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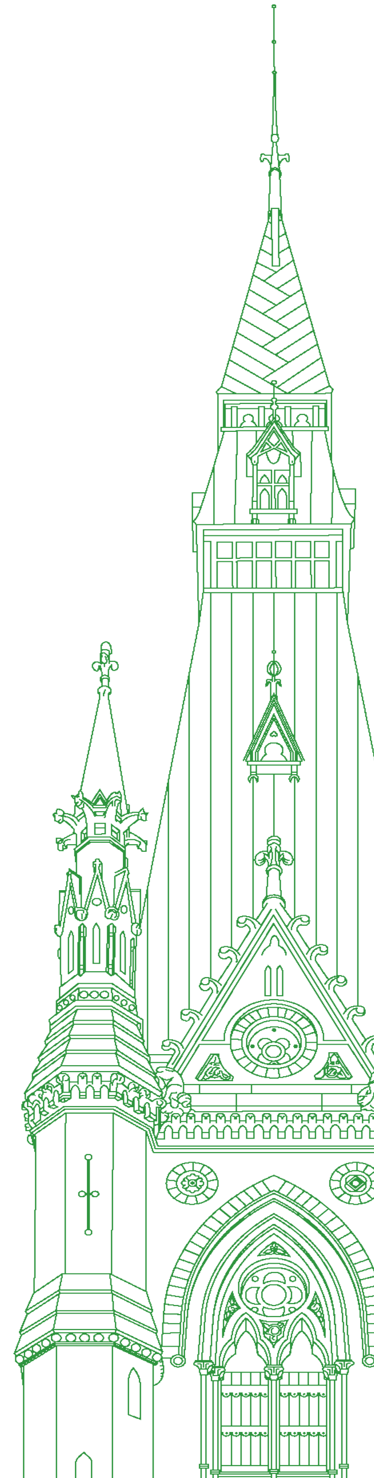

Chair: The Honourable Marc Garneau

Standing Committee on Indigenous and Northern Affairs

Friday, May 6, 2022

● (1300)

[*Translation*]

The Chair (Hon. Marc Garneau (Notre-Dame-de-Grâce—Westmount, Lib.)): Good afternoon.

I call the meeting to order.

Welcome to meeting number 18 of the Standing Committee on Indigenous and Northern Affairs.

[*English*]

We are gathered here today on the unceded territory of the Algonquin Anishinabe nation.

[*Translation*]

Today, we are continuing our third study, which focuses on the administration of the non-insured health benefits program and its accessibility to indigenous peoples.

[*English*]

On our first panel, we'll be hearing from the Honourable Patty Hajdu, Minister of Indigenous Services, and officials from the Department of Indigenous Services and the Department of Crown-Indigenous Relations and Northern Affairs.

[*Translation*]

Keep in mind the Board of Internal Economy's guidelines for physical distancing and mask use.

[*English*]

To ensure an orderly meeting, I would also like to outline a few rules to follow.

Members or witnesses may speak in the official language of their choice. Interpretation services in English, French and Inuktitut are available for the first part of today's meeting. Please be patient with the interpretation. There may be a delay, especially since the Inuktitut has to be translated into English first before it can be translated into French, and vice versa.

The interpretation button is found at the bottom of your screen, in either English or French or Inuktitut. If interpretation is lost, please inform me immediately, and we'll ensure interpretation is properly restored. The “raise hand” feature at the bottom of the screen can be used at any time if you wish to speak or to alert the chair.

Before speaking, please wait until I recognize you by name. If you are on the video conference, please click on the microphone icon to unmute yourself. For those in the room, your microphone will be controlled as normal by the proceedings and verification officer. When speaking, please speak slowly and clearly. When you're not speaking, please put your mike on mute. As a reminder, all comments should be addressed through the chair.

Colleagues, all of you know the standard procedures for these meetings.

We are about to hear from Minister Hajdu. Minister Hajdu has requested to speak for eight minutes. As you know, our routine motions normally limit this to five minutes. I understand that Ms. Gill and Ms. Idlout are fine with eight minutes.

I'd like to ask the Conservatives whether they're okay with eight minutes.

The Clerk of the Committee (Ms. Vanessa Davies): Mr. Vidal indicated that the Conservatives are fine with that, sir.

The Chair: Thank you very much.

With that, I'll turn the microphone over to Minister Hajdu.

You have the floor for eight minutes, Minister.

Hon. Patty Hajdu (Minister of Indigenous Services): Thank you very much, Mr. Chair, and thank you to my colleagues for giving me a bit of time.

Kwe Kwe. *Tansi*.*Unnusakkut*. Good morning.

I, too, am on the traditional and unceded territory of the Algonquin Anishinabe people today, but from the traditional Robinson-Superior Treaty area, and I'm very happy to be here.

I think that, first of all, in this conversation it's our duty for all of us to acknowledge that colonization, through displacement, discrimination and systemic racism, has caused immense intergenerational trauma for indigenous peoples and has perpetuated inequities in the determinants of health and well-being.

In line with Canada’s commitments under the UN Declaration on the Rights of Indigenous Peoples and the Truth and Reconciliation calls to action, addressing health inequities is a key priority for Indigenous Services Canada.

To “reconcile” means that we must move forward on, importantly, equality, truth and self-determination, and on services that are designed by and for indigenous peoples, with sufficient funding and supports in place for people to access them. We need to do better, because health care is a right for all Canadians.

We recognize the strength of indigenous peoples, families, youth and communities who have been pushing governments to find a holistic, distinctions-based approach that will improve access and culturally relevant, trauma-informed and community-based services. We know that there is still much work to do together. The federal government cannot act alone in implementing all the changes necessary. Through conversations with indigenous partners and the provinces and territories, however, we can chart a path forward to better serve indigenous, Inuit and Métis communities across the country.

The non-insured health benefits program administered by Indigenous Services Canada is one area where considerable work has been done to address these inequities. The program provides first nations and Inuit with health benefits that are not covered by provinces and territories, including things like prescriptions and over-the-counter drugs, dental and vision care, medical supports and equipment, mental health counselling and transportation to access health care services that are not available locally, regardless of where clients live in Canada. These benefits are different from other private or public health insurance programs because they're not income-tested and there are no copayments or deductibles.

The NIHB pharmacy benefit is one of the largest publicly funded drug plans in the country, and it's guided by three expert advisory committees of highly qualified health professionals who provide impartial and practical expert medical advice.

In partnership with the Assembly of First Nations, we're working to review the NIHB program. It provided partners an opportunity to identify and address gaps in benefits and streamline service delivery to be more responsive to client needs, and this collaborative work has resulted in tangible changes, such as additional supports for expectant mothers so that they don't have to travel alone if they need to travel outside of their communities to deliver their babies.

The NIHB program also engages regularly with the Inuit Tapiriit Kanatami to discuss Inuit-specific issues.

With the signing of the 2017 Canada-Métis Nation Accord, we have begun to transfer funding for distinctions-based, Métis-specific programming to Métis governments.

As someone who has worked on the issue of mental health and substance use for over two decades, and as someone who regularly hears stories from communities each time I'm on tour, I'm also acutely aware that there is no one single approach or program that will address the varied, complex and interconnected drivers of mental wellness.

The department works closely with first nations, Inuit and Métis partners to improve service delivery, which means supporting increased access to quality, culturally grounded wraparound care, such as Nishnawbe Aski Nation’s choose life program. It means making sure that federally funded programs provide flexible supports to organizations that support people to stay connected to their culture, traditional healing and traditional ways of being. For example, under our government, for the first time, coverage is provided for traditional healer services in support of mental wellness.

We've made significant recent investments to improve mental wellness in indigenous communities, to a total of about $645 million in 2020-21. Budget 2022 proposes to commit an additional $227.6 million over two years for trauma-informed, culturally appropriate and indigenous-led services to improve mental wellness.

These investments included a renewal of essential services, such as crisis lines and mental health and cultural and emotional support to former Indian residential schools and federal day school students and their families, as well as those affected by the issue of missing and murdered indigenous women and girls.

● (1305)

Medical transportation is also essential for rural and isolated communities. While provinces and territories manage the delivery of physician and hospital care, we know that this is not always possible. In 2020 and 2021, NIHB invested $525.7 million in medical transportation. This is about 35.3% of the total NIHB expenditures. This, along with other prenatal supports, ensures that families get the support where they need it.

The NIHB dental program is also universal. That means it covers all eligible first nations and Inuit individuals regardless of age, income or other measures of socio-economic need. Again, recipients don't need to pay deductibles or copayments and have no annual maximum.

In 2016, NIHB established an external advisory committee to support the improvement of oral health outcomes, and we are committed to working with other partners to take best practices as we look to explore dental coverage for all Canadians.

Mental wellness, medical transportation and dental are just three examples of the comprehensive supports provided through NIHB. There is much more work to do, and I'm committed to working together with indigenous leaders and communities to improve services.

I am very pleased that I have Valerie Gideon, the associate deputy minister, and Scott Doidge, director general, non-insured health benefits, in the room with me. As well, Dr. Evan Adams, deputy chief medical officer of public health, whom you heard from earlier this week, and Keith Conn, assistant deputy minister, first nations and Inuit health branch, are on video. They will help me in responding to your questions.

Meegwetch. *Nakurmiik*. *Marci*. Thank you.

The Chair: Thank you very much, Minister.

We'll now proceed with the first round of questions, beginning with Mr. Vidal.

Mr. Vidal, you have six minutes.

Mr. Gary Vidal (Desnethé—Missinippi—Churchill River, CPC): Thank you, Mr. Chair.

Thank you, Minister, for being with us again today and for talking about some of these very important issues.

Minister, as you talked about in your comments, and as I think you're fully aware—you were out in Saskatchewan a few weeks ago—in my riding people travel great distances to access medical services to attend appointments. You talked about medical travel in your comments. There are a lot of people who rely on that in my riding in very significant ways. Because of the great distances, they are often hours and hours away from these appointments. In the last few weeks, on multiple occasions, I've heard from people who operate the medical taxi companies about how they're struggling with the increased costs of things like fuel. Those are exaggerated, obviously, in a remote location and with the distances. I see my colleague from the Bloc nodding, as we shared some common questions today in question period about remoteness. These are a lifeline for many of these people. If the medical taxi companies can't survive the increasing costs, that creates a whole new issue for us.

We heard from the vice-chief of the FSIN the other day about the ongoing reviews. We referenced them today as well. I'm curious as to whether there is anything going on in that process in the context of this medical taxi service. Is there some review that creates a fee that adjusts with fuel prices or anything that would help these businesses survive?

● (1310)

Hon. Patty Hajdu: Thank you very much, MP Vidal.

I'll generally say that inflation is top of mind right now for Indigenous Services Canada, not just with respect to this aspect of medical care but certainly with respect also to infrastructure development and many other aspects the department supports.

Maybe I can turn to Val or Scott to answer these questions specifically.

Ms. Valerie Gideon (Associate Deputy Minister, Department of Indigenous Services): I'll start, and then I'll invite Scott to add briefly.

To reimburse mileage rates we use the National Joint Council commuting assistance, which actually does take into account cost drivers such as inflation. We are in the process now of doing a review of the medical transportation benefit with the Assembly of First Nations. We made a change last year, for example, by increasing by 25% meal and accommodation rates in response to calls that we hadn't sufficiently increased our rates for a number of years.

I'll invite Scott to speak to anything that's more specific to the medical taxi issue.

Mr. Gary Vidal: If you could be brief that would be great. I have such limited time and I have lots of questions.

Mr. Scott Doidge (Director General, Non-Insured Health Benefits Directorate, First Nations and Inuit Health Branch, Department of Indigenous Services): I would have nothing to add then.

Mr. Gary Vidal: Okay, that was brief. Thank you.

Minister, another thing you talked about—and I think you are well aware of the problems with this in my riding—is the challenge of mental health. When I was first elected in 2019, one of the first things I dealt with was a crisis at one of the first nations very close to my community.

One of the things that I hear on the ground when I talk to the leaders in my communities is that they're looking for something as kind of a whole-family approach, rather than an individual approach.

Is that going on through the non-insured health benefits? Is there some openness to some new ideas? Where are we at with that?

Hon. Patty Hajdu: Thank you for using that example, because there are communities in my riding doing exactly that kind of innovation: recognizing that substance use and mental health issues are actually systemic, community problems, and not so much individual problems. That certainly fits well with an indigenous lens—that holistic lens of community wellness. Yes, there is flexibility for programs designed and delivered by indigenous people.

I referenced the choose life program in my remarks. This is a youth suicide prevention program that was designed and delivered by the community. With the flexibility of that design, individual communities can adapt it to their needs. Yes, there is flexibility in the funding so communities can provide family and social group...all kinds of alternative approaches.

Mr. Gary Vidal: Thank you.

Mr. Chair, I'm sorry. I didn't start my clock today, so you're going to cut me off at some point. I don't know where I'm at in my questions today.

The Chair: You have a minute and a half.

Mr. Gary Vidal: Thank you. I'll be very quick with my next question.

Minister, you referred to this already, but I want to ask you more directly about it.

If there was an organization with innovative, culturally sensitive ideas, and it wanted to do a pilot project and get some support for those ideas—not just a community-based or family-based thing, but also.... In a lot of our areas, we have to do this regionally as well, because we can't be everywhere. If there are ideas like that, which they want to bring forward, what would the process be?

How hard is it to get the department to do some out-of-the-box thinking on things it's never done before? That's the way I would say this.

● (1315)

Hon. Patty Hajdu: I'll answer generally and then turn to Val.

It depends on where that community group is. For example, if it's in an urban setting, it can be a bit more challenging. If it's in a first nation or regional community—a tribal council, for example—I think there's quite a bit of flexibility at the department to work quickly on a conceptual idea and then actually implement it on the ground.

Val, do you want to add to that?

Ms. Valerie Gideon: I would say it's exactly that. Wherever possible, we're finding horizontal ways to work across sectors, so that we can be more flexible in our policy authorities and funding envelopes.

The Chair: Thank you very much, Mr. Vidal.

We'll now go to Mrs. Atwin for six minutes.

Mrs. Jenica Atwin (Fredericton, Lib.): Thank you, Mr. Chair.

Thank you, Minister, for being with us today.

I'm speaking from unceded Wolastoqiyik territory here in Oromocto, New Brunswick.

Minister, I want to thank you again for your remarks and your willingness to acknowledge that things have not been perfect up to this point. You're really committed to righting some of the wrongs. It's very refreshing to hear that humility.

You and I both share a passion for mental health and mental wellness. It is Mental Health Week here in Canada, so I'll pick up on a couple of great questions that Mr. Vidal asked. You mentioned traditional counsellors, and it makes me think about the community of Attawapiskat, in particular, when they lost many youth simultaneously. They asked for things like culturally appropriate mental health supports and indigenous-led programming.

Could you talk a bit more about how our government is investing in cultural healers for mental health, and how that has been expanded in the last little while? Thanks so much.

Hon. Patty Hajdu: I'll try not to eat up most of your time, because you're right. This is an area I'm passionate about.

I think flexibility in the way indigenous people, and even non-indigenous people, can access mental health and substance use supports is critical to moving forward on this very difficult issue. For far too long, governments, including ours, tried to overlay a very western approach on wellness or healing, in particular around substances. It is a very individualistic approach. One-on-one counselling or even 12-step programs—which I know are undoubtedly very helpful for some people—don't have a cultural lens or perspective that can necessarily easily translate in some communities.

As Val said.... We know her as Val; that's how accessible she is. As Val said, working with communities on an innovative approach that will work in their communities is what I think will really be a game-changer, because the many communities I work with in my own riding tell me that substance use and mental health are systemic problems. Think about the people in your life who you've loved and who have suffered. You can send someone away for treatment, but if they come back to exactly the same system, it's very hard for them to stay recovered.

Some communities, like Long Lake 58 in my riding, are doing entire friend group treatment and other group approaches that help the person and others lean on each other in their journey of recovery.

Mrs. Jenica Atwin: Thank you so much.

In the spirit of talking about some of the other improvements—because that's clearly an improvement that's been made to the NIHB system—what are some of the other areas that have been looked at by the department to make sure it's more user friendly perhaps, or that accessibility piece?

We've had some pretty powerful testimony in our committee so far around this, and some of the areas may still need a focus on improvement. What's been done so far to increase the accessibility of this program?

Hon. Patty Hajdu: Val, maybe I can turn to you in a moment.

I think the top line I would say is that the department is really leaning into self-determination, autonomy, equity and, of course, honesty. I think using those principles to guide the redesign of programs has helped to shift the trajectory of the department overall.

Scott or Val, maybe you can talk about what that looks like in practice.

Ms. Valerie Gideon: I can start. I can give you lots of examples.

It's the fact that now every pregnant woman who needs to birth outside of her community has access to an escort. The criteria is no longer limited to a medical need. In dental, we've significantly increased coverage for preventative services, for example, adults having coverage for fluoride treatments. Before it used to be limited more to children. We've removed a number of pre-approval requirements for a number of our pharmaceutical and medical supplies and equipment categories.

We have information that's publicly available around all of the improvements we've made through the joint review process we had with the Assembly of First Nations. I believe you're going to hear from one of our core committee members who's been part of that process through the First Nations of Quebec and Labrador Health and Social Services Commission. There are gender affirmation treatments and products, and support for that, removing pre-approval requirements for a number of those.... These are just examples.

I would say that having first nations and Inuit representatives who provide us with feedback very directly has helped us tremendously to improve access, and we're continuing down that path.

● (1320)

Mrs. Jenica Atwin: If I could follow up on that, what does that process look like, where you're getting feedback from users of the program? What are the mechanisms for communicating, perhaps a complaint or a suggestion?

Ms. Valerie Gideon: We started out with a chiefs assembly resolution, which is pretty powerful, and then a Minister of Health commitment to actually undertake the review process. We went benefit by benefit.

We funded the Assembly of First Nations to coordinate the process. They identified regional representatives and NIHB navigators. We have over 30 NIHB navigators who are first nations- or Inuit-employed, who are working directly with clients and then coming back and giving us that feedback.

These are examples of how we have a very active network of first nations and Inuit—client representatives, really—coming to us for those service improvements.

Mrs. Jenica Atwin: Thank you.

The Chair: Thank you very much, Ms. Atwin.

There were only about 10 seconds left there.

[*Translation*]

We now go to Mrs. Gill for six minutes.

Mrs. Marilène Gill (Manicouagan, BQ): Thank you, Mr. Chair.

I would like to thank Ms. Hajdu, Ms. Gideon, Mr. Doidge and Mr. Adams for being here today.

Minister, as you know, administration of the non-insured health benefits program has been centralized since 2013, and that extends to the predetermination of benefits, billing, the provision of dental care and so forth. We have heard, however, that since the program was centralized, a good many issues have persisted. The system now has even more red tape, when people had been calling for less bureaucracy and more flexibility.

The Assembly of First Nations Quebec–Labrador told us that it was able to interact and communicate more effectively with program administrators when there was a Quebec office. Basically, the system worked better.

Again today, we are hearing that the problems have only gotten worse. Delays in payment and reimbursement for services are increasingly common. Nevertheless, these are essential services. Problems also exist on the health care provider side of things. They are simply choosing not to provide services to this population. Obviously, when service providers don't get paid, it creates problems for them, so they choose not to participate in the program.

Since the system isn't working, are you considering decentralizing administration of the program? If not, what can you do, or what will you do, to make sure that members of first nations have access to the services?

[*English*]

Hon. Patty Hajdu: Maybe I can just highlight a couple of points and then turn to Val or Scott, but I will say that the NIHB program encourages dentists to enrol directly with NIHB so that clients don't have to be billed and face charges at the point of service. I guess that would be a form of decentralization, in that, no matter where a dentist lives, they can work directly with NIHB and clients can have that direct access.

Also, we provide coverage of travel costs to access dental services when not provided in the community or in a residence. Again, it's trying to make sure that, no matter where a person lives, they are fully able to access care regardless of their location.

Maybe you can talk a bit about the decentralization in general, Scott.

Mr. Scott Doidge: Sure.

With respect to service providers, we watch our provider enrolment numbers very carefully to make sure we're not losing providers. For example, with dentists, over the last five years we've actually had a 12% increase in the number of dentists who are actively providing services, so these aren't just dental offices that register just in case they see an indigenous patient. These are active service providers.

With respect to some of the concerns you—

[*Translation*]

Mrs. Marilène Gill: Sorry to cut you off, but I just want to clarify something here.

You said the number of participating dentists had gone up. While that may be true in urban areas, the number of dentists has not increased where I'm from, a remote region. Things always have to be adjusted to account for remote areas, and I wanted to point that out. The numbers may be positive in some places, but that really has no impact on places that only have one dentist. I'm not even talking about remote communities, because they don't have any dentists, and people there have to travel 200, 300 and sometimes 400 kilometres to see a dentist.

Sorry to have cut you off. You can continue.

● (1325)

[*English*]

Mr. Scott Doidge: When it comes to those types of situations—and thank you for clarifying—we do our best to provide contract dental services, whether through contract dentists or hygienists, in order to try to get their services into the community. That is the number one priority, and a lot of our expenditures in dental are really geared towards that.

We're always open to trying to devise ways to improve how we can deliver those types of services, because the fee-for-service business model, where people have to leave their community, is really not optimal. Certainly, we're open to any and all feedback to try to improve that service.

[*Translation*]

Mrs. Marilène Gill: I had asked about decentralization. What about that? I realize that it's not a short-term solution, but are you open to the idea since the Assembly of First Nations Quebec–Labrador is telling you that the model isn't working, that it strongly recommends a different model or even a return to the old one, with improvements of course? That is something first nations, themselves, are calling for.

[*English*]

Ms. Valerie Gideon: I was just going to say this.

[*Translation*]

We have been working for several years with the First Nations of Quebec and Labrador Health and Social Services Commission on a governance project so that first nations can take over all of our department's services in the area of health and social services.

At the national level, the centralization of dental care has allowed us to meet standards consistently across the country. Previously, there were regional offices where payments could sometimes be 12 weeks late. The only way to deal with the capacity issue in our regional offices was to centralize administrative services and better support the 15,000 dentists registered in the program.

Mrs. Marilène Gill: Was an assessment done to see if there were places where it was not going well? I've had people tell me that things were working well before the change, but things got worse after the change. You're helping someone, but at the same time you may be hurting someone else.

Ms. Valerie Gideon: Our last evaluation was in 2015. By the way, we have started a new evaluation process, which will run until 2017 or 2018. We will then have an overview of the situation and ask this specific question.

[*English*]

Hon. Patty Hajdu: I might add this, which I think Val touched on briefly. As you know, in my mandate letter I am mandated to create codeveloped health legislation with indigenous communities and/or regions, and that is a form of decentralization that's working extremely well, if you look at B.C. and the First Nations Health Authority.

Increasingly, self-government is proving to be a way of decentralization that is meeting indigenous people's needs, so that's an exciting piece of work coming.

[*Translation*]

The Chair: Thank you, Ms. Gill.

Ms. Idlout, you have the floor for six minutes.

[*English*]

Ms. Lori Idlout (Nunavut, NDP): [*Member spoke in Inuktitut as follows:*]

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[*Inuktitut text interpreted as follows:*]

Thank you.

I welcome you to this. I've enjoyed the presentation. It's informative.

[*English*]

Hon. Patty Hajdu: Mr. Chair, we're not getting the interpretation, so I can't hear the question. I'm sorry.

The Chair: Okay.

As we said, it takes a little while to get the interpretation. Let's go ahead and wait. Be patient.

Go ahead, Ms. Idlout.

Ms. Lori Idlout: [*Member spoke in Inuktitut as follows:*]

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[*Inuktitut text interpreted as follows:*]

I welcome you to this very informative presentation.

I have a question about traditional healers. They are life counsellors and, most often, a lifeline. How do you recognize and validate the important work they do in the community?

If you can let us know how you can further assist traditional healers in doing their work, would you let me know now?

[*English*]

● (1330)

Hon. Patty Hajdu: Thank you very much.

I'm sorry for the confusion at the beginning.

Increasingly, people across the country are talking about the value of traditional healers. That's why we've moved to be able to compensate traditional healers for their work.

I will turn to Val to talk about how traditional healers are selected and how they're recognized.

Ms. Valerie Gideon: In 2017, through the non-insured health benefits program, we were able to access funding for the first time to support first nations and Inuit to include traditional healing services. They manage those services, so they identify their traditional healers, they compensate them and they support the services. The government does not do that directly. For example, IRC, the Inuvialuit Regional Corporation is funded to provide those services.

We also offer services through the Indian residential schools health support program. Again, there are many northern residents who access that program.

For traditional healing services, we do not recognize them or certify them or anything. We usually receive a letter or a note from the Inuit or the first nation community organization that advises that this traditional healer or this cultural practitioner is recognized or is part of their services.

Ms. Lori Idlout: [*Member spoke in Inuktitut as follows:*]

ᑭᖕᒍᓂᐊᒍᑦ ᑎᑎᕐᑲᖁᑎᒍᑦ ᓇᓗᓇᐃᕐᕕᐅᔪᓐᓇᖅᐱᑖ ᑖᒃᑯᐊ ᑭᓇᒃᑰᒻᒪᖕᖏᑦᑕ ᓇᓗᓇᐃᖅᑕᐅᓂᐊᕋᑦᑕ ᓇᓕᐊᑦ ᑎᒥᐅᔦᑦ, ᑖᒃᑯᐊ ᑎᒥᐅᓂᖕᒋᑦ ᑭᓇᒃᑯᓐᓂᑦ ᐃᓕᑕᖅᓯᑎᑦᑎᖃᑦᑕᕐᒪᖕᖏᑦᑕ ᓱᕐᓗ ᐅᖃᖅᑲᐅᒐᕕᑦ ᐃᓄᐃᑦ ᐃᓅᕕᐊᓗᐃᑦ ᓇᒻᒥᓂᖁᑎᓕᓐᓈᖕᒋᑦ ᑖᒃᑯᐊ ᐱᓕᓐᓂᐊᓐᓂᖃᖅᑎᑦᑎᓲᑦ ᖃᐃᑕᐅᔪᓐᓇᕐᒪᖕᖏᑦᑕ. ᐊᒻᒪᓗ ᐱᖃᑖ ᐊᐱᖅᑯᑎᖃᖅᑲᐅᓚᓚ ᐋᓐᓂᐊᕐᕕᓕᐊᕐᑐᓄᑦ ᐊᐅᓪᓚᖅᑎᑦᑎᓂᖅ, ᑖᓐᓇ ᖃᓅᖅ ᐋᖅᑭᓲᖕᒍᒻᒪᖕᖏᔅᓯ ᑐᑭᓯᔦᒪᓚᓚ, ᓲᕐᓗ ᑐᓴᐅᒪᓂᖃᕐᒪ ᐃᓐᓇᐅᔦᒥᑦ ᑕᐃᔭᐅᔪᖅ ᓇᒪᓐ ᓂᖕᒋᐅᑦᓯᐊᖅ. ᑖᓐᓇ ᓄᓇᕗᒻᒥᐅᓄᑦ ᐊᒥᓱᓄᑦ ᖃᐅᔨᒪᔭᐅᓪᓗᓂ. ᑖᓐᓇ ᓇᒪᓐ ᓂᖕᒋᐅᑦᓯᐊᖅ ᐊᔪᖅᓯᓯᒪᓚᐅᕐᒪᑦ ᐃᒻᒪᓯ ᕕᔅᒥ ᐱᔾᔦᑕᐅᓪᓗᓂ ᓘᑦᑖᓪᒍᖅ ᐅᖃᖅᓯᒪᒻᒪᑕ ᐊᔪᖏᔭᕐᒪᑕᒎᖅ ᐱᕚᑎᖅᑕᐅᔦᓐᓇᕐᓂᖕᒋᓐᓂ ᓄᓇᒥᔭᖕᓚᓐᓂ. ᑖᒃᑯᐊ ᓇᒪᓐ ᓂᖕᒋᐅᑦᓯᐊᒃᑯᑦ ᐃᓚᖕᒋᑦ ᑎᑎᕐᑲᓕᐅᖁᓗᐊᖅᓱᑎᒃ ᖃᓄᖅ ᐸᐃᓇᓂᐊᖅᑕᖕᒋᓐᓂᒃ ᐸᕐᓇᐃᓯᒪᑦᓯᐊᖅᓱᑎᒃ ᐸᕐᓇᒃᓯᒪᔦᑦᖃᖕᓚᑦᑎᒋ ᑭᓇᒃᑯᑦ ᐱᓕᕆᖃᑦᑕᕐᓂᐊᖅᓱᑎᒃ, ᖃᓄᖅ ᐸᐃᓇᓂᐊᖅᑕᖕᒋᓐᓂᒃ ᐸᕐᓇᐃᓯᒪᑦᓯᐊᖅᓱᑎᒃ ᐸᕐᓇᒃᓯᒪᔦᑦ ᖃᖕᓚᑦᑎᒋ ᑭᓇᒃᑯᑦ ᐱᓕᕆᖃᑦᑕᕐᓂᐊᕐᒪᖕᖏᑦ ᖃᓄᖅ ᐃᑲᔪᖅᑕᐅᖃᑦᑕᕐᓂᐊᕐᒪᖕᖏᑦ ᑐᓂᐅᖅᑲᐃᑦᓯᐊᖅᓱᑎᒃ, ᑭᓯᐊᓂ ᐋᒃᑳᖅᑕᐅᖕᒋᓇᕐᒪᑕ ᑖᒃᑯᐊ ᓚᕗᒪᒃᑯᓐᓄ, ᑖᒃᑯᐊ ᐃᓚᒌᔭᐅᔦᑦ ᓇᒻᒥᓂᖅ ᑮᓇᐅᔭᕐᓂᒃ ᐱᕈᖅᓴᐃᓕᓚᐅᕐᒪᑕ 20 ᑕᐅᓴᓐ ᐅᖕᒪᑖᒍᑦ. ᑖᓐᓇ ᖃᖕᒪᑦᑕᕈᓐᓇᖅᓯᑎᑕᐅᓪᓗᓂ ᓄᓇᖕᒪᓄᑦ ᓴᓪᓕᕐᒧᑦ, ᐊᓱᐃᓛ ᐊᖕᒋᕐᖁᓚᐅᕐᐳᖅ, ᑐᓴᐅᒪᖕᒋᓐᓇᓕᖅᑐᒍᑦ ᓈᒻᒪᒃᑐᖅ, ᐃᓅᓯᖃᑦᓯᐊᖅᑐᖅ, ᐆᒪᑦᑎᐊᖅᑐᖅ. ᑖᓐᓇ ᓇᓗᓇᐃᕈᑕᐅᒻᒪᑦ ᓘᑦᑖᖅ ᓈᓚᒃᑕᐅᓂᖅᓴᐅᓚᐅᖅᐸᑦ ᖁᕕᐊᓱᙱᓪᓗᓂ ᓅᓚᖅᑐᒥᒃ ᐃᓅᓯᖃᐃᓐᓇᖁᔭᓚᐅᖅᑐᖅ ᐃᒻᒥᓯ ᕕᔅᒥ. ᑖᓐᓇ ᑐᑭᓯᒃᑲᓂᖅᐸᓪᓚᓚᒃᐸᖁ, ᖃᓄᖅ ᐊᐅᓚᓂᓚᖅᑲᒪᖕᖏᓯ, ᖃᓄᖅ ᑐᓴᖅᑕᐅᓂᖅᓴᐅᓲᒪᖕᖏᑦᑕ, ᐊᖕᒋᕐᖁᕈᒪᐸᐸᑕ ᐊᖕᒋᕐᖁᓇᐊᖃᕐᓂᖕᒋᓐᓂ

[*Inuktitut text interpreted as follows:*]

I would like to have in writing what is available and who those resources and counsellors are who are listed as your traditional counsellors. You say that the Inuvialuit Regional Corporation has a list of traditional counsellors. It would be very helpful to have the list. Thank you.

Secondly, I want to ask you about people who go on medical travel. What are the agreements when it comes to medical travel?

I have heard of an elder by the name of Raymond Ningeocheak. Many people know him in Nunavut. He was at the Embassy West in Ottawa, suffering from dementia. The doctors had said that they could not bring him back home because they had no specialized caregivers for his condition. The family petitioned to have him brought home for his last days. They identified caregivers within the family who would look after him, with a schedule. They provided all that, but the doctors kept refusing the family, so the family members fundraised over $20,000 to have a charter bring him back home for his final days. He went home.

Now we know he is happy. He has good caregivers in the family. It shows us and the medical people that an elder who was unhappy and removed from his homeland into a foreign land can survive in his own home environment.

How can we make it understood that we, too, are capable of looking after our own elderly and sick if they are homesick for their homeland in their final days?

[*English*]

Hon. Patty Hajdu: First of all, what a touching story. It's one I've heard all across the country from indigenous people. Many indigenous communities are trying to adjust to increasingly more local elder care, whether it's the creation of long-term care homes, which many communities are working on, or more supports for active at-home aging, which many people would prefer than long-term care homes. We have to do better for elders across the country, and I would agree with you. You're raising a really important point.

Maybe Scott can speak about the specific topic, but from my perspective, as minister, you're right. The evidence has shown over decades that the closer people are to family and home as they age, the happier and more content they are, and their quality of life is much better. That actually matters.

I think we can do more in this space, and I look forward to working with you on that. I would also like to turn to Val or Scott, if they have anything to say about this specific situation.

● (1335)

The Chair: Ms. Gideon, go ahead very quickly, please.

Ms. Valerie Gideon: The Government of Nunavut makes the direct decisions around the coverage, but we pay the cost of that. We do have a partnership table with them, so we can talk about this situation in collaboration with them.

On long-term care, we do have a mandate, since 2019, to work with first nations and Inuit to develop options together for a better continuum of care services, including long-term care, not just at the level of specialized services but more for this community approach.

The Chair: Thank you very much.

We have time to start a second round at this point.

Mr. Schmale, you have five minutes.

Mr. Jamie Schmale (Haliburton—Kawartha Lakes—Brock, CPC): Thank you very much, Chair.

Good afternoon, witnesses. I apologize for not being there in person, but I do appreciate your testimony and contribution here nonetheless.

Minister, during our last meeting, we heard from three witnesses when we were conducting our study. One was a Plains Cree family physician, one was the president-elect of the Canadian Medical Association, and the other was the vice-president of the Indigenous Physicians Association of Canada. Each one of those individuals talked about the crippling bureaucracy that is slowing the care of individuals in their community.

Were you aware of this situation? Have you heard this before?

Hon. Patty Hajdu: Not having heard their testimony, it's a bit general for me to comment on that. However, I will say that the department is working right now to eliminate the layers of bureaucracy and to move more quickly to self-determined models of care that will go a long way in reducing some of the bureaucratic hurdles.

Mr. Jamie Schmale: In some of the testimony we heard, we heard of physicians trying to beg whoever was on the phone from the program to approve certain levels of treatment that would most likely have been easily passed through any other existing system, such as a provincial system or what have you. There was even one story that Dr. Makokis talked about, where he had to threaten the department itself with bad media coverage in order to get the treatment his patient needed and deserved.

Can you also tell us about some concrete steps you're taking to maybe improve training, or how the department is speeding this up?

Hon. Patty Hajdu: I will turn to Val to talk about the training, but streamlining the process of payments for providers for Express Scripts and access to benefits like dental care and vision care is a top priority for the department.

Val, maybe you can talk about, from a practical perspective, what that means with individual employees.

Ms. Valerie Gideon: We did implement a mandatory culturally competent training policy in 2020 for all employees in the department. A couple of years ago, within the first nations and Inuit health branch, where NIHB is housed, we also implemented an aboriginal peoples employment program, as it was called at the time.

We asked all areas of the branch to identify positions that would be targeted specifically for indigenous employees on the basis of the need for cultural competency in those particular jobs, or if they were offering direct service, partnering or liaising with first nations and Métis communities or clients. We implemented a number of improvements.

On the NIHB side, we also have removed a number of prior approvals on pharmaceuticals or medical supplies and equipment that relate to the health conditions that were raised specifically by Dr. Makokis. For example, with respect to HIV treatments, these are considered open benefits, and we now have no need for a predetermination for a number of pharmaceuticals or products relating to gender-affirming supports.

Mr. Jamie Schmale: Do you know how many indigenous individuals, either the total or the percentage, are working within this program or at least are taking the calls from indigenous physicians or health care providers?

● (1340)

Mr. Scott Doidge: I don't have the exact number. It's something that we could provide.

I would also note the composition of the expert committees the minister referenced in her speech. Many of those members are practising indigenous physicians, dentists and folks who would provide us with advice around medical supplies and equipment.

Mr. Jamie Schmale: Thank you.

Mr. Scott Doidge: We can get you those figures.

Mr. Jamie Schmale: Yes. I'm just curious, because I can't remember which witness it was, but one of them did speak about the fact that there were little to no indigenous employees working to take the calls who would understand and who wouldn't ask questions like, “Well, can't you walk?” instead of asking for transportation. Quite troubling situations like that were brought up.

Minister, recently the First Nations Financial Management Board, which I know you know about—it's a top-notch organization supporting economic development for indigenous communities—wrote a letter to the standing committee that we're addressing here today. In that letter, the executive chair summed up the situation, using the example of housing. Mr. Harold Calla said, “While the budget makes significant investments in new housing, it does nothing to change the failed systems for getting homes built nor change the pay-as-you-go systems that support [indigenous] housing.”

Minister, are you tackling the systemic inequalities that keep these indigenous people in poverty, poor health and without adequate housing? Clearly, although the money is nice, I think most people are looking for outcomes.

Hon. Patty Hajdu: Thank you, Mr. Schmale.

I will say, yes, absolutely. First of all, I also respect the work of the board tremendously and the very practical recommendations. We'll be working with a number of partners to streamline how we get the significant investment in housing out the door as quickly as possible. It is my goal to spend every dollar as quickly as possible, obviously through first nations leadership, to build those homes. This is the top priority for many first nations leaders across the country.

You're absolutely right that it's a critical social determinant of health. In fact, it's so much so that it's deeply connected to outbreaks of COVID, outbreaks of tuberculosis and of course many other health outcomes. It's a priority for me. The department and I have had many conversations already on how we can streamline the process of getting money through the door. I'm working with my ministerial colleagues on that as we speak.

The Chair: Thank you, Mr. Schmale.

We'll go to Mr. McLeod for five minutes.

Mr. Michael McLeod (Northwest Territories, Lib.): Thank you, Mr. Chair.

I want to say thank you to the minister and her team for taking the time to talk to us today about this very interesting and very important issue of NIHB.

One of the main concerns about NIHB that I hear from my constituents and from indigenous governments in Northwest Territories is around escorts for medical travel. It seems very inconsistent. Some people qualify and some don't. Some jurisdictions allow for more medical escorts than others. It's not very clear. This point was echoed by Minister Green from GNWT on her presentation to committee at the last meeting.

My first question is this. Is the Government of Canada able to make the changes needed to make the process for getting an escort for medical travel easier and also clearer?

Hon. Patty Hajdu: Thank you very much.

As you know, we work in partnership with provinces and territories, including Northwest Territories, to augment the cost of medical transport. Absolutely, we have been working on ensuring that people do have escorts, as I think we've talked about—for example, adding the ability for a pregnant mother to have an escort of her choice so that her birthing experience is much improved. Children also are always covered for an escort. There's also coverage for a client to have more than one escort, if needed, for medical or legal reasons. Those are requests that are considered on a case-by-case basis.

Maybe I can turn to you, Scott, to speak about the process of applying for an escort and the areas you see that we could streamline.

Mr. Scott Doidge: Thanks very much.

Escort travel is certainly something that we know will continue to be a conversation that we need to have, probably through the AFN joint review, when we're able to get back to the business of the medical transportation review. At any point, we are certainly willing to work through our regional offices as well as through first nations partners who administer aspects of non-insured benefits to make sure that the policy framework is clear, well understood and being applied in a consistent manner.

Unfortunately, I don't have good figures to provide to the committee other than to say that we do have high utilization of escorts in NIHB. For example, we had nearly 1,600 mothers who travelled for childbirth, which is—

● (1345)

Mr. Michael McLeod: I'm going to interrupt you. I was looking for an answer on how you're going to make it better. You pointed to some of the areas. I appreciate that.

I recently had a friend who had cancer and was very sick. He was sent to Edmonton by air ambulance from Yellowknife. The diagnosis was terminal cancer, and he was then told to travel back on commercial aircraft. He didn't have his shoes or a jacket, because he was medevaced there. We need to be more sensitive when it comes to dealing with people who are so sick that they are brought in on an air ambulance and can barely walk. It was really embarrassing to have to try to find a way to explain that or talk about that.

One of the key ways to improve the medical escorts element is to make the non-insured health benefit more culturally appropriate. In my riding, we have residents and elders in small communities who don't speak English, and a lot of them can't eat or refuse to eat hospital food or western food. They feel very uncomfortable just leaving their community to go to Yellowknife, for example, never mind going south to larger centres like Edmonton.

In what ways is the government able to make NIHB more culturally appropriate?

Hon. Patty Hajdu: I will say, MP McLeod, that I'm happy to take the specifics of that particular case back to the department, because I share your outrage. That shouldn't have happened to that individual and we would like to look into the case.

You mentioned, for example, translation or personal care. There is coverage for an escort in those situations. A non-medical escort, such as a family member or a person chosen by the client, is covered to accompany them.

It's important when we hear cases like that, and really, for all members of Parliament who hear of cases like that in their constituencies, to bring them to me as the minister or to the department, so that we can follow up to find out what went wrong. I obviously have no specifics about this case, but it shouldn't have happened. Someone shouldn't have been discharged with no shoes and no winter coat and stuck on a plane to travel back without any care. That's unacceptable and we'll get to the bottom of that particular case.

The Chair: Thank you, Mr. McLeod.

We'll go to Madame Gill.

[*Translation*]

You have the floor for two and a half minutes.

Mrs. Marilène Gill: Thank you, Mr. Chair.

I want to go back to the red tape issue. Obviously, the first nations and Inuit of Quebec have questions about what they see as an archaic way of doing things. I have to say that this has more impact on some communities than others, when we talk about the fax machine, for example, or letters.

Let's take my constituency as an example. There is an area of 400 kilometres without roads, where the post arrives in a very uncertain way. Depending on the time of year, the mail sometimes arrives after three, four, five or six weeks. These are huge waiting times. It is also a region where there is not necessarily a network giving access to the Internet. So you see the difficulty.

The same goes for the language issue. Often, there are professionals who do not want to take these steps because of the administrative burden.

What can you do to address this? On the one hand, there is the language issue, of course. On the other hand, some practices should be adapted to the 21st century, so that people in the communities are not discouraged when it comes to making claims.

[*English*]

Hon. Patty Hajdu: Those are all very good points, Madame Gill.

I will say that the department makes every effort to be able to communicate in both official languages with providers. I would imagine that there are things like direct deposit that are available to providers, so that we can avoid delays with mail, for example. There are a number of other ways to make sure that people are getting their payments on time.

Mr. Chair, with your permission, I want to amend something I said earlier. I'll leave it to you as to when it is the best time to make that amendment.

On your issue, Madame Gill, it is a commitment of the department that services are available both to client and practitioner in the official languages, as well as multiple choices for how payment is remitted.

● (1350)

[*Translation*]

Mrs. Marilène Gill: I understand. It's nice in theory, but in practice it doesn't necessarily work for some people. I know some who don't speak either language, so it's very difficult for them. There is also the issue of literacy. Sometimes it is very complex for people, who are not always supported in this process. So I would like us to think about this. Indeed, the situation is very different depending on the communities, territories and age groups.

We want everyone to have access to the program, so it would be a matter of ensuring that this is the case and modulating the program according to people's different needs. There are currently people who can't make it and it's difficult for them. That's what we see in our offices.

The Chair: Thank you, Ms. Gill.

I noticed that your statement ended with a comment.

[*English*]

Minister Hajdu, can you quickly make that amendment and then we'll carry on?

Hon. Patty Hajdu: Yes.

In response to MP McLeod's comment about the person discharged without shoes or shirt, I neglected to mention that the hospital in the territory would also have a high degree of responsibility in making sure that the person was cared for.

I will say that it's disappointing to see, at all levels—provincial and municipal governments—people abdicating their responsibility to provide equitable care. That is a perfect example of a situation where a provincial service needs to be reflecting on their treatment of the patients in their care.

The Chair: Thank you.

We'll go to Ms. Idlout now.

Ms. Idlout, you have two and a half minutes.

Ms. Lori Idlout: [*Member spoke in Inuktitut as follows:*]

ᖁᔭᓐᓇᒦᒃ. ᐊᐱᖅᑯᑎᖃᕐᓂᐊᕋᒪ ᐋᓐᓂᐊᕐᕕᓕᐊᖅᑐᓄᑦ ᐃᑲᔪᖅᑎᒋᔭᒃᓴᖕᒋᓐᓄᑦ. ᑐᓴᐅᒪᐃᓐᓇᐅᔭᕋᑦᑕ ᓃᕐᑲᐃᒻᒪ ᓄᓇᕗᒻᒥᐅᑦ ᐊᐅᓪᓚᓂᐊᕐᑲᐃᓐᓇᓃᖕᒍᒻᒪᑕ ᐋᓐᓂᐊᕐᕕᓕᐊᖅᓱᑎᒃ ᐊᒻᒪᓗ ᐊᒥᓱᒻᒪᓂᐊᓗᐃᑦ ᐃᑲᔪᖅᑎᕐᑲᐃᓐᓇᓂᐊᕐᑲᓃᖕᒍᒻᒪᑕ ᓃᕐᑲᐃᒻᒪ ᓇᒻᒥᓂᖅ ᓄᓇᒋᔭᒻᒥᓂ ᑕᑯᔭᐅᔪᓐᓇᙱᒻᒪᑕ. ᑖᒃᑯᐊ ᐋᓐᓂᐊᕐᕕᓕᐊᕐᑐᑦ ᐊᑭᓕᖅᑐᖅᑕᐅᓇᓂ, ᑖᓐᓇ ᖃᓄᖅᑑᑎᒋᐋᓐᓇᖅᐱᓯᐅᒃ? ᐊᑐᓕᕐᑯᕗᒍᓐᓇᖅᐱᓯᐅᒃ? ᑖᒃᑯᐊ ᐋᓐᓂᐊᕐᕕᓕᐊᖅᑐᑦ ᐃᑲᔪᖅᑎᖕᒋᑦ ᐊᑭᓕᖅᑐᖅᑕᐅᕙᓐᓇᕐᑯᓪᓗᒋᑦ, ᐱᔾᔪᑎᒋᓗᐊᖅᐳᒍ ᐃᓛᓐᓂᒍᑦ ᐊᑯᓂᐊᓗᒃ ᐊᐅᓪᓚᖅᓯᒪᕐᑲᑦᑕᕐᒪᑕ ᐊᑭᓕᖅᑐᖅᑕᐅᓇᑎᒃ ᐊᐅᓪᓚᖅᓯᒪᓪᓗᑎᒃ, ᐃᓛᓐᓂᒃᑯᑦ ᐊᑯᓂᐊᓗᒃ ᑕᖅᑭᓂᒃ ᐊᐅᓪᓚᖅᓯᒪᕚᒃᐳᑎᒃ, ᐃᓚᒥᓐᓂ ᕿᒪᐃᓪᓗᑎᒃ, ᐃᖅᑲᓇᐃᔮᒥᓐᓂᒃ ᕿᒪᐃᓪᓗᑎᒃ ᕿᓇᐅᔾᔭᙳᕆᑦᓯᐊᖅᐳᑎᒃ ᐃᑲᔪᖅᑎᐅᕆᐊᓖᖕᒍᒻᒪᑕ, ᐃᑲᔪᖅᓯᒪᓪᓚᓂᐊᓗᒃᐳᑎᒃ ᐋᓐᓂᑐᖅᑲᙱᓐᓂᓕᓂᓂᐅᑉ ᒥᒃᓵᓄᑦ.

[*Inuktitut text interpreted as follows:*]

Thank you.

My question is about medical escorts.

We hear over and over that Nunavummiut have to go on medical leave, and most of them require medical escorts to travel. They go on a volunteer basis as medical escorts, with no pay. We want to make sure that those essential, much-needed service providers are paid or remunerated for their services. Some of those medical escorts can be gone for a long time, up to a month. They are away from their families and children. They have to take leave from their jobs, and sometimes they lose their jobs when they become medical escorts and they are escorting patients.

[*English*]

Hon. Patty Hajdu: Thank you very much, MP Idlout.

I think this is a challenge with anyone who has a sick member of their family or a member of their family requiring medical care. It's a challenge for the non-clinical medical support person to have time away from their own daily activities. It's something that I'm sure will come up in the review with the AFN, and we'll make sure that it's flagged.

To my knowledge, medical escorts are not compensated right now. This isn't a unique problem in terms of indigenous communities. We've certainly heard this in non-indigenous communities as well. However, there's a significant pressure when there is an aspect of travel and remoteness that's additional.

We'll flag that for our conversation with the AFN review and certainly follow up with you in the discussion that happens.

Ms. Lori Idlout: [*Member spoke in Inuktitut as follows:*]

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[*Inuktitut text interpreted as follows:*]

Very quickly, I have another question.

Is AFN also looking at Inuit issues, or do you look after Inuit people in your region?

[*English*]

Hon. Patty Hajdu: I would imagine not specifically.... We will make sure, though, through the new policy that's been approved by ITK, that ITK is, of course, fully consulted.

On the compensation for medical escorts, I know, and probably some MPs know more than I do, that there is a new benefit through employment insurance for caregiving of a very sick family member. That was something that our Liberal government introduced and passed a number of years ago. It's something to flag for escorts, that there is some provision of care through EI. Unfortunately, it wouldn't apply if the person was not employed, but there is a benefit for employed individuals losing access to income as a result of the severe illness of a family member.

● (1355)

The Chair: Thank you, Ms. Idlout.

Colleagues, we have only a few minutes left, and I would like to finish the round.

I would ask the Conservatives and then the Liberals to limit their questions to a two-minute period, please.

If that's possible, then I have Mr. Vidal...or maybe it's Mr. Shields.

You have two minutes.

Mr. Martin Shields (Bow River, CPC): Thank you, Mr. Chair. It's Mr. Shields.

I have a quick question, in the sense of establishing the dental fee for services for social determinants.

Are those established by province? I know the fee scale for dental in Alberta. Is it the same fee schedule for indigenous services as it is for others? Do you adopt the dental fee-for-service scales?

Mr. Scott Doidge: We have a fee schedule that we've developed ourselves. It is based on every provincial dental association's fee guide. We work within that fee guide in terms of reimbursing restorative and preventative services. We pay a range of between 85% and 100% of the fee guide. It's something that's set by the provincial dental associations.

Mr. Martin Shields: It's between 85% to 100%. Why don't you just adopt it directly?

Mr. Scott Doidge: It depends on the nature of the service that's being offered. We try to reflect the fees that are paid through private insurance as well as provincial programs.

Mr. Martin Shields: I understand that, but there is a severe mistrust in the indigenous population because of that variation. Do you understand that mistrust is there as to why they are treated differently?

Mr. Scott Doidge: It's certainly something that we hear about, and we've made a lot of investments over the last few years to make sure that our fees are competitive. We work with every association to deal with those issues.

Mr. Martin Shields: So you are aware.

When we're talking about reconciliation, trust is critical. I don't know why they would trust us to begin with, from what we've attempted to do to them. When you have a differentiation, do you understand how hard that is to overcome when you continue to have a differentiated scale?

Hon. Patty Hajdu: Maybe I can respond, Mr. Shields.

I take it, from the nature of your question, that you will be supporting budget 2022, unlike the many other budgets that the Conservatives have voted against. That's how we get to a place where we can provide equity, by continuing to make ambitious investments in the equal treatment of indigenous people in this country. I'll look forward to watching you vote.

Mr. Martin Shields: Thank you, Minister.

I'm done. Thanks.

The Chair: Mr. Badawey, you have a couple of minutes.

Mr. Vance Badawey (Niagara Centre, Lib.): Thank you, Mr. Chairman.

Mr. Doidge, I'm going to ask you a specific question. It's something I've been working on over the past few weeks with respect to access to advanced diabetes technologies for indigenous adults who currently have only case-by-case access to advanced glucose monitoring technology through the NIHB program.

In that regard, for example, an indigenous adult who may be eligible to access the Ontario drug benefit program could access advanced glucose monitoring technologies such as flash glucose monitoring. However, if they are not eligible for the public plan nor have any access to a private insurance plan, they would have to be reviewed by the NIHB program before even being considered to have access to this life-changing diabetes technology.

Is this an issue of NIHB not having the funding it needs to improve access to innovative technologies, which many non-indigenous people are already benefiting from?

Hon. Patty Hajdu: Maybe I can start, parliamentary secretary.

Mr. Vance Badawey: Go ahead, Minister.

Hon. Patty Hajdu: Thanks for the hard question.

The honest answer is, yes, we need additional funds to be able to universally cover that particular medical equipment. I am working on that as we speak. It has undoubtedly been lobbied for by many pharmacists in my riding and across the country.

It is technology that can reduce the burden of illness for people living with diabetes and improve health outcomes. I would argue that it would decrease the burden on our health care systems as well, although that's never the primary reason we would do something.

Let me take that away to continue to work on that. I'll look forward to your support in those efforts.

Mr. Vance Badawey: Thank you, Minister.

● (1400)

The Chair: Thank you, Mr. Badawey.

With that, I'd like to thank Minister Hajdu and her officials for coming today for this first hour of our afternoon committee. We very much appreciate your opening statement and answering our questions.

With that, colleagues, we're going to suspend momentarily as we prepare for the next panel.

Thank you very much.

● (1400)

(Pause)

● (1400)

The Chair: I'll call the meeting to order.

Welcome, everyone, to the second hour of our committee today.

Our panellists this time are Colleen Erickson, board chair of the First Nations Health Authority; with Richard Jock, CEO of the First Nations Health Authority. Second, we have Jessie Messier, interim manager, health services, First Nations of Quebec and Labrador Health and Social Services Commission; as well as Isabelle Verret, adviser, health access services, First Nations of Quebec and Labrador Health and Social Services Commission. In the third group, we have Mr. Carl Dalton, CEO, Nishnawbe Aski mental health and addictions support access program, as well as Orpah McKenzie, director, e-health telemedicine services, Nishnawbe Aski mental health and addictions support access program.

Welcome to our witnesses today. Some are in person, and some are with us virtually.

The way we proceed, as you probably know, is that each group will have five minutes to speak in the order in which I named them, and that will be followed by a question period.

If you're ready, either Ms. Erickson or Mr. Jock, you have the floor for five minutes.

● (1405)

Ms. Colleen Erickson (Board Chair, First Nations Health Authority): Greetings.

My name is Colleen Erickson, and I am Dakelh from the Nak'azdli, which is in the north region. I am also honoured to serve as the chair of the board of the First Nations Health Authority.

I would like to start by acknowledging the territory from which I call in this morning, the land of the Squamish, the Musqueam and the Tsleil-Waututh. I would like to thank the people who have endeared themselves to this land since time began for allowing us to conduct this business in their territory.

I'd also like to acknowledge the chair and the members of the standing committee. Thank you for the opportunity to be a witness in the study of the administration and accessibility of indigenous peoples to the non-insured health benefits program.

The First Nations Health Authority—the FNHA—is a health and wellness partner to over 150,000 first nations people and 203 first nations communities across B.C. Alongside our governance partners, the First Nations Health Council and the First Nations Health Directors Association, we work together towards our shared vision of healthy, self-determining and vibrant B.C. first nations children, families and communities.

In 2013, the FNHA entered into a historic agreement with Health Canada to assume responsibility for delivering health benefits. During the following five years, the FNHA established new partnerships and engaged extensively with communities to redesign the benefits plan. The new wellness-centred plan focuses on removing barriers to accessing care while supporting our most vulnerable clients. The plan reflects the needs and the priorities of first nations in B.C. and supports self-determination.

Historic mistreatment of first nations people in Canada has resulted in generations of trauma, racism and unequal access to health care services. While status first nations people across Canada have access to basic health benefits, we believe that the policies and funding levels perpetuate health inequities. These challenges are further exacerbated by anti-indigenous racism that exists in the health system.

Part of our goal was to eliminate health disparities, and I will now invite our chief executive officer, Richard Jock, to speak about the changes we have implemented to our benefits plan as a result of our extensive community consultations and where we are going next in our transformation journey.

Thank you.

Mr. Richard Jock (Chief Executive Officer, First Nations Health Authority): Thank you, Colleen.

Part of our submission is a brief that we have submitted to the committee. It gives a fair amount of detail about our delivery of the health services that we call first nations health benefits, which are known nationally as non-insured health benefits.

One of the things I want to comment on in the short amount of time we have left is that partnership has been a key operative term and an approach we've used throughout our work over the past eight years. For example, we partnered with communities as an important way to drive the work going forward. Similarly, we partnered with B.C. PharmaCare to create a new drug plan and a mechanism for delivering services very effectively. We used our experience there to engage further with communities on the development of an involved dental plan, which has yielded a lot of benefits and success within the first nations community and population.

We've also transformed our service delivery system from manual systems to electric systems and have included ways not only to access services in a more seamless way, to be clear and transparent about it, but also to provide quicker access and repayment where needed.

We still have work to do in the area of medical transportation which, I would say, is our next challenge. As I say, we will do that in partnership with a client-centred approach that measures satisfaction and provides continuous quality improvement as a key principle.

Thank you.

● (1410)

The Chair: Thank you very much, Mr. Jock.

We'll now turn to our second group of witnesses.

Jessie Messier and Isabelle Verret, I'm not sure which one of you will speak or if both of you will, but you have five minutes.

[*Translation*]

Ms. Jessie Messier (Interim Manager, Health Services, First Nations of Quebec and Labrador Health and Social Services Commission): Good afternoon.

First of all, I would like to acknowledge the unceded territories we are on.

We thank the members of the committee for allowing us to outline the issues related to the administration of the non-insured health benefits program and access by first nations to this program.

My name is Jessie Messier. I am non-native, and I am the interim manager of health services with the First Nations of Quebec and Labrador Health and Social Services Commission. With me today is Isabelle Verret, who is Wendat, and who is the advisor for health access services for the same organization.

We'll begin by highlighting the complexity of the processes for accessing program services. Indeed, these processes don't take into account the realities or the real needs of first nations.

The administrative burden required to provide access to non-insured health benefits, or NIHB, has frustrated professionals, who view it as a significant overload of work. In recent years, many professionals have decided to stop working with the program, leaving patients to pay for services and seek reimbursement on their own. Sometimes it can take several weeks between the request for pre-approval for a service and the response from the program indicating whether the request is accepted or refused. This reality is of great concern, especially for remote and isolated areas where the number of professionals located close to the community is limited.

The lack of awareness by professionals and first nations of the program's services is an additional barrier to access. All eligibility criteria for services and treatments are not transmitted, which is a major barrier for professionals who must determine the best treatment plan for their patients. This issue creates unacceptable delays for patients and professionals, who must take specific steps to have some of these services covered by the program.

This reality can have a significant impact on the health of our populations. As a result, the program forces first nations to justify certain medical treatments that are available to the vast majority of Canadians. This contributes to the continued systemic discrimination against first nations in the health care system.

In order to improve the knowledge of program professionals and the accessibility of services for patients, several strategies should be put forward. For example, information on the realities of first nations and the specifics of the services offered to them should be included in university training programs as well as in training offered in the provincial health system. Eligibility criteria should also be communicated openly to professionals working with this clientele.

Better support, adapted to the local reality of first nations, would increase access to services for a population with urgent health needs, given, among other things, the prevalence of chronic diseases.

Further complicating access to the program is the fact that the management of the various program services is shared between the NIHB national office and the NIHB regional office.

In recent years, the administration of some services that were previously managed regionally has been centralized in Ottawa. We note that this centralization has distorted the collaboration and communication that existed between the regional administration, the communities, the beneficiaries and the service providers. The adapted approach, the proximity and the relationship of trust that were established facilitated better access to services and minimized the effects of several administrative difficulties. Regional management also provided a better understanding of the specific needs of first nations at the local level.

The support and accompaniment provided to suppliers is now diluted in a uniform national approach that is rigid in relation to our reality in Quebec. While we understand that the goal of centralization was to better manage federal government resources, in reality, this has created significant challenges, including delays in authorization and reimbursement for services. It is essential that quality control mechanisms be established and closely monitored, all in cooperation with first nations.

As is the case with many programs and services for first nations, the NIHB program operates at the margins of programs established by provincial governments and is implemented without any real alignment.

First nations' eligibility for some provincial programs is often ambiguous and inconsistent across provinces and territories in Canada. Flexibility in access to the NIHB Program would allow for services that are tailored and complementary to what is offered by provincial and territorial governments.

The issue of responsibility for payment of services is also an issue we would like to draw your attention to. The NIHB program requires first nations to approach private or government insurance programs in advance of any application to the federal government. In addition to causing significant and unreasonable delays, this can be very complex for individuals who are not familiar with this type of approach or for whom English or French is not the first language.

● (1415)

The elements we are bringing to your attention today are just concrete examples of the many challenges first nations face when accessing services under the NIHB program.

It is essential that the work begun in 2014 as part of the joint review of the program continue in partnership with first nations to find concrete and sustainable solutions. Until then, the federal government must ensure that first nations are kept at the heart of any decision affecting the management of and access to the program.

The Chair: Ms. Messier, I would ask you to wrap up, please.

Ms. Jessie Messier: In closing, we believe that efforts must be made to support first nations in asserting their self-determination. The necessary support and resources must be made available to them to analyze and improve the current service offering and, therefore, eliminate any form of systemic discrimination toward our populations.

The Chair: Thank you, Ms. Messier.

I would like to give everyone a quick reminder. I know there's a lot to say, but it's important not to speak too quickly because we must allow our interpreters to do their job.

[*English*]

We'll now go to the third group.

Mr. Carl Dalton and Orpah McKenzie, you're in the room. You have five minutes for whichever one of you wishes to speak.

Thank you.

Ms. Orpah McKenzie (Director, Keewaytinook Okimakanak eHealth Telemedicine Services, Nishnawbe Aski Mental Health and Addictions Support Access Program): [*Witness spoke in Severn Ojibwa as follows:*]

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[*Severn Ojibwa text translated as follows:*]

Thank you. I greet all of you who are here, including those who are listening from afar. I thank the Creator/God for giving us this beautiful day and for giving us good health. Amen.

[*English*]

I greet all the people who are joining us from a distance and all those here as well.

I'm asking the Lord to help us and bless us. I thank Him that He's given us a beautiful day today. I thank Him also for health and well-being.

Good afternoon.

We are honoured to have the opportunity to appear before you today to share the incredible effort of the NAN Hope mental health and addictions support access program in providing care to the 49 communities of the Nishnawbe Aski Nation in northern Ontario.

My name is Orpah McKenzie. I am the director of e-health services at Keewaytinook Okimakanak eHealth Telemedicine, a provincially integrated telemedicine network that provides access to thousands of physicians, nurses and allied health care providers for 26 NAN communities. I am joined by Carl Dalton, CEO of Dalton Associates, a mental health organization that offers a culturally safe and attuned clinical workforce as well as mental health program development and management expertise. In partnership, our organizations designed and deliver NAN Hope.

NAN Hope began as an innovation in response to the NAN COVID-19 task team's investigations that revealed a high need for mental health and addictions support for the NAN region, given the challenges that were caused or exacerbated by the pandemic and resultant restrictions. To this day, NAN Hope is the only NAN-wide mental health and addiction support program, and we are honoured to have served over 1,000 NAN citizens since launching in August 2020.

NAN Hope strives to create a safe and trusting environment for the people and communities we serve. The fact that NAN Hope has been able to grow and expand is precisely because we have worked hard to build trust and shared care within the NAN region and have proven ourselves to be exceptionally responsive when needs arise that impact mental health and addictions at a community or individual level.

I'll turn it over to Carl.

Mr. Carl Dalton (Chief Executive Officer, Dalton Associates, Nishnawbe Aski Mental Health and Addictions Support Access Program): To meet the needs of NAN citizens in both remote and urban settings, NAN Hope offers a virtual, holistic, rapid-access approach to mental health, addictions and crisis support that is available 24 hours a day, seven days a week and 365 days a year by telephone, web chat, video and text messages.

NAN citizens have immediate access to crisis counselling, long-term counselling, navigation assistance and ongoing case management, all of which has resulted in our ability to save lives in real time in partnership with our community partners.

Our program is distinct from many existing services because we maintain relationships with clients, remote nursing stations, doctors and community-based organizations. We accept referrals and conduct outreach. We don't wait for calls to come in.

We offer barrier-free services in English, Ojibwa, Oji-Cree and Cree. We have a strong roster of respected and experienced counsellors, many of whom are indigenous and all of whom are regulated health professionals or trained in indigenous cultural healing and helping practices. Uniquely, NAN Hope also hosts regular virtual healing circles and virtual community cultural gatherings, which have been well attended during the pandemic time.

Currently, we are launching a mapping tool on the NAN Hope website, after having extensively mapped existing local and regional mental health and addictions services. This will take the onus from NAN citizens who must often navigate confusing pathways to access services in settings outside of their homes. With this application, we can better fill gaps, ensure against duplication and identify existing services.

In addition to the virtual support offered by NAN Hope, we do receive calls from communities for in-person mental health services. Recently, we received some additional funding to answer this call. However, our request to extend that funding and to continue offering in-person services in remote communities that are in crisis has not yet been approved. We recommend that the Government of Canada invest in the growth of NAN Hope, so that we can deliver critical crisis and mental health services in remote or fly-in communities when called to do so.

We wish to own space to deliver services in the urban centres of Thunder Bay, central Ontario and Timmins, Ontario—where many NAN citizens reside—to receive in-person services and primary health care services.

NAN Hope was originally funded for only one year; however, we have obtained an extension to March 31, 2024. We are grateful for the additional two years of funding. However, we would like assurance that we're putting infrastructure in place over these years to deliver a longer-term mental health and addictions support access program in the north. We request longer-term, increased funding for at least five years to allow NAN Hope to truly take root, grow and gain sustainability.

We appreciate your time and attention to these critical matters. This is an essential next step for continuity of mental health care in the NAN region.

Thank you.

● (1420)

The Chair: Thank you, Mr. Dalton.

We'll now proceed to a round of questions, beginning with the Conservatives.

I believe it's Mr. Shields for six minutes.

Mr. Martin Shields: Thank you, Mr. Chair.

Thank you to the witnesses for being here today and for sharing their information and stories with us.

I would like to go to the witnesses here in the room who just finished.

You used words like “trust”, “shared”, “relationships”, “referral” and “outreach”. Obviously, there must have been some groundwork ahead of time on what you've done before you started this program. This just didn't start out of the blue.

You have developed these things before. Is that right?

Ms. Orpah McKenzie: Yes.

There were established partnerships from KO eHealth. KO has been in existence for about 30 years already, so we do have an established relationship with some of the communities. I would say there are about 26, at least for those we currently have telemedicine sites in. Telemedicine was established about 20 years ago.

Mr. Martin Shields: Right, so you've done a lot of the work in the past, which allowed you to take the next step.

You ended talking about funding, in the sense that you're program funded and you need more of a guarantee of that funding. It's one of the things that I do talk about on this committee.

You're talking about a program that's taken years of work to get to the stage where you are implementing the next stage, but funding is the key for this to continue.

Mr. Carl Dalton: That's correct. We have built relationships for the last 25 years, and we work in remote communities in different ways alongside community members. When the pandemic happened, there was a COVID-19 mental wellness task team representing communities across the NAN region. They made a request, at that time, to the federal government for a pandemic fund for, essentially, a 24-7 crisis service, and we entered into that.

That service gained and built trust over that year, and was probably needed for many years before this. As the uptake and partnerships grow, there's a consistent call for service from the communities themselves—both urban and remote communities.

● (1425)

Mr. Martin Shields: The need was there. You developed a program that was beginning to work and you have outcomes that are working. You have some positive outcomes, but the challenge now is understanding how you're going to fund this ongoing. That's what you're facing.

Mr. Carl Dalton: That's correct. We've heard clear feedback, and we believe this program should stick around for many years to come and continue to evolve and be responsive to the needs of the communities.

Mr. Martin Shields: You established it with the sense of mental health and addictions. Those are huge and growing problems.

Mr. Carl Dalton: That's correct.

Mr. Martin Shields: You identified it and you found a solution.

Do you find other people coming to you and asking how you did this?

Mr. Carl Dalton: Yes. We worked with the government and communities to get the funding approved, and we started the program in 30 days, sir.

Mr. Martin Shields: You started it in 30 days.

Mr. Carl Dalton: Within 30 days, we had the counsellors and workforce available, and we built the infrastructure. It evolved over time so that, now, not only are the communities reaching out for services but well-trained, experienced indigenous clinicians are reaching out to us and asking how they can be a part of it.

Mr. Martin Shields: You mentioned that a number of indigenous people who understand the cultures, communities and geography are involved in this. Are you attracting more, as you say, to these types of programs?

Mr. Carl Dalton: Yes, I think we're appealing to a workforce that is there, but they want to use their own choices and voices, because they know how community operations happen. They know how healing happens. They want a say in that. Our program allows for that flexibility, and for a responsive budget rather than a strict mandate.

Mr. Martin Shields: It's proactive in the sense that this is going to lessen the costs in the future, as well as save lives. That's what you're looking at.

Mr. Carl Dalton: That's correct.

Mr. Martin Shields: That's fantastic.

Thank you, Mr. Chair.

The Chair: Thank you, Mr. Shields.

We'll now go to Mr. Weiler.

You have six minutes.

Mr. Patrick Weiler (West Vancouver—Sunshine Coast—Sea to Sky Country, Lib.): Thank you, Mr. Chair.

I'd also like to thank the witnesses for joining us today to provide their knowledge and experience to today's important meeting and to the study we're doing.

I'd like to begin by acknowledging that I'm streaming from the ancestral, unceded territory of the Musqueam, Squamish and Tsleil-Waututh peoples.

We were quite fortunate, earlier this week, to have Dr. Evan Adams join our committee to share some of his thoughts on his lived experience in the early days of establishing the FNHA. However, I'm very interested today to hear from Ms. Erickson and Mr. Jock about the FNHA's experience in delivering health care with your approach focused on wellness.

Maybe we can start with a general question. Perhaps you could describe the experience of the FNHA in delivering the non-insured health benefits program in British Columbia.

Mr. Richard Jock: One of the key elements is trying to focus on the patient, the client, the person. I would say what we've done with the immediate set of transformations is base our work on that and make the work accessible and transparent. The pharmacare program is one that we have designed in partnership with the provincial government, which mirrors the types of therapeutics that are available to all people in B.C. The other part of that is that we also still own our program and we are able to adjust that program to our specific needs and interests. I would say that's one aspect.

With dental and pharmacy, what we've done is work with providers. One of the things we've been able to do is get the almost universal buy-in of the providers for this. We have also moved from a very slow and cumbersome paper process to electronic processing. We follow 100% of the fee guide, and it's one that, as I said, is done in partnership with and fully endorsed by the dental association of B.C. Those kinds of relationships are also important.

Simple or smaller things, like eyeglasses, and transforming them so that there are no longer waits or predeterminations enables quicker access to things that are really needed.

I would say that's been our approach. It has taken time and it requires us to have a continued partnership with the national program, because there are some areas that continue to need resolution, and there are new things like devices, which were mentioned earlier, as well as things like new drugs and biologics, which are new and very expensive. We need to look at ongoing and future solutions if we're going to have a sustainable approach to this.

● (1430)

Mr. Patrick Weiler: Thank you.

Go ahead.

Ms. Colleen Erickson: I was going to add that one of the things about the FNHA is that we have really comprehensive engagement with our communities. These plans are very much designed by the community and, as we roll them out, the community provides us with very quick and comprehensive feedback as to what's working and what's not working. That enables us to design a plan that serves everybody.

Mr. Patrick Weiler: Thank you both for that.

Ms. Erickson, maybe I could quickly follow up on your last point, speaking to some of the advantages of being able to deliver health care in culturally appropriate and contextually specific areas. Could you please speak a bit more to how you're able to deliver services at the local level in that manner?

Ms. Colleen Erickson: Again, it goes back to the engagement that's in the community. British Columbia is very diverse in that we have many nations, so there's not one program that will fit everybody. That's what's so unique about our program here in British Columbia. First nations people in B.C. worked very collectively and collaboratively to build the FNHA.

It was many nations getting together, so our engagement pathways were established and it was a very comprehensive process that took many years—I believe it was over 10 years—before the first nations assumed control of their health. Having those comprehensive engagement pathways into the community, people are very much connected to their program and advise us as to how to design programs.

Mr. Richard Jock: If I could add to that quickly, we have regional offices where we have VPs who are involved with local service delivery aspects. That's not only the input and engagement, but right down to service delivery. We are getting that closer to the ground.

Mr. Patrick Weiler: To touch on that, as well, we've heard from other witnesses in the study that there have been issues with delays and administrative burdens. How has the FNHA been able to approach issues like that? Has your model been able to address that as well?

Mr. Richard Jock: I would say there are some key elements. One of them is that the electronic system actually minimizes any delays. The other part of that is that, by clearly following the fee schedule at 100%, the providers have confidence in what they can do. There's not a lot of checking back and forth. They can actually focus on providing service to the client. When the providers are enabled to provide that service, the access results in much more engagement by the providers, so that we don't have the issues of people not wanting to provide services to first nations people, or some of the complications and implications of having people pay up front. I would say there are a number of areas where we do that.

We also have apps for those who have phones and access to computers. People can check their eligibility and actually see what they've been provided. There are those kinds of more forward-looking ways of approaching wellness overall. I think we've put a lot of premium on that and the communication that goes with it.

● (1435)

The Chair: Thank you, Mr. Weiler.

[*Translation*]

I'll now give the floor to Mrs. Gill. You have six minutes.

Mrs. Marilène Gill: Thank you, Mr. Chair.

I'd like to thank all the witnesses who are with us today.

My questions will be mainly for Ms. Messier and Ms. Verret, from the First Nations of Quebec and Labrador Health and Social Services Commission. Of course, a few minutes isn't much time to say everything we'd like to.

Ms. Messier, can you give the committee more recommendations? You talked a lot about management and administration, but you certainly have other priorities that are just as important to you. Indeed, it's possible to do several things at once.

What do you recommend this committee do, on an urgent basis, to facilitate access to the program not only for the first nations of Quebec and Labrador, but ultimately for everyone?

Ms. Jessie Messier: Thank you for the question.

Several recommendations were made as part of the joint review of the program, which began in 2014.

It is a priority that work continue not only in consultation with first nations, but also in collaboration and partnership with them. First nations communities and various first nations advocacy groups have developed mechanisms to find creative ways to deliver services that are sometimes outside of the program's processes and administrative framework. When it comes to the basket of services available to first nations, the government needs to think about—

I'll slow down. I certainly understood the good advice I got.

Mrs. Marilène Gill: Ms. Messier, if you have anything else to add to your answer, please send it to us later. The committee can take note of it.

Ms. Jessie Messier: It's a topic of interest and passion.

It's about having some flexibility to allow communities to propose and implement innovative solutions. Whether it's transportation, dental care or other services, there are other ways of delivering services. Sometimes providing a service through the private sector, for example in the transportation sector, can lead to savings in overall costs. So, thinking about a more holistic vision for health and the basket of services could be a way to properly manage the public funds that are provided through the program. Ultimately, it's about recognizing the legitimacy of the communities, which must be at the heart of the thoughts and solutions proposed. That is a central element.

As of today, absolutely no decision, no direction, no change must be implemented within the framework of the NIHB program without first nations having had an opportunity to analyze the impacts on their populations. That is sort of what we deplore, meaning that first nations often find themselves behind decisions that are made unilaterally in the country, without being able to link services together, putting in place safety nets for people who are more vulnerable or thinking about different solutions. This is central to this reflection and to the continued work on improving the program.

There is also a need to ensure that work continues, that information is shared with professionals and that adequate support is provided to patients.

There is a one piece of data that we don't see anywhere: we don't know how many patients will ultimately not get the service. At the First Nations of Quebec and Labrador Health and Social Services Commission, we have exchanges with professionals. We have a liaison officer who provides support to communities in the Quebec region. Many professionals have told us that many patients will forego a service when they are told there are additional fees. However, that information is nowhere to be found.

Earlier, Valerie Gideon mentioned that there were 15,000 dentists enrolled in the program. However, how many of them actually follow the fee schedule for the services provided? They may be registered in the program, but are their services actually accessible to first nations populations?

This absolutely must be taken into account when considering improving the program.

● (1440)

Mrs. Marilène Gill: Ms. Messier, do you have any recommendations for modulation, which I think should be done on a community-by-community basis? As you said, each community has its own needs and realities. There is also a big difference between more urban and remote areas. What I hear on the ground is that it is difficult. Service delivery is envisioned in one way, whereas there are many realities.

You also talked about empowerment, but what would you recommend about remote communities? I'm thinking about mail, for example.

Ms. Jessie Messier: The issue of mail is a good example of how the administration of the program needs to be modernized.

One of the challenges we often see in small communities or in very remote areas is that there are very few professionals to deal with. There are monopolies. There are a number of components of the NIHB program that coexist, particularly when it comes to medical transportation. It allows residents or the local population to travel to obtain care. In return, the program limits this transportation to the nearest professional, who may be a professional charging exorbitant prices for services because they are in a region where, due to a lack of competition, they hold the monopoly. This makes it harder for people to access services.

So I think that communities should be allowed to choose their professionals, even if it means going further for care, and the basket of services that corresponds to their reality. That would certainly be one way of increasing the accessibility of services.

Mrs. Marilène Gill: Thank you.

The Chair: Thank you, Mrs. Gill.

[*English*]

Ms. Idlout, you have six minutes.

Ms. Lori Idlout: [*Member spoke in Inuktitut as follows:*]

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[*Inuktitut text interpreted as follows:*]

Thank you, Mr. Chairperson.

First, I want to welcome you all. It's very useful information we're hearing, because we also see, when you present before us, how capable we are as aboriginal people in the fields of work that we do.

I think I will ask all of you this, in the order of your presentation. With your experience in the health field and work to date, what recommendations do you have to improve NIHB as they exist today?

[*English*]

The Chair: I suggest we start as Ms. Idlout suggested, with the First Nations Health Authority.

Mr. Richard Jock: I'll make a few comments, and then I'll ask Colleen to add to that.

One thing that has been really important is to adopt a different approach to designing the system. We've learned through our process that what has worked well for us is when we pick a provider that will then partner with us to design the program. Rather than putting out specifications and program design and having people bid on delivering it, we've had a much more partnered approach to our work with providers. This has yielded a much different product, one that's based on mutual respect and respect for our communities, as well as a desire to provide that service in a culturally safe way.

The other part is that we've worked with our partners to look at the administrative costs. We start with a certain amount, and we adjust it based on our experience. Rather than going hard and cold on the business side, up front, we've worked with businesses to achieve our objectives. We are doing that and using technology, and we look forward to doing a similar approach with medical transportation, which is one of the biggest challenges.

● (1445)

[*Translation*]

The Chair: Thank you.

Do you want to add anything, Ms. Messier?

Ms. Jessie Messier: In answering a question from Mrs. Gill earlier, I touched on the whole issue of flexibility. I would add that in order to improve the program overall, there has to be client-centred thinking.

It's important to ensure that every step is taken to facilitate the patient's experience within the system, whether it's an administrative step, a request for justification or any step that facilitates the relationship between the patient and the professional. It's important to understand that it's very difficult for a patient to have to ask their health care professionals for justifications, especially when you consider the history of first nations and all the discrimination their members have experienced in the various health systems.

So it's important to ensure that each step is taken in the sincere interest of patients and in a way that promotes their well-being.

The Chair: Thank you.

[*English*]

Ms. McKenzie or Mr. Dalton, would you care to reply to Ms. Idlout's question?

Mr. Carl Dalton: Can we please get another summary of the question, as we both missed it? Our earpieces weren't operational.

The Chair: Ms. Idlout, perhaps you can repeat the question.

Ms. Lori Idlout: [*Member spoke in Inuktitut as follows:*]

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[*Inuktitut text interpreted as follows:*]

With your experience and work to date, what recommendations do you have to improve NIHB as it exists today? What improvement does it need?

[*English*]

Ms. Orpah McKenzie: I can probably speak to that.

I worked as a health director for 10 years, when I first went to KO. That was one of the biggest issues we experienced. There were a lot of issues around travel and being able to be heard, I guess, in the area of providing escorts, especially for the elderly and young children, and also for people who were suffering mental health issues, and those kinds of things. That's what we were hearing.

I know it's still ongoing. We are on the line between the north, Sioux Lookout, and Winnipeg. Many times, when I fly, I see patients who are there. There are young moms who are struggling with small children and the elderly who are struggling to get in and out of planes and stuff. There is no one there to help them or there are inadequate people to help them. The other thing is that, basically, the whole of vision care is uninsured. When you speak about vision care and the lack of services in the communities, that's always been an ongoing thing.

I know that transportation.... I know the Sioux Lookout First Nations Health Authority. I'm a board member there too. We get a lot of complaints from people who are experiencing difficulties in the area of non-insured when they need to travel out for medical care, especially for care that's far from home.

In Thunder Bay, especially for people who have not had the experience of going out and being placed in...especially the hotels. There are hostels there. Even the hostels may sometimes have their issues, but being placed in hotels that are very foreign to them, a very foreign environment, and not having somebody there to provide support for them, has also been a major issue as well.

● (1450)

The Chair: Thank you, Ms. McKenzie, and thank you, Ms. Idlout.

We'll start a second round and get as far as we can within the time allotted.

We'll start with Mr. Schmale for five minutes.

Mr. Jamie Schmale: Thank you very much, Chair.

Thank you to the witnesses for their testimony. It's a very interesting topic we're talking about, and we're hearing more interesting testimony today.

I might start with the First Nations Health Authority. It might be a bit off-topic, but it was kind of brought up in the opening testimony regarding mental health and addictions. I was very interested to hear about your two-eyed seeing program.

Could you expand on that? I know it's a bit off-topic, but I'd love to hear more about that and the results you're having.

Mr. Richard Jock: Two-eyed seeing is actually a concept that is very broad. It really refers to the ability to deal with the overall Canadian context, but also to see things from a first nations context. It does apply to our approach to mental health. It applies to our medical officers in how we provide our services to first nations people. It applies to the general notion that there's a first nations perspective on health that's equally important as we approach health matters, and that we look at things through that lens.

When we're delivering our programs—and we do have an array of services that have been provided through virtual means because of the pandemic—part of what has been a critical element to that is making sure that our services are culturally grounded. At minimum, the providers have gone through our prerequisites in terms of training, so that we screen out those who are not interested or not capable of providing culturally safe services.

That's a general context. It applies to research, and it applies to data. It really applies quite broadly across what and how we do our services.

Colleen, would you have any additional comments?

Ms. Colleen Erickson: The first nations people we serve are very much front and centre and remind us quite often that this is the critical part of all our programs, especially in regard to mental health programs, that it has to be applicable to who we are at this moment. Two-eyed seeing is a very critical part of that. It also creates real innovation and.... I'm not sure what the word is, but it very much strikes home to who we are as first nations people and it goes further to the healing. It's much faster.

Mr. Jamie Schmale: In terms of Indigenous Services, the department itself, how much interaction does your organization have with it?

Mr. Richard Jock: The partnerships we have include our continued partnership with ISC, the Ministry of Health in the province and also the Ministry of Mental Health and Addictions.

I would say there is an ongoing relationship. We have, for example, a letter of mutual understanding that we sign every year with the ADM of Indigenous Services Canada at the first nations and Inuit health branch. Folks like Valerie Gideon were really instrumental in helping us launch and implement our approach.

I would say there's a continued relationship and a need to address some of the continued systemic barriers that we see and also to deal with the sustainability of our approach.

Ms. Colleen Erickson: We also have the tripartite agreement, whereby we meet with the federal government and the provincial government twice a year to share what's happening in the FNHA and reaffirm our partnerships.

● (1455)

The Chair: Thank you, Mr. Schmale.

We'll go to Mr. Powlowski for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you.

I'd like to address my questions to the two people from NAN.

Before I became a member of Parliament two and a half years ago, I was an emergency room doctor for 17 years in Thunder Bay. Back then you didn't have your program of virtual mental health services. I'm happy to hear you started that, but I want to ask you about the in-person services. I gather you've applied for funding for that, but as of yet you have not received it.

I shouldn't tell you a story, because whatever I say doesn't get in as witness testimony; it's your testimony that does. Working in the Thunder Bay emergency room for a lot of years, there were a number of people who I got to know pretty well because they were pretty consistently in the emergency room. They were people who were homeless, had alcohol addiction problems and were from NAN communities. When I saw them repeatedly and they had increasingly high levels of alcohol, it was pretty clear to me that if something wasn't done quickly, they wouldn't be coming in anymore. It happened pretty frequently with the homeless people that you got to know them, but eventually you'd hear that one of them had died. It was almost always related to alcohol.

I have to say, Thunder Bay emergency didn't do a very good job with these people. Maybe they're doing a better job in the last couple of years, but as far as I know, we did very little. I don't know what addiction and mental health services were available. Detox certainly exists. The nursing stations in the communities exist and there are treatment programs, but I would occasionally phone up the nursing station from the communities these people came from and suggest they should think about flying them back up to their community to try to straighten them out before it was too late. Often, that was the case.

Could you tell me a little bit about what existing programs are available for such people from your communities—often, they're down in Thunder Bay—in order to address their addiction and mental health problems?

Mr. Carl Dalton: Thank you for your questions.

In terms of what existing programs are available, just recently and throughout the pandemic the communities have taken it upon themselves to build land-based treatment detox centres and wellness centres. Your advice when you were calling up nurses' stations a few years ago, that's exactly what's happening with the building of camps and working away at wellness piece by piece, when they can.

We're also hosting pretty innovative detox programs ourselves that are led by the community or chief and council. We're bringing in health care practitioners. I know that some innovative programs have been renting hotels for a couple of months to do a grand detox and do a lot of community development work in the meantime. By that, I mean they're finding housing for people, making sure there's food and making sure there are opportunities for a family to join them or for care. We're trying to make sure there's an aftercare plan once we go through this piece.

The reality is that many people still go through the public detox system, which means we do our best. We're building the technology to know the wait times for beds. When something opens up, doctors can start to call in and ask for that. That's something an emergency doctor often calls us about. As soon as we started the program, we heard from doctors right away in the hospitals. We started to pick up some of the aftercare so that, when they were released, there at least was a contact.

In the last two months, we've had a proof of concept with delivering in-person services under the NAN Hope piece. We have a lot of virtual care navigation, but we actually have people in the urban centres now who can go and pick people up after an emergency, get them to a hostel or housing component, and make sure they have food. We've had great feedback in the last two months. We applied for a year's funding and we received two months—

Mr. Marcus Powlowski: Who did you apply to for the funding?

Mr. Carl Dalton: The federal government had public health measure surge capacity funding available to us, which we were made aware of. We worked together with our partners to apply for it.

● (1500)

Mr. Marcus Powlowski: You're certainly welcome to follow up with my office. I can kind of follow up with that and try to encourage the government to do that.

The other thing—

The Chair: Mr. Powlowski, we're at our limit, unfortunately.

[*Translation*]

Go ahead, Mrs. Gill. You have two and a half minutes.

Mrs. Marilène Gill: Thank you, Mr. Chair.

I'd like to ask Ms. Messier another question. Earlier, she mentioned the idea of improving communications, collaboration and consultation between all parties. She named the federal government, among others, but also the Government of Quebec and the first nations. I would simply like her to tell us more about that.

Ms. Jessie Messier: Clearly, right now it's essential that mechanisms be put in place to facilitate the creation of a true continuum of care. The fact is, each province has a health care network in place, and it's often the primary network providing primary, secondary and tertiary services. This network provides some services in its facilities that are funded by the provincial government. There is no real connection between services, when patients are discharged, for example, to facilitate the continuum of care. Therefore, no link is necessarily made with the community. The workers who release patients are not necessarily aware of the services the federal government provides. Sometimes people will leave the facility without the proper dressings, and it can take a while for authorizations to come through.

Therefore, I think we need some reflection on that, so that each of the stakeholders can play their role. The federal and provincial governments have a role to play, but the communities also have a central role to play. We need to make sure that we optimize the involvement of each of the stakeholders to be able to create a true continuum of care, so that patients don't run into barriers when they have to navigate a system to receive care. That system really needs to break down all the barriers that patients can face when multiple jurisdictions are involved.

Mrs. Marilène Gill: Ms. Messier, I'd like to ask you another question about health care funding.

We know that health care gaps currently exist in Quebec and any of the provinces. Do you feel that increasing health transfers could also be beneficial to first nations people? This does not preclude my question about all the other changes that should be made. Having said that, do you believe that an increase in health transfers could have a positive impact on first nations people?

Ms. Jessie Messier: It could have a positive impact, as long as it comes with an obligation for the provincial government to provide real services to first nations. Currently, the Quebec government doesn't offer any services within first nations communities, except for medical services. I exclude the Cree Nation from this, because it has a special agreement with the province. With respect to the other first nations communities, the government does not provide occupational therapists or other health care professionals within the communities, for example.

So we can increase the budget, but if it doesn't come with a real commitment from the provincial government to provide meaningful services to first nations people, regardless of where they live, the impact may not be as great.

The Chair: Thank you, Mrs. Gill.

Ms. Idlout will finish off the round of questions.

[*English*]

Ms. Idlout, you have two and a half minutes.

Ms. Lori Idlout: Thank you so much.

I just have a quick question to follow up on MP Powlowski's questions and experience as a doctor, and what I'm sure is much of the experience of the health care system that provides services to first nations, Métis and Inuit.

Would each witness agree with me that what they experience as service providers when they see first nations, Métis and Inuit patients is the direct result of the deep impacts of colonialism? Because of that direct impact of colonialism, it is now more important than ever that the federal government has the responsibility to provide holistic, culturally appropriate and sustainable funding to address these mental health issues so that we can ensure that the impacts of colonialism are being reduced.

Qujannamiik.

The Chair: Thank you.

It's a big question, but please give short answers. We'll start with the FNHA.

● (1505)

Mr. Richard Jock: I would just say that there are two aspects to colonialism. One of them is that you really need to focus on the residential school context and to realize that we need to look at trauma-based services, that we need to refocus much of what we do to look at nation-based approaches and to have these models of trauma-based services and healing. I think this is totally consistent with the Truth and Reconciliation Commission, but I would say it is also based on what we're experiencing here in B.C. with Tk'emlúps and their discovery of 215 graves. Also, this is really widespread and affecting every community in B.C., and I would assume across Canada.

Colleen.

Ms. Colleen Erickson: I would just concur with your comments, Richard, and just say that the FNHA has, since the discovery of the graves, had to be very diligent in our partnerships with the ministries and with all agencies to deal with the crisis that was before us. I think that, going back to two-eyed seeing and the fact that we see things and we deliver innovative programs that are designed to address colonial structures and the institutionalized programs that we received, they've been innovated. I think that our response has been a little bit more comprehensive.

The Chair: Thank you, Ms. Erickson.

[*Translation*]

Did you want to add something, Ms. Messier?

Ms. Jessie Messier: I'd like to quickly point out that the First Nations of Quebec and Labrador Health and Social Services Commission doesn't provide services directly to members of the public. However, the dramatic story of Joyce Echaquan in Quebec shone a bright light on the consequences of colonialism and the discrimination resulting from it. I can only agree with your position to think about and promote a holistic approach, as long as it's determined by the first nations people themselves.

The Chair: Thank you.

[*English*]

Finally, Mr. Dalton or Ms. McKenzie, would you like to respond to Ms. Idlout's question?

Ms. Orpah McKenzie: I could respond.

Yes, I've really seen in my work over many years that colonialism definitely has had an impact on the lives of the Nishnawbe Aski people. I can speak only for our own people, because that's where I've worked most of my life.

I think that working together in the last few years with various levels of government and other groups to create programs has been one of the main things we've done to try to ensure that everybody knows where we're coming from, and that we have a voice, whatever project we're working on, especially in the area of virtual emergency care, which was started about four years ago. We now have 17 communities hooked up to virtual emergency care.

This year, we've been working on four extra sites, but with the pandemic, it's been slow going. We're still working on it, but I think the more we try to work together.... I look at some of the things from the work that's been done with the.... I forget what it's called, but anyway, if we can take a look at some of those recommendations, I think that would help us to address some of the issues that have been plaguing us, I guess, in the areas of health and mental health over so many years.

Meegwetch.

The Chair: Thank you very much, Ms. McKenzie.

This brings our panel to a close.

I would like to thank all of the witnesses for being with us this afternoon.

[*Translation*]

Thank you for sharing your testimony and answering our questions. It's been very informative for the committee and will help us in our deliberations.

● (1510)

[*English*]

Thank you again, everyone. I wish everyone a happy Mother's Day.

With that, this meeting is adjourned.

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