wider doorways and hallways, and a ground level washroom facility so that we can plan for the future and allow people to stay in their homes.

I'm wondering if that's something you feel should be taken into consideration and how that could be approached with the communities looking to build housing, because we know that there is a significant need within a lot of communities to build new housing. Maybe it's something that should be suggested or thought about in terms of the long term.

Mr. Keith Conn: That's a really great question, because first nation leaders, through various fora, discussion documents, and resolutions have called for affordable safe housing for seniors and the elderly in communities, and on those very points of accessibility and non-barrier homes, etc. Communities have taken initiatives as well in terms of developing seniors' complexes or elders' homes. They have all kinds of terminology for it, but it's exactly that.

I think it's certainly something that we should be looking at in terms of a larger, holistic approach to housing. It's not just about long-term care. It's about adequate and safe affordable housing for seniors. This has come to us directly from communities in terms of the need to look at that.

Mr. T.J. Harvey: Even from a non-indigenous standpoint it's something that just makes common sense. One of my best friends is a C5 quadriplegic. You would never know that he was in a wheelchair unless you met him. His home has been constructed in such a way that there's zero-barrier access.

The point is that if we construct homes the right way at the point of construction, there is no significant cost but the long-term benefit to those communities is immeasurable because it's going to allow so much more flexibility.

Mr. Keith Conn: Exactly.

Mr. T.J. Harvey: That's it.

The Chair: The questioning now moves to MP Viersen.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Madam Chair, and thank you to our guests for being here today.

On assisted suicide, that was one of the first bills we worked on when I got here. Do you keep any records as to how that's affecting our first nation communities?

Ms. Robin Buckland: That's a tough question. In terms of medical assistance in dying, certainly it's quite obviously a delicate question.

From a home care perspective—recognizing that it's the area I'm most directly responsible for—the way we have been looking at it within that program is in terms of the importance of making sure we have good investments in palliative care and end-of-life care prior to having the discussion about medical assistance in dying.

I guess I don't have an answer for you, other than to say it's a question that we need to explore further and talk about with our partners.

Mr. Keith Conn: In all my privileged travels in this country, I have not heard of any requests for or intervention in supporting an individual in community for medical assistance in dying. I'm not aware of any particular requests. If I had, it would certainly be out there, to be honest. It would be like, “Pardon me...?”

● (1615)

Mr. Arnold Viersen: Yes, because we've heard that....

Mr. Keith Conn: Palliative care is the way. We've been directed by the communities that we need a strong palliative care program for dying with dignity in the community, with family.

Mr. Arnold Viersen: I'm glad to hear that.

You were mentioning that there are several on-reserve facilities already. How does a community go about acquiring the necessary funds to start one of these? I have 14 first nations, and I know that a number of them.... One is 200 kilometres from any major centre and they've been petitioning the province in particular to help them build a facility. Are there funds available through one of your streams?

Mr. Keith Conn: Do you want to take a stab at that, Robin?

Ms. Robin Buckland: No, you go ahead.

Mr. Keith Conn: Okay. I'll start.

As we alluded to earlier, we have no policy program coverage for long-term care facility construction.

In most cases—perhaps Brenda can speak to it as well—communities have been resourceful in terms of own-source revenues, monetization from the private sector, or other streams of revenue—for example, from the First Nations Finance Authority. They've created the momentum, built the facilities, and then secured the operation and maintenance for running these long-term care facilities from the provinces or territories, generally speaking.

Brenda, I don't know if you have any details.

Ms. Brenda Shestowsky: No, not any more than that. I would say that most communities, as Keith said, are quite resourceful in seeking out contributions through the private sector. Some provincial governments are very interested, particularly right now, in partnering with communities to develop long-term care facilities, and the majority would use own-source revenue.

Mr. Arnold Viersen: If a first nation person is in a long-term care facility and you were off reserve, you fund that service...?

Ms. Brenda Shestowsky: We fund the copayment charge for the individual. There may still be a gap in the operating cost of the facility.

Mr. Arnold Viersen: Would that same funding be available to them if it were a facility on reserve?

Ms. Brenda Shestowsky: Yes.

Mr. Arnold Viersen: On the palliative care bit that you talked about earlier, we've seen palliative care initiatives coming through the House of Commons. How is that being rolled out through your organization?

Ms. Robin Buckland: I'll also respond to MP McLeod's question in terms of the dollars. I didn't offer much specificity, but I just found it within my notes. The budget for palliative care is $19.5 million over four years and, as I've said a couple of times, we very much want to work with our community partners to determine how the palliative care will roll out. Each region will work with our partnership tables to decide how they will implement palliative programs in their respective communities. It will differ across regions.

Mr. Arnold Viersen: How much time do I have left?

The Chair: You have about a minute and a half.... Oh, I'm sorry. The clerk has reminded me that you only get five minutes.

Mr. Arnold Viersen: Thank you for the extra 33 seconds, then.

The Chair: I like to be generous, especially with you.

MP Dan Vandal.

Mr. Dan Vandal (Saint Boniface—Saint Vital, Lib.): Thank you for your presentation.

I want to go back to the issue of facilities. You mentioned that 29 facilities received funding. I believe it was Robin who said that, or was it Brenda?

Ms. Brenda Shestowsky: Yes, 29 facilities have received it.

Mr. Dan Vandal: Also, 53 facilities were own-source facilities. Are the 29 part of the 53, or did I make a mistake?

Ms. Brenda Shestowsky: There are 29 facilities that currently have residents in them that receive funding through the assisted living program. There is another—

Mr. Dan Vandal: Is it the individuals who receive funding or is it the facility?

Ms. Brenda Shestowsky: If the client is resident off reserve, the funding goes to the facilities sometimes, and sometimes it will go to the individual. It depends on the relationship that the community has established with the off-reserve community. For the on-reserve communities, the funding would go directly to the band for them to take care of those individuals in the facility.

● (1620)

Mr. Dan Vandal: Okay. You also mentioned own-source facilities. What is that?

Ms. Brenda Shestowsky: I would say that the majority of facilities have had the infrastructure developed through own-source revenues. The department has not funded the construction of the facilities. There are some facilities that have not sought out assisted-living funding. Some bands have developed facilities on reserve and have not sought out funding through the assisted living program to support those individuals.

Mr. Dan Vandal: Is my number accurate? I heard you say 53.

Ms. Brenda Shestowsky: The total number...? We have 24 that have not asked for funding through the program and 29 that received funding.

Mr. Dan Vandal: For a total of 53?

Ms. Brenda Shestowsky: Yes.

Mr. Dan Vandal: In terms of geography, is there one province that has more facilities than others, or are they evenly distributed, which I doubt?

Ms. Brenda Shestowsky: No, they're not evenly distributed. There certainly are a fair number of them in Quebec, and in Yukon as well.

Mr. Dan Vandal: I'm from Winnipeg. How is Manitoba doing?

Ms. Brenda Shestowsky: Manitoba has 10 facilities on reserve.

Mr. Dan Vandal: Okay. I'll have more on that later.

On home care, I have experience with home care through my mother, who lived in an urban setting—she has since passed—where the workers came every day and went home at the end of the day. It was fairly simple and very valuable. How does it work on an isolated reserve?

Ms. Robin Buckland: As I mentioned, the band is funded through the contribution agreement. They set up their home and community care program. They hire the nurses and the home support workers. They manage the program.

The program was nicely designed. Certain things have to be seen. For example, the nurse needs to do an assessment of the individual and what their care needs are.

Mr. Dan Vandal: The individuals live in the community.

Ms. Robin Buckland: They could live in the community. They could visit the community. A recurring theme is that you'll see various models. In isolated communities it's much like nursing stations, with issues in terms of trying to recruit and retain nurses.

Generally speaking, the program is similar to what you would see or what you would have experienced with your mother.

Mr. Dan Vandal: Okay.

Your departments are not involved in the actual hiring of the workers. You contract with the bands and first nations across the country.

Mr. Keith Conn: Correct. Through contribution agreements, the communities and the leadership and the health department will determine how they manage and deliver the home care program. Ideally they're hiring local people. They're employing nurses who are part of the community, optimally.

Mr. Dan Vandal: Is that the same model for the facilities, or do the bands and the first nations operate the facilities themselves?

Ms. Brenda Shestowsky: They do.

Mr. Dan Vandal: Thank you.

The Chair: Questioning now moves to MP Kevin Waugh.

Mr. Kevin Waugh (Saskatoon—Grasswood, CPC): Thank you, Madam Chair.

Welcome to all.

To pick up on Mr. Vandal's questions, I've seen the gaps here. It's Monday through Friday, nine to five, with no night coverage, no weekends, and no holidays. Nine to five is nothing, but that's 5:01 p. m. till the next morning. We probably have no weekend service in a lot of these communities. We have no holiday service.

Ms. Robin Buckland: No, you're right. When the program was originally designed in 1999, we ran with a budget of $90 million every year—Keith will correct me if I'm wrong—until budget 2017. There was no increase. I think the branch worked really hard to find additional money to insert into the home care program. With budget 2017, we now have the additional resources, so communities will get that. Hopefully, there will be opportunities to extend services and provide the physiotherapy that wouldn't have been there previously.

Often what happens after hours in a remote and isolated community is that the senior citizen would need to visit the nursing station to receive care. If you're not mobile, sometimes that's challenging. For sure there have been significant gaps.

● (1625)

Mr. Kevin Waugh: I take it that's $36 million per year over the next four years. I've done the division.

Who decides where that goes?

Ms. Robin Buckland: Maybe Keith will expand on that.

It's a formula that's based on population size and the remoteness. That's how the funds are divided.

Mr. Keith Conn: Basically, yes. We work with our partners in each region and territory to look at the best way of allocating. It is a formula-driven process to ensure that there's some equity across the board. It's also to ensure that for the smaller communities, there's a base with at least one full-time home and community care nurse as opposed to half-time.

To go back to your earlier question, whilst nine to five sounds so black and white and so rigid, I don't think it's the reality in a number of communities. They might start at eight, end at four, or go into the evening, depending on the need. Robin can correct me on this, but I think another aspect that's important to note is that home care nurses work with the families. They work with the daughters and the sons and the aunties to help out on the basic administration of bandage replacements or what have you. It doesn't end at five, per se.

Again, the band determines, with their local health department, what the best regime is. They will adjust and be flexible. Nine to five sounds too “clinical”, or whatever the right word is. I don't think it's the reality in terms of what the communities want and need.

Generally, with the new investments you'll see a lot more mobility and flexibility in terms of design and hours. That's important to note.

Mr. Kevin Waugh: Thank you for that.

Who's responsible for the education? I just came up from Nunavut, and there are communities of 200 and 300 who can't speak a language other than their own. Who's in charge of training these people? We've often heard that language is a barrier, so it would be a big barrier in health. Who's in charge of the education aspect of training, not only for first nations but also Inuit, Métis, and other languages?

Ms. Robin Buckland: Who's responsible for the training of the people delivering the services in those communities?

Mr. Kevin Waugh: Yes. Let's say I want to be in Chesterfield Inlet, or heaven knows, with a population of 400.

Ms. Robin Buckland: With our home care program and with our regions, we have regional staff who would work to support the communities.

Mr. Kevin Waugh: When you say “regional”, can you clarify that?

Ms. Robin Buckland: Sure. Indigenous Services Canada has headquarters—that's us—here in Ottawa, and then there are regional offices. For example, in Manitoba it's in Winnipeg. Staff there are responsible for working with the bands and the communities that have been funded to deliver home care. They work with them to take care of the education that's required of the nurses, the ongoing education to make sure that they have the competencies they need to be able to deliver the services.

One thing Keith spoke about was the importance of hiring locally. Speaking to the language issue, you're more likely to be able to hire somebody who would speak the language that's spoken in the community if you hire locally. The region works with the band and the community to make sure that the individuals are trained.

● (1630)

Mr. Kevin Waugh: Okay.

The Chair: I need to move on with the questioning so that it's fair.

Questioning now goes to MP Anandasangaree.

Mr. Gary Anandasangaree: I'll give my time to MP Vandal.

The Chair: You're causing a lot of trouble on my sheet here.

Mr. Gary Anandasangaree: Dan, maybe they could finish answering that question first.

Mr. Dan Vandal: Yes, sure, if they need more time.

Mr. Keith Conn: To MP Waugh's comment on the challenge in the north in terms of the Inuit communities and of course Nunavut and the territorial governments, we've transferred all the resources and funding for home care. They partner with communities and the various service delivery organizations to ensure that they have a culturally competent workforce. That's their area of interest. I know they're doing a lot of progressive work there with lay people in the community who could be part of the home care team. It's not always just the home care nurse.

There are some interesting innovations happening there, and I just wanted to touch on that.

Mr. Dan Vandal: I have a general question. All three of you have been doing your jobs for a few years, I imagine.

Mr. Keith Conn: I'm acting for one year, apparently.

Mr. Dan Vandal: Just as a general question, what's the greatest need out there? If we could make a recommendation to improve the system, what would you suggest?

That's an open question.

Ms. Robin Buckland: For us, I would say, looking at the issue of long-term care, we're really trying to make sure that we don't determine the solution before we've really assessed the problem. Again, I would look at the importance of working with partners and thinking about that continuum of care. Long-term care isn't necessarily the solution for everybody. We're looking across the continuum at options for everybody that would work for everybody as individuals and communities.

That's certainly the focus we've been taking.

Mr. Dan Vandal: Do you have anything to add?

Ms. Brenda Shestowsky: I would agree that looking at a continuum of services will be really very important, because the needs of each community will be very different. The needs of people are very different even within communities. We need to have an approach that is flexible and that allows services to be delivered as they are needed.

I think partnerships will also be very important. As people around the table have pointed out, economies of scale remain an important consideration in terms of looking at how we can build partnerships to ensure that services can be delivered when they're needed.

Mr. Keith Conn: My little two cents is that your committee researchers will no doubt find some interesting environmental scans, research documents, and discussion documents to kind of drill down and do a deep dive on that very question around what's needed, the variations of needs, and how to look at this holistically from a continuum perspective in terms of analysis. It's out there. Some of it's dated but still current and relevant to today's reality.

Mr. Dan Vandal: Obviously, you can look at the social determinants of health. If you improve those, you are doing a lot.

I don't have any more, Chair.

The Chair: We can wrap up with MP Romeo Saganash.

Mr. Romeo Saganash: Thank you, Madam Chair.

I want to get back to those barriers you spoke about in the presentation. It was fascinating to hear you say, and to read in your document, that the continuing care working group study in 2006-08 “revealed gaps that are still relevant today”. You then go through the barriers. One of them is related to long waiting lists for provincial and territorial facilities.

What kind of data do we possess in that regard? For instance, do we have data with respect to first nation and Inuit occupancy in those provincial and territorial facilities?

Ms. Robin Buckland: I do think we have that information available. I don't have it at my fingertips, but I think we certainly could pull that together for the committee. The wait times are long.

● (1635)

Mr. Romeo Saganash: Yes, the waiting lists are long, but I imagine it might also be difficult for first nations or Inuit to access those facilities at times. I was in not Nunavut but the Yukon not too long ago, speaking with the indigenous leaders there, and they mentioned that it was difficult for their own people to access those facilities. There might be some challenges in that respect as well. Is that possible?

Ms. Robin Buckland: For sure. The other point that I think is worthwhile pointing out is the fact that the wait times are long, but is the care that's received in the long-term care facilities culturally appropriate? Too, is it culturally safe? I think that's another thing that's important to take into consideration—long wait times, and then making sure that people delivering care in the long-term care facilities have the cultural competencies required to deliver the appropriate services.

Mr. Romeo Saganash: Does your department plan to revisit the study that was done in 2006-08 and to address those barriers?

Ms. Robin Buckland: We are. We've been asked to look at the issue of long-term care and explore what the policy options are. We actually have CIHR, the Canadian Institutes of Health Research, working with us to put on a “best brains exchange”, a knowledge-sharing event, in June. That will look at the issue of long-term care and the potential models. What are the innovative models that can be drawn upon to be able to meet the needs of indigenous people in Canada? Hopefully, from that we'll go on to further develop our thoughts in terms of how to meet those needs.

The Chair: Thank you.

We've run out of time. I want to thank you for coming out. We appreciate your comments. Thank you for participating.

We'll now be moving in camera. I want to thank everyone who attended. I wish you well. Have a great weekend. Adios.

Gary.

Mr. Gary Anandasangaree: Before we move in camera, I have a summer intern. I just want to make sure the committee is okay with....

The Chair: It's fine.

[*Proceedings continue in camera*]