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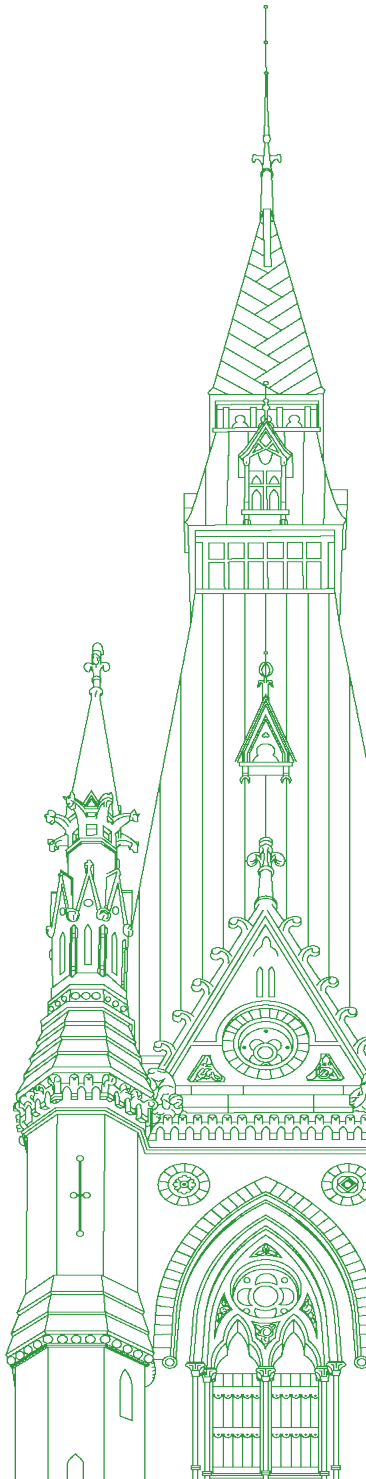

Chair: Mr. John Williamson

# Standing Committee on Public Accounts

**Thursday, March 3, 2022**

● (1105)

[*English*]

**The Chair (Mr. John Williamson (New Brunswick Southwest, CPC)):** I call this meeting to order.

I must say, coming in here today, there was activity and there was discussion. It is starting to feel like a regular Parliament again. It's a very nice sign.

Welcome to meeting number eight of the House of Commons Standing Committee on Public Accounts.

Pursuant to Standing Order 108(3)(g), the committee is meeting today to undertake a study on "Report 11—Health Resources for Indigenous Communities—Indigenous Services Canada".

[*Translation*]

Today's meeting is taking place in a hybrid format, in compliance with the House order of Thursday, November 25, 2021. Members can attend in person or remotely using the Zoom application.

The proceedings will be made available through the House of Commons website. So you are aware, the web broadcast will always show the person speaking rather than the entirety of the committee.

[*English*]

I would like to take this opportunity to remind all participants to this meeting that screenshots or taking photos of your screen is not permitted.

[*Translation*]

Given the current pandemic situation and in light of recommendations from public health authorities, as well as the Board of Internal Economy's directive of October 29, 2021, to remain healthy and safe, everyone attending the meeting in person must follow the health rules.

[*English*]

As the chair, I will enforce these health measures for the duration of the meeting, and I thank members in advance for their co-operation.

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

[*Translation*]

Members and witnesses can speak in the official language of their choice. Interpretation services are available for this meeting. On the bottom of your screen, you have the floor, English and French as options. If you can no longer hear the interpretation, please let me know immediately, and we will ensure it is correctly re-established before we continue with our meeting.

Please use the raise hand feature, which is on the main toolbar, if you would like to speak or get the chair's attention.

[*English*]

For members participating in person, proceed as you usually would when the whole committee is meeting in person in the committee room.

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—and I should probably learn this as well—please speak slowly and clearly. When you are not speaking, your mike should be on mute.

[*Translation*]

I remind you that any comments from members and witnesses must be addressed through the chair.

[*English*]

With regard to a speaking list, the committee clerk and I will do the best we can to maintain a consolidated order of speaking for all members, whether they are participating virtually or in person.

I would now like to welcome our witnesses.

From the Office of the Auditor General, we have Andrew Hayes, deputy auditor general. It's good to see you again, sir. We also have Glenn Wheeler, principal, and Doreen Deveen, director.

From Indigenous Services Canada, we have Christiane Fox, deputy minister; Dr. Tom Wong, chief medical officer, chief science officer and director general; and Robin Buckland, director general and chief nursing officer.

You have five minutes to make your opening statements. I will go to the deputy auditor general.

Mr. Hayes, you have the floor for five minutes.

**Mr. Andrew Hayes (Deputy Auditor General, Office of the Auditor General):** Thank you, Mr. Chair.

We are happy to appear before your committee today to present the results of our audit of health resources for indigenous communities.

I would like to acknowledge that this hearing is taking place on the traditional unceded territory of the Algonquin Anishinabe people.

Joining me today are Glenn Wheeler, who was the principal responsible for the audit, and Doreen Deveen, the director who led the audit team.

This audit focused on whether Indigenous Services Canada provided personal protective equipment, nurses and paramedics to meet the needs of indigenous communities and organizations during the COVID-19 pandemic. Overall, we found that Indigenous Services Canada adapted quickly to respond to the COVID-19 pandemic. During the pandemic, the department relied on the national emergency strategic stockpile to supplement its own supply of protective equipment.

Before the pandemic, the department was providing equipment and health care workers to 51 remote or isolated first nations communities. We found that during the pandemic, the department expanded access to protective equipment to all indigenous communities when provinces and territories were unable to meet the demand. It also expanded access to protective equipment to other individuals, such as police officers and people sick with COVID-19 or caring for a sick family member.

During the first 10 months of the pandemic, the department responded to more than 1,600 requests for multiple pieces of protective equipment. We found that communities, many of which are remote, received their shipments on average within 10 days of requesting equipment.

● (1110)

[*Translation*]

However, we found a number of weaknesses in the way the department managed its own stockpile of personal protective equipment before and during the pandemic. The department did not have complete and accurate data on the stockpile's contents. We also found that the department had not followed its own approach in procuring sufficient equipment before the pandemic. As a result, it did not have enough of some types of protective equipment in its stockpile when the pandemic broke out.

We also found that, in relation to providing nurses and paramedics to communities, the department streamlined its processes for hiring nurses in remote or isolated first nations communities. In addition, the department made its contract nurses and paramedics available to all indigenous communities to respond to additional COVID-19 health care needs.

While the department took steps to increase capacity, the number of requests for extra nurses and paramedics also increased. As a result, the department was unable to meet more than half of the 963 requests that it received between March 2020 and March 2021 for extra nurses and paramedics.

The pandemic aggravated pre–existing challenges in meeting nursing needs in remote or isolated first nations communities. Several factors contributed to nursing shortages in many of these communities, including the national shortage of nurses, the challenging nature of the work, the diverse skill set required to work in remote or isolated communities, and poor housing.

Mr. Chair, this concludes my opening remarks. We would be pleased to answer any questions the committee may have.

[*English*]

**The Chair:** Thank you very much.

Now I'll call Deputy Minister Fox. You have five minutes, please.

**Ms. Christiane Fox (Deputy Minister, Department of Indigenous Services):** Thank you.

*Kwe kwe*. *Ullukkut*. *Tansi*. Hello.

I want to acknowledge that I'm on the traditional and unceded territory of the Algonquin people.

Thank you for inviting me to speak to our department's response to the Auditor General's report concerning health resources for indigenous communities during the COVID-19 pandemic.

In the report, the Auditor General made two overall recommendations. The first was concerning personal protective equipment. The OAG noted that the department should review how we manage our stockpile of PPE, making sure that we have accurate records to ensure we have the right amount of stock for this current pandemic and any future emergencies.

[*Translation*]

To respond, we reviewed our inventory from before the pandemic. We then looked at how quickly the personal protection equipment—

[*English*]

**Mr. Eric Duncan (Stormont—Dundas—South Glengarry, CPC):** I have a point of order, Mr. Chair.

**The Chair:** Yes.

**Mr. Eric Duncan:** There was an issue with translation, but I believe it's been fixed. Thanks. I'm sorry.

**The Chair:** Please proceed, Ms. Fox.

[*Translation*]

**Ms. Christiane Fox:** Thank you, Mr. Chair.

We then looked at how quickly the personal protection equipment was being used during the first year of the pandemic, and overall, we were satisfied that we had enough equipment from the Public Health Agency of Canada to meet the needs of communities.

We must also recognize the challenge of acquiring this equipment on an international scale. In response to the recommendation, we also started working with the Public Health Agency of Canada on a joint automated inventory management tool. This will give us accessible, up-to-date information on the stockpile.

This past summer, we worked with a contractor to finish a full recount of all the equipment. That enabled us to update our inventory tracker accordingly.

I am very pleased to say that the department's inventory target has increased from six to 12 months' worth of equipment in its stockpile at all times.

● (1115)

[*English*]

We have now moved from a six-month to a 12-month supply at all times. We're also committed to conducting monthly inventory analysis so that we can be proactively managing the PPE stockpile, staying on top of trends and anticipating any needs. Finally, we're reviewing our chain of PPE custody and disposal practices to ensure a stable inventory.

[*Translation*]

The Auditor General's second recommendation concerned the shortage of nurses and paramedics.

The report said that the department should work with remote or isolated first nations communities to look at other ways to address the shortage of nurses and to review the nursing and paramedic support that communities received.

The department agreed with that recommendation. In response, we are now collaborating with the 50 first nations communities that we serve directly and the 29 communities that are managing their own nursing stations.

Supported by budget 2021, we are focusing on three areas: hiring new nurses, keeping them in the job and lessons learned during the pandemic.

[*English*]

All of this work is being done in partnership with nursing leadership within the department and our indigenous partners, and under the umbrella of the nursing health human resources framework. We're examining how we can better recruit and retain nurses by enhancing nursing supports and increasing access to practical nurses and nurse practitioners to augment the existing registered nurse workforce. The department has established and managed surge nursing and paramedic contracts to complement our workforce. Since April 2021, there have been over 11,000 service days of surge supports provided to help maintain essential clinical services in remote communities.

We're also working to create an internal primary care nurse service team. In time, this team will provide us with added flexibility to respond to the need for additional nursing resources. We're making improvements in areas such as customized nurse supports to resolve frontline issues related to IT, compensation and security.

We're also working to enhance our clinical practice supports and, of course, our continued 24-7 access to a customized nurse employee assistance program. As we all know, our frontline workforce has been working very hard under challenging circumstances throughout the pandemic.

[*Translation*]

We thank the Auditor General for the valuable recommendations, and we feel that the changes we have made have strengthened our response to this pandemic. They will also put us in a stronger place to respond to future health care needs.

*Meegwetch. Qujannamiik. Marsi. Merci*. Thank you.

[*English*]

**The Chair:** Thank you, Ms. Fox. I think I might know your father. He used to be in politics, didn't he?

**Ms. Christiane Fox:** That's correct, yes.

**The Chair:** Yes, very good.

Mr. Duncan, you have six minutes.

**Mr. Eric Duncan:** Thank you, Mr. Chair, and to our witnesses for being here today.

I want to focus my questions on the shortage of additional health care staff, as alluded to in the opening statements.

For context, I'm proud to represent and work with the community of Akwesasne in my riding of Stormont—Dundas—South Glengarry, and while not being remote, it is an example that certainly speaks to the challenges of attracting and retaining health care staff. Dr. Ojistoh Horn is the only full-time general practitioner at one of the clinics in Akwesasne, for example, a community of 25,000. She works with two nurse practitioners who cover about 14,000 patients.

There was a good CBC article that came out at the beginning of the pandemic, and it notes—to get into my question—that even before the pandemic, as Mr. Hayes alluded to in his opening comments, there were some challenges already arising. This was before the pandemic exacerbated the challenges.

Mr. Hayes, for statistics purposes, there's one thing I was wondering. You provide data on the services being met or not met during the pandemic. To give us a context, do you have—and if not, the deputy minister might be able to provide our committee with this—an idea of the request for services prepandemic and what was met and not met so that we can understand perhaps the volume and percentage of success in meeting those requests? Did you look at that data, and if not, can we get that?

● (1120)

**Mr. Andrew Hayes:** I do not have that data on hand. The deputy minister might have a perspective on that, though.

**Mr. Eric Duncan:** I'll go to the deputy minister then.

**Ms. Christiane Fox:** In terms of the question itself, I would say that the [*Technical difficulty—Editor*] that were requested in terms of surge during the pandemic were very much to complement the additional requirements beyond the staff we currently have in communities. It would be a different type of tracking in the sense that we have a permanent workforce in various indigenous communities across the country. At the time of the audit, it was actually 51 communities where we managed direct services and 28 where the service had been transferred to the indigenous communities. At this time we're at 50 and 29, because we transferred a community in Quebec.

In terms of the needs on the ground, it would have been assessed and met by the primary health team in the community, supported by the 18 physicians we have across the country, the regional medical health officers and the staff.

In the pandemic we saw an increased demand for surge support that would not necessarily have been common prior to the pandemic. We could probably provide the committee with statistics on the number of clients we saw per community, our workforce in the communities prepandemic and our workforce in communities postpandemic. I think that could give you an indication of the need surge during the COVID-19 pandemic, if that's helpful.

**Mr. Eric Duncan:** That would be. Thank you for that and for the backgrounder.

On the contracts being distributed, how were they advertised and what did they look like? I'm assuming you worked with provincial partners, and obviously indigenous communities directly, but what more advertising or promotion was done in that sense?

I'll have a supplemental afterwards about what more could be done, but I'll leave it at that for the first part.

**Ms. Christiane Fox:** Thank you for the question.

Just to give you a sense of context, we employ 862 nurses within Indigenous Services Canada. In addition to that, at this moment in time we have approximately 600 nurses and paramedics on our roster of contracted nurses. We use that roster in order to fill surge and even in order to fill the requirements within communities. It's very much a mix of Indigenous Services Canada personnel plus surge contractors.

How do we get those? We definitely do work with the province. In fact, as you can imagine, during the COVID-19 pandemic health human resources was a challenge across the country. Therefore, we sometimes had to compete for that health human resource capacity. We had to think about what some of the creative ways were we could attract and retain. We worked with colleges and universities and with first nations-led institutions like SIIT to try to get that health human resource capacity in indigenous communities.

I can speak to efforts going into the future, but definitely at this point we relied on ISC nursing staff and contract staff, and then used different ways to advertise and look for skills. Even within our own group, we have nursing staff who are in communities. We also have nursing staff within the department who are doing policy work. We look at our own workforce. We look at the retired workforce. Could we bring people back to be on contract with us, even if part time?

The last thing I would say is that we also instituted ISC CARE, which was turned around in about two weeks. It was a safe air transport that actually moved people from communities and that facilitated, safely, the arrival of our HHR personnel. We were able to fly over 5,400 health human resources in and out of those 51 communities.

● (1125)

**Mr. Eric Duncan:** Thank you.

**The Chair:** Thank you very much.

Mr. Dong, you have six minutes, please.

**Mr. Han Dong (Don Valley North, Lib.):** Thank you very much.

First of all, I want to take this opportunity to thank the Office of the Auditor General for a very timely report and recommendations.

I also want to thank the public servants, especially the medical officers and scientists, who have guided the government with their expertise and facts. It was one of the biggest reasons that Canada was praised around the world as a nation with a better response to a pandemic that we haven't seen in 100 years. Sincerely, please convey my gratitude to all the public servants under your supervision.

I want to talk about the first recommendation. The Auditor General's report specifically talked about the stockpiling of PPE. I heard about the management of surge support for the indigenous community.

Deputy Auditor General Hayes, in your findings, was there any particular focus on the fact that PPE has an expiry date? Was that factor applied to the readiness of the department when it came to support for indigenous communities?

Then I'll move to the deputy minister on this point as well.

**Mr. Andrew Hayes:** Thank you very much for the question.

Our findings on the department's stockpile focused in on the fact that there was inaccurate and incomplete information of the amounts that were in stock. Before the pandemic there was an approach that was expected to have been followed to have the appropriate amounts in the stockpile, and we found that it wasn't indeed followed.

During the pandemic we identified errors in the stockpile, whether from manual errors in inputting information on materials or equipment received, or from the actual contents of the stockpile. Our recommendation was focused on accuracy and completeness. We didn't comment on the expiry dates. However, as we mentioned in the PPE and medical device report, that is an important factor to be aware of as you manage a stockpile.

**Mr. Han Dong:** To the deputy minister, I just want to add another layer to the domestic production and manufacturing capacity, because we know there was a lack of that in the very beginning of the pandemic. Adding in the expiry nature of most of the PPE, going forward, how would the ministry better manage the stockpile of the PPE?

**Ms. Christiane Fox:** Thank you very much for the question.

I think we definitely took the recommendation on, and I think there would be two components that I would point to in terms of the department's response.

The first would be around the automated tool, which is very much centred on both outbound PPE and inbound PPE, having a very good sense of the type of PPE, the supply, the quantity, and where it's going. To give you a sense, since the beginning of the pandemic we received 2,241 requests coming into the department. Over 20 million units of PPE have been shipped. At this stage, 2,201 have been delivered.

Through this automated system and through the changes that we've done in the department, we can really track the flow of PPE that we have and we are able to determine both the expiry and the gaps in supply, whether it be gloves, sanitizers or whatever it may be. We have a very good sense of that. I think, as I noted in my remarks, that new tool, the sophistication that we brought to our current systems and how we manage the flow have allowed us now to build our supply to a 12-month turnaround period.

The way we worked with communities was that we would approve requests within two days of coming in and ship them right away. The average arrival of the PPE would be within 10 days.

I should also note that we provided PPE to the 51 communities and their health care workers, but we did not limit our PPE stock to just those health workers. If a school called, if a police officer called, if there were needs in the community, we did everything we could to respond to that need, and that was not limited to on reserve. We actually sent PPE supply to urban indigenous centres to be able to provide those essential supports for urban indigenous individuals who found themselves out of the community or even in very dire situations, in terms of the indigenous homeless population. It was very much not just limited to that.

How does it help us going into the future? I think we have a much better system to plan and track and to enable us to have confidence in our ability to meet the demands as they come in.

● (1130)

**Mr. Han Dong:** Thank you very much.

I'll stay on the supply issue. You mentioned it taking about 10 days, Does that take into account a pandemic setting? Every country around the world is competing for those PPE. Going forward in the future, will we still, in the end, revisit the crisis situation, beginning with the lack of PPE?

**The Chair:** I'll need a 10-second answer, please.

**Ms. Christiane Fox:** With our 12-month supply we're in a much better position than we were prepandemic. I think we do our best to get to communities as quickly as we can. We also have to remember that some of these communities are quite remote. It's not like shipping the supply just to Toronto. It's shipping it to sometimes very isolated and remote areas.

**The Chair:** Thank you.

[*Translation*]

Ms. Sinclair-Desgagné, go ahead for six minutes.

**Ms. Nathalie Sinclair-Desgagné (Terrebonne, BQ):** Thank you, Mr. Chair.

I want to begin by thanking all of our witnesses.

Like my honourable colleague opposite, I want to say that your work is very important and has been especially important in the most difficult moments. As we know, you work with more vulnerable populations, and they are often the ones who suffer the most during pandemics like the one we have been going through over the past couple of years. I thank you for your work.

Some of you may know this, but, in Quebec, when we talk about first nations, we do so from nation to nation. We have considered first nations as our brethren since 1603, since the Grande Tabagie de Tadoussac, when an alliance was established. According to some historians, that should actually be considered the founding year of New France.

But enough of the history lesson. My questions will mainly focus on the 2014 strategy, which has not been implemented. Stockpiles were not replenished in time, despite the strategy that was even developed by you.

I would just like to know what may have happened and why that strategy has not been implemented.

**Ms. Christiane Fox:** Thank you for your question.

We were able to recognize that, although the 2014 strategy was a hybrid one, we were exclusively counting on equipment from the Public Health Agency of Canada. Moreover, as we have seen since the beginning of the pandemic, there was a true shortage of equipment internationally.

If we look at the 2014 model and where we are now, the changes we have had to make have primarily consisted in not relying strictly on equipment percentage and what we received directly from the agency, but also in meeting needs by purchasing directly from the department.

It is also important to say that measures may not have been in place in 2014 for a daily review to be carried out. Now, a monthly review is done to determine what articles are in stock and what their expiry date is, and to really better understand what we have or don't have, so as to be able to meet needs. Unfortunately, the process has been more ad hoc than based on an automated system.

What we experienced during the pandemic and the recommendations we have received have given us an opportunity to review our methods. Before the fiscal year's end, in late March 2022, we are really entering the phase where this tool is starting to get tested. We will then continue to fine tune it to ensure that it meets not only the current needs, but that it will continue to meet needs going forward.

**Ms. Nathalie Sinclair-Desgagné:** That's what I was planning to ask next. You were a step ahead of me.

We are seeing a difference of nearly 600,000 items between items that were accounted for in inventory stock tables and what was recorded. That is a lot of items after all.

If I have understood correctly, you are saying that those errors were due to the process and that they will not recur thanks to the new processes that have been set up.

● (1135)

**Ms. Christiane Fox:** That is our tool's objective, to better understand not only what we are purchasing and what we are doing in terms of contracts, but also what is being done in warehouses. That second initiative will help us.

We must not only be able to properly understand what is in the warehouses, but also have good knowledge of practices with a contractor who ensures that the way stocks are managed allows us to know what we have and enables us to keep articles in the department with a view to their distribution.

**Ms. Nathalie Sinclair-Desgagné:** That's very good.

Mr. Chair, do I have about one minute left?

**The Chair:** You have one and a half minutes.

**Ms. Nathalie Sinclair-Desgagné:** Great, thank you.

Ms. Fox, you are talking about the plan and tool that should be ready by late March 2022.

I know this is surprising to many people, but we are already in March 2022.

**Ms. Christiane Fox:** Yes, I know. Concerning the tool as such, we are carrying out a test, which actually has two components. One concerns outgoing personal protection equipment items and the other one concerns incoming items.

The test we do involves everything. That test will be done before the end of the fiscal year, and we will begin soon.

However, as you know, information technology systems must be tested. They also need strengthening. So we cannot just rely on the new system. We must work to ensure the system is good and reliable. As in any large project, there will be challenges. We must have strategies to address them. So that is the test we will start using at the end of the year.

**Ms. Nathalie Sinclair-Desgagné:** So it is being implemented. That's great.

That will be all. Thank you.

**The Chair:** You had only 15 seconds left. Thank you very much

[*English*]

Mr. Desjarlais, you have six minutes, please.

**Mr. Blake Desjarlais (Edmonton Griesbach, NDP):** Thank you very much, Mr. Chair.

I often find these studies difficult, because I've experienced in many ways, like in the last committee meeting, what this work means in communities and on the ground.

Madam Fox, you have spoken quite highly about the work that's been done here, but there are tremendous gaps. The work of our committee is to identify these gaps and to ensure that you know of them, so please don't take anything I am about to say personally. I hope that it informs your work better and we can ensure that lives are saved, because lives were lost. My uncle died on reserve during COVID, 15 days after a request from the community went out for PPE.

That is someone's responsibility. They never got the services in time. They never got what was really needed so that the community could truly protect itself, and this isn't a new story for indigenous people. We've experienced this time and time again, whether it was tuberculosis during the residential school period—when Canada failed to act to protect my grandmother and my uncles, who died in that institution—or before that with smallpox. At times, it was deliberately brought to communities.

These are the types of communities we are dealing with. They are communities that are trauma-informed by those experiences.

I remember growing up with stories from my *kôhkom* and *cimošôm* about how scary it was when the Indian agent would come with a medicine chest and they were uncertain as to what was in it, but they were even more afraid of what wasn't in it. Many of these nations have signed treaties with Canada, asking for a guarantee for health like the medicine chest clause.

The medicine chest clause is something that every treaty group in this country wanted to ensure Canada understood clearly. I have heard from Treaty 6, Treaty 7 and Treaty 8 that, on this clause, Canada failed to uphold its obligations to ensure they had the proper resourcing as per the treaty that's been guaranteed.

I really appreciated my colleague from Quebec's mention of nation-to-nation relationships. There is a lot that Canada can learn from that framework. In my community, in Alberta, we didn't have that support. We didn't even have the ability to protect our elders.

A part of this I want to mention.... I'll spread this out over a few rounds, but in particular in the report, your action plan states something that I found to be a glaring discrepancy with what the Auditor General asked for. I am looking at your action plan that was provided in response to report 11. On page four of 14, there is an action item response to what the Auditor General requests to engage first nations communities in staffing processes. You and your ministry have reported the response to that action, in item 2.1:

> Working with the Nursing Leadership Council, and the Nursing Retention and Recruitment Steering Committee, ISC will examine its current recruitment model....

Does the deputy minister think that's satisfactory for engaging with first nations communities in staffing processes?

● (1140)

**Ms. Christiane Fox:** I would start by saying that everything we do is in partnership with indigenous leadership across this country. When we talk about our response to COVID, it was never just ISC nursing staff. There were always first nations health pandemic response teams. There were mobile mental health units that were first nations-led, working side-by-side with our ISC nurses and physicians. There were multiple tables that were put in place, not just for the response in terms of PPE but in terms of vaccinations and the "Protect Our Elders" campaign.

This is what I would say. First, I would offer my condolences to you on the loss of your uncle.

The second thing I would say is that we cannot do these hiring practices independently of our discussions with communities. As the goal of this department is the health transfer of services, it's empowering communities to take that on. Part of their short-term strategy is to try to fill gaps and then the important work that we're doing on long-term strategies to have indigenous students in post-secondary institutions—

**Mr. Blake Desjarlais:** Deputy Minister, I'm asking specifically about the action plan. Can you make mention of 2.1 of your action plan, which states, "Working with the Nursing Leadership Council, and the Nursing Retention and Recruitment Committee"? Why not respond directly to the Auditor General when they say to engage first nations communities in staffing processes? Why not make that an action item?

**Ms. Christiane Fox:** Maybe we can be more precise, but it is part of the action item. It is part of our talent acquisition and management. They are central to it, and it's not limited to our nursing staff. We do that even for our senior executive team. We have indigenous leadership on the interview board, so it is absolutely something that we take on board. It is absolutely something that we are building into our hiring practices for the department.

**Mr. Blake Desjarlais:** Thank you very much.

In regard to this consultation work, you mentioned that there were mobile working units, and I think you said there were 18 and upwards of 80 staff. This country has a massive geography of indigenous peoples, and you know as well as I do that these staff are unable to accommodate the true need for these services across the country. Would you recognize that there's a tremendous amount of work that still needs to be done to ensure that this is truly satisfactory, because this isn't satisfactory?

**Ms. Christiane Fox:** I want to clarify that we have 862 nurses working for us. The 18 were specific to medical health officers, like Dr. Anderson in Manitoba whom we worked very closely with on the pandemic.

I want to make it clear that the 18 are physicians. Is that enough? No, this is the network that this department has, and that network works with more provincial and territorial health experts along the way. I don't want to make it sound like it's just the 18. It's part of the network that we have within this department. These are physicians. Those physicians also work with others. We have nursing supports and we have our contract surge.

**The Chair:** Thank you.

Mr. Patzer, you have five minutes.

**Mr. Jeremy Patzer (Cypress Hills—Grasslands, CPC):** Thank you very much. I'm going to start with the Auditor General's office.

There are many instances throughout the report where it references the allocation of scarce resources COVID-19 interim response strategy, and it specifically references that they would provide 2% of bulk purchases to Indigenous Services Canada. Do you have any dollar amounts for what that 2% ended up costing, in terms of actual dollar value?

**Mr. Andrew Hayes:** I don't have numbers for that.

I would mention that, with the other report we provided, we talked about the fact that the market was very dynamic through the pandemic, and prices would have fluctuated all the way through the pandemic, including up until now.

**Mr. Jeremy Patzer:** Right, but does that number exist? Do you have that number somewhere else, so you could table it with the committee to give us the total dollar figure?

**Mr. Andrew Hayes:** We wouldn't have an up-to-date or accurate dollar figure for that, given that our work on this report and the other report was completed in early 2021. In order to get that information, we would need to also engage with Public Services and Procurement Canada to have a more up-to-date number.

● (1145)

**Mr. Jeremy Patzer:** Is that something you think you could get and table with the committee? I think that would be a relevant thing to have.

**Mr. Andrew Hayes:** I will see what I can do with our people. We don't have an audit going on in Public Services and Procurement Canada right now, but I'll reach out to see what we can find.

**Mr. Jeremy Patzer:** Thank you.

In regard to that, we saw at the beginning of the pandemic that we sent a lot of PPE overseas. When we look at this 2% threshold and ISC in general, were they exempt from having their PPE sent to other parts of the world, or were we able to leave that strategic stockpile in the hands of ISC?

**Mr. Andrew Hayes:** My understanding is—and I'm drawing on the other report that was studied as well—that the scarce resourcing strategy was developed at the beginning of the pandemic to make sure there was enough capacity in the national emergency strategic stockpile, the Indigenous Services Canada stockpile and the provincial-territorial requirements. I think that the question of what went overseas versus what was in the stockpile is different.

**Mr. Jeremy Patzer:** On page 18 of the report you said, "Because of the COVID-19 pandemic, we did not visit Indigenous communities or organizations during our audit."

To clarify, for consideration of this report, do I understand correctly that this means you would normally visit these communities? Do you believe that some information may have been missed because there was no physical presence on the ground in these communities?

**Mr. Andrew Hayes:** Our normal approach would be to visit communities and engage directly with the leaders and elders. In this case, because of the circumstances, of course, we weren't able to do that, so there is a possibility that we didn't have the information we would have received if we were able to visit these communities. However, we did see evidence in the files of consultation by the department, phone calls and Zoom calls, etc., which isn't as useful in the grand scheme of things when you can visit, but under the circumstances, that's what we were left with.

**Mr. Jeremy Patzer:** Thank you.

In exhibit 11.2, I find it interesting to look at the breakdown per province. We see that Manitoba received almost 800,000 masks. Across the board, they had a much higher amount of PPE sent to them, as compared to, say, Saskatchewan or Ontario. When you look at the population that is served by Indigenous Services Canada and compare the population numbers to the amount of PPE sent, why did Manitoba receive a vastly larger amount of PPE than any other province?

**Mr. Andrew Hayes:** The deputy minister might be able to answer part of this question.

For the purposes of our audit, we were focused on what the department did when faced with responses from the communities. What was happening in a particular province, whether it was the prevalence of the disease or the circumstances of distributing PPE—the access in the province—is ultimately all different.

In our report, we did identify which were the three top provinces for the department to respond to.

**The Chair:** That is your time. Thank you very much.

Mr. Fragiskatos, you have five minutes, please.

**Mr. Peter Fragiskatos (London North Centre, Lib.):** Thank you very much, Chair.

Thank you to our witnesses for their work and for appearing.

In the report, recommendation 11.61 states:

> Indigenous Services Canada should work with the 51 remote or isolated First Nations communities to consider other approaches to address the ongoing shortage of nurses in these communities and to review the nursing and paramedic support provided to all Indigenous communities to identify best practices.

The department has agreed to that recommendation.

My question is on the 51 first nations and engagement. It's a question to the deputy minister. How exactly will engagement proceed? Are communities prioritized according to a particular set of criteria? If so, what are those criteria? How does engagement unfold in these cases?

● (1150)

**Ms. Christiane Fox:** Thank you very much.

I should specify that, at the time of the audit, it was in fact 51 communities, but we have transferred the service in one case. If I use the figure of 50, it's to show that we're at a different place now than we were, and it's great news in terms of the agenda for health transformation that the Quebec community has taken on.

In terms of how we will engage, I think the first thing is that we engage regularly. We have nursing staff in community at all times. For the 51 communities, there are constant communications between the chief, the band council and the health directors. That engagement happens consistently on the needs.

Specific to the recruitment and retention, what we want to talk to leadership about is not just how we recruit and retain, but how we modernize the practice environment. What is the well-being of the workforce? How do we encourage members of the community to pursue a career in HHR, and what are some of the supports that are required? How do we maintain a nimble and agile search?

These are sometimes very challenging postings. They're remote. They're rural. Over the summer, I spent some time with our nursing staff in Sandy Lake, Pikangikum and Norway House.

I think the strategy and the engagement has to be not just about what they need in terms of primary health care needs, but it also needs to be future looking. What does the health infrastructure in the community look like? What is the path towards the talent development? The department has emphasized health transformation, and that is about empowering communities to take on the health services for their communities.

We also talk a lot about health teams. The reality is that our health professionals, at times, are doing work that is perhaps administrative, in addition to their day-to-day work. How can we create these teams that are paramedics, nurses, physicians and lab technicians to conduct X-rays? How can we engage the community?

When I was in Sandy Lake, the X-ray technician and the person doing the rapid test kits or the GeneXpert testing for the community was a member of the community who was hired and then embedded into that nursing team. I think these are the types of engagements that we need to have.

**Mr. Peter Fragiskatos:** Thank you very much for that.

Deputy Minister, throughout the report, the phrase “best practices” is used a number of times. In talking about the need for the department to approach things with further engagement of indigenous communities and health practitioners as a view to coming around to establishing best practices, “best practices” is never defined.

I only have a minute or so left, so I won't put it to the Auditor General. I think the more important question would go to the department. How are best practices defined here? Is it reflective of indigenous principles around health care? Are there other ideals infused within that conception of best practices? How will the department approach best practices? What does that mean?

**Ms. Christiane Fox:** I have three thoughts on that.

The first one, in terms of best practices, is probably the most important: ensuring that we have culturally relevant health services for indigenous communities. That means training. It means hiring indigenous professionals to manage health services. That is a best practice that needs to be across the country.

The second piece is around innovation. We talk about tools that can help us, like IT systems that can help track PPE, but beyond that, what are some of the innovations in terms of best practices that we can adopt? We have teams that now have connectivity. If you're in northern Saskatchewan, you can connect with a physician in Regina or Saskatoon. What types of virtual care technologies can we do? These are some of the best practices—

**The Chair:** Ms. Fox, I'm going to have to leave it there. Thank you.

**Ms. Christiane Fox:** Thank you. I'm sorry.

[*Translation*]

**The Chair:** It's okay. No problem.

[*English*]

I'm just trying to keep things on track.

[*Translation*]

Ms. Sinclair-Desgagné, go ahead for two and a half minutes.

**Ms. Nathalie Sinclair-Desgagné:** Thank you, Mr. Chair.

My next question will mostly focus on the labour shortage issue, which has not spared first nations communities. I am especially interested in knowing more about this, which comes from the Auditor General's report:

> Several factors contributed to nursing shortages … the challenging nature of the work, the diverse skill set required to work in remote or isolated communities, and inadequate housing.

When work is offered to staff coming from far away, can you explain to me how it is possible not to be able to make adequate housing available to them?

● (1155)

**Ms. Christiane Fox:** Thank you for your question.

The pandemic has exacerbated the housing shortage in some of our indigenous communities. We know this will affect not only community members, but also staff, such as nurses, professors and police officers who come from elsewhere and work in those communities. That is one of the challenges we are facing in recruitment.

Let's take for example a community where, in normal times, we have enough housing for three to five nurses. However, owing to COVID-19, more staff had to be sent there for augmented teams. Given that context, there was occasionally no housing available for everyone.

That is a reality. The department is really trying to resolve the housing shortage issue. I think we have invested just under $1 billion in that initiative since 2015. Further investment is needed and will continue to be provided. That is the reality of our human resources services. They must think of not only housing, but also the safety—

**Ms. Nathalie Sinclair-Desgagné:** Okay. Thank you, Ms. Fox.

You mentioned an envelope to help address that housing shortage. Do you have any other numbers for us? Do you have objectives, deadlines, an action plan specifically for the housing shortage, which, as we know, is serious?

**Ms. Christiane Fox:** Absolutely. We will be able to submit to you the investments planned over the coming years. As I mentioned, $991.5 million has already been invested in communities. At this time, 1,000 projects are underway. There are 3,500 new homes, 7,000 renovation projects have been carried out—

**The Chair:** Thank you very much, Ms. Fox.

I understand that you have many things to tell us, but I must follow the rules when it comes to speaking time.

[*English*]

Mr. Desjarlais, you have two and a half minutes, please.

**Mr. Blake Desjarlais:** Thank you very much, Mr. Chair.

My questions will be directed to the deputy minister of Indigenous Services.

On the same line of questioning as my colleague from Quebec, related to housing, this is a systemic problem that the government has been aware of for generations. Before I was even born, my father had to build his own cabin in the northern part of Alberta, and we lived there. We lived there without clean water, and we lived there without power. We lived there without the basic things that many Canadians expect in a country as wealthy as the one we have. Throughout his time there, he eventually moved out of that house when he started to have children, and he attempted to get a government-sponsored house. Once he did, he already had four children, who ended up growing up in poverty. My oldest four siblings—I'm one of eight—during that time had many of the sicknesses that affected the community.

Housing is critical to health. Imagine if you had someone come into your house, which is overcrowded, with one bedroom and one bathroom, and there are eight people or 12 people living in your house, and then one comes home sick—you're all going to get COVID. That's what happened in indigenous communities across this country, because the housing crisis is real, and it's a massive indicator. The Auditor General even mentioned it in his statement. The Auditor General even mentioned in paragraph 9 of his statement that it was one of the criteria:

> The pandemic aggravated pre-existing challenges in meeting nursing needs in remote or isolated First Nations communities. Several factors contributed to nursing shortages in many of these communities, including the national shortage of nurses, the challenging nature of the work, the diverse skill set required to work in remote or isolated communities, and poor housing.

That's a massive issue. If we've had these year-long plans year after year after year for the last 50 to 100 years, I'm not confident that this ministry has the ability to actually fix this plan. We need to know and we need to get down to the bottom of where it needs to be fixed. I'm interested in results and making sure that this doesn't happen again. I don't want to see more kids die. I mentioned in the last committee meeting that I've seen that.

I also want to mention in regard to the PPE supply that, when I was working in Alberta on behalf of indigenous groups, we actually met with the former minister of Crown-Indigenous Relations and she committed at that time to supplying isolation units for northern Alberta communities. Zero were delivered. That wasn't in this report, though. Zero isolation units were delivered to any of the Métis settlements in Canada. Not one Métis settlement got an isolation unit, and the minister committed to that—I was on the phone with her—and people passed away.

I would like the deputy minister to comment.

● (1200)

**The Chair:** I'm afraid the comment is going to have to wait for your next round, sir.

**Mr. Blake Desjarlais:** The next round...yes.

**The Chair:** Thank you.

Next up, please, is Mr. Lawrence.

You have five minutes.

**Mr. Philip Lawrence (Northumberland—Peterborough South, CPC):** Thank you, Mr. Chair.

I'm looking back, but I want to be helpful to the department, hopefully, going forward.

According to the Auditor General's report, in 2014 the department developed a procurement plan. However, it wasn't followed.

Deputy Minister Fox, I know that you are a great communicator, but briefly, if possible, could you tell me where the failing was? Was it a failure of resources from the government? Was it a failure of the department? Where did that failure happen?

**Ms. Christiane Fox:** Thank you very much for the question.

I wasn't here in 2014, but my understanding is that there was a reliance on the national emergency stockpile, and probably, in terms of when you talk about the “gap”, the gap was probably not a thorough assessment and a regular monitoring of the PPE supply and the state of the PPE that was in our possession. I think that's what, frankly, we're moving away from, to go towards this new system.

**Mr. Philip Lawrence:** Thank you, Deputy Minister. We'll get back there.

Here's my concern, though. This sort of pandemic, as one of my colleagues rightfully said, was a one-in-100-year event, but we will have other significant events that will happen in the coming years. Are you assessing your other areas? Are there other gaps there? Is there a need for additional government resources? If you had a wish list, are there things where you'd like additional funding so we don't get caught again?

**Ms. Christiane Fox:** There are enormous needs within indigenous communities. In terms of future planning, I think we are taking the lessons of the pandemic for PPE specifically. I think I mentioned moving from a six-month supply to a 12-month supply, which allows for that buffer zone if ever we were to face a similar event.

What I think we need to really think about is emergency management in this country, and that is not just exclusive to a health pandemic. We faced significant challenges over the last two years, because not only were we facing a COVID pandemic, but in addition to that, we had fires and flooding. The requirement for PPE and safety protocols was not limited to a community. It was also important when there were evacuations. Data, I think, is a huge area of concern in terms of well-managed health human resources and health services that are culturally relevant.

**Mr. Philip Lawrence:** Thank you, Deputy Minister.

You just said something I wholeheartedly agree with. I believe that in many sectors of the government—and this goes back multiple governments—we haven't invested appropriately in data management. I'm glad there's going to be data management involved in PPE, but is there a particular area in which the government could invest more money with respect to data management and maybe climate change resilience or something else specifically that maybe you'd take the opportunity to get on the record?

**Ms. Christiane Fox:** We absolutely think that data, capacity and governance are key to supporting indigenous leadership in this country for all areas of EM, health or economic development.

**Mr. Philip Lawrence:** With respect to the PPE, my understanding is that you were using nothing more sophisticated than spreadsheets up to this point.

Are there other significant areas in which your department is relying simply on spreadsheets to support data management? To be clear, I don't blame you. I think this is, as I said, a failure by multiple governments to invest in data management.

**Ms. Christiane Fox:** In full transparency, I would have to do a full review of the department. One thing that does come to mind is that, for data from our nursing stations that support communities, we should have access to better systems. These go beyond just the nursing station in terms of how they interact with the provincial data systems, but I do think modernizing our data from nursing stations would be a key priority as well.

● (1205)

**Mr. Philip Lawrence:** Thank you. Those were excellent answers.

I'll just finish with one short question here to keep the chair happy. How much of the PPE that you are procuring or asking for is made in Canada and how much is made by indigenous-owned businesses?

**Ms. Christiane Fox:** I would have to check on that.

Of what we've received, 2% would actually be procured by PSPC and by the Public Health Agency of Canada. Then we also sent funding directly to indigenous communities to purchase their own PPE, some of which may have been from indigenous businesses. I would also note that we have a 5% target for indigenous procurement, and this department will be—

**The Chair:** Thank you. Your point was made.

Ms. Yip, you have five minutes. Go ahead, please.

**Ms. Jean Yip (Scarborough—Agincourt, Lib.):** I'd like to thank Mr. Lawrence for realizing the importance of investing in data management. That's always great.

I'd like to thank all the witnesses for appearing today.

Welcome, Dr. Wong. My first question is for you. How were children, seniors and those who were immunocompromised treated during the PPE and nursing shortages, such as those requiring medical care for diabetes or cancer?

**Dr. Tom Wong (Chief Medical Officer, Chief Science Officer and Director General, Department of Indigenous Services):** Thank you very much for the question.

All of us in the department, even before the pandemic, have been very concerned about the most vulnerable population within each community, whether it's first nations, Inuit or Métis, especially individuals who are elders or who have diabetes or cardiovascular diseases. All of the individuals are at much higher risk of complications from COVID.

Because of that, one of the top priorities of the department was to convince the provinces and territories of the importance of prioritizing indigenous peoples for vaccination and to get public support for all other public health measures. Also, every day within each community and our regions we need to support the regional leadership and the health directors to try to make sure that, to the best of their ability, they can support the protection of the elders, pregnant women, children and other individuals. If we don't take care of the most vulnerable, we will not be able to eventually come out of the pandemic and minimize both hospitalizations and fatalities in the communities.

However, that being said, all of the long-standing social determinants of health, including housing, water, etc., are contributing to the vulnerabilities of the members of the communities, and those must be addressed.

**Ms. Jean Yip:** Ms. Fox, just to stand up on Dr. Wong's answer, is there anything that can be done in the future to help these vulnerable groups should there be another crisis?

**Ms. Christiane Fox:** Absolutely. With some of the planning that's being done now, given the pandemic and the lessons we've learned to date, and hopefully postpandemic when we can really focus, there are going to be strategies in place in terms of how we manage the most vulnerable. That could be everything from housing to the anti-racism in the health care system strategy and our post-secondary strategy. There are a number of issues—I think housing is a key determinant of health—so we have to focus on these things.

I would also speak to the potential for health transformation and service transformation and empowering communities by having funds to allow them to take over those services.

We are seeing some examples of what health transformation can look like. We have NAN in northern Ontario. We have MKO in Manitoba. We have a group in Nova Scotia that has a proposal to take over health services and governance for 13 first nations. I think that the empowerment of those communities will help the most vulnerable, but it's not limited to just health. If you think about early learning and—

**Ms. Jean Yip:** Thank you.

Dr. Wong, despite the lifting of restrictions across the country, there continues to be a concern about outbreaks. Are there any more outbreaks in the indigenous communities? I heard there was one in a Saskatchewan first nation. What is being done to support them in terms of PPE and health care?

● (1210)

**Dr. Tom Wong:** Thank you so much for raising this.

One of my concerns is that the public tends to look at the fact that the omicron wave is coming down in all of Canada, and in some parts of the north as well. However, that does not mean there are no outbreaks. Every day, there's a new outbreak. There's another outbreak in this community and that community, so one size doesn't fit all. Public health measures need to be commensurate with what's happening in the community. If there's a big outbreak in the community or surrounding the community, and the ICUs around the community are full, that's not the time to relax public health measures. As a matter of fact, it's the time to actually redouble vaccinations and other public health measures.

**The Chair:** Thank you very much. I appreciate it.

We're now entering our third round. This is likely going to be our last round, because we have some committee business to take care of in the last 15 minutes.

Without further ado, Mr. Duncan, you have five minutes, please.

**Mr. Eric Duncan:** Thank you, Mr. Chair.

To the deputy minister, I want to follow up again on the aspect of staffing and some of the challenges there. I always hate asking for more statistics. If you don't have them, this isn't a make-work project, but you alluded to the recruitment aspect of working from a wide variety of demographic angles, I'd call it, trying to encourage people who have just come out of college or university as well as people who have retired and are possibly looking to work up north for short periods of time.

Do you have a breakdown of what you've found most successful so far? I don't think it's a lack of effort by the department or indigenous communities to attract staff. The reason I'm asking is this: What more can we do that the federal government is not doing already to bridge that gap? Again, this was a challenge not only during the pandemic with the surge demands. This was a challenge before then, and it will remain a challenge after COVID as well.

**Ms. Christiane Fox:** Thank you for the question.

I should say we have 862 nurses. I'd say about 50% are in remote and isolated communities and about 600 of them are on contract.

What worked in terms of strategies? Ideally we tried to ensure first that people had the right training and culturally relevant experience in order to work in an indigenous first nations remote community. That's really important. It's not just the kind of recruitment that a provincial government would do, for instance, for something in a hospital setting in downtown Toronto. That training is a really important requirement.

In terms of the contract nurses, is it a perfect system? It's not always. However, a lot of people don't necessarily want to commit to full-time employment, so this can be a really rich way to enhance the supports and have a workforce that we can call upon. We did have some successes in recruiting more people through the contract.

By changing our hiring practices and actually making more effort—not just putting up posters but also seeking candidates through various channels, indigenous networks, hospital networks, colleges and universities—we were able to hire 177 new staff who are part of this 862 now, and those include nurses and paramedics. I think it's more about being more proactive and not just using older approaches like putting a job poster on a website but really going after that talent.

The last thing I would say is that this idea of having surge teams that can be mobile and move to a crisis or be needs-based could be a really interesting way to not require someone to make a commitment to live in a particular area for weeks on end, year after year. Maybe someone would like that flexibility of coming in and out of community and not necessarily staying long term. That is something that I think could have some promise as well and could help meet some needs.

**Mr. Eric Duncan:** Thank you for that.

This may be the last aspect. When we talk about recruitment of medical professionals who are coming out of college or university, I know there has been a high level of student debt and young people having difficulty finding employment. I think in today's labour market it's a completely different situation, but one of the things I'm wondering about is whether there have been any discussions in the department about incentives for young people looking to pay off student debt and gain experience. Could there be some sort of extra incentive so that they would not only be paid but also pay off their student debt at a perhaps accelerated rate if they worked in communities that are underserviced or more rural or remote?

Do you have the ability or flexibility in your department to offer that, and has there been any conversation about that when you have talked about new strategies to address the recruitment shortage both prepandemic and during the pandemic?

● (1215)

**Ms. Christiane Fox:** Thank you for that question. I would say that during the pandemic and even postpandemic in conversations we're having within teams, we are looking at innovative approaches. We are looking at ways, and I think the one that you've raised is similar to how sometimes teachers college or a nursing program has students go and do a service in a community for a period of time. There's nothing concrete at this stage, but I think those are some of the ideas we're trying to focus on in terms of innovative ways.

I would say that, with respect to funding through the anti-racism strategy, ensuring that we have enough indigenous youth who have a path towards post-secondary and funding that post-secondary is probably the most promising route, because the talent that is within communities is what we have to develop and maximize. That's what health transformation is about.

From my perspective, as the deputy of the department, if we can increase the number of indigenous students in some of these areas—not just those in HHR but also water operators, engineers and construction professionals—these are the—

**The Chair:** Thank you, Ms. Fox. I appreciate it.

We turn now to Ms. Shanahan for five minutes.

Go ahead, please.

**Mrs. Brenda Shanahan (Châteauguay—Lacolle, Lib.):** Thank you very much, Chair.

I was very interested, actually, in the comments of one of my Conservative colleagues. I think it was Eric talking about Akwesasne. Yes, it's in your region, and it got me thinking about Kahnawake, which is technically not in my riding of Châteauguay—Lacolle but we are very close neighbours. They basically took over the management of their COVID-19 response and actually had no cases for many months until there were outbreaks almost everywhere. It was very interesting to see just how independent they were in putting forward their directives.

I don't really want to know if they obtained PPE from Indigenous Services—that's really their business—but if they had needed to obtain it, because of course they're an urban reserve, could they have obtained it? I'm asking the deputy minister.

**Ms. Christiane Fox:** Thank you very much for that question.

Yes, as I've said, we provided PPE to communities, not just limited to the health professionals or the ISC employees or the contract nurses. We really try to take an all-of-community approach to the PPE. If a community would have made a request, they could definitely have gotten PPE through our distribution channels.

The second thing they could have done was use ICSF money—indigenous community support funding—to purchase their own PPE if they preferred to do it that way. That was a second option that a community would have. Then, of course, we would also provide PPE to urban indigenous centres, just because of the need and the accessibility challenges they were facing with provincial and territorial governments.

The answer to the question is, yes, they could have and would have that channel to make that request.

**Mrs. Brenda Shanahan:** Very good.

I would like to offer the balance of my time to my colleague MP Desjarlais, please.

**Mr. Blake Desjarlais:** Thank you very much, Madam Shanahan.

I want to continue my line of questioning related to housing capacity and the isolation units that were openly promised to indigenous nations, including the nations that I represented during this pandemic. What are the deputy minister's comments related to the housing crisis on reserves and the inability of our stockpile to accommodate situations where isolation was required?

**Ms. Christiane Fox:** Thank you for the question. I'll say three things.

The first thing is that we definitely agree that the housing challenge and overcrowding had an impact throughout COVID-19. Overcrowding does present huge challenges for health. That would be my first point.

My second point would be around temporary isolation and alternative accommodations. We did provide infrastructure for temporary isolation requirements for communities, and that was also because of conversations we had with leadership who did not necessarily want to use the school gym or the school library, just because of what it meant for the children in their communities, so there were some isolation units sent across the country. There were different types for different purposes, and that was one strategy. The second was alternate accommodation outside the community. In cases of very vulnerable populations, they were flown out to a hub, perhaps in Winnipeg, where they would be in isolation hotels where we would provide some support.

My final comment would be that throughout the omicron crisis, because of the spread, when it hit a household, we had to make determinations, because sometimes people would isolate at home, which meant that the support shifted from isolation outside the home to supports within the home, and that meant food deliveries, wellness checks and ensuring well-being in the isolation of individuals at that time.

But I will say wholeheartedly that overcrowding was a challenge.

● (1220)

**Mr. Blake Desjarlais:** How many isolation units?

**Ms. Christiane Fox:** I will have to get that for you. I don't think I have the exact number across the country, but I will get that to the committee for sure.

**Mr. Blake Desjarlais:** I believe that's probably time for this round, Chair.

**The Chair:** It is.

Actually, in fact, Madame Sinclair-Desgagné asked to switch with you, so if you want to keep going for another three minutes, you have the floor.

**Mr. Blake Desjarlais:** Thank you very much to both my colleagues, Madam Shanahan and Nathalie.

I want to continue now to speak specifically about consultation. I think consultation is one of the keystones in making sure we have strong partnerships in Canada. I've seen good, successful partnerships. I've seen government in fact do these partnerships and be part of some amazing partnerships, but there are some that have continued to lack. I think this is where one of these areas exists: within health. I know it was mentioned that you worked with some of these 51 nations.

Specifically, how many of the 51 nations were consulted directly by you and senior members of the ministry?

**Ms. Christiane Fox:** By me, I did a number of all-chiefs meetings throughout the different COVID pandemic time periods. For instance, I would have done the all-Saskatchewan chiefs committee. I did the all-Ontario chiefs committee. I did direct outreach to Cross Lake, Berens River or Shamattawa when there was a particular issue.

This has been an extremely challenging situation for the entire department. I would say that we have regional offices across the country and regional health directors that liaise directly with a band and council. I have spent a lot of my personal time getting back to chiefs directly, speaking to them directly, for them to know that they have an option if they need some supports, but I have to empower our regions as well, obviously, to work directly with them. All 51 have been consulted. All 51 we had regular engagement with, and even—

**Mr. Blake Desjarlais:** I'm sorry, but I have limited time, Deputy Minister. I want to ask one more question.

When you say “consulting”, there's a difference between discussion and consulting. Of course, with consultation, that framework requires an ongoing dialogue.

I spoke to the grand chief of Treaty 8 last week, and they mentioned that they did not prefer the consultation scheme currently being employed by the government. They thought it was inappropriate and it was diminishing of their nation-to-nation rights and treaty obligations. Would you agree?

**Ms. Christiane Fox:** I spoke to Treaty 8 two nights ago. I spent a couple of hours with them, because they did not feel that we should be engaging broadly on our health legislation. The message I had for the chiefs of Treaty 8 was, “We want to hear from you. We respect the treaty relationship. You may not agree with health legislation at the end of the day. You may not want to take this path, but let's together figure out the path you do want to take. That dialogue will be important.”

They gave us a series of dates when they want to sit down. They also want to have this conversation with the Minister of Crown-Indigenous Relations. I heard from them directly, and I did hear their frustration.

**Mr. Blake Desjarlais:** I'm really pleased to hear that. That's remarkable.

What about the Métis settlements consultation?

**Ms. Christiane Fox:** We have ongoing conversations with the Métis settlements. We have ongoing conversations with the MNC and with the MMF. We did a lot of work with the MMF during the pandemic, as opposed to—

**Mr. Blake Desjarlais:** Not the MMF but the Métis settlements.... Have you consulted with them?

**Ms. Christiane Fox:** I have not consulted directly with the Métis settlements, no.

**The Chair:** Thank you very much.

[*Translation*]

Ms. Sinclair-Desgagné, go ahead for two and a half minutes.

**Ms. Nathalie Sinclair-Desgagné:** Thank you very much.

My question is very brief. We are discussing a broad topic, and I would like Ms. Fox to give me a short answer.

Do you allocate funding to various groups according to needs, so according to demand, or in proportion to on-reserve population?

● (1225)

**Ms. Christiane Fox:** We do a bit of both. We were providing specific amounts based on population. There were two funding streams. There was the public health stream and there was the stream encompassing food safety and perimeter security for the community. By using those two streams, we provided direct funding to all the communities. In addition to that, there was a way to allocate money to target needs. We really made to ensure that the process for accessing those funds would be quick.

**Ms. Nathalie Sinclair-Desgagné:** According to the figures I have on hand, in 2019, for instance, Indigenous Services Canada gave a 7% of its resources to indigenous peoples of Quebec, even though they account for 11% of Canada's total indigenous population.

How do you explain that discrepancy?

**Ms. Christiane Fox:** Are those figures global or do they concern only health? I am not 100%—

**Ms. Nathalie Sinclair-Desgagné:** Fortunately, there was still no pandemic. So it was globally speaking.

**Ms. Christiane Fox:** I think it may also come from different funding sources. I will have to check that.

There are different ways to do things. Some funding is provided to communities based on programs. Some communities have had a 10-year agreement and they are receiving a more long-term funding block. Some communities have been transformed, especially in the Quebec context. In Quebec, for example, an umbrella organization such as the FNEC, the First Nations Education Council, would have been able to receive funding because it represents its 22 member communities. That organization would receive funding [*technical difficulties*] indigenous for education because it provides services to its 22 member communities.

It depends a little bit on the context. Those are examples that come to mind to answer your question.

**Ms. Nathalie Sinclair-Desgagné:** Yes, but very quickly, that funding would always come from the department of Indigenous Services Canada. So, regardless of whether it is going to education or to an umbrella organization, does the funding always basically come from Indigenous Services Canada or can it come from other departments?

**The Chair:** I would ask for a very brief answer, please.

**Ms. Christiane Fox:** Funding comes from us, but there is also funding that would come from other departments. For example, housing funding may come from the Canada Mortgage and Housing Corporation.

[*English*]

**The Chair:** Thank you.

We will turn now to MP Patzer, please.

You have five minutes, sir.

**Mr. Jeremy Patzer:** Right on. That's good.

I have a follow-up question for the deputy minister. It's in regard to exhibit 11.2 and why Manitoba received exponentially more PPE than all the other provinces.

**Ms. Christiane Fox:** Northern Manitoba and Ontario were probably our most challenged communities in terms of the outbreak. Not only would they have received more PPE as a result of.... There were communities like Norway House, Shamattawa or Red Sucker Lake that seemed to be in a continuous mode of outbreak. We would get the numbers down, and numbers would go up again. They likely received more PPE as a result of the outbreaks and the needs within the community.

Many of those communities would also decide, at times, to accommodate their most vulnerable populations outside community, for example, in Winnipeg, Thompson and various areas, so PPE would be delivered not just to the communities but also to the isolation centres. That's another reason.

Many of those communities also made requests for assistance, so the military was sent in. We needed to ensure that, throughout all of those peak periods, those supports were there not just for the community members but the staff, including the first nations pandemic response team or the AMC ambassadors, who were deployed into community.

**Mr. Jeremy Patzer:** In paragraph 11.58, the AG notes that the department chartered dedicated air services to transport nearly 5,400 passengers from April 2020 to March 2021.

Can the department share more on information on this, such as the airline used and the costs associated with this program?

**Ms. Christiane Fox:** I can get the committee the final costs. It's actually something that's still ongoing in some parts of the country, specifically for the Sioux Lookout First Nations Health Authority communities in northern Ontario.

The decision to provide this service was in consultation with our first nations partners, who felt there was a risk with our health human resources flying commercially to get to and from their communities. Therefore, to minimize that risk, they suggested that charters be deployed with which we agreed.

It was also a means not only to get our health human resources into communities but also to transport some PPE and fast-track the delivery of urgent items. We did have over 5,400 HHR travel on that system into 51 communities. It was done in order to protect our nursing workforce, to protect communities and to ensure no disruption in travel in light of what was happening at airlines at that moment.

In terms of where we're at, we do have a contract now that we can draw on should we need to resume the service, or if ever there is a requirement for either a future wave or variant. For the time being, we have the possibility of extension. However, we will get you the exact figures and who the contractor was.

● (1230)

**Mr. Jeremy Patzer:** On that last point, regarding the contractor, was this a sole-source contract, or was this something you put out to tender for competition?

**Ms. Christiane Fox:** We've spent $51 million to date, just for your awareness. I just saw that detail in my notes.

I'll turn it over to Robin Buckland to speak to the contracting process.

**Mr. Jeremy Patzer:** If you could include, Ms. Buckland, whether it was a sole-source or open-source contract?

**Ms. Robin Buckland (Director General and Chief Nursing Officer, Department of Indigenous Services):** I don't have the details in terms of whether it was sole-sourced or open-sourced, but we did work with Public Services and Procurement Canada. We went through all the appropriate processes to put that contract in place. As soon as I have it, I will give you that information if it was sole-sourced or done by a competitive process.

**Mr. Jeremy Patzer:** It's very important to make sure that, at the end of the day, we got the right bang for the buck for taxpayers while still providing a high-quality service that was clearly needed. Most Canadians would agree with the fact that the service provided was needed, but at the end of the day, when we say sole-source contracts, it sometimes gets people a bit excited for certain reasons.

**The Chair:** Thank you, Mr. Patzer.

Ms. Bradford, you have five minutes.

**Ms. Valerie Bradford (Kitchener South—Hespeler, Lib.):** Thank you so much.

Thank you to our expert witnesses today. It's been fascinating.

There's no question that COVID was a great learning opportunity for all of us, and perhaps no more so than at Indigenous Services Canada.

I'm going to direct my questions to Deputy Minister Fox. Basically, the Auditor General's report identified two areas of concern and improvement. The first one being PPE. That was clearly the more easy one to address.

The workforce issues are much more complicated and complex, particularly in health care and isolated areas with which you are dealing. I know that many employers offer isolation pay and bonuses to attract people to these remote communities, because their living conditions aren't as desirable, and of course the isolation. Does your department do that?

**Ms. Christiane Fox:** Yes, we do. We obviously have to work within our collective bargaining agreement, but these are challenging positions and, in terms of incentivizing our nursing staff and helping in the recruitment, we do provide some incentives. We can provide the committee with a bit more detail on that.

I think you're right to note that these are quite challenging postings. At times, it means that people need to be away from their families for two to four weeks, especially during the pandemic. Sometimes our nursing staff was up in remote and rural communities for a longer period of time to try to limit that back-and-forth, which was another personal sacrifice they had to make to respond to the COVID-19 pandemic.

**Ms. Valerie Bradford:** It's not just the living conditions. It's also the working conditions. That's the other problem. I know that very often you hear about maybe only two nurses for an entire community, and they're carrying the whole load without backup and without people there to support them.

I know there has been a lot of work on digital backup and on supporting health care practitioners with video. Was that utilized at all so that people could maybe do a video consultation to see what was going on with a particular patient who might be more challenging?

● (1235)

**Ms. Christiane Fox:** Absolutely, and I personally visited some of our nursing stations and saw that very equipment, where you have an emergency room within the nursing station and there will be a 24-7 unit connected to a major hospital so that outreach to a physician to support the nursing staff on the ground can be done. In some of the nursing stations, we've also been able to add equipment like X-ray machines, which in the past weren't there. That just helps with medevac in reducing the burden on unnecessary travel for appointments.

I do think that virtual care is an area we absolutely have to look into. There are really innovative robotics technologies when it comes to virtual care in the north that I think would be really interesting to think about using more broadly in our northern communities, both indigenous and non-indigenous.

**Ms. Valerie Bradford:** I agree. It's so disruptive to have to relocate patients when they're in a critical care situation away from their family support network. We want to avoid that, not just from a cost-effective perspective, but it's obviously better care if you don't have to do that.

One thing you did address—and I think we're all aware of this—is that the fatigue and mental wellness of the nursing workforce are a great concern. Can you tell me how this is being addressed? What support mechanisms are in place for helping with the mental health situation of some of these overtaxed, exhausted, burnt-out health care practitioners?

**Ms. Christiane Fox:** It's something that definitely keeps me up at night. We have formal processes and systems in place with employee assistance and a dedicated support service exclusively for our nursing staff, which is not common to all of our employees across the system and which I think is important.

We need to have regular conversations with our nurses, and that's through town halls and it's through direct contact. I reach out from time to time directly to a nurse, after either an incident or a challenging situation, and make sure to visit our nurses in communities so that I can hear from them about what goes well and what doesn't go so well.

I think that part of that mental health and wellness and those supports is going to be key. They are exhausted, so we're trying to find ways to have that surge capacity, which is why I talked about the mobile health surge team and, when our teams are exhausted and mental health and wellness are at risk, having the ability to replace them and have people recoup. I think every regional executive responsible for health is having those discussions directly with our nursing staff.

Highlighting what they do, when I joined this department I did the nursing awards, which is something we do to recognize the heroic efforts of our nurses. Someone said, “If you save a life, you're a hero, and if you save over a hundred, you're a nurse.” That stuck with me, because that's what they do every day. I just wanted to share that.

**The Chair:** Thank you. That is a lovely way to end today's meeting.

I want to thank everyone for appearing today.

I want to thank our team for working out the technical bugs.

Deputy Minister Fox, I should say as well that your previous minister, Dominic LeBlanc, speaks very highly of your capabilities. I did not want you to think I was suggesting that your dad's legacy in any way overshadowed how this committee viewed your work. I think you've proven that today. I just wanted to pass on your previous minister's remarks as well.

**Ms. Christiane Fox:** Thank you very much, Chair.

**The Chair:** Again, thanks to all our witnesses for appearing and for being ready to appear today.

I will now close the public portion of our meeting and suspend for about two minutes to give our committee members a moment before we go in camera.

Thank you again.

[*Proceedings continue in camera*]