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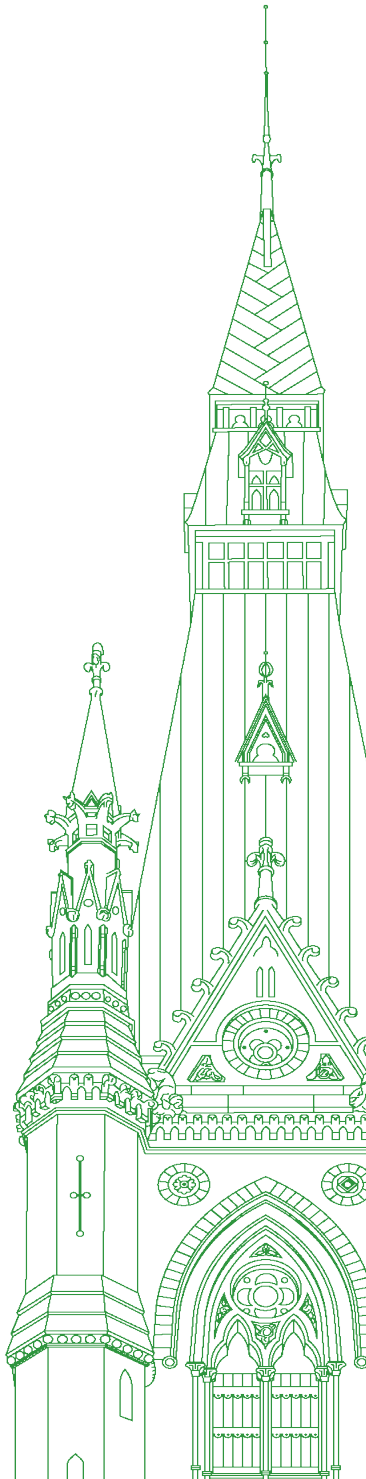

Chair: The Honourable Marc Garneau

Standing Committee on Indigenous and Northern Affairs

Tuesday, May 3, 2022

● (1530)

[*Translation*]

The Chair (Hon. Marc Garneau (Notre-Dame-de-Grâce—Westmount, Lib.)): Good afternoon, and welcome to the 17th meeting 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 is on the administration and accessibility of indigenous peoples to the non-insured health benefits program.

[*English*]

In our first panel today, we'll be hearing from the Honourable John Main, Minister of Health, Government of Nunavut; the Honourable Julie Green, Minister of Health and Social Services, Government of the Northwest Territories; and the Honourable Tracy-Anne McPhee, Minister of Health and Social Services, Government of the Yukon.

[*Translation*]

I would like to remind you to respect the requirements of the Board of Internal Economy regarding physical distancing and wearing masks.

[*English*]

To ensure an orderly meeting, I would like to outline just a few rules for our witnesses and members 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 for either English or French, or Inuktitut. If interpretation is lost, please inform me immediately. We'll have a pause and we'll fix the problem before we carry on.

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. When speaking, please speak slowly and clearly. When you're not speaking, your mike should be on mute. As a reminder, all comments should be addressed through the chair.

For each organization, each witness will begin this proceeding by speaking for up to five minutes. We'll start with the Honourable John Main, Minister of Health, Government of Nunavut.

Minister Main, you have five minutes.

● (1535)

Hon. John Main (Minister of Health, Government of Nunavut): *Matnaugavit*.

I'm going to speak in Inuktitut briefly and then switch to English.

[*Witness spoke in Inuktitut, interpreted as follows:*]

Thank you.

I want to start by thanking the committee members for the invitation to attend as a witness on this important topic. I'd like to take a moment to recognize the member for Nunavut, Lori Idlout. *Ublutti-aq,* good day.

[*English*]

Good day.

As you are likely aware, since the creation of Nunavut in April 1999, certain vital aspects of the non-insured health benefits program, NIHB, have been coordinated by the Government of Nunavut's Department of Health on behalf of the Government of Canada. We achieved the coordination and delivery of this program through a series of contribution agreements negotiated between our governments.

NIHB is essential to our territory in ensuring reasonable accessibility to non-insured health services and is considered a vital portfolio that often reaches the public spotlight here in Nunavut.

This program—I have a few examples—provides the means by which a child in Arctic Bay can be escorted by their mother to a specialist appointment in Iqaluit without incurring costs for travel, accommodation or expenses. It ensures that an elder in Kugluktuk can obtain corrective lenses to see family on the horizon returning from a hunting trip and that our residents who seek care in their neighbouring jurisdictions are as comfortable as possible during vulnerable moments in their care and healing journey.

The challenge of providing a wide range of care and services to a small population over an immense geographic landscape makes access to all required medical services difficult.

While changes to the NIHB program are at the discretion of the Government of Canada, Nunavummiut employed by the Government of Nunavut are directly involved in delivery of this program and in turn advocate on behalf of Nunavut Inuit to improve access to non-insured health care services.

Currently under the NIHB program, we're responsible for the delivery of medical transportation, accommodation and meals, dental services and eye exams by an optometrist. Unfortunately, while the services just listed have been successfully delivered to our residents, we have run into issues in having them fully covered under NIHB, creating costs that our government has been perpetually required to assume.

The territory has lost hundreds of millions [*Technical difficulty—Editor*]—

The Chair: Madam Clerk, I see a freeze on Minister Main. Has everybody else noticed the same?

The Clerk of the Committee (Ms. Vanessa Davies): Yes, sir. We're going to address it right now.

Unfortunately, Minister Main was dropped. We have a tech on it.

The Chair: In the interests of time, do we have the other two witnesses with us at the moment?

The Clerk: Yes. I see Minister Green and I see Minister McPhee.

I see that Minister Main is still with us.

● (1540)

The Chair: You have about two minutes left. Could you resume your presentation, please?

Hon. John Main: My apologies. It's Nunavut Internet at its best—average.

The territory has lost hundreds of millions of dollars by covering costs not fully covered under the NIHB. This is lost funding that we could have been funnelling into improving health care programs, services and infrastructure here in Nunavut.

Over the last four years, our respective governments have been working together in negotiations towards a resolution. I'm pleased to advise that recently we have seen movement. Since the 2020-21 fiscal year, the Government of Canada has agreed to an increase in the medical travel copayment amount, a notional $20-million increase to the NIHB contribution agreement, as well as a supplemental $58-million contribution agreement intended to cover remaining incurred NIHB expenses, an interim measure to facilitate these discussions. While we're still in negotiations, opportunities like this one here today allow us to listen, ask questions and educate each other to ensure we're working together for a common cause.

It's expected that a long-term agreement between the federal government and Nunavut will be reached before the end of the 2022-23 fiscal year, an achievement both parties can be proud of. As we move towards this milestone, the Department of Health will continue to collaborate with the Government of Canada to ensure that services are accessible and provided to Nunavummiut.

Another area of concern I'd like to mention briefly is the provision of dental services and eye exams. Like many jurisdictions across Canada, Nunavut is facing a backlog in these areas due to COVID-19, which is impacting our residents. Aside from the shorter-term challenge, there is a larger question around whether the number of service days established within the NIHB will be sufficient to meet the dental and eye needs of Nunavut residents in the longer term.

Once again, *matna*. I look forward to answering any questions. My apologies for the technical difficulties.

The Chair: No problem. Thank you, Minister Main.

We'll now go to Minister Green.

You have five minutes.

Hon. Julie Green (Minister of Health and Social Services, Government of the Northwest Territories): Thank you very much, Mr. Chair.

I'd like to thank you and the committee on indigenous and northern affairs for the opportunity to contribute to your study of the accessibility and administration of the non-insured health benefits program.

I am on the line from Yellowknife, capital of the Northwest Territories and traditional home of the Yellowknives Dene First Nation and the Métis.

As Mr. Main explained and as is similar here, the GNWT administers portions of the NIHB program on behalf of the federal government, with a service agreement worth $16 million a year. Our current agreement with the federal government expires on March 31 of next year, so the timing of your discussion is important. You have an opportunity to recommend changes that will strengthen the NIHB program.

First, I have a little background on the NWT. We have a population of 44,000 residents living in 33 communities dispersed across one million square kilometres. A total of 44% of the population is eligible for benefits under NIHB and an additional 6% receive Métis health benefits. Métis health benefits are aligned with NIHB and are paid for by the territorial government at a cost of $3 million a year.

Because of the number of small communities and a lack of access to year-round roads, access to benefits under NIHB, particularly medical travel, are critical to good health outcomes. The GNWT offers benefit programs pegged to the same level of coverage provided under the federal NIHB program to eligible residents, including the Métis and non-indigenous populations.

The GNWT recognizes the importance of providing a safety net to residents to reduce financial barriers to access health benefits not covered by the NWT health care plan. The GNWT's medical travel policy, for example, mirrors NIHB and offers the same benefits.

The federal government has been an important partner in supporting the integrated service delivery model by providing funding to improve health services in areas of home care, mental health and addictions, system innovation and, most recently, of course, to assist in the response to COVID-19.

Now I would like to explain some aspects of the GNWT role in the federal NIHB program. The GNWT administers some parts of the NIHB program, as I said, on behalf of the federal government, including medical travel, dentist trips to communities, applications for medical supplies and equipment, arranging for the vision care team to visit communities for their NIHB clients and pharmaceutical coverage.

Our role as an administrator puts us in a position where we implement the federal program and the public holds us responsible for it. In fact, we are the filling in the sandwich. This is not our program; however, in our role as administrator, we do receive feedback from NIHB clients on issues and concerns with the program, which we share with the federal government for their awareness. Based on our experience in administering benefits, we know that not all residents who self-identify as indigenous have access to non-insured health benefits because their Indian Act status is in dispute.

Medical travel, as I mentioned, is a very important part of the benefits of the NIHB program in the NWT, given how remote most communities are. It's also the area in which we receive the most complaints. The complaints address who is eligible for a non-medical escort and the timeliness of approval for medical travel and for escorts. As Mr. Main outlined, the GNWT incurs additional costs associated with medical travel that are not recognized or remunerated by Canada. For example, 75% of the cost for non-medical escorts for NIHB clients is based on its service criteria and currently costs the GNWT $3 million a year.

To support opportunities to provide feedback on the NIHB program, GNWT works closely with ISC to facilitate trilateral engagement sessions with indigenous governments, and we expect one of these sessions to be held later in the year.

Our vision for the future of NIHB administration comes from the TRC calls to action, in particular action 20, which states in part “we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples”.

● (1545)

One way to implement this action and advance reconciliation is to explore opportunities for greater direct involvement and leadership for NIHB in the NWT by indigenous government organizations.

We are happy to work in partnership with the federal government and the IGOs. I hope this information is helpful, and I look forward to answering any questions you may have.

Thank you.

The Chair: Thank you very much, Minister Green.

We'll now go to Minister McPhee.

If you're ready, you have five minutes.

● (1550)

Hon. Tracy-Anne McPhee (Minister of Health and Social Services, Government of Yukon): Thank you for the opportunity to be here this afternoon.

I'm speaking to you from the traditional territory of the Kwanlin Dün First Nation on the Ta'an Kwäch'än Council.

Thank you to my colleagues across the north for the important details about how the NIHB process operates in their territories. We have some similarities and some differences.

In the Yukon context, we have 14 individual first nations that operate here in the territory and reside in their traditional territories. Eleven of those first nations are self-governing under the Umbrella Final Agreement from the early 1990s. That makes us a bit different and unique compared to other parts of Canada.

While I certainly agree with my colleagues about the benefits of the NIHB process, our approach is certainly not as coordinated as, for instance, that in the Northwest Territories, which administers the federal program. Our Canadian system of health care is complex, a patchwork of policies and legislation and relationships.

We certainly submit to your committee for your consideration that a better coordinated approach is needed, but it does remain a challenge. In order to improve clarity and consistency of delivery, we are working hard here in the territory to improve our own system and certainly to make changes to the way in which NIHB operates in conjunction with the Yukon system and how we provide service delivery to individual Yukoners, which, of course, is the primary goal. That is critical.

A number of years ago, we had an independent review of Yukon's health care system, which was known as “Putting People First”. One of the recommendations from “Putting People First” was, in fact, to have a better coordinated system with the NIHB. It indicated that uncertainty in that process definitely causes inequities. The territory has the responsibility to provide universal publicly funded insured health services to all residents of the Yukon territory, including Inuit, Métis and first nations individuals. Our “Putting People First” is an example, I think, of a health transformation project, and we know others have happened across Canada. It is aimed at improving health outcomes and access to services for all Yukoners, and in the process we are now focused on determining how first nations people can be a part of implementing the “Putting People First” recommendations from a transformational standpoint.

We know that will require organizational capacity and ultimately engagement with our Yukon first nations as well as service delivery improvements, not only in the Yukon health system but in NIHB and the way in which the two interact. We're focusing on new models of health service delivery.

The current process we have, without going into too much detail, involves NIHB being a pair of last resorts with respect to determining whether or not individuals happen to be status first nations individuals or otherwise and whether or not the Yukon health care system makes looking after their costs a priority. The lack of coordination does create barriers to service consistency.

As I've noted, our own insured health services need to be improved, and we are focusing on that. The “Putting People First” focus will be for people-centred, patient-centred, client-centred, trauma-informed wraparound services across the territory. This is particularly critical at this time when better coordination will be our goal, especially as we face the substance-use health emergency here in the territory that was declared by our government on January 20.

We are seeking to provide harm-reduction strategies that are new and improved. We certainly have individuals who, for instance, would qualify to have treatment outside of the territory for addictions, which might be covered by Yukon government. They might be covered by NIHB. Those two things are not necessarily the same. The locations they might be able to go to for treatment are not necessarily the same, and that certainly provides confusion.

● (1555)

That whole process, those experiences and the lack of coordination, I'll say, exasperates individuals and adversely affects those Canadians who are often most in need.

Our experience here in the territory is also that individual first nations governments—of which we have 11—often end up absorbing costs for health services that are not theirs and for which other governments are provided funding, whether they be the Government of Yukon or otherwise.

I want to focus just for a moment—I know my time is running out—to come up with a few solutions.

I think language is incredibly important as we proceed to modernize our structures and make sure they are meeting the needs of Canadians.

I think we need to recognize that diverse governing structures do exist across Canada for first nations, Inuit and Métis people. Perhaps references to “traditional territory” or “self-governing first nations”, rather than just “reserve”, or “on reserve”, is just a small example. We do not have reserve land or individuals who live on reserve here in the territory and, unfortunately, just referring to the language sometimes confuses folks.

We are very supportive of a trilateral table and tripartite conversations. I think Yukon's unique situation can contribute to some of those solutions. We are very committed to doing that work at those tables because we do think that this is a system that is ripe for improvement, but we can do that together in partnership.

There is an example of some rather successful reciprocal-type agreements that exist, for instance, with the first nations governments and Canadian provinces and territories around social assistance, as an example, so there is a framework—

The Chair: Minister, I'm going to have to ask you to wrap up.

Hon. Tracy-Anne McPhee: Yes. Thank you so much.

There is a framework that might be a guide for us.

I appreciate the opportunity to chat today. Thank you.

The Chair: Thank you, Minister McPhee.

We'll start with the first round of questions.

Mr. Shields, you have six minutes.

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

Thank you to the honourable ministers who are presenting today. It is very much appreciated.

Minister Main, we've heard from the Minister of the Northwest Territories the percentage of the population that would qualify for NIHB. Do you have that number for Nunavut?

Hon. John Main: It's roughly 85% Inuit. Nunavut is overwhelmingly Inuit. I can get a more accurate number and get back to the committee in writing if that would help.

Mr. Martin Shields: That would help, and it relates to my next question.

In a decision-making process, if it were block-funded—in determining that the block funding had the amount in it—do you believe you have the expertise to make the decisions for your residents that need to be made?

Hon. John Main: If it were block-funded, there would have to be an escalating payment schedule, because what we're seeing here in Nunavut year over year in the demand for services is that our needs are increasing quite steadily when it comes to medical travel and when it comes to mental health and addictions.

I think it's a reflection of the very young population we have. We've very young. If you look at the demographics, you can see that it's very wide at the bottom end of the age categories.

We also have some very serious social determinants of health issues that we're dealing with here in the territory, such as housing, so—

Mr. Martin Shields: Minister, I understand that. I'm sorry to interrupt. I have limited time.

I understand, and I know what the determinants of health are.

My question is, though, with the funding. Do you believe you could make the appropriate decisions to match those health standards?

● (1600)

Hon. John Main: I would have to take some time and ponder that. I apologize. I just can't give you an answer off the cuff. That would be such a shift for this program to go to block funding, because right now it's based on the services and based on the quantity and those can vary from year to year, and as I mentioned, they are increasing. I can't fully understand how a block funding model would work. It would be such a drastic change from the existing program.

Mr. Martin Shields: Thank you.

This is how the provinces work and it's one of the things that I would ask about. It's how the provinces deal with their health.

Minister Green, from the Northwest Territories, what is the number one recommendation you would have if you could change it? This committee could make a recommendation.

What is your number one issue that we could have as a recommendation that would make it work better for those health determinants for the NIHB clients in your territory?

Hon. Julie Green: It would certainly be helpful if medical travel was fully funded and there was some consideration of the escort policy and whether it was a culturally safe escort policy. We get a lot of complaints from people coming from small communities who are not accustomed to travelling to places even the size of Yellowknife, which is a very small city, let alone to Edmonton and further south. They would like people to accompany them. Elders, especially, would like people to accompany them.

This kind of compassionate accompaniment is not considered in the benefits of NIHB. They consider whether you need interpretation, mobility assistance and so on, but not compassionate travel. I'm concerned that what we're offering is not really culturally appropriate to the population, and I would like to see some discussion around that as a change.

Thank you.

Mr. Martin Shields: Thank you.

Minister McPhee, I think you have moved into an area that I see happening, even in my own riding, when you talk about language, for example. Could you explain a bit more about the recommendation that you started with?

Hon. Tracy-Anne McPhee: It's incredibly important that the language be inclusive. A lot of our interactions with the federal government, not only on this topic, involve us starting, although we've been at this for a while. There's great understanding now throughout government that there are no reserves in the territory and that we have first nations governments that are governing their own traditional territories under the Umbrella Final Agreement.

However, there's no provision for any of those languages or inclusion of that kind of governance structure in policies or in directives that come out, even in programming that comes out through a budgetary process, for instance. As a result, first nations governments and our government, all getting quite sophisticated, are saying, “Okay, where do I fit into this program? How does my governing structure benefit from this program? Will we qualify?” It's these kinds of things.

My point is that we should be as inclusive as possible, and language is a good place to start.

Mr. Martin Shields: Thank you, Ministers.

The Chair: We'll now go to Mr. Powlowski. You have six minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): It seems like escorts not getting approved is a major problem. Who makes that determination of whether or not someone is approved? What are the reasons that are most commonly given for not approving someone?

Ms. Green suggested that if you need somebody as an interpreter, they'll get it approved, or if you need somebody because of your lack of mobility, they'll be approved, but if it's because you're someone from Cambridge Bay who has never been outside of your community, and you speak a bit of English, you're out of luck. If you don't speak any English, you get someone to come with you.

Is that the biggest reason for not approving escorts? Is there an appeal process? This is a major question. It seems like it affects all of you. As a doctor having worked in Nunavut, I know that there aren't tertiary medical resources and there aren't a lot of specialists, if any, in those places, so they have to be referred out.

I'll ask all of you about the process, why people are being denied escorts and whether there is any effective appeal process.

Could we start with Minister Green, and then you can pass it on to other people?

● (1605)

Hon. Julie Green: We mirror NIHB with our own ministerial policy on medical travel. The policy has four or five criteria, but none of them involves cultural safety or dislocation compassion or whatever. They speak strictly to areas such as mobility; interpretation; about to give birth; and needing help to understand an aftercare plan and so on.

Our territorial policy has an appeal process. I'm not sure if the federal government has an appeal process for its administrative side of the program, but an appeal process is a good idea. If there isn't one in place, it would be useful to have it so that people who are denied an escort can have someone else take a look at their file and see if it would be useful.

That's my view on it. I'll ask John Main what he thinks.

Hon. John Main: Thank you.

When it comes to escorts, I think Minister Green explained it quite well. I share the concern around the lack of cultural sensitivity, I guess, included under the program. One of the issues we have around escorts is that from time to time a second escort is required if it's, say, for example.... At the end of the day, I like to talk about examples, because this program is about people. It's not dollars and cents. It's about health care for Canadians who live in the north or who are [*Witness spoke in Inuktitut*]—indigenous.

When you look at second escorts, in some cases we get requests from clients in the case of a child who is undergoing cancer chemotherapy. In some cases, the parent who is escorting that child needs support. It can be very heart-wrenching. That's an example where, for that second escort, as the Government of Nunavut we could approve that, and we will bear the cost on compassionate grounds.

In wrapping up my response, I'd like to mention that we have seen some improvements in this area through the Inuit child first initiative, which is a new and kind of exciting avenue for Inuit in terms of second escorts and additional family travel around medical needs.

Hon. Tracy-Anne McPhee: I'll be very brief.

The non-insured health benefits approve escorts that are considered medically necessary in our context. That tends to be quite a narrow criteria.

I agree with my colleagues and certainly with the examples given.

Mr. Marcus Powlowski: What you said, Minister McPhee, was kind of interesting, because Minister Green said there were about five criteria and you're saying that it's whether it's medically necessary. Is there no common one requirement for escorts that applies all across Canada?

Hon. Tracy-Anne McPhee: Yes, understand that there is the basis of one. It's generally wrapped around this concept of “medically necessary”, and I think that's even what Minister Green is saying as well. There are a few criteria but they [*Technical difficulty—Editor*] are sort of in that basket, if I can say it that way.

Of course, as the NWT administers the federal program through their system, they may well have incorporated some of those. I'll leave that to her.

● (1610)

Mr. Marcus Powlowski: This is probably less of a question and more of a comment.

Minister McPhee, I thought your comment about needing more than one escort when there's a child, especially in a life-threatening situation, was an excellent point.

Thanks.

The Chair: Thank you, Mr. Powlowski.

[*Translation*]

I will now give the floor to Mrs. Gill.

Mrs. Gill, it is my understanding that you will be sharing your time with Mr. Morrice. So you have six minutes to share.

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

I would like to thank Ministers Main, McPhee and Green for their appearance before the committee today.

I have some questions for them regarding non-insured health benefits, specifically in the north. I think the issue of accompaniment, which we've already touched on, is one of them.

Would you like to make any other recommendations to the committee with respect to the fact that the territories are remote and therefore naturally receive fewer health services?

My question is for all of the ministers.

[*English*]

The Chair: Why don't we start with Minister Green, if you care to comment? We'll then go to Minister Main and to Minister McPhee.

Hon. Julie Green: Thank you, Mr. Chair.

I want to clear up a bit of confusion that I see between my answer and Minister McPhee's answer. The escorts that I am talking about are non-medical escorts. They are not there to provide any kind of medical service. They are there to assist the person getting on and off the plane, to speak in the language of their origin, to accompany someone who's having a child, and so on and so forth. They are non-medical escorts.

We've had representation from people who would like the escort criteria to correspond with age. That is to say, if you're over a certain age, you would automatically receive an escort. It turns out now that the older you are, the more likely an escort will be approved, but that's not always the case.

Having a wider availability based on age is one possible way to address the question of how to bridge the gap for someone coming from a very small community to a city the size of Edmonton for medical services. It is truly bewildering in ways that those of us who have been in those big cities—

[*Translation*]

Mrs. Marilène Gill: Thank you, Minister.

We are running out of time. Mr. Main, Ms. McPhee, I don't know if you would like to add anything else to the list of recommendations.

Hon. John Main: Thank you very much for your question.

[*English*]

In terms of the escort piece, adding some flexibility within the policy would be valuable. It would allow the territorial health departments to consider things such as cultural considerations and language considerations when looking at who gets a non-medical escort.

The other recommendation I would have is around the Inuit child first initiative. Right now it's very new, and I'm very appreciative of it. The Inuit child first initiative and the non-insured health benefits are in silos. They don't talk to each other very well or mesh very well. That's something that I believe could lead to improvements, if we could figure out ways—specifically for the Inuit—to make those two streams work better together.

Thank you.

The Chair: Go ahead, Minister McPhee.

Hon. Tracy-Anne McPhee: Thank you so much.

I must say that I agree with the concept of flexibility. That's the umbrella, with respect to how the policies are written and interpreted. That would allow us to take into account, for instance, compassionate reasons and culturally appropriate considerations, as well as language and medical concerns. However, the flexibility is key.

● (1615)

[*Translation*]

The Chair: Mrs. Gill, are you going to turn it over to Mr. Morrice?

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

The Chair: Thank you, Mrs. Gill.

[*English*]

Mr. Morrice, you have about two minutes.

[*Translation*]

Mr. Mike Morrice (Kitchener Centre, GP): Thank you, Mrs. Gill.

[*English*]

I hope to have time for two questions.

My first is to Minister Green.

I hope all parliamentarians in this place are committed to following through on the Truth and Reconciliation Commission's calls to action.

Minister Green, you spoke about call to action 20 specifically. Do you have any additional recommendations for this committee with respect to NIHB to ensure that we follow through on call to action 20?

Hon. Julie Green: In order to advance reconciliation, it's important to take cultural safety into consideration. There's a lot of mistrust in the health system, even to this day, because of the way it has been administered historically. If there are ways to take that mistrust into account and to allay it by providing more flexibility, as Minister Main said, I think that would go a long way toward meeting this recommendation.

Thank you.

Mr. Mike Morrice: Thank you, Minister Green.

At the last meeting of this committee, Vice-Chief Pratt from AFN shared that.... His words were “For our first nations, NIHB can be seen as a bureaucratic and intimidating entity.” He went on to talk about concerns with respect to “cost containment” ahead of “adequate and timely medical benefits”.

Would any of the ministers be open to sharing their views on recommendations that would address the concerns raised by Vice-Chief Pratt?

The Chair: You'll have to direct that to one minister, because we won't have the time.

Mr. Mike Morrice: How about Minister McPhee?

Hon. Tracy-Anne McPhee: I do think it's what I spoke about with the concept of a coordinated approach. I think we need to be at a trilateral table. I think we need to really work at the details and the practicalities of how the program operates on the ground, as opposed to in the concept of policy only: What are the effects of that? I think we've heard some great examples today of what that could be, and also of a coordinated approach. That would have to be individual to the territories, because I don't think the three of us do things the same way across the top of the country.

I know that we would welcome partners to come and have those discussions and discuss how the NIHB program works and how it doesn't work, and how we can also make improvements in our systems.

The Chair: Thank you, Mr. Morrice.

We'll now go to Ms. Idlout.

You have six minutes.

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

First, thank you, and welcome to this committee. Your presentations are very interesting.

I welcome John Main, a minister of the Nunavut government in health. It is good to see you.

I will raise this question to all three of you in the order of your presentations.

In your opinion, will paying indigenous wellness counsellors the same rate as the academically certified mental health professionals have a positive impact on indigenous peoples' health and well-being?

The Chair: Minister Main, you could start off.

Hon. John Main: [*Witness spoke in Inuktitut, interpreted as follows:*]

Thank you.

Regarding this, yes, I agree. It would be very beneficial to have equal payment and to acknowledge both the traditional and the academic, but the non-insured health benefits do not have that. They have a policy or policies that they need to improve, including traditional healers or counsellors.

Yes, it would be very beneficial for Inuit if our own counsellors and professionals could be paid the same rate and recognized as such.

Thank you.

● (1620)

The Chair: Next is Minister Green.

Hon. Julie Green: Thank you.

It's very important that people see themselves reflected in the health care staff. It builds confidence in the system.

We've recently started a program here whereby we have hired indigenous wellness counsellors who were trained at Rhodes college in B.C. We have made a community fund, and communities can choose to hire them directly to provide counselling services in their communities. We've had good uptake with that fund.

People are very proud that their community members have gone for this training and are returning to provide this service in their communities. We would want them to be paid on a par with non-indigenous counsellors so that the jobs are attractive to them.

The Chair: Now we have Minister McPhee.

Hon. Tracy-Anne McPhee: Thank you very much.

I think the impact of culturally sensitive and culturally informed treatment cannot be overstated. I think the opportunity to have consistent equality in wellness counsellors' pay is absolutely the case.

We know that health care is moving slowly—albeit moving—to the concept of patient-centred treatment and wraparound services, and we know that culture—and language—is such an important part of that. Clearly, we need to make sure that all varieties of treatment are available and counselling is available and that the quality of pay is critical.

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

Thank you.

Do you think the medical escorts provide a valuable service? They should not be volunteering only. They should be paid as well. What do you think?

Ms. Lori Idlout: Correct.

The Chair: We'll do it the same way, with Minister Main going first.

Hon. John Main: [*Witness spoke in Inuktitut, interpreted as follows:*]

If the escorts were to be paid a salary, it would be helpful, because they leave their jobs and go on leave, for a long length of time sometimes, without pay. They also have so many incidentals when they are escorting family or patients. They are incurring personal costs constantly. Yes, their food is paid for, and their accommodation is paid for, but there are the incidental costs that they incur themselves as well as for the person they are escorting. They become financially responsible for the patient.

Not having a lot of access to money, not having money, is very common for many of us. Yes, I do believe that the incidental costs they incur for any length of time as escorts and for looking after their patients should be considered. I agree.

The Chair: Go ahead, Minister Green.

Hon. Julie Green: I recognize that time is valuable and that people give it up to be medical escorts. My concern is about the cost. We mirror NIHB to our whole population. We have about 18,000 medical travel trips a year, not all of them with escorts. Maybe about a quarter of them are with escorts. That would be a considerable extra expense for the Government of the Northwest Territories, even if the NIHB covered all of the NIHB clients.

Our health system is in a deficit. That deficit has been growing every year, so I'm concerned about that. While I recognize the value of offering payment to someone who is giving up their personal time, maybe an honorarium would be a more affordable way to do it.

This is a challenging question. I understand that it comes with a good intention, but I'm concerned with the cost.

Thank you.

● (1625)

The Chair: Minister McPhee, go ahead.

Hon. Tracy-Anne McPhee: Certainly medical travel in the north is a way of life. We're doing more and more services locally all the time, but some, of course, just cannot be done.

It's an important question. I agree with Minister Green that ideally it would be something that could be done. An honorarium process could be more predictable as far as costs go, perhaps, with averaging or understanding medical travel amounts, but we do have to recognize the aging population and the opportunity for those costs to increase. Again, as I think Minister Main said, this is about people. It's not about costs only, but we have to be mindful of that. An assessment process or some version of that would also probably be beneficial.

The Chair: Thank you, Ms. Idlout.

Unfortunately, we've run out of time. We have to follow this with another panel.

Minister Main, Minister McPhee and Minister Green, I want to thank you for giving your time today. Thank you for answering our questions and making presentations. You've provided valuable input to our study. We very much appreciate it. Thank you very much.

With that, we will suspend for a few minutes while we move to the next panel.

Thank you.

● (1625)

(Pause)

● (1630)

The Chair: I call the meeting back to order.

We'll start this second panel.

Welcome to our witnesses. Today, we will have with us Dr. Alika Lafontaine, president-elect of the Canadian Medical Association; Dr. James Makokis, appearing as an individual, who is a Plains Cree family physician of the Kinokamasihk Nehiyawak Nation in Treaty No. 6 territory; and Dr. Evan Adams, vice-president of the Indigenous Physicians Association of Canada.

Welcome to all three of you.

The way we'll proceed is that you will each have five minutes to speak. After that, we will go into a round of questions. We have an hour for all of this.

Dr. Alika Lafontaine, please go ahead. You have five minutes.

Dr. Alika Lafontaine (President-Elect, Canadian Medical Association): Thank you very much, Mr. Chair.

I'm pleased to join the committee from Treaty 8 territory today, which is the traditional and present-day territory of the Woodland Cree, Dene and Métis nations.

I am Dr. Alika Lafontaine, a Métis anesthesiologist of mixed indigenous ancestry working in Grande Prairie, Alberta. It's my pleasure to appear before you as president-elect of the Canadian Medical Association and commend the Standing Committee on Indigenous and Northern Affairs for undertaking this study and inviting the Canadian Medical Association to be a witness.

Improving the administration and accessibility of the non-insured health benefits program is a key part of addressing the health inequities between indigenous and non-indigenous people in Canada. The Canadian Medical Association is committed to promoting equitable access to timely, quality care in all Canadian health systems, and strongly supports indigenous health transformation toward these goals.

The CMA recognizes that the most important voices in this evaluation are those who are directly impacted. These are the first nations and Inuit patients who access these services directly. We hope that communities, families and patients who utilize the NIHB program are fully engaged and heard throughout this study.

I hope to enhance this discussion by sharing two perspectives. The first is the lived experience of non-indigenous physicians who support patients eligible for NIHB programs. The second is my own personal experience as a specialist physician in a regional centre servicing Canada's north. Unlike my primary care colleagues, I do not interact with NIHB directly, but I support patients who depend on NIHB programs like medical travel to safely transport them to and from our regional hospital. It is important to acknowledge that without NIHB, many patients would be without any meaningful access to certain types of care, including surgical access and in-person specialist consultation.

Canadian physicians agree that NIHB needs modernization. Modernization should reduce fragmentation in the patient experience and provide efficient and clear decision-making pathways for physicians and NIHB administrators to make patient care decisions. Health care systems should be focused on getting patients to the right care at the right time, in a patient-centred way.

The CMA has long advocated for reducing health care fragmentation through modernization. Our recent call for federal leadership on pan-Canadian integrated health human resource planning is a case in point. Similarly, we support the increase and consistent integration of resources within the NIHB program to promote better coordinated care for patients, and more effective engagement of health providers supporting and advocating on behalf of patients navigating these programs.

Fragmentation can be considered in different categories. I will address two.

The first category is overly complicated workflows, where roles are poorly understood. There is a considerable amount of time and energy that physicians, patients, their families and NIHB administrators use in navigating paperwork and decision-making structures. Unlike provincial and territorial medicare, where physicians can provide direct approval and access to services, the added administrative layers of the NIHB create opacity on the physician's role and jurisdiction in these processes. The CMA's president, Dr. Katharine Smart, is a pediatrician in the Yukon. Dr. Smart's experience of teaching herself how to utilize and navigate NIHB on behalf of her patients and families is a shared experience of many physicians across Canada.

The second category is a lack of integrating modern technology toward patient-centred, patient-engaged efficiency. Navigating paperwork and people can take up hours of their physicians' time, filling out paperwork and looking to connect with people over the phone. These paper forms must then be faxed through an asynchronous communications system that dooms too many of these requests to disjointed dead ends. The physician is often the last to learn the loop was never closed, delaying care and often resulting in worsening patient outcomes. NIHB has yet to be tightly integrated with a mature, centralized patient experience and quality improvement departments, so these situations are likely not tracked or addressed in a broadly consistent way.

Secure, digital communication where patients engage with providers on their own journey from beginning to end now exists in many health systems across Canada. In place of a series of noncontiguous faxed forms, secure digital communication can close that loop, informing, tracking progress and answering questions regarding a medically necessary request that is processed through the NIHB. It also provides a digital audit trail that could improve patient experiences and iterative quality improvement.

Colonization, systemic racism and lack of investment in health care infrastructure add additional layers of complexity to the modernization of the NIHB—

● (1635)

[*Translation*]

Mrs. Marilène Gill: I raise a point of order, Mr. Chair.

[*English*]

The Chair: Stand by, Dr. Lafontaine, please.

Madam Gill.

[*Translation*]

Mrs. Marilène Gill: Excuse me. The sound quality was poor, but the interpretation has just started again.

Thank you.

[*English*]

The Chair: Are you okay now?

[*Translation*]

Mrs. Marilène Gill: Mr. Chair, the interpreter reports that the witness does not have the appropriate headset. Perhaps that is why the sound quality is poor. If the witness could provide his speaking notes to the committee, it would help the interpreters to do their job.

I am passing the message on to you.

[*English*]

The Chair: Okay.

Thank you very much.

Dr. Lafontaine, apparently you don't have the normal headset that we use for our interpreters.

I would ask you to conclude, but speak a little more slowly.

Dr. Alika Lafontaine: Sure. I'm sorry about that.

In conclusion, the CMA recommends that this initiative be coupled with sustained investments to address the ongoing structural inequities that marginalize indigenous peoples. That's the inclusion of indigenous peoples in societal systems and sectors and a commitment to collaborative and respectful relationships with indigenous patients and communities.

Thank you, Mr. Chair.

The Chair: Thank you, Dr. Lafontaine.

We'll now go to Dr. James Makokis.

Doctor, you have five minutes.

Dr. James A. Makokis (Plains Cree Family Physician, Kinokamasihk Nehiyawak Nation, Treaty Number Six Territory, As an Individual): [*Witness spoke in Cree*]

[*English*]

I'm from the Saddle Lake Cree Nation and am a descendant of signatories of Treaty No. 6. I'm one of the few indigenous physicians who grew up with their people and who work with their own people. Presently I work on Kinokamasihk. I am testifying as a user of the current NIHB program and as a Nehiyawak physician who treats Nehiyawak, also users of the NIHB program, on a daily basis.

I greet you today in the language of my people, Nehiyawewin, which comes from these lands upon which your people now sit, welcomed by my ancestors nearly 500 years ago, a language imbued with sacred teachings of natural law that governs our people, with laws that roughly translate to kindness, love, honesty, sharing, respect, family, trust, reciprocity, fairness, equity, care, longevity and, above all, honour for our mother, the earth, and all of its inhabitants.

The same language was used to agree to a treaty that allowed for your ancestors to respectfully share these lands in exchange for peace and friendship, mutual understanding and the promise of health and health care, also know as the medicine chest clause, to be honoured for as long as the sun shines, the grass grows and the rivers flow and as long as there are native peoples. In English legalese, this would be represented by the phrase “in perpetuity throughout the universe”.

If the promises of the treaty had been truly honoured, I'd speak to you in my own language, and all of you would fully understand what I am saying. We'd sit around a fire, begin our conversation in ceremony with a prayer and the guidance of a pipe, the keeper of our laws. We would sit and discuss these matters until the matter at hand was resolved.

Yet, I sit here and speak to you in English, a foreign language, with much too short a time limit to articulate the shortcomings of a program that shouldn't even be an issue because everything I'm going to discuss was already promised to us over 150 years ago when your ancestors agreed to a treaty.

To discuss these matters as an indigenous physician is insulting because not only are our health and health care guaranteed by our treaty, which continues to be in full force and effect, but the Government of Canada ushered in the era of truth and reconciliation in an attempt to correct the reality of what is actually happening to our people, which is genocide. Yet I still have to sit here and point out the ways in which NIHB not only continues to fail to provide adequate health measures for our people in the most basic ways, for example by giving patients an insufficient number of catheters while NIHB bureaucrats instruct these same patients to wash and reuse their catheters, which goes against medical standards, but also does so in communities with boil water advisories, as was the case when I practised in my own nation, Saddle Lake, in 2013.

We wonder why indigenous peoples have higher rates of kidney disease and dialysis. We wonder why, when ISC nurses asked me to assess a 17-year-old Cree person from my community who had suffered a spinal cord injury, I found a stage 4 sacral ulcer. For those of you who don't know what that means, the ulcer was so deep I could press on her tail bone. Why did she have this? NIHB would provide her with a new wheelchair at only limited intervals, but children grow and she outgrew her wheelchair, causing these pressure ulcers. Jordan's principle was passed in an effort to address these issues, but still they persist.

This February, it took two months to get an appropriate nutritional formula for a four-month-old Cree baby at a time in their life when their brain was developing the most. We wonder why indigenous youth do not graduate from high school.

To get anything covered through NIHB requires extensive and exhaustive advocacy. I once required post-exposure prophylactic antiretroviral HIV drugs after I performed a procedure in my clinic. The ID specialist recommended I take two drugs within 72 hours of the incident. NIHB denied the claim. I then had to get on the phone myself and speak with the NIHB bureaucrat, who then directed me to the national pharmacist of the NIHB program. I had to tell the national NIHB pharmacist, “If you do not give me these anti-HIV medications, I will be at Canada Place on Monday morning with the Grand Chief of the Confederacy of Treaty Six stating that your policies have possibly caused one of the few indigenous physicians in this country to contract HIV, and it will be in the media. Is that what you want?” Only then was this medication provided. How would a regular person be expected to know how to navigate and advocate through this bureaucratic mess? And we wonder why indigenous peoples have the highest rates of HIV infections.

On April 25, our home care nurse stated that NIHB would not cover wound supplies for a 65-year-old Cree woman who was palliative, dying at home, with metastatic cancer. She required daily dressing changes and NIHB would only give one dressing every three days. I had to spend 60 minutes on the phone with the NIHB bureaucrats and speak with a supervisor to explain that if the patient died of sepsis, I would record how their actions contributed to her untimely death.

It is only when physicians make drastic statements that supplies, equipment and medication are covered. We should not have to do this. Family physicians, specialists and allied health professionals repeatedly state how difficult it is to work within this program and to attain appropriate coverage for indigenous peoples and they ask how this can be improved.

● (1640)

I recommend that the NIHB program be evaluated by indigenous scholars, allies and users of the program and then changed to create an inclusive, responsive and comprehensive program that actually meets the real health needs of indigenous peoples. The current NIHB system only further contributes to our early morbidity and mortality, and its use is a risk factor for our early death.

Hiy hiy.

The Chair: Thank you, Dr. Makokis.

We're now ready for Dr. Evans.

You have five minutes.

Dr. Evan Adams (Vice President, Indigenous Physicians Association of Canada): Thank you very much.

I am here as a dual representative: as the deputy chief medical officer at first nations and Inuit health branch headquarters in Ottawa, but also as the vice president of the Indigenous Physicians Association of Canada.

The Indigenous Physicians Association of Canada is invested in supporting indigenous physicians across the country, indigenous patients and clients and indigenous health and transforming the system. We understand that the colonial experience and the “health interrupted” of indigenous peoples are major factors in their unwellness. We advocate for self-determination and governance, or indigenous control over indigenous health services, recognizing that health services, access to health services and health services as a determinant of health are in a spectrum of the social determinants of indigenous health, which I'm sure you have heard about quite often here.

There are a few items that the Indigenous Physicians Association of Canada would like to touch upon, such as the need for good, distinctions-based first nations, Inuit and Métis public health data—or, really, just health data—so that we get a clearer picture of where we're working and how our clients are doing, which will point us in a direction of wellness.

There are many areas where indigenous peoples need help and support, but here are a few. One is communicable diseases. Also, mental health and wellness have been identified quite early as a need, particularly by the chiefs of Canada. Others are social determinants of health, such as housing, and, of course, the areas where we work: in communities, or within the territories of first nations, Inuit and Métis, and within our clinics and hospitals.

You've probably heard by now about a number of aspects of the non-insured health benefits program, but I wanted to touch upon a few areas where we often complain or hear complaints.

One is the NIHB program appeals process. If coverage for a benefit through the health benefits program is denied, clients, parents, legal guardians or a representative of a client may appeal the decisions. There are three levels of appeal available. Appeals are assessed by a different program official at each appeal level. The NIHB program aims to send clients a written explanation of the decision for an appeal within 30 business days 80% of the time under normal circumstances after receiving completed appeal documents.

The First Nations Health Authority of B.C. understood that the timeliness of the appeals program was difficult and endeavoured to do quality improvement so that the period of time for response and for appeals was considerably shortened.

Next is medical transportation to access traditional healers. The non-insured health benefits also support access to traditional healing services through the medical transportation benefit, which provides eligible clients with coverage for transportation to access health services not available locally, including traditional healing services.

In terms of catheters, they were a topic of discussion a couple of years ago, but this bears reiterating. Items covered under the NIHB program's medical supplies and equipment benefit are intended to address our clients' medical needs in relation to basic activities of daily living, such as eating, bathing, dressing, toileting and transferring. In 2017, NIHB increased coverage for disposable intermittent urinary catheters to four per day and removed the prior approval requirement.

The non-insured health benefits program reviews its services and coverage regularly. We have a non-insured health benefits oral health advisory committee, which is made up of several dentists. Their bios are available on our website.

Our drugs and therapeutics advisory committee includes seven physicians and a few lay people and is chaired by Dr. Derek Jorgenson and vice-chaired by Dr. Marlyn Cook, an indigenous physician from Manitoba.

● (1645)

We also have a medical supplies and equipment advisory committee, which includes vision care experts, a registered nurse, a family physician, a public health physician, a health economist, an ophthalmologist, a podiatrist, etc.

As a side note, I absolutely understand that quality control and the improvement of the quality of services for first nations, Inuit and Métis are an important aspect of system transformation. We take that transformation seriously and understand that consultation with health experts and health leaders, like the indigenous physicians here, is extremely important. This is beside speaking to indigenous clients and indigenous leaders, like chiefs.

I'll end my statement there. I'm happy for discussion.

Thanks very much.

● (1650)

The Chair: Thank you very much, Dr. Adams.

We'll proceed to a round of questions, and we'll start with Mr. Vidal.

You have six minutes.

Mr. Gary Vidal (Desnethé—Missinippi—Churchill River, CPC): Mr. Schmale is going to take our first slot, Mr. Chair.

The Chair: Very good.

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

Thank you to our witnesses for that testimony. A lot of the common theme we've heard, especially from our first two witnesses, revolved around bureaucracy and the slowdowns that can occur when a government department gets too big and too bureaucratic. As it was pointed out, it costs lives in some cases. We've heard testimony in the veterans committee where veterans have to reapply to prove that their limbs are still missing. This seems to be a common theme.

I'll start with Dr. Makokis, if I can, and then maybe Dr. Lafontaine can jump in. As you pointed out in your testimony, it seems that bureaucracy only moved when you hit the panic button and shocked the department into doing its job. This must be extremely frustrating for you, as was very clear in your testimony.

How would you go about, as some people have suggested, restructuring the department as a whole so that it functions properly?

Dr. James A. Makokis: It's a complex question with complex solutions. I used to work in a first nations and Inuit health branch as a university student, so sometimes I walked by the NIHB employees and staff and had a listen to the conversations that they were having with our people. Some of them were around medical transportation, which was mentioned previously, and they would ask, “Why can't you just walk to the health centre?” There's no public transportation on reserves, as people know.

What I find is that the bureaucrats who work under the program are completely out of touch with the reality of the lived experiences of people on the reserve and the communities that they're supposed to provide care for. They act as an extreme barrier to the provision of basic, standard care. They don't have any training about indigenous peoples, about indigenous peoples' health, about our treaty promise to health and the provision of health care, medical services and supplies. That is a huge issue.

You mentioned a second piece, which is the tremendous advocacy that physicians or health providers have to do to navigate and get items covered under that program. As indigenous physicians, other indigenous colleagues and I, who work with our own people, routinely have to get people's names and supervisors and document them in the medical chart. We literally say, “You will cause the death of this patient. I'm documenting this and your name will be on the death record as, potentially, one of the contributing causes.” Only then are items covered under this program.

It shouldn't take that level of advocacy. Most health professionals don't even know how to navigate through this system, because they're not taught about it within their professional schools, whether that's in medicine or pharmacy. It's only when we are forced to work within this system that we have to figure out which buttons to press to ensure that something is covered.

When we compare that to any other extended health benefits, whether that's Blue Cross, Manulife or any of the other ones in this country, providers routinely say that the NIHB program is the most difficult and causes the most harm to patients when they want to access it. It is also the most humiliating for patients to access, when they're at the provider's, looking to have their pharmaceutical or their medical equipment covered and having to stand there and advocate for themselves to great lengths to ensure that they receive proper care.

Mr. Jamie Schmale: Dr. Makokis, thank you. That was great. It actually answered my second question, which was about how it compared with other programs.

I will get back to you in two seconds. I just want Dr. Lafontaine to quickly chime in.

● (1655)

Dr. Alika Lafontaine: Thank you for that question.

For the interpreters, if my headset is causing problems, let me know and I will switch it out to something different.

When we look at bureaucracy, I think it's sometimes an easy target when things fall apart. I'm not saying that bureaucracies need to be big, but we do need people whose job it is to measure metrics, follow costs, make sure that workflows get followed through, audit and do all those other things. This takes people time and effort. Otherwise, that responsibility falls onto whoever else is left within the system. We know that one of the major causes of burnout among physicians is actual administrative work, so I will try to temper some of that criticism of bureaucracy in my answer.

I think the challenge is workflows, actually. The federal government is not a provincial or territorial medical system. ISC has gone through an evolution. They've changed from a program that's usually based on grant funding or other things to a more sustainable program where they are trying to design and create health systems in partnership with first nations and Inuit and Métis nations across the country. Along the way, they're revisiting those workflows and asking questions. Do three people have to approve this? Can just one person sign off on this? Could the responsibility for signing off actually go to the physician?

These are the same struggles we have within our provincial and territorial medical systems. Me having to phone an administrator to get permission to do a surgery at one in the morning, say, could create adverse problems for a person who needs an open fracture fixed in the middle of the night. I think the redesign could be leaning towards understanding what the workflows are trying to get out of the system and lining that up with the needs of patients—right care, right person, right time, and in a place that's as convenient to them as possible.

In your last panel, there was a comment from one of the panellists that sometimes we can't create these systems because of the cost or limited resources. We know that health human resources are at a critical point right now. Trying to work through what's best for the patient, and trying to line up those approvals and auditing processes to make sure that we're compliant with workflows that work in their best interest, I think is our recommendation from the CMA—to explore this type of program redesign.

The Chair: Thank you.

We will now go to Mr. Hanley, who is sharing his time with Ms. Atwin.

You have six minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much.

Thanks to all three panellists for a really fascinating discourse. Certainly, a common theme is incorporating first nations indigenous leadership and patient experience into program design but also maintaining that public accountability of running what needs to be a publicly funded institution. I appreciate that there is a balance.

Dr. Adams, you and I have known each other in many different roles over the years. When I look back at your experience with the First Nations Health Authority, you were one of the instrumental people, I think, in helping to design the First Nations Health Authority. I think it's a really good example of incorporating first nations leadership into program design.

I wonder if you could comment briefly on what you learned from that and how you might apply that to how we can address some of the inefficiencies, perhaps, that have been witnessed in talking about NIHB.

Dr. Evan Adams: That's great. This is a subject area that I can talk about for a while.

The First Nations Health Authority has been evolving for many years and now is a first nations health organization that has close to 1,000 employees helping about 160,000 first nations people in B.C.

There are a few themes. One is self-determination. It doesn't make sense for first nations health to be run from Vancouver or from Ottawa. Perhaps more local workers and local knowledge could be incorporated.

We've understood that sometimes our workers, who are meant to be helpful and not hurtful, are not well versed in our communities and community needs, and that a clerk in an office in Vancouver making health decisions that supersede those of an indigenous physician who's on the ground—or any physician or health care worker on the ground—is completely inappropriate, and we had to change the way that business was practised.

As many of you know, with quality improvements, making changes—just very simple business practices like how quickly you can get a scalpel to an operating room—requires quite a lot of co-operation and an admission by those workers in that chain that they can do better.

In B.C., that was the beginning of that transformation, and we made quite rigorous commitments through first nations leadership, but also at a tripartite level. Since I've arrived on the call, I haven't heard a mention of the responsibility of provincial services, which is the lion's share of services. They employ doctors and nurses and run hospitals and clinics, so it's the co-operation of the province, the federal partners, the first nations and particularly the first nations health leaders, not just leaders. Chiefs can make some change, but health leaders like Dr. Lafontaine and Dr. Makokis absolutely need to be a part of that process and part of the rigour of making change. They hold the moral high ground in order to ask for those quality changes.

Thanks.

● (1700)

Mr. Brendan Hanley: I'll let Ms. Atwin continue for the six minutes.

Mrs. Jenica Atwin (Fredericton, Lib.): Thank you so much, MP Hanley.

With my brief time, there's so much I could say, but I would first like to acknowledge that I'm speaking on the unceded territory of the Wolastoqiyik here in New Brunswick.

Again, with my limited time, I want to thank you, Dr. Makokis, for your testimony today. In particular, the honesty is really going to help inform our work in moving forward.

As well, for Dr. Lafontaine, congratulations on your election. Actually, the previous chair, Dr. Ann Collins, happened to be from Fredericton.

My question is for Dr. Adams. I'm a big fan, by the way. I have to say that.

In some of the themes that have been coming up, we've talked about the need for this to be indigenous-led—absolutely—the need to address systemic racism within the system and informed advocacy and all these pieces.

I know that a big piece of the Indigenous Physicians Association of Canada is looking for that capacity building. How can provinces, territories and communities recruit and support indigenous doctors and medical professionals to help deal with some of these issues?

Dr. Evan Adams: That's an excellent question. I hope you will keep asking that question of a number of professionals.

Really quickly, absolutely, I'm getting learners ready so that they're eligible to apply to medical school, and that's in undergraduate and even high school programs.

Admissions is another area. Also, then, there's the area of support for indigenous learners who are in medical school, because they are quite unique. They are like those who are here. They have phenomenal responsibilities within their communities as community leaders, cultural leaders and keepers of indigenous knowledge, besides going to medical school. Also, many of them are older and many of them already have families, so they need support. They're a different kind of learner than the average medical student. Last of all, they need jobs.

It's wonderful that we can be working in hospitals and clinics alongside our non-indigenous colleagues, but really, indigenous physicians need to be able to ascend. They need to sit alongside chiefs, as their medical officers. Indigenous people can have their own medical officers as their senior health advisers, and we need indigenous physicians and other health care professionals at the highest levels to ask for accountabilities and change.

Thanks.

Mrs. Jenica Atwin: Is there more time, Mr. Chair?

The Chair: No. I'm afraid that has just run out the clock. Thank you, Ms. Atwin.

[*Translation*]

We will now go to Mrs. Gill and Mr. Morrice.

Mrs. Gill, you have the floor for six minutes.

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

I would like to thank all the witnesses again, Mr. Lafontaine, Mr. Adams and Mr. Makokis.

Thank you for your testimony, which is varied.

Moreover, you work on the ground. You really see the reality in its most concrete and certainly most difficult way as well.

I would have liked to hear you make recommendations to shed light on all the difficulties you are facing. I've heard about the paperwork, in fact. I know that back home in Quebec, the Assembly of First Nations of Quebec and Labrador often comes back to this issue, which is very problematic for them. It prevents people from receiving care. If you can enlighten us, please do so.

My question is for all three of you.

[*English*]

The Chair: Dr. Lafontaine, would you get us going on that one?

Dr. Alika Lafontaine: I think that's a really good question: What do you recommend to fix some of these problems?

I'll keep my comments focused.

First, you need people to provide the services. I think we have to look at that need the same way we do with respect to an integrated, pan-Canadian health human resources plan. Just as Dr. Adams and Dr. Makokis mentioned, it is a struggle to recruit indigenous physicians into indigenous communities to provide care to indigenous patients. That's extremely important.

Second, it's not just about comparing costs internally against the NIHB program. We also have to look at relative care between provincial and federal systems. The goal of the CMA is advocating for equitable care. This means that, when you come through a door, whether you're indigenous or non-indigenous, you receive the same care, the same sort of access and the same type of timely service.

Finally, as we look toward making changes, there are things we can learn from indigenous health systems, and there are things we can learn from medicare. We're introducing pharmacare and dental care, hopefully, into our national medicare regime. We have decades of experience on how that has worked and not worked within indigenous communities, which we can learn from. We have decades of experience on how to fix other problems that indigenous communities are going through within medicare.

Thank you.

● (1705)

The Chair: Thank you, Dr. Lafontaine.

Go ahead, Dr. Makokis.

Dr. James A. Makokis: One, it's important, when we look at the provision of medical care and medicine, that we follow medical practices that are keeping up with the current times. If we look at the processes that exist within the NIHB system, there are flow charts of multiple steps that patients have to jump through. The clearest example is rheumatoid arthritis. People should not end up in wheelchairs with amputations, disabled, because they're not provided with the proper medication that exists today in the form of biologic and immunological agents—things like Humira. Instead, those patients have to take older medication, and their joints are completely destroyed by that time. They end up disabled and dying. We should not be seeing that in a country like Canada. We need to follow medical advice and recommendations that keep up with the fast pace of medicine.

Two, if we look at our original agreement within the medicine chest clause, which is a symbol of health care that would evolve into the future, it was all-encompassing. It included medicine as it would evolve—the pharmaceutical drugs that would come, and medical equipment and supplies that would come. Again, there are very rigid parameters as to how people can access this. If we look at diabetes and foot ulcers.... The basic principles of wound care include VAC or having patients wear Aircasts to off-load pressure. None of those are provided. Then we see that the rate of amputation among indigenous peoples is the highest in this country.

We actually need to provide care that reflects the needs of the state of health of indigenous peoples, which is the worst among any group across this country. That is not something our ancestors agreed to when we agreed to share this country in peace and friendship. Ultimately, 150 years later, we're in worse condition than when our relatives arrived on the shores of this country.

The Chair: Thank you, Doctor.

Go ahead, Dr. Adams.

Dr. Evan Adams: Yes, and I hope we have talked about UNDRIP and decisions being made about indigenous health without indigenous people at the table.

That time should be over for a couple of reasons. Indigenous decision-making is more than making a system faster so that more indigenous people can have more drugs faster. That is not the point.

With indigenous consultation, we can decide which parts of the system need to be addressed. We need to look upstream and downstream, of course, as well. We take the criticism at first nations and Inuit health branch.

We need to stop people from falling off the bridge rather than trying to help them once they're in the water. Upstream investments in our peoples means spending money on children and on prevention in the social determinants of health. If FNIHB cures your cancer, but we return you to homelessness, unemployment and poverty, have we really done our job?

We really need to be holistic. Indigenous people are very holistic in their approach and they're very clear on what improvements need to made. If they're at the table, we simply have to talk to them. If they're at the table, they will point in many directions where we can invest time and make improvements.

Thanks.

● (1710)

The Chair: Thank you.

Mr. Morrice, I'm afraid we've run out of time, but perhaps in a quick second round you might get in there.

We now go to Ms. Idlout.

Ms. Idlout, you have six minutes.

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

Thank you.

First of all, I wish to thank you three for coming to give us this presentation.

I know that when it comes to first nations, Métis and Inuit, you may be limited with some of the Inuit and other aboriginal groups. The one I can relate to is Dr. Makokis. As you are in direct [*Inaudible—Editor*] and you are a care provider, I admire that very much.

I wish to ask you this now, Dr. Makokis. In what ways do shortfalls in NIHB funding for both traditional indigenous medical systems and western clinical services impact indigenous people?

Dr. James A. Makokis: Thank you so much for your question, MP Idlout.

This is all a very long answer. When we look at the state of indigenous people's health in this country, it's directly proportional to the systemic dismantling that has occurred through federal policies and laws.

Our people had our own health systems, method of health, healing and medicines that helped to keep our people strong, well and healthy well into the ages that we're currently living with all of the advance of Western medicine technology and pharmaceutical drugs.

We know that the federal government, from 1884 to 1951, banned ceremonies, including potlatches, indigenous medicines and ways of being that formed the fabric of our medical system. We're seeing the direct results of that in the high rates of chronic disease, infectious disease, suicide and mental health issues that Dr. Adams mentioned.

For there to be a dramatic transformation in all of these health statistics, we need to systematically rebuild indigenous health systems. That starts with funding indigenous healers, elders, medicine people and young people who can train in their footsteps. We're at the verge of the possible extinction of our knowledge as it relates to indigenous medicines when it comes to how to keep our people healthy and well.

We know, when we look at research from the Aboriginal Healing Foundation, that indigenous peoples routinely rated our own medicines and access to our healers and medicine people higher and more important than accessing Western medicine, physicians and Western allied health professionals.

When we look at the non-insured health program, as Dr. Adams mentioned, yes, travel to see elders and traditional medicine people is covered, but the compensation to them as practitioners within our own health system, which has been decimated by Canadian law, is not covered. It's left up to the patient to cover themselves. We stopped paying for physician services when the Canada Health Act was implemented back in the 1980s and funding was provided by the federal government to provinces and territories to help pay for physician services.

We also have to pay for indigenous health services practised by our own people for our own people. We know that it works the best. We've had Western medicine for the past—I don't know how many—decades, and we haven't seen a transformation in indigenous mental, physical or spiritual health. What we need is our own medicine supported in a systematic way that has longevity and that our people can access. That's what they're looking for. We haven't seen any funding or resources put towards this.

Indigenous physicians who work with our own elders and healers would be a tremendous resource to help to guide this process, working in conjunction with our own people and our own leaders within our own communities. Unfortunately, there are very few indigenous physicians with that background, but there are some who would be willing to provide this help and guidance.

● (1715)

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

Thank you.

I will make this last question short. Can you give an example of a transfer of health services to indigenous nations? Would you provide an example of what you've seen in transferring to indigenous people?

Dr. James A. Makokis: I know that Dr. Adams mentioned the First Nations Health Authority, which is constantly referred to as the example across the country of what should be done.

I know that, in the province of Alberta, for example, which has Treaty 6, 7 and 8, some nations within Treaty 8, like the Bigstone Cree nation, have taken over their NIHB program. I have patients who access that; I see them as a frontline provider.

What I and other indigenous physicians who work with that program have found with that particular program is that it's even more difficult to get pharmaceutical drugs, medications, equipment and supplies covered. What I observe happening is that the restrictions that were under NIHB are exacerbated. I'm not sure if, in this transfer of funds to the nations and communities themselves, the funding is further restricted so that communities and nations are then administering their own poverty with funds that are given and transferred from federal programs and things like that.

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

Colleagues, we have a little bit of time left. I'm going to make a proposal that we start the second round with three minutes to each of the first two speakers and then one question each for the third and fourth speakers. That way, we can probably finish on time.

I'm going to start with the Conservatives. I'm not exactly sure who would be the speaker, but they would have three minutes.

Mr. Jamie Schmale: Thank you, Chair.

I'll just pick up from where Dr. Makokis was in our last conversation, and I will go to Dr. Lafontaine.

When you're talking about the costs, it seems that, as was mentioned, instead of having three people decide you have to sign off on something before you actually see some movement, there could be some real efficiencies by changing those dollars from funding bureaucrats to actually going to the care of individuals.

Dr. Alika Lafontaine: I do agree with that statement. I think in exploring the workflows we do have to be careful that we don't assume that those costs can be immediately transferred to patients, but I do believe that, yes, your comment is correct.

Mr. Jamie Schmale: Dr. Makokis.

Dr. James A. Makokis: I'm sorry, but can you just repeat your question?

Mr. Jamie Schmale: I was just talking about costs, where we have, in some cases, excess bureaucracy and how, if we improved, as Dr. Lafontaine said, the workflow to ensure that things were getting done in a timely and efficient manner, we might be able to hopefully move some of those dollars into actually funding the care that's needed.

Dr. James A. Makokis: Yes. If you look at Onion Lake Cree Nation, they're looking at having treaty-based funding given directly to the nation to administer and look after its own health agreements and look after the priorities of their own nation in terms of health.

As we know, if we look at the bureaucracy of Indigenous Services Canada, the money that's provided for indigenous people is actually siphoned off by this large bureaucracy, and a very small amount actually ends up getting to the people who require it the most.

So I do agree that, yes, the bureaucracy does take a lot of this money when it's actually required by indigenous peoples who, again, have the worst health outcomes of this country. Nations like Onion Lake Cree Nation, which are leading in this area, would be examples to learn from.

Mr. Jamie Schmale: Dr. Makokis, just out of curiosity, in those painful stories that you presented here to committee, when you had to basically, as I mentioned before, hit the panic button before you saw any movement, was the person on the other end of the line actually somebody from the department who had medical experience or was it just somebody who happened to pick up the phone that day?

● (1720)

Dr. James A. Makokis: The people in NIHB who are trained to answer the phone are non-medical professionals. Sometimes they do hire medical professionals, as I mentioned, such as the national pharmacist, and there are regulated health professionals who are a part of that program, but largely it's just regular people without a medical background who follow the flow charts and decision-making processes given to them by Health Canada under NIHB. I have to advocate to these non-health professionals about somebody's personal health history and try to get across to them my medical decision-making process when they don't have any background or understanding about that.

The Chair: Thank you very much.

We'll now go to a Liberal, Mr. Badawey.

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

I'll be splitting my time with Ms. Atwin, but I do have one question. I appreciate the time split with me.

With respect to Dr. Makokis' comments, as the PS for Indigenous Services Canada, I'm very much interested to work with you, Doctor, as well as with Dr. Lafontaine and Dr. Adams, to establish a direction for community health and a more formalized community health plan.

To all three of you, is there or has there been established—I'll use these words—"a strategic plan" with respect to overall community health within indigenous communities, on reserve in rural areas, in smaller communities and in other on-reserve communities as well? Has there been a strategic plan that's been consistent or that the three of you wish would be implemented on reserve?

The Chair: In the interest of time, I'll direct that first to Dr. Adams, if you want to comment, then Dr. Makokis and then Dr. Lafontaine.

Dr. Evan Adams: Sure.

B.C. has a tripartite first nations health plan. The first document was quite slim—I think under 10 pages. The next plan after they finished their initial mandate was much longer. I think first nations, Inuit and Métis have actually described well where they would like to invest and where their priorities are. I think it would be very welcome to just have them lead those kinds of directions and investment. It doesn't make sense to enact care that hasn't been asked for, and from a distant location. It really needs to involve local peoples.

Thanks.

The Chair: Thank you.

Dr. Makokis.

Dr. James A. Makokis: I think one of the issues that we routinely see as indigenous physicians who work in the community—there are very few of us who do that—is that we are left out of the decision-making process, and we're actually not asked about our routine experiences that we have as we interface with these programs.

When I talk with other allied health professionals like pharmacists, optometrists, opticians and nurses, they have the same experiences when it comes to these programs. I think that's one of the biggest challenges. We actually need to speak with, dialogue and have conversations with the users of these programs, who then can articulate these types of experiences that are real world and real time with real people of what they routinely go through on a regular basis.

I know that in the previous panel the importance of having chaperones was raised. Chaperones can be life-saving for individuals who routinely face systemic racism within the health care system, because they're going to be the ones who advocate and see that in real time. We know what happened with Joyce Echaquan, as well as many others within the health care system of Canada, where people are dying because of systemic racism.

We actually need to have conversations with the users of the program, with the bureaucrats who are often forced to sign non-disclosure agreements that they can't talk about the injustices they see within the program. You can talk with some of the Indigenous Services Canada nurses I interface with routinely who see the injustices but are unable to bring them to the attention of media because of these NDAs that they're forced to sign. Under their own regulatory profession and advocacy as nurses, they're not able to bring that forward.

I think there are many issues. Those are just the tip of the iceberg, and I think this conversation needs to be expanded to include more people.

● (1725)

Mr. Vance Badawey: Let's do that.

Dr. Lafontaine.

Dr. Alika Lafontaine: I was part of an alliance called the Indigenous Health Alliance from 2013 to 2017. It had more than 150 first nations across three provinces participating in it. There was Nishnawbe Aski Nation in northern Ontario, Keewatinowi Okimakanak in northern Manitoba and the Federation of Sovereign Indigenous Nations. We had the support of AFN. We were meeting with ministers, and at the time I gained a real insight into the question that you just asked.

If you use the example of cooking, what I think we often ask communities to do is walk into a kitchen with foreign ingredients and cook what they want. I think that's how it is with health care for many people who aren't in health care or have been through a past patient experience. They don't really know what they don't know, and they don't know how the pieces fit together.

The most valuable thing that we did with that alliance, and something that we try to do here at the CMA, is give people examples of what to cook. We teach them what the different ingredients are and how they mix together. I think if you're looking at scaling different approaches, it's giving first nations, Inuit and Métis communities across the country the ability to pick and choose what they want to eat, but then understand about nutrition, about cooking, the ingredients, etc.

The question is not if people can cook; it's if they can cook with what we give them. I think we have to change our orientation from asking if communities have capacity, to assuming that they have capacity but do they have the supports they need to make better decisions?

The Chair: Thank you very much. It's an interesting analogy, Dr. Lafontaine.

[*Translation*]

Mrs. Gill, you may ask a question or yield the remaining time to Mr. Morrice.

Mrs. Marilène Gill: I'm sorry, I thought you were talking to Mr. Morrice.

Of course, Mr. Chair, I'll give the remaining time to him.

Thank you.

[*English*]

The Chair: Thank you.

Mr. Morrice, you have time for one quick question.

[*Translation*]

Mr. Mike Morrice: Thank you again, Mrs. Gill.

[*English*]

Thanks to all the witnesses who joined us this afternoon. I was particularly struck by the comments you shared, Dr. Makokis, including on the limitations and inadequacies of this very committee structure and the fact that I can only speak with you in English.

If there's anything you haven't had a chance to already share with this committee, I want to just offer you the time to share that now.

Dr. James A. Makokis: Thank you so much for that opportunity.

If I think of my own family's experience in interfacing with not only the Canadian health system but with NIHB, there is a tremendous number of years of loss of life. Again, when I reflect on what our relationship is supposed to be as a treaty descendant in Treaty No. 6, that's not what it is supposed to be.

In our lifetime we want to see the transformation for the betterment of our children, of our grandchildren and great-grandchildren to be able to live and thrive and be the best possible human beings, *ayisiyiniw*, that we are meant to be here together.

It shouldn't take the tremendous amount of advocacy and work to obtain the basic, most foundational provisions of providing care. What we often hear as indigenous physicians from Indigenous Services Canada is that this program is comparable to any other federal program, including the ones that MPs have access to. I would challenge you to switch your program from your extended benefits that you currently have to the one that people who are Inuit and first nations are forced to use, and you can see how quickly the things that you routinely take for granted for your health, for your family's health, are taken away and removed. When you go and access care, the basic humanity that we strive to provide all people, as is in the mission of Health Canada to improve the health of all people within this country, changes suddenly.

I think that when we look at health transformation from an indigenous perspective, we need to rebuild the indigenous health system. We've seen over the past two years with COVID what happens when there's a threat to a health system, how quickly it crumbles, how quickly many of the provincial and territorial health systems were on the verge of collapse, and that's only after two years, let alone from 1885 to 1951 when we couldn't even access our own health system because we couldn't leave the reserve due to the past system, for example.

When we think of things in that perspective, there's a lot of work that needs to be done to rebuild the indigenous health system and support indigenous health healers, medicine people and elders, who when we do this will actually start to see a change in the morbidity and mortality that we have become so used to when we talk about indigenous people and indigenous people's health and the deficits around these.

In my lifetime, that is something I would like to see as someone who is 40 years old, who is one of the non-fluent Cree speakers in our community. In the next 20 years, there's the potential loss of the Cree language. If that happens, we're going to see worse health outcomes than we already have.

I know Dr. Adams talked about upstream health determinants, and language is an important part of that. With upstream health determinants, traditions and culture is an important part of that, and that's what we need to focus our attention on, and that's really what reconciliation is.

● (1730)

The Chair: Thank you, Doctor.

Ms. Idlout, would you like to finish with a question?

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

Yes, very much, one question.

I have a question to Dr. Makokis.

I'd like to ask you as a physician, do you have the ability to prescribe and refer patients to traditional healers? If you do, how does that work?

Dr. James A. Makokis: Again, MP Idlout, I have spent a significant amount of time with our elders and medicine people, learning our own medicines and traditional medicine practice alongside my western medical journey. During medical school breaks, I would go home and spend the summers with elders. During weekends, I would go home and learn from them.

There are very few indigenous physicians who do this. There are a handful of us who do that. As part of our regular practice, we routinely refer to healers and medicine people and elders within our own community, because we know the network that exists there, and they trust us.

This is an important part of our health system, and, unfortunately, this is not compensated. What I do as a physician and what I've done in the past is that, working fee-for-service, I would do a home visit with an elder and the patient. I would bill the provincial health system for a home visit fee, and I would split that fee fifty-fifty, so that the elder or traditional medicine person was compensated equitably to what I was compensated. I did that myself.

This is not something that's sustainable. Most health professionals—most doctors, most nurses—would not donate 50% of their salary to someone. That's what we really need to talk about: how we are going to adequately compensate our medicine people and elders who are identified by our own people and who we use in the community. It's a very important part of our health system.

Yes, I do that. It's not compensated. It needs to be compensated. There needs to be more of that.

If we look at the Diné College in the Navajo Nation, they have a training system for indigenous traditional medicine people and for Navajo students to learn from their own elders within their communities. We need to have processes for doing that in this country, whether that's indigenous medical students, indigenous medical schools, where we're training alongside our elders and traditional medicine people and providing care in a culturally safe, appropriate way that is as equal and as valid as western medicine.

● (1735)

The Chair: Thank you very much.

On behalf of all the committee, I would like to thank our witnesses today, Dr. Lafontaine, Dr. Adams and Dr. Makokis.

Thank you for your testimony. Thank you for your candour. I think you've provided very valuable input to this committee's work, and we very much appreciate it. Thank you.

Please, Mr. Badawey, go ahead.

Mr. Vance Badawey: Thank you, Mr. Chairman.

Just quickly, to all three doctors, my office will be reaching out to you to get some more time in and to discuss some of the things we talked about at today's meeting.

I want to thank you for your time today.

The Chair: Thank you.

With that, this meeting is adjourned.