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• (1605)

[*Translation*]

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

Welcome to meeting number 19 of the Standing Committee on Indigenous and Northern Affairs.

[*English*]

We are gathered here today on the unceded territory of the Algonquin Anishinabe nation. We have just a couple of housekeeping matters to take care of before we start the panels.

The clerk distributed to everyone the budget for our fourth study, and I would like to see if we have the committee's approval for this budget. What does the committee say? Do we have approval?

Some hon. members: Agreed.

The Chair: Very good. That's approved. Thank you very much.

I remind everyone that the lists for the first 12 witnesses for the study are due by noon this Friday, May 13. That's six witnesses for the Liberals, four for the Conservatives, one witness for the NDP and one witness for the Bloc. The rest of the witness lists are due at noon on May 20. This is to give the clerk the ability to book witnesses in advance since we'll be coming up soon, after our May break week, on the study.

[*Translation*]

Today, we are continuing our third study, which focuses on the administration of the non-insured—

Mrs. Marilène Gill (Manicouagan, BQ): Sorry to interrupt you, Mr. Chair.

My understanding was that the Bloc Québécois and the NDP were each allowed to invite two witnesses. If I'm not mistaken, that was Ms. Idlout's understanding as well.

The Chair: That would mean we would have more than 12 witnesses.

[*English*]

It's six, four, one and one.

[*Translation*]

We are continuing our study on the administration of the non-insured health benefits, or NIHB, program and its accessibility to indigenous people.

[*English*]

Before I introduce our first panel, I have a few notes.

Please wait until I recognize you by name before speaking, and if you are on the video conference, please click on the microphone icon to unmute yourself. For those in the room, your microphone will be controlled as normal by the proceedings and verification officer. When speaking, please speak slowly and clearly, and when you are not speaking, your microphone should be on mute. I remind you that all comments should be addressed through the chair.

Today's committee meeting is like all committee meetings. We will introduce our guests and they will have five minutes each to speak, after which we'll proceed with a question period.

I would like to introduce our three witnesses today: Mr. Lee Thom, elected official of the Kikino Metis Settlement; Frances Chartrand, minister of health and wellness of the Manitoba Métis Federation; and, finally, from the Métis Nation of Saskatchewan, Marg Friesen, minister of health, and Adel Panahi, director of health.

I would like to start the testimony of the witnesses. We'll begin with Mr. Lee Thom.

Mr. Thom, you will have five minutes for your presentation. Go ahead.

Mr. Lee Thom (Elected Official, Kikino Metis Settlement): Thank you, sir. It's an honour to be here.

I'll make this quick. I have some really good notes, and hopefully I can stay focused. It took me a while to get here, but I'm here.

First of all, my name is Lee Thom, and I'm from the Kikino Metis Settlement. Kikino is in northern Alberta. It is two hours north of Edmonton. I'll give you a quick history on the settlement, and then I'll go into my three topics that I've elected to talk about today.

The Metis Settlements of Alberta in 1990 were given the Metis Settlement Accord from the province of the day. That gave 1.2 million acres of fee-simple land, which brought us the land base. We were then given some funding to build our infrastructure and our communities. That was the accord.

With the accord ending in 2011, there was short-term interim funding, which led, in 2013, to the LTA, and now we're at the end of the LTA. The LTA was put in and designed for us to continue our future funding, with schedule J being one part of the LTA that was to give us beneficial ownership of mines and minerals, which didn't happen.

Long story short, and it's a very long story that I'm making short here, in 2017 the Metis Settlements signed an MOU with the federal government and Minister Bennett. A piece of that was to protect our lands through section 35 rights.

A 2018 framework brought a framework agreement with a bunch of items, the main one being health. There are 10 of them, but I won't go through that, as I'm cutting into my time here on my topics, but health was one of the most important ones. Right now the Metis Settlements are in discussion with the province, and always have been, about three main topics: senior services, mental health and addiction.

On senior services, in our community we have right now anywhere from 80 to 100 seniors who have no access to dental or vision support. A lot of barriers come up with transportation, education and training for our local workers and people to supply services. We're told at Metis Settlements that the services are at arm's length, and the hope is that some day we can have facilities that can house the services that are so important to our community as a small municipality.

I'm right off my notes now. I know what I'm talking about. I don't like to be scripted, so I'm just going to continue as Lee Thom.

Mental health and addictions are big contributors to rural crime, senior abuse and problems we have in our community now with youth lacking participation. Program funding for youth to access sports is huge. Creating campaigns that are anti-drug and alcohol.... I really think that health ties to the home: healthier homes, healthier people.

I really believe that addressing mould in our communities and dealing with inefficient housing in the days of climate change now and the movement towards energy efficiency in their homes have a big impact on health. Our homes are inefficient. We're in dire need of funding that supports housing. Housing is tied to health.

We need funding that supports policing. Policing is tied to reduction in rural crime and everything that comes with mental health and addictions and senior abuse. There's so much we can talk about.

I had my scripted notes, and I may have missed a few things here but, as you can tell, I like to speak from my heart, and I like to come as a Métis person from a Métis settlement and make the government understand that we signed two agreements in the past. The 2018 framework agreement identified 10 things again. I want to make that point clear. Since then, we haven't had the traction that we would hope to have that would identify line-item dollars for the Metis Settlements specifically. We tend to be budgeted as Métis communities, and there are a lot of Métis communities, but Alberta is unique. It's the only province that has land-based Métis, and the only province that has land-based Métis with infrastructure, with roads, with staff, administration and elected people.

• (1610)

Good governance is a huge part of our system. Without good governance, programs that we offer to our members, such as 50-50 repair programs, where people can access dollars to repair their homes, to gain medical travel.... Some of the programs that we have in our communities are very important to our members.

• (1615)

The Chair: Mr. Thom, we're past the five minutes.

Could you wrap up, please?

Mr. Lee Thom: Yes. I'll wrap up quickly. I'm sorry.

I think we need to follow the obligations that were identified in the 2018 framework agreement. We're on health today. I understand that, and I did give some things on health.

The signing with Minister Bennett was the day when there was supposed to be reconciliation from that time, but I haven't seen the traction. Being elected now, I haven't seen the movement. I think the federal budget needs to acknowledge the Metis Settlements directly, with flow-through funding to address all issues.

Thank you very much.

It's an honour to be here. Thanks for your time.

The Chair: Thank you, Mr. Thom.

We'll now go to Frances Chartrand.

Ms. Chartrand, you have five minutes.

Ms. Frances Chartrand (Minister of Health and Wellness, Manitoba Métis Federation): Good afternoon, everyone.

I would like to thank you for allowing the Manitoba Métis Federation to speak here today. We are looking forward to this study on indigenous peoples' access to the non-insured benefits program and are excited to start a conversation on improving the health of our Red River Métis citizens.

Before I start the discussion, I would like to provide a few definitions and a little information about our identity.

The Manitoba Métis Federation is the indigenous collective that was historically known as the Red River Métis. We are Canada's negotiating partners in Confederation and the founders of the great Province of Manitoba. Our collective or community goes beyond borders, and our citizens are today located within what is now Manitoba, as well as elsewhere inside and outside of Canada.

With our July 2021 Manitoba Métis Self-Government Recognition and Implementation Agreement, the MMF is the federally recognized government of the Red River Métis, also known as the Manitoba Métis, a distinct indigenous people whose rights are recognized and affirmed as protected by section 35 of the Constitution Act, 1982.

The Manitoba Métis Federation has undertaken substantial health research based on samples of over 70,000 of our citizens. While MMF citizens are not covered under non-insured health benefits, the 2010 Métis atlas and subsequent studies have shown that overall health and life expectancy of Métis are poorer when compared to the rest of Manitobans. Social determinants of health, including socio-economic status and access to services, factor largely in this. The findings of our research indicate that the rate of chronic illness is extremely high in our communities. Heart disease is 40% higher than in the general Canadian population; arthritis is 22% higher; diabetes is 34% higher, and diabetes-related lower limb amputations are 49% higher.

In order to provide equitable and culturally appropriate services, Métis citizens in Manitoba require health and social programs and services that are developed and delivered by Métis citizens and Métis people.

In 2017, a prescription drug program was developed by the Manitoba Métis Federation and introduced to assist Métis seniors in need to ensure they were not out of pocket for medication expenses. To date, our prescription drug program has been funded solely by the Manitoba Métis Federation, despite our attempts to work with Canada to develop a partnership.

The PDP covers a comprehensive range of prescription drugs and over-the-counter medications listed on the Manitoba pharmacare formulary. In addition, a small range of medical supplies and equipment items are covered by the program. At present, for the PDP supports, you have to maintain a current and valid MMF citizenship card; you have to be 55 or older; you have to have an annual income of \$25,000 or less; you have to be enrolled in the Manitoba pharmacare program; and you have to agree to use MEDOCare Pharmacy as the sole dispensary.

The utilization rate of the program among eligible Métis seniors and older adults continues to rise. It has doubled from 2019-20 to the 2021-22 fiscal year. The program utilization is projected to climb, as seniors are known to have a higher prevalence of certain chronic conditions compared to younger Canadians, as well as lower incomes on pension plans.

Unlike non-insured health benefits medical coverage for first nations individuals, the PDP does not cover diagnostic services such as examinations, radiographs, audiology services, preventative services, orthotics, dental care and medical transportation and accommodation, to name a few. MMF is working on expanding the program to cover the services stated above to alleviate financial burdens on low-income Métis older adults. There is a demand for more and broader range of services. The Métis can work in complementarity with Manitoba and Canada.

• (1620)

The Manitoba Métis have the right to self-determination as recognized in the United Nations Declaration on the Rights of Indigenous Peoples, and the inherent right to self-government recognized and affirmed by section 35. The right to self-determination includes the right to health in all its forms. This includes the administration and delivery of health care services, setting our own priorities, administering our own health care budgets and managing our own resources.

Provisions are needed to negotiate agreements or to promote the health, safety and welfare of Métis citizens within a defined area of pharmaceutical and medical services, and to enhance access.

The Chair: Ms. Chartrand, I'll have to ask you to wrap up. We're over five minutes.

Ms. Frances Chartrand: Okay.

We are prepared to work with Canada at the technical level on the negotiation of agreements and participate in the development and promotion of health legislation that will ensure that our elders and vulnerable Métis citizens have the health services they require.

Thank you very much for having me here to present today.

The Chair: Thank you, Ms. Chartrand.

We'll now go to our next witnesses. We have Marg Friesen and Adel Panahi.

I'm not sure whether you're going to divide your time or have just one speaker, but you have five minutes.

Thank you.

Ms. Marg Friesen (Minister of Health, Métis Nation-Saskatchewan): Thank you.

Taanishi. Hello, everyone.

Good afternoon, Mr. Chair and committee members. Thank you for providing us this opportunity to participate in your hearing today.

I'm here as the minister of health with Métis Nation-Saskatchewan to speak to you about non-insured health benefits for our Métis citizens. They have identified it as a top health priority across our homeland.

You've heard from our president, Métis National Council president Cassidy Caron, recently. I'd like to provide further details on the health experiences of our people, and I want to specifically comment on the non-insured health benefits.

Métis Nation-Saskatchewan is one of the four governing members of the MNC. We represent the Métis citizens in Saskatchewan. Our Métis nation legislative assembly governs our people and also enacts legislation and regulations for the conduct of the Métis Nation-Saskatchewan.

Our people have a holistic understanding of health, shaped by larger social structures that include kinship ties, community, identity and culture, and especially connections to the land. These principles are foundational to any work that addresses health inequities faced by Métis people.

Colonization is an important social determinant of health that contributes to the health inequalities faced by Métis peoples to this day. Examples of colonial practices include residential schools, day schools and industrial schools. There's a large proportion of Métis children in care, which we'd like to address, and there is ongoing systemic racism in our health care institutions.

In the last several years, MN-S has carried out several engagement sessions across the province, across our 12 regions, and has reached out to over 800 citizens. They have expressed their top priority, which is non-insured health benefits, and would like to see that come to fruition in the future. I'd like to share some of their experiences with you today.

Regarding affordability of health care and medication, many citizens cannot afford to prioritize their health. For example, citizens may choose between their basic needs, such as shelter and food, and their medications and prescriptions. We've also heard stories across the homeland that some folks who are living on a fixed income, particularly elders and seniors in our communities, in order to ensure that people are getting the medications or the prescriptions, share prescriptions among their family members who take the same medication or with other community members, neighbours or friends. This is quite alarming to us as health care advocates. We'd like to address that.

High food costs and costs for testing equipment, such as diabetes implements and equipment, are barriers to good health for Métis citizens. This barrier is especially concerning among, as I mentioned, our seniors and elders. There's an urgent need to support the cost of prescription medication for seniors and to prioritize home care and long-term care in our local communities. Oftentimes our elders are shipped away because the long-term care facilities are outside their communities. We know, and learned from experience in listening to citizens, that this is often the case, and then they lose contact with their families and their connection to the land, and their community life as well. That is a concern for us.

We've also heard stories about cancer patients living hundreds of miles away from cancer centres and sleeping in their vehicles because they couldn't afford hotel accommodations after their treatment. It's too far for them to go home when they're not feeling well after a cancer treatment. That is concerning for us as well. It's very common for Métis families and communities to regularly host fundraisers to raise money so that families can afford to stay in a hotel and to ensure that their needs are met when they're going through cancer treatments.

• (1625)

During the pandemic, MN-S started a medical travel assistance program to support the costs of fuel, food and accommodations required by high-need and low-income people who have medical appointments and access that program. Since July 2020 we've supported 965 citizens to attend almost 4,000 medical appointments. The cost is just over \$500,000. These numbers demonstrate the sig-

nificant need for Métis-specific medical travel assistance, yet the program does not have sustainable funding.

The Northwest Territories is the only jurisdiction in Canada that sponsors non-insured health benefits for Métis citizens. The program is administered by Alberta Blue Cross, an external service provider, and covers eligible prescription drugs, dental services, vision care, medical supplies and implements or equipment, as well as medical travel benefits. This program provides a successful model that the MN-S can implement across the Métis homeland in Saskatchewan in collaboration with the federal and provincial governments.

MN-S and other MNC governing members—

The Chair: Ms. Friesen, I'll have to ask you to wrap up, please.

Ms. Marg Friesen: Thank you.

They are ready and committed to develop a program that is financially sustainable to meet the health care needs and priorities for Métis citizens.

Thank you again for the opportunity to articulate the immediate health priority of the MN-S and express the voice of Métis citizens across Saskatchewan. We welcome any questions you may have.

Maarsii.

The Chair: Thank you, Minister.

We'll now proceed to the questions.

Ms. Stubbs, I believe you're first up. You have six minutes.

Mrs. Shannon Stubbs (Lakeland, CPC): Thank you, Mr. Chair.

Thank you to all the witnesses for being here today. I think probably all of us share the view that we only wish we had more time to hear from you and to have question exchanges.

I'm going to ask Lee some questions. He hails from my neck of the woods. I want to appreciate his pointing out the unique position of Métis settlements in Alberta. It's a point I'm trying to emphasize on behalf of Albertans repeatedly in this committee—indeed, in part because four of the eight Métis settlements are in Lakeland.

Lee, Minister Hajdu was here on Friday. She said, “we have begun to transfer funding for distinctions-based, Métis-specific programming to Métis governments.” You're an elected councillor of the Métis government in Kikino. I just want to clarify. Has Kikino received any funding from the federal government, or has anyone from the federal government reached out to the settlement?

• (1630)

Mr. Lee Thom: I'd be glad to answer that. It's pretty straightforward. We do not get any funding in Alberta through other Métis affiliates. We are stand-alone. We have been really advocating for our own voice to represent our own membership through our own governance and to speak for ourselves, basically.

Shannon, the answer to your question is no, no, no. We've never received any federal funding for this program.

Mrs. Shannon Stubbs: Can you give us any sense of whether federal public servants, anyone from the department or any of the government offices have reached out to your governance council and to the settlement to work on helping to deliver Métis settlement needs with regard to health insurance and other services, given the 2016 Daniels decision about the federal government's duties?

Mr. Lee Thom: No. We've had no communication thus far. We've been trying to work on an agreement that would be tripartite with the province and the federal government and to take care of some of the obligations of the Daniels decision. With section 91(24), the Métis people are now considered Indian as far as the Indian Act goes. We've been advocating, since that decision of 2013, to get those rights and to secure our land base, I guess securing it in the Constitution of Canada and securing our section 35 rights.

Shannon, there's a long and a short answer. The short answer is, no, we've had no communication with the federal government. We need it. We are ready for it. The settlements are open for business. Health is a business. Housing is a business. They're all businesses, because at the end of the day, they're all going to identify a line item in your federal budget that says, "Metis Settlements General Council".

Mrs. Shannon Stubbs: Thanks, Lee. I think probably all Canadians want to see actions and outcomes matched with words and promises. I hope that the necessary work gets going in co-operation with the Métis settlements.

Lee, can I get you to expand on the innovative ways and what your community has had to do to provide for yourselves and for your people? You and other witnesses certainly did point out all of the different aspects of health outcomes and health determinants. Since you haven't received funding for services that other indigenous communities get—vision, dental, mental health supports, medication, medical transportation—could you expand on what your community has put in place to get your community members the treatments that they need?

Mr. Lee Thom: I can expand on that, for sure.

Right now, we have an agreement with the province. Our members have access to Alberta health care. These programs, like the non-insured health benefit program we're speaking about now, have never been offered to us, nor do we have access to them. Right now, the province supports our community with an RN who's been here for 17 years with our community. It's a provincial support.

Locally, we are very innovative in taking care of our elders who need assistance. We have budget line items in our budget that support our elders with \$1,100 annually to assist them with medication and medical transportation issues. Also, our community comes together very often for fundraisers. I heard another lady mention

fundraisers in her speech. It's key to understand that the Métis people, in a community that's somewhat at the lower end of earnings, can come together and bring their dollars to the table to assist our members. That's another very innovative one. It's very touching to see our community come together to support through fundraising.

Right now, in the budget we have, the \$1,100 per senior is a medical fund. That's what we've been doing for now. Most of our programs are provincially supplied right now. There's nothing extra, nothing on top of that, including the program we're talking about now.

• (1635)

Mrs. Shannon Stubbs: Thank you.

The Chair: Thank you, Ms. Stubbs.

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

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I'd like to direct my questions to Ms. Chartrand, but first I have a question.

Does the Manitoba Métis Federation represent all Métis in Manitoba, or just people who are part of the Red River Métis association? If you're Métis in Manitoba, but not from the Red River association, who represents you?

Ms. Frances Chartrand: We're a Métis government, not an association or a department. We represent all Métis who have ties to the Red River Métis as per our definition.

Mr. Marcus Powlowski: I worked a few years in Norway House as a doctor in a hospital. As you know, there's the Norway House first nation, but there's the Métis settlement right beside it.

Do you represent them, or are they represented by some other body?

Ms. Frances Chartrand: Yes, we represent them. We have direct contact with our local chair there, whose name is Lloyd Flett. We have seven regions across the province of Manitoba, and Lloyd Flett is part of the Thompson region.

We represent all Métis citizens, regardless of where they live.

Mr. Marcus Powlowski: Very good.

I know Lloyd. I remember him from back when I was there. Say hello to Lloyd.

I would comment—and this will lead to a question—having worked there a couple of years in the hospital.... Am I correct that the people who happen to be from the Métis community—who, in a lot of ways seem pretty similar to the people who live in the first nations community—don't get the same benefits?

They don't get the same travel arrangements, they don't get dental, their don't get their eyeglasses paid for and they have to pay for all their medications, because they're Métis. Everyone right next door in the first nations community gets all that paid for. Is that right?

Ms. Frances Chartrand: Yes. I can answer that question.

No, we're not similar to first nations. We have our own language, our own culture and our own beliefs. You are absolutely right regarding first nation reserves and Métis communities. First nation reserves get access to all the programming and health services. The Métis citizens have to travel hundreds of miles to see a doctor. I come from a small community in central Manitoba. I live a mile from a first nations community. If I want to see a doctor, I drive right by the first nations health hub and health centre and have to travel 125 kilometres to go to see a medical doctor.

When you think about health services and health programs, and you think of the lack of supports and programming that we have across the province of Manitoba, you could tell by our research that the Red River Métis citizens have no programs and services. In fact, we get absolutely no funding or any support from the Province of Manitoba for any programming we do for our Métis citizens.

Mr. Marcus Powlowski: You quoted some statistics. You said the Métis population had a 40% higher incidence of coronary artery disease, a 34% higher incidence of diabetes and a 49% higher incidence of amputation. Is that compared to the indigenous population, or presumably the whole population?

Ms. Frances Chartrand: It's compared to the whole population.

You probably know Dr. Judith Bartlett. She led the file and she led the research when we did the Métis atlas in 2010.

Mr. Marcus Powlowski: Do you know how that compares to the numbers for the first nations communities? Is it worse, better or about the same?

Ms. Frances Chartrand: Ours is worse. In fact, when we look at the research—we have a shorter version on our line—it's comparable to everyone. Our heart disease, our diabetes and our arthritis were higher than for any—even first nations—citizens across the province of Manitoba.

Mr. Marcus Powlowski: Do you think that's a result in part because of the lack of non-insured health benefits and because you don't get the same quality of medical services as first nations people?

Ms. Frances Chartrand: Not only first nations people, but I would say we don't get any health benefits compared to any citizens in the province of Manitoba and across Canada.

Mr. Marcus Powlowski: Okay.

You mentioned the PDP program. What does PDP stand for?

• (1640)

Ms. Frances Chartrand: The PDP program is a prescription drug program that was initiated by the Manitoba Métis Federation.

At our annual general assembly, after we found out all the research and everything that came through, we asked our citizens across the province of Manitoba what we could do to help our elders, our seniors and the most vulnerable. The direction they gave

us was to go and find money and financial supports to help pay for their medication.

You heard earlier from some of our colleagues who were presenting that they're sharing medication. When you look at the poverty, and you look at the health of Métis grandparents who are raising their grandchildren, would you buy food for your grandchildren or would you pay for your medication? Would you pay your hydro bill or would you pay for your medication?

Then look at the information I shared earlier regarding how Métis citizens die earlier than any citizens across the province of Manitoba.

Mr. Marcus Powlowski: Where does the funding for the PDP program come from?

Ms. Frances Chartrand: We're presently working with the federal government to come up with a plan. However, for all of the programming that we presently do the funding comes from our internal economic build. We're also looking at a tripartite solution where we work with the province, the federal government and the Métis government.

The Chair: Thank you.

We will now go to Madame Gill.

[Translation]

Mrs. Gill, you may go ahead. You have six minutes.

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

I'd like to thank the witnesses for being with us today.

We've heard from a number of witnesses in the past few meetings, and they raised an array of issues. Métis representatives often referred to the Constitution. Witnesses spoke about section 35 of the Constitution Act, 1982, discussions with provincial governments and the challenges indigenous people face. Ms. Chartrand, for instance, told us about how people have to choose between their health and basic needs such as shelter. We also heard about the inequity.

What are the reasons behind that persistent inequity?

The question is for all of the witnesses.

[English]

The Chair: Ms. Chartrand, if you want you can start off and then we will go to the other witnesses as well for comment.

Ms. Frances Chartrand: I don't speak French so I probably need some assistance regarding the question. I would like to apologize now for that.

The Chair: It's not a problem. Did any of the witnesses get the translation?

I will turn to Ms. Friesen if you wish to comment.

Ms. Marg Friesen: Yes. Thank you.

One of the inequalities between indigenous peoples of Canada is access to health care. First nations citizens have access to non-insured health benefits and preventative programming and screening. Métis citizens do not.

Even though we are members of indigenous peoples of Canada, and we are under section 35 of the Canadian Constitution, we do not have the same benefits as our first nations relatives. It causes a great deal of inequity, and geography is a large factor in how folks access services.

[Translation]

Mrs. Marilène Gill: Sorry to cut you off, but I have a limited amount of time.

I brought up the persistent inequity, because I wanted to know what the reasons behind it were, in your view. We are here to find answers. We are working from the principle that inequity exists, so what should we do?

Someone mentioned tripartite discussions with provincial governments, but I am wondering why the inequity persists to this day. People should have the right to receive health care worthy of the name. Community members frequently have to travel to access that care because health care facilities are so far away.

In your view, what are the reasons for the persistent inequity?

Ms. Marg Friesen: Thank you for your question.

[English]

Yes, I'd like to answer that.

I think one of the major barriers is the discussion and the conversation, and who is representing the Métis people of Canada. Our jurisdictions are very distinct although we are collaborative. Métis peoples have never had this opportunity. The national accord on health signed in 2017 and the self-government agreement that the Métis Nation signed in 2019 really distinguish what it is that Métis citizens are lacking in their communities across the country.

We're specifically talking about non-insured health benefits, because we would like to see equity for the Métis citizens in Saskatchewan we represent, and Métis citizens of Canada across the country.

As Ms. Chartrand, my Manitoba colleague, has stated, Métis citizens die earlier than other Canadians across the country because of their access to health care and the large inequities in prevention and screening. There isn't breast cancer screening in the north. The mobile—

• (1645)

[Translation]

Mrs. Marilène Gill: Again, I apologize for interrupting you.

You're saying that consultation is lacking. The Métis are not at the decision-making table and are having to deal with a lack of services. They actually receive no coverage under the NIHB program.

Is that correct?

[English]

Ms. Marg Friesen: Absolutely, this is what we Métis are saying, “Nothing about us, without us”. We are saying that Métis need to be at the table to represent our people in a good way, in good faith, and we do have an open and good relationship with the Government of Canada and the Government of Saskatchewan. We are looking for opportunity, for inroads, so that we can begin the conversation and begin the distinctions-based approach to health care for Métis citizens.

[Translation]

Mrs. Marilène Gill: Thank you.

The Chair: You have 14 seconds left, Mrs. Gill.

Mrs. Marilène Gill: All right.

Mr. Chair, I think Ms. Chartrand was having trouble—

The Chair: I'm going to explain what to do.

[English]

Just before we go to the next person to ask questions, this is for Ms. Chartrand and Mr. Thom. In case you're not aware of it, there's a little icon that looks like a globe near the bottom centre of your screen, and if you press that, it will allow you to choose what language you want to hear. If you hit “English” when somebody is speaking French or Inuktitut, you will hear it in English. This is so that you can listen to the questions, because we have three languages here.

I see Mr. Thom understands it.

Are you with us, Ms. Chartrand? Good.

Mr. Lee Thom: Can I make a comment on the question? I think I can. I understood.

The Chair: If you do it very quickly.... Thank you, Mr. Thom.

Mr. Lee Thom: I'm sorry. I didn't understand the French and I didn't realize about that.

Following up on the comments that were made, the inequalities, we need to look towards the obligations in the Supreme Court decision in Daniels. That's where all the answers lie, I think: things that come out of the section 35 rights for Métis; and also for the Métis settlement specifically, the 2018 federal framework agreement that was signed with Minister Bennett, the minister of the day.

Communication is huge, and there is a lack of communication between Métis communities and governments like yours. The federal government needs to educate itself on the demographics of Métis people, and I believe we can all be at the table together to discuss important things such as health. There are so many more things to discuss, but I would like to see Ottawa and all governments be aware of the different demographics. That's huge.

That's everything. Thank you.

The Chair: Thank you, Mr. Thom.

Ms. Chartrand, I see you have your hand raised. Do you want to speak?

Ms. Frances Chartrand: Yes, I also just want to make a comment. The question she was asking was about the reason Red River Métis citizens have been neglected by the Indian Act. If you look at the historical policies and you look at what's in place today, I think they're continuing to do that.

When you look at jurisdictional battles, a perfect example would be Jordan's principle and the programming they have. Think about that little first nations boy from Norway House who everyone was trying to fight for. Who was going to be responsible for him? He died in Winnipeg. If you think about the Métis people who are sick and need to see the doctor, who need to go for medical services, whose jurisdiction is that? We all need to work together towards a trilateral agreement for the betterment of Red River Métis citizens. We don't want to play political football anymore.

Thank you.

• (1650)

The Chair: Thank you, Ms. Chartrand.

We'll now go to Ms. Idlout, who has six minutes.

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

First, I want to thank you for giving your presentation here and welcome you to the committee.

I welcome the Métis. You have to be involved, as you are indigenous as we are. We have benefits that you're entitled to. You too are indigenous, and there is no question about that. We fought for ours, and I understand that you have to fight for yours today.

Frances also mentioned Jordan's principle. Yes, we know Jordan's principle and we call it Bear Witness Day. I stood for that today in the House.

I want to ask you all a question. What would you recommend to be equal and to have the same recognition, just as Jordan's principle has forced aboriginal people to be recognized as such? What do Métis people need to be recognized legitimately and legally as indigenous people with the rights that they should have?

I would like the three of you to respond to that.

The Chair: Thank you.

Perhaps we'll start with Minister Friesen.

Ms. Marg Friesen: *Maarsii*. Thank you for the question.

I think for Métis citizens in Saskatchewan, in order to be on an equal playing field, there needs to be a commitment from our federal partners with the Government of Canada and a commitment from our province to work together to build programs that are equitable for Métis citizens and Métis children. A lot of Métis children fall through the gaps and then they experience all the social determinants of health: poverty, lack of housing and lack of education. They're disconnected from their families, their roots and their com-

munities. They're disconnected from the land we thrive on. I think it's really important that we come to the table as a partner, not only as a service provider but as a receiver, an equal partner.

I'd just like to turn it over to my colleague Mr. Panahi.

Mr. Adel Panahi (Director, Health, Métis Nation-Saskatchewan): Thank you, Minister Friesen.

What Métis want—and this is what I have from our people—is to have non-insured health benefits. Yes, Jordan's principle is important. We have had to deal with it. I receive a lot of calls from hospitals when they have a young mom there and a baby was just delivered and they are looking for a car seat. There are no car seats for Métis citizens because they don't have access to Jordan's principle. When they go to the social workers—the workers who provide Jordan's principle and the supports for indigenous people—Métis can't get those.

For non-insured health benefits, there was a question about what this inequity is from. I'd like to share a story from the honourable member Vidal's jurisdiction about a Métis cancer patient. The reason they die sooner than other people is that a Métis cancer patient, for example, had an appointment for chemotherapy and he was hitchhiking to get to his chemo because he wasn't able to get to the medical taxi that was available for first nations and he couldn't afford travel. It was from northwest Saskatchewan. This is the reality that we are seeing. What we want for our citizens in the Métis nation, across the homeland, is to have access to equitable, non-insured health benefits that are self-determined and self-governed by Métis governments.

Thank you.

• (1655)

The Chair: Thank you.

Minister Chartrand, did you wish to comment?

Ms. Frances Chartrand: Yes, please.

Thank you for the question.

What the Métis government in Manitoba wants—the Red River Métis—is ongoing funding. We're looking at A-base funding, constant funding, where we don't have to go back. We don't want partial agreements. We don't want one-year or two-year agreements. We want to make sure that the money is there and we can move forward.

In fact, for your information, we're the only Métis government that has won in the Supreme Court, and we have a land base. We won the Supreme Court hearing in 2013, so now we're working with the federal government to move forward. We referenced the Daniels decision quite a few times during the discussion today. It's our inherent right. We are recognized by the federal government. We want a nation-to-nation accord that ensures our Red River Métis citizens do not go without health care.

We just heard Adel talking about an example. We have citizens and babies who are going through a bunch of heart-wrenching disabilities, where parents have to pay out-of-pocket, where we have to do fundraising, where we have to count on the Métis government in Manitoba because the Province of Manitoba and the federal government are not listening to our pleas about making sure we have programs and services like the Inuit and first nations do. We want to go back to who we are and where we come from, and we want programs and services so we don't have to beg for money—beg for programs and services. We're a Métis government and we want a nation-to-nation accord to work together.

The Chair: Thank you.

Go ahead, Mr. Thom.

Mr. Lee Thom: I'd love to answer that.

I have chronological steps for how we can work better and do better. The first thing is recognizing Métis people as section 35 rights holders. I think that's key, and everything else should follow.

Another thing is to identify and educate yourselves on all the affiliates that are available, or not available, in the word "Métis"—the different demographics of our communities. Inherent rights are all Métis rights and we all enjoy them, but when it comes to the demographics of the communities and different governance models, the Métis settlements are legislated in the province of Alberta. I think governments need to educate themselves on different affiliates so the money gets in the hands of the proper communities.

The funding will follow once we assert our rights, but governments need to educate themselves that Alberta is unique to Canada. It has eight Métis settlements, 9,500 members on a land base of 1.2 million acres, and legislated, fee-simple provincial land. That will separate us, but I don't ever come with the attitude that we're better. I think Métis people have inherent rights, and section 35 rights will secure those inherent rights. All we have to do is educate the government on how to split the funding.

I'll leave you with this: Leave no one behind. I think that's the key. Educate yourselves on everyone and leave no one behind, because the Métis settlements have been left behind for far too long. My hope is that we'll get a day where we're heard and represented in the federal budget.

The Chair: Thank you, Mr. Thom.

I'm going to go out on a limb and say we'll do a second round if each speaker can speak to one person and each can do it all in a minute. That's the challenge I'm giving you, if you choose to take it up.

Mr. Vidal, do you wish to?

Mr. Gary Vidal (Desnethé—Mississippi—Churchill River, CPC): Can you explain that to me again? I'm sorry. I think I misunderstood.

The Chair: Can you ask your question succinctly to one person?

Mr. Gary Vidal: We're to ask just one question and not take five minutes?

The Chair: No, unfortunately, we're—

Mr. Gary Vidal: Okay, fair enough. I understand where you're going now, Mr. Chair. Thank you. I won't start my clock. I'll be succinct.

Minister Friesen and Mr. Panahi, I appreciate your being here.

We heard from Cassidy Caron, the president of the Métis National Council. You refer to that and I'm going to summarize. She talked about medical transportation being an issue. You shared the tragic story. I know you represent 12 regions in Saskatchewan, mine being northern. Medical transportation is a big issue. You talked about having an existing system that you're trying to build.

Could you tell us how we can improve on that, in the context of non-insured health benefits? You're doing it on your own. How could that be improved so that we don't have people getting left behind from a transportation perspective, as in the story you shared? That is a tragedy.

• (1700)

Ms. Marg Friesen: *Maarsii* for the question.

To answer your question really succinctly, the program that we initiated was through COVID, and it was sustained by COVID support funds. It's not sustainable at this time, because of course the COVID support funds have been depleted. We've done very well to introduce that medical transportation, but as I mentioned earlier, there is a significant need. This project demonstrated the fact that people need access to medical transportation.

As you are aware—you're from Saskatchewan—there is no longer a public transportation system, so people have to rely on friends and family to get them to their medical appointments in an urban centre. Sometimes it's eight hours away, so that's a barrier. The geography and the lack of public transportation are definitely barriers. We are looking for more sustainable, committed funding for medical transportation.

The Chair: Thank you.

Next is Mr. McLeod.

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

Thank you to everybody who presented here. As a Métis person, I was getting a little nervous when you started talking about Métis citizens dying earlier than the rest of Canadians.

Voices: Oh, oh!

Mr. Michael McLeod: In the Northwest Territories, we're in a little bit of a different situation, because we do have Métis Health, and it's a good program. It's oversubscribed, but every community also has compassionate travel.

We heard from the NWT Métis Nation here several meetings ago, when they talked about housing. Now, housing money has flowed to the national indigenous organizations. The NIOs have received money, but the NWT Métis Nation didn't get any of the housing money.

If the government decides to have money flow to the national indigenous organizations, which one of your organizations would get money? Could you give us just a short answer?

The Chair: Is that directed at a particular person?

Mr. Michael McLeod: To all three—

The Chair: No. We only have time for one.

Mr. Michael McLeod: Okay. It's for the Alberta guy, Lee.

The Chair: All right, Mr. Thom. It's for you.

Mr. Lee Thom: Right now, for the Métis settlements, we don't have a national representation. We have a president who advocates for us and a lobbyist group in Ottawa. We are not included in that funding. Any funding that comes to Alberta through our MNA, our region, is not shared, and that's the truth of the matter. We don't get it.

As controversial as that might sound, it is what it is. I think we need to change our times and we need to focus on listening to land-based Métis. Our settlements are communities—living, breathing—with roads, schools and water, with everything that comes with a small municipality and are in dire need of funding. Right now, we are under-represented in Ottawa.

The Chair: Thank you.

[Translation]

Go ahead, Mrs. Gill.

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

Ms. Friesen, we talked about inequity. The lack of recognition is, of course, a huge inequity. You also mentioned a number of times how difficult it was to access care because of geography and the remoteness of communities.

Can you talk more about how geography makes it harder for people to access health care and what other effects it can have?

[English]

Ms. Marg Friesen: Thank you for that question.

Geography does play a great factor in accessing primary health care, acute health care and ongoing treatments for health and well-being. The approach we've taken is the same as that of both my Métis colleagues across the country. As Ms. Chartrand has stated, leave no Métis behind. It is the same as Lee has stated: Leave no Métis behind.

We would like equitable.... Just take medical transportation as an example. Yes, we would like it to be equitable so that if you live in

the Far North you have access to a medical taxi, medical transportation or an ambulance to bring you to a centre where your needs are going to be cared for and where your health care is going to be addressed.

We would have more prevention and screening for people whose health needs may be undiagnosed, and where people are diagnosed too late we would like to prevent that from happening. Yes, they accept the treatment, but maybe not because it's too far to travel.

We need cancer spaces, cancer lodges, for community members and their families, their caregivers, to be able come to an urban centre where they can comfortably receive their treatment, live their life through their cancer journey and be well cared for.

● (1705)

[Translation]

The Chair: Thank you.

[English]

Ms. Idlout, did you have a question?

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

I have no questions at the moment. I just want to thank you for your wonderful presentations, all of you.

It's become very clear that you have been left behind and there's a lot of catch-up you have to do. Do you have any final things to say to us? I would like to hear from you what's really important to you.

Ms. Marg Friesen: *Maarsii* for the comment.

We would like to be an equal partner at the table when we are discussing health care and non-insured health benefits for Métis citizens in Saskatchewan. We represent the government of Métis Nation in Saskatchewan. However, our citizens are saying this is a top priority for us. We would like to be able to sit at the table as an equal partner and not be left out of the conversation or the commitment or the financial obligations for indigenous peoples of this country.

Thank you.

The Chair: Thank you very much. That brings our question period to an end.

I'm sorry it was not any longer, but I'd like to thank Mr. Lee Thom for being with us. I'd like to thank Minister Chartrand and Minister Friesen and her colleague, Adel Panahi, for your testimony today and for answering our questions. This is an extremely important and serious subject, and we very much appreciate your input and your frankness with us today. Thank you for coming. I hope you found it worthwhile.

With that, we will suspend momentarily and get ready for the next panel. Thank you very much.

• (1705) _____ (Pause) _____

• (1710)

The Chair: Colleagues, we're now going to begin our second panel. This evening we have three witnesses and I'll name them. We have Rudy Malak, a pharmacist at Little Current Guardian Pharmacy who is here as an individual. We also have Angela Grier, who is with us in the room.

[*Translation*]

She is the lead for indigenous initiatives with the Canadian Counselling and Psychotherapy Association.

[*English*]

She's also here as an individual. Finally, we have Marceline Tshernish.

[*Translation*]

She is the director of the health sector for the Innu Takuaihan Uashat Mak Mani-Utenam community.

[*English*]

She is with us virtually this afternoon. I hope I didn't mess that up too much.

I would like to welcome our three witnesses as we continue our study on non-insured health benefits. We are really looking forward to your perspective.

I will ask Mr. Rudy Malak to speak first, and then the other two. You have five minutes.

Mr. Malak, if you are ready, you can start your presentation now.

Mr. Rudy Malak (Pharmacist, Little Current Guardian Pharmacy, As an Individual): Hello. Good afternoon, and thank you for having me today.

My name is Rudy Malak. I'm a pharmacist and one of the owners of three pharmacies on Manitoulin Island. I'm joining you today virtually from Manitoulin Island, which is the ancestral home of six of the Anishinabe first nations.

Thank you for the invitation to appear before the committee and to participate in the study of administration and accessibility of indigenous peoples to the non-insured health benefits program. I hope I can provide useful information that can be considered to improve the program and provide easier and quicker access to care for people who are in need.

I'm here to highlight some of the hardships that people go through to get the care that they need. Some of the things I'd like to discuss that delay access to care in the pharmacy world include the prior approval processes. There are limits to a number of eligible products and, sometimes, there are permanent conditions. Things should be indefinitely approved, especially if it's a permanent condition. Examples of that are ostomy supplies and having to renew them every three months.

Another [*Technical difficulty—Editor*] are the special authorizations processes. Some medications have limited-use paperwork in-

volved. Examples are prescriptions written at an emergency department or prescriptions for chronic conditions.

Another thing that delays access to care is the wound assessment processes, which are very difficult to fill out and get approved. An example of that is that we deal with acute open wounds, but the process to fill out the paperwork for NIHB to accept it could take hours, weeks or days, so it's a very long process to get approved.

Another example is the diabetic flash glucose monitoring system. It is not covered, and I assume it's due to funding. Reducing complications of diabetes early will save a lot in the future. I believe the limiting factor is funding and allocation, but a lot of money would be saved in the long run if we reduced the burden on the health care system. That can be done through primary prevention and intervening before health effects occur.

Early education about health can prevent short- and long-term impacts. Continuity of care once diagnosed or discharged will reduce costs and improve outcomes. Home care will improve the quality to the individual and reduce hospital readmissions. Removing red tape that hinders progress will make things easier.

Due to the complexity in the processes and procedures, a lot of pharmacies are not able to serve NIHB clients. This is because of the time needed to complete one task, or because of the lack of funding to the provider. A major part of the day is spent dealing with a lot of paperwork or on the phone trying to get something approved, instead of providing direct patient care.

I'm sure every department and committee would like to provide the best possible care to our most vulnerable patients, but the amount of paperwork, phone calls and bureaucracy involved makes everything difficult, time consuming and financially not feasible.

I'm here to express my opinion and relay information of what happens at the pharmacy level on a day-to-day basis. I'm passionate about helping people and trying to provide the best possible care and service that I possibly can. I would like people to have a dignified life. A person who is already sick or has a medical condition should not have to worry about paperwork, approval processes, coverage discrepancies, expiry of approvals, etc. All that does is make them lose hope in the system.

I've only listed a few examples that may delay patient care. I'll leave the rest of the time to clarify or to answer any questions you may have.

Again, thank you for the opportunity to join you today.

• (1715)

The Chair: Thank you, Mr. Malak.

We'll now go to Ms. Grier.

You have five minutes.

Ms. Angela Grier (Lead, Indigenous Initiatives, Canadian Counselling and Psychotherapy Association): [*Witness spoke in the Blackfoot language*]

[*English*]

Thank you, Mr. Chair. I extend my appreciation for the invitation to participate today.

My name is Angela Grier, and I'm a proud member of the Piikani first nation of the Blackfoot Confederacy, where Alberta and Montana are situated. I'm the indigenous initiatives lead for the Canadian Counselling and Psychotherapy Association, CCPA, and a mental health practitioner whose career has spanned over 25 years working with indigenous peoples and communities.

I'm here to speak to the important issue of first nations' mental health and the current barriers to care upheld by the federal government since 2015.

In 2015 CCPA's Canadian-certified counsellors, CCCs, were delisted as mental health practitioners from the non-insured health benefits program, NIHB, for first nations and Inuit in provinces that had not yet regulated the profession of counselling. As a result, access to essential mental health services was restricted depending upon the province of residence.

Section 91(24) of the Constitution Acts 1867 to 1982 says the federal government has jurisdiction over "Indians, and Lands reserved for the Indians", and this includes health. However, deferring to provincial regulatory authority and status to determine eligibility of mental health providers is unconstitutional.

In doing so, the federal government is excluding qualified and competent providers and creating a Jordan's principle scenario in which first nations peoples are falling through the cracks. By restricting access to CCCs, who are currently eligible providers in other federal health benefit programs as well as in the First Nations Health Authority, which is NIHB's counterpart in British Columbia, the federal government is not providing equitable access to mental health care for all indigenous peoples, nor at the same standard as they are providing it to non-indigenous Canadians. This policy also discriminates against CCCs who are first nations or indigenous practitioners like me.

As NIHB is the primary source of mental health funding, many cannot practise in their communities or traditional territories. The mental health needs of indigenous peoples are higher than average due to the harms brought about by colonization, residential schools, the sixties scoop and the reservation system. The TRC's calls to actions, UNDRIP and the national inquiry on MMIWG all call for an increase in access to mental health supports.

Early intervention is key to preventing substantial costs downstream. We know this. Related to delayed or lack of diagnosis, deterioration on wait-lists, psychiatric hospitalizations, medications, dependency issues and loss of life, indigenous people are twice as likely to reach out for mental health supports. The mental health component of the NIHB program is seeing the fastest growth. This

highlights the significant need for intervention and prevention from culturally competent Canadian-certified counsellors.

These CCCs are an integral part of a solution to address this mental health crisis. They hold a master's degree, go through a rigorous evaluation and adhere to a robust code of ethics, including a section on working with indigenous peoples, communities and contexts. It's among the first of its kind.

In Treaty 7 alone, which is my treaty area, our first nations communities of Piikani, Kainia, Siksika, Tsuut'ina and the three Stoney-Nakoda nations work tirelessly to combat chronically acute health environments upheld by Canada's inequitable policies. The toll on staff, communities and clients includes pushing beyond human levels into toxic levels of stress to merely survive. Surviving is not thriving.

Our daily losses to the opioid war alongside leading global suicide rates indicate the maladaptive experience since contact. We were in pandemic states long before COVID-19. Help is needed now to save lives.

Mr. Chair, in the interest of equitable access to mental health services for indigenous peoples, CCPA urges the indigenous affairs committee to recommend that Indigenous Services Canada immediately reinstate CCCs in unregulated provinces under the NIHB program. This will add close to 1,500 providers in Alberta, Manitoba, Saskatchewan and Newfoundland and Labrador.

Thank you.

• (1720)

The Chair: Thank you, Ms. Grier.

We'll now go to Ms. Tshernish.

Ms. Tshernish, you have five minutes.

[*Translation*]

Ms. Marceline Tshernish (Director, Health Sector, Innu Takuaikan Uashat Mak Mani-Utenam): Thank you for inviting me to speak to you today.

My name is Marceline Tshernish, and I am Innu. I belong to the Uashat Mak Mani-Utenam community, on the north shore. I am the director of the health sector, and I am here representing my organization, Innu Takuaikan Uashat Mak Mani-Utenam, or ITUM.

During my presentation, I will focus on some of the challenges around health care accessibility faced by members of my community, especially those families who are most vulnerable. The main challenges we face as members of first nations revolve around health care and services, as well as access to information regarding the benefits available to first nations communities.

The process to access health benefits is onerous, and the wait times, significant. Those wait times affect the quality of care received by community members. The red tape involved in accessing health benefits contributes to a lower quality of life for first nations members, who have to go through two levels of government in order to access care and services. For care that is not covered by the Régie de l'assurance maladie du Québec, members have to turn to the NIHB program for first nations and Inuit, and submit another claim. If their claim is denied, they have to initiate an appeal process, which is extremely complex, both for patients and for health care professionals. They may have to go through a number of steps and appeals.

As Mr. Malak pointed out, access to pharmaceuticals is a tremendous challenge for members of my community. The approval process for exception drugs under the NIHB program is hard to understand and involves so much red tape that it erodes access to pharmaceuticals, in contrast with the provincial process and system that apply to the rest of Quebec's population. This highlights the inequity between the two jurisdictions.

Access to information related to the benefits procedure is also a challenge for members of my community.

Mr. Malak gave examples of what members of the population experience when trying to access medical supplies and equipment. Generally speaking, these are patients with permanent conditions, who have to go through the claims process over and over again to access the care and basic equipment they need. That is extremely onerous.

In addition, when patients do receive information, it is often quite incomplete. The procedure for the supporting documents patients have to provide is not explained clearly. I would also say that the health care professionals, themselves, do not fully understand the procedures for the NIHB program.

Palliative care is another example where patients face restrictions in accessing pharmaceuticals. When a physician prescribes a medication such as a narcotic to alleviate pain, the pharmacy receives the prescription and must then send the physician a palliative care form to fill out and return. Finally, the pharmacy has to send the completed form to the NIHB program. That gives you a sense of the extensive red tape involved before the suffering of a patient at the end of life can be alleviated. In some cases, it can take up to 48 hours for the patient to receive the medication.

Now, I would like to turn to another aspect of the NIHB program, medical transportation. In Uashat Mak Mani-Utenam, we provide the coordination for that part of the program, but it is underfunded and coverage is limited.

• (1725)

We have neither the ability to tailor the eligibility criteria so that the services meet the needs of first nations members nor the ability to provide culturally safe services.

In many ways, the cultural safety dimension of health care is ignored because the eligibility criteria do not take into account the holistic approach advocated by first nations, including in relation to escort claims.

The Chair: Thank you, Ms. Tshernish.

If you would kindly wrap up your remarks, it would be appreciated.

Ms. Marceline Tshernish: All right.

The medical transportation component is underfunded, so the band council has to cover the difference to ensure that families have adequate escort support.

When it comes to mental health counselling, our traditional knowledge is not recognized, so we cannot provide counselling and other services within the community.

What's more, patients do not have the option of requesting a second medical opinion when they are not satisfied with the service available locally. The in-hospital experiences of first nations members, experiences we have all seen, must be taken into account if mistrust in the health care system is to be addressed. Some community members even refuse to seek care outside the community because they do not trust the system.

• (1730)

The Chair: Thank you, Ms. Tshernish.

We will now begin the question-and-answer portion.

Starting things off is Mr. Shields for six minutes.

[English]

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

I appreciate the witnesses today and the information that they're sharing with us.

I'll start with you, Mr. Malak, and the pharmacist world you talked about. I think you talked about connecting with people to get a lot of permissions. I think we may have heard that from other witnesses before, and from others today.

When you call and you need to get approvals, are there people at the other end of the line who have any medical knowledge? Are you talking with people who understand the medical questions that you would need to get approved?

Mr. Rudy Malak: Thank you for the question.

I do not think so. No. Can I explain just briefly how the process of calling a helpline works?

Mr. Martin Shields: You bet.

Mr. Rudy Malak: The prescription comes from the doctor. We try to process it. It says, “special authorization required”. We call ESI, Express Scripts, Inc., which adjudicates on behalf of NIHB. We apply for the prior approval. NIHB sends the approval to the doctor. The doctor has to fill it out properly and send it back to NIHB. Then NIHB sends it back as either approved or denied.

There are multiple people involved. Faxes get lost. Sometimes the doctors are not available anymore, or the doctor has written a prescription and left already.

I had an incident yesterday where the patient came in and, after one month, the process is not complete. It went to the doctor's office. The paperwork got lost or they didn't know what to do with it, or the doctor wasn't available. The patient has not started their diabetes medication for over one month because of that.

Mr. Martin Shields: Thank you for running through an example like that.

From your point of view, when you have to go to that next level, would it make a difference if somebody had medical knowledge when you moved to that next level?

Mr. Rudy Malak: That might help a little bit, yes, but at the end of the day, it has to go to the prescriber who has actually written the prescription to fill out the paperwork and say whether the patient fits the criteria for that medication.

Mr. Martin Shields: What's the step that needs to happen, then, to make it work for you?

Mr. Rudy Malak: I believe that medications that need prior approval should be like the provincial plan, where there's something called “limited use”, a sheet of paper that we send directly from the pharmacy to the doctor. The doctor signs it and sends it back. If we have that documentation, we're allowed to process it to the provincial plan.

It turns out that the NIHB process is overly complicated. There are four or five different people in between: the prescription to us, the pharmacists; the pharmacist to NIHB; NIHB to the doctor; the doctor back to NIHB; and then NIHB back to the pharmacy. You can imagine how many people are involved.

Mr. Martin Shields: How many of them don't have any medical knowledge? That would be my guess.

We've heard this before. It has to be something that's discussed within the pharmaceutical organization. Has this been brought to you? Is it a discussion? Has it been brought forward anywhere?

Mr. Rudy Malak: Not to my knowledge, no.

As I mentioned in that opening statement, a lot of pharmacies do not know how to deal with and provide service to NIHB clients. Because of the number of different departments and phone numbers, they don't know what to do. Sometimes they just say, we don't know how to do this.

Mr. Martin Shields: And the patient gets left.

Mr. Rudy Malak: The patient's already in stress. They're frustrated, they leave and they don't get care.

Mr. Martin Shields: Thank you.

Ms. Grier, thank you for your presentation.

Since 2015 and the delisting in the last seven years, are you familiar with any lobbying or efforts to change this?

Ms. Angela Grier: Yes, we've been working tirelessly within CCPA to lobby for some of these changes and movements to expand the practitioners. As well, within individual first nations they are doing their best to lobby with NIHB currently within the mental health clinics. That's going on to provide space for CCCs, because in the absence of those spaces we have paraprofessionals filling professional counselling roles.

On federal reserves we don't have regulation like the provinces do. We're not having the unions or all of that oversight that we need. We're not getting the professionals we need for the acute health environments that we have. There is quite a bit of advocacy that continues to go on. Even first nations psychologists are advocating for this.

• (1735)

Mr. Martin Shields: What kind of response do you know you've had as you've lobbied for this change back? Have you heard any feedback for why not?

Ms. Angela Grier: Not that I can say, sir.

Mr. Martin Shields: The organizations have made the case and continue to lobby, but has there just been silence?

Ms. Angela Grier: Within NIHB it's always from the central headquarters' perspective that everything's okay. There are no problems or wait-lists. I work on the ground. I work in these communities that have unregulated colleges, such as Alberta. I can tell you that is not the case. The information that is flowing through these administration systems of NIHB and INAN are not accurately depicting what's happening on the ground.

For the practitioners who are working in these communities NIHB is asking for seven and a half hours a day, for example, of direct client service. That's not industry standard. That's going to burn out any practitioner. Industry standard is four to five clients a day, yet NIHB is pushing our clinicians now in order to say, “You have no wait-list and you have all the therapists you need, because you have seven and a half hours a day.”

What people don't realize is that, on the ground, those clients aren't always showing up to appointments. We have transportation barriers. We have crisis communities. People are struggling with basic needs to be able to make it to their counselling appointment, which they desperately need.

So, yes, there are a lot of inconsistencies throughout this bureaucracy.

The Chair: Thank you.

We'll now go to Mr. Battiste.

Mr. Battiste, you have six minutes.

Mr. Jaime Battiste (Sydney—Victoria, Lib.): Thank you, Mr. Chair.

I'd like to thank the witnesses for their testimony so far today.

I come from a first nations community in the Mi'kma'ki called Eskasoni, where we have our own health care unit as well as our own mental health. I know that they're hard-working folks and they've at times come to me with very important asks about the importance of having a health care system that's culturally relevant and in the Mi'kmaq language. It's really important that, when we move forward, it's in a way that's reflective of the indigenous cultures in that area.

I'm very happy to see that, in the most recent budget, 2022, we provided \$227 million over two years, starting in 2023, to maintain trauma-informed, culturally appropriate, indigenous-led services to improve mental wellness and support efforts initiated through budget 2021 to “co-develop distinctions-based mental health and wellness strategies.”

I'm wondering if the witnesses could talk a little bit about the importance of ensuring that the health care system is culturally appropriate and reflective of the various indigenous cultures across Canada. I think if we can start in the room that would be a good starting point.

Ms. Angela Grier: Thank you. It's nice to see you, Jaime.

Leroy and Amethyst say *oki*. I just wanted to pass that on.

What you spoke about is the nation-to-nation relationship that we're hoping for across our communities. We've seen the deferral of different ministries to provinces, such as child welfare and education, and this deferral has not raised the rates of success in those areas. In similar environments, such as health and mental health, because it's easier for the government to treat us as municipalities, we don't necessarily vote in these provincial governments to speak about our issues.

We have first nations governments that speak about those issues. They're being completely overstepped and dismissed in these discussions, yet the provinces are taking on that responsibility. I can tell you, from some of the experiences that I've had, they do not share or understand the intricacies of a first nation, the legal and jurisdictional issues of a first nation and the needs of our first nation.

I would support more of that nation-to-nation relationship and federal acts, such as the family act that was recently implemented to address the children's services overrepresentation in crisis. Along those similar lines, I believe that will help move things forward.

• (1740)

Mr. Jaime Battiste: Following that, please make sure that you say hello to Leroy and Amethyst for me, as well. Give my best regards to them.

Can you talk to us about any specific areas around Canada that are getting it right with mental health, and doing it in a way that really reflects the nation-to-nation responsibilities that we have as a government? Are there any that have been successful models for the rest of Canada, where we can see progress being made in a culturally appropriate and reflective way?

Ms. Angela Grier: Yes. I'd like to give an acknowledgement to the Siksika first nation's Siksika Health Services. The mental health clinic there is led by a Blackfoot clinical doctor, Dr. Adolpho. She is a Blackfoot member. Her training as a clinician and as a Blackfoot member is the place where we need to be.

It's providing the most competent model of delivery, because you need people from that community within the senior administrative positions who are practitioners, not lawmakers. You need people on the ground who can have those relations with the province and the federal government in order to negotiate the best needs for the community.

I believe that they have a great system out there. I'm sure there are a lot more, but I'm thinking about locally. From the clinical perspective, I have never seen such an environment on a first nation that has legally and ethically maintained the integrity needed for this type of delivery at this level of the acute health environment.

Mr. Jaime Battiste: I know I don't have a lot of time left, but I want to ask all three participants—

The Chair: You have 50 seconds, Mr. Battiste.

Mr. Jaime Battiste: —the following question.

If we were to invest money in a certain area of indigenous health that needs more capacity for indigenous health care workers, where do you think we would best make those investments? Answer quickly, please, all three participants.

Ms. Angela Grier: It's mental health.

Mr. Rudy Malak: It's mental health, absolutely, and addiction.

Mr. Jaime Battiste: Can you be specific in terms of mental health supports? There are case workers out there. What do we need?

Ms. Angela Grier: We need CCCs.

Mr. Rudy Malak: We need follow-ups. People get diagnosed, and then they don't get the follow-ups, counselling, the cognitive behavioural therapy and the psychotherapy. It's not just medication. They need counselling and follow-ups constantly.

The Chair: Thank you very much.

[Translation]

Go ahead, Mrs. Gill. You have six minutes.

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

I would like to thank Ms. Grier, Mr. Malak and Ms. Tshernish for being with us today. Their experience on the ground will no doubt inform our work.

I have some questions for Ms. Tshernish, the director of the total health and wellness sector for the ITUM.

Ms. Tshernish, I'd like to hear more about your experience on the ground.

Do you have recommendations to share with us? The committee doesn't have a lot of time to do its work.

Tshinashkumitin.

Ms. Marceline Tshernish: Thank you for your question.

I would come back to mental health. One of Uashat Mak Mani-Utenam's priorities would be to invest in mental health programming for youth. Those programs do not exist in our community right now, and I don't think the provincial landscape is much better. We are really in need of those services because we are seeing children in psychological distress at a very early age, even at the elementary school level. Substance abuse is another major problem in the community.

Care and services related to chronic illnesses would be another priority, including promotion, prevention and even healing. Another concern is access to medical supplies and equipment, as well as pharmaceuticals, because the application and approval processes should be streamlined, and that is true for all benefit claims.

Memorandum of understanding should be established with the various care providers, whether dental care providers or private clinics, to streamline the process and ease the burden on patients. It is also important to ensure that culturally safe health care services are available. We need funding to ensure that our own expertise in healing is recognized, particularly for services provided in the community, and we should be allowed to develop our own eligibility criteria in that regard.

Those are the issues I would flag at this time.

● (1745)

Mrs. Marilène Gill: Thank you, Ms. Tshernish.

You can send us the portion of your opening statement that you didn't have time to get to. That will ensure the committee can take your comments into account.

Throughout today's meeting, people have frequently referred to the land and the community, whether it be Nutshimit or Nitassinan.

Can you talk more about that?

I would like to know how that aspect could be integrated. As I understand it, the connection to the land is not recognized, but it is part of the healing process.

What would you recommend to the committee on that front?

The question is for all three witnesses. Perhaps you can go first, Ms. Tshernish.

Ms. Marceline Tshernish: For us, health is a whole. First nations have a holistic view of the health care system. A person's well-being stems from the well-being of their family, the people around them and the environment in which they live. Given the history of families being expelled from Nitassinan land to indigenous communities, we firmly believe in the importance of reclaiming our knowledge.

Right now, we are looking at how we can take full advantage of our healing approaches on the land. We hold information sessions for client groups of various ages to make sure that they can choose

between so-called traditional medicine and the medicine that represents us, as first nations. Members of the community are clearly interested, and we are already seeing the effects of Nitassinan- or land-based healing on people's well-being.

I would be remiss if I did not mention the loss of language. Earlier, the discussion focused on the importance of providing care to first nations members in their language. That is a problem when it comes to the care and services we provide.

[*English*]

The Chair: Thank you, Madame Gill.

Madam Idlout, you have six minutes.

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

Thank you.

I want to thank Angela and the other people for their presentations. These are very informative and very important issues that you've raised. It is clear that the Métis have been treated differently than the Inuit and first nations have.

I have a question for Rudy Malak.

I want to understand this better. When you're a pharmacist, you are well informed—it's your business. How long does it take for you to get paid by the NIHB after you have billed them? What is the waiting time?

● (1750)

Mr. Rudy Malak: I believe it's two weeks.

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

Thank you.

I know that as a business person I would be worried if I wasn't getting paid on time, because it would put my business at risk. Has that ever happened to you?

Mr. Rudy Malak: It definitely has, but what has happened is that it's not the delay. It's the decline or the nonpayment.

If I can, I'll give a quick example. A patient has an ostomy. An ostomy is an opening in their abdomen. They've had cancer and the removal of part of their colon, let's say, and this is their only way to excrete waste out of the body. They need pouches, they need flanges and they need tens of different items to be able to excrete that waste out of their body.

We've applied once and twice and three times, let's say, and months and months have passed. When the patient comes in, what am I going to do? Tell him that I cannot give it to them? I've given them multiple supplies, and because I haven't received approvals or the doctor hasn't filled out the document or...or...it has been months and months and months.

Sometimes, yes, the lack of approvals sometimes may not.... We don't refuse care, but sometimes we ask the patient if they can pay for it or if they can go to their health centre so that they can also advocate on their behalf there, because the process is very tedious, very difficult and very time-consuming. Yes, we sometimes cannot get paid if things are not done correctly and on time.

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

As another final question to you, are you often paying out of your own pocket when these situations arise because the paperwork is not done, because the approval hasn't been done or because it's not covered by NIHB? I think you would not be the only one in the pharmacy who is sometimes paying out of your own pocket when you serve indigenous people, supposedly under the NIHB.

I have heard that some Inuit have been told, "We cannot pay. These are to be paid out of your pocket." Then the pharmacist has refused to give us our medication because it wasn't approved.

Mr. Rudy Malak: Sometimes that does happen. Yes, that is correct.

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

When that happens, can you illustrate to us how damaging that could be to your own business and how much you are paying out of pocket when those situations arise?

Mr. Rudy Malak: It's very damaging to the patient, first off, because they leave. They can be frustrated. Some people can fight on their behalf and go speak to the doctor or go to the health centre, but some other patients are vulnerable. If they have a mental health issue or if they have, let's say, schizophrenia or something of significance, so that they cannot fight on their behalf, they just leave. They don't get the care, and they end up in the hospital somewhere because they can't fight for themselves.

For some people who have come again and again, we ask them to also help us. We ask them to call the doctor, call the office, call NIHB and call the health centre. That's the only way to get things moving.

• (1755)

The Chair: Thank you, Ms. Idlout.

We're going to proceed very quickly to a second round. I believe Mr. Schmale is up.

Mr. Schmale, you have five minutes.

Mr. Jamie Schmale (Haliburton—Kawartha Lakes—Brock, CPC): I'll start with Mr. Malak.

I don't think anyone has brought this back up, but at the beginning, did you say, "Faxes get lost"?

Mr. Rudy Malak: Absolutely.

Mr. Jamie Schmale: Can you tell me about that? Will you run me through that process? How does that work? First, you dust it off...?

Seriously, can you run me through that?

Mr. Rudy Malak: I don't know the mechanism, but we send a fax to the NIHB for approval. Sometimes we follow-up three or four days later and say that we sent an approval and ask if there is any response. They say they didn't get it. Well, I know I sent it and I have confirmation that it was sent, but they haven't received it, so we have to start the process again. Then, I believe they would fax the document to the doctor's office. The doctor's office would fax it back to NIHB and then NIHB would fax us back at the pharmacy.

Yes, it can get lost. The network or the fax is busy, or whatever it is. It does happen that faxes get lost.

Mr. Jamie Schmale: The fax gets busy. That's something I haven't heard in a while. Say it's 2005....

Has anyone brought up the fact that we don't need to use faxes anymore and it's probably more efficient to do something else?

Mr. Rudy Malak: Yes, but that is probably a system that has to be integrated between the departments, ESI, the doctors' offices, the NIHB call centres and the pharmacies. Yes, there's Internet, but which system has to integrate within the others? It's a process. That's an IT issue that I don't know much about.

Mr. Jamie Schmale: That sums up government perfectly right there. Oh my goodness. Wow.

Ms. Grier, you are nodding your head on that. This is amazing. This really is. Do you want to add to that?

Ms. Angela Grier: I echo his sentiment that we're at the mercy of the professionals who are around that in this environment.

Right now I believe the federal government is exploring the racism going on in the health care system. Again, we're at the mercy of individuals who may not always have our best interests...but they do enjoy the funding they receive. They may not have the cultural competency to work within our populations. We're at the mercy of these individuals.

I echo Lori's comment on people who do not want to do business with NIHB. I know a lot of practitioners who say no. They say they don't get paid on time. There are too many bureaucratic errors. There are all of these issues, and they won't do it. We're actually creating more barriers and wanting more.... The competent professionals that we need under NIHB are leaving.

I'm not saying it's all of the clinicians out there. There's a diversity of course. There's a spectrum. Really, in Canadian society, if you want to pick a therapist, you have the choice to go and try people out. The therapeutic alliance between the client and the therapist is the most important aspect. I work with young people who tell me that it's so good to work with me, because they had to tell their white therapist what it's like on the rez. They wonder why they have to keep explaining and educating her, whereas with me there is none of that. I grew up in these communities. I work in these communities. I'm from these communities.

With our work as professionals and as subject matter experts in our communities, we should be the ones who are being pulled together within your organization to look at this information as the subject matter experts, not the politicians.

Mr. Jamie Schmale: Okay.

That goes to the same thing with the faxes. If they are extremely slow about even changing the way they're doing business to be flexible enough to make changes that are happening on the ground, it's like pushing uphill here.

Ms. Angela Grier: Absolutely. That's why I mentioned in my speech, sir, that we're pushing past our human limits. We carry toxic stress with us with each and every generation, so we can advocate and stay alive and not go the way of our ancestors with what was done to them.

We're pushing through these bureaucratic environments that are systemic and that can be overturned by simply changing this policy.

• (1800)

Mr. Jamie Schmale: That's unbelievable.

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

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

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

I'd like to thank all of our witnesses for joining us today for this really important study. It's amazing to hear about some of the archaic systems that are still in place right now.

I'd like to start with a question, through you, Mr. Chair, to Ms. Grier.

My colleague MP Battiste had asked all three of our witnesses here about where the federal government investments in indigenous health care can best be placed. I think you were starting to get at some of the investments in mental health. I want to give you the opportunity to really expand on that and share that with this committee.

Ms. Angela Grier: Thank you.

I was just mentioning that, in these unregulated provinces, the fiduciary responsibility the federal government has over first nations under section 91(24) and within the Indian Act is being deferred to provinces to determine our fate. Within first nation communities, we have tirelessly organized politically to try to create unity among chiefs' associations, like AOTC in Alberta, or the chiefs' association in Saskatchewan or Manitoba. These entities are some of the arms that come from the community. No disrespect to the AFN or any of that affiliate, but those chiefs are not elected from our communities. They're elected through regions by the chiefs of those regions. Then the leadership of our communities carry the knowledge of our communities, and their technicians are people like their health directors, who provide them direct information on the ground as to what's happening.

It's really important, and even in our own bureaucracies, we have to try to weed out some of our own political interference in that. How do we get the stakeholder, the actual subject matter expert's voice, like mine or like my supervisor's and so forth, like those of these amazing people I'm with today, to get that direct information, instead of politicizing it and keeping it removed as if it's something on a shelf? This is while we're sitting here struggling and trying to maintain people's lives, trying to keep people alive.

Mr. Patrick Weiler: Thank you.

You mentioned something else that was very troubling to hear, that just because of some of the bureaucratic troubles with NIHB, some of your colleagues are now moving away from the NIHB program. I'm just curious. Could you speak a little bit more about how they're leaving this program, how their services are being offered and how people can access them?

Ms. Angela Grier: Right now, individuals who are leaving the NIHB program or shying away from it are creating sort of the bottleneck of the wait-list that will occur. Sadly, because the NIHB statisticians here in Ottawa don't have the picture of what's happening on the ground, again it's being reflected in a way that's not accurate.

There are practitioners who have developed competency through working with indigenous communities. You don't get competency just in school. You have to have experiential competency. You have to know the community, participate in the community, be a part of our communities in order for you to say that you are competent. Then you can work because you know our community. Then, of course, you have ethical practice standards and all that continuing education that you do to work towards those competencies.

The truly most competent practitioner is the indigenous practitioner for indigenous people. However, we have a long way to go until we can fill those spaces with full first nation, indigenous practitioners. Until then, we work very hard with our settler populations to ensure that they're competent and that things are indigenous-led. Our indigenous circle chapter has worked tirelessly to create the code of ethics that we implemented from their work on the ground.

I'm not sure if I was answering the question or not.

Mr. Patrick Weiler: Absolutely, and maybe I'll just direct the last question to Mr. Malak.

On some of these challenges you've raised today, what responses are you getting from NIHB, especially with respect to the major delays that you're experiencing in getting responses?

• (1805)

Mr. Rudy Malak: According to the people on the phone, it's out of their hands. They don't know. They can't do anything about it. If something's not approved, it's not approved. We can try to appeal it, but it goes to people and then it goes to other people, you know. Then it comes back as "declined".

The Chair: Thank you very much.

Go ahead, Madame Gill.

[*Translation*]

You have two and a half minutes.

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

Ms. Tshernish, in response to my last question, you touched on indigenous languages at the end of your answer. If I'm not mistaken, that is the first time the issue was raised in relation to the NIHB program. I'd like to give you an opportunity to finish what you were saying.

Of course, you can also have a few minutes to add any recommendations you may have forgotten to mention earlier.

Tshinashkumitin.

Ms. Marceline Tshernish: *Tshinashkumitin*, Mrs. Gill.

When I mentioned language earlier, I was referring to the holistic way in which the Innu view health. I sincerely believe that language is an integral part in the delivery of health care services to first nations communities. It is a way of safeguarding culture in health care. It is also an important lever in preserving our knowledge and a tool that can support nation-to-nation engagement.

The languages of first nations are obviously very difficult to learn, but I have seen non-indigenous professionals make an effort to reach out to members of our community. The connection that can be formed in communicating with the patient is quite significant. As I said, language can be an excellent lever.

During the earlier discussion about care, someone commented that the tools being used were really archaic, and that struck a chord. That is our experience as well. However, other recommendations could be implemented to make care more accessible. For example, certain clients could automatically have access to escort coverage when receiving care in major centres or tertiary care. Actions could certainly be taken to ease the administrative burden.

Another issue that came up earlier was the wait times for exception drugs. The physician is the one who prescribes the drugs, but the entire NIHB process serves in some ways to challenge what the physician has prescribed. In some cases, the process prevents us from providing the quality care clients are entitled to, and that is wrong.

The Chair: Thank you.

Go ahead, Ms. Idlout. You have two and a half minutes.

[*English*]

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

Thank you.

I have a question for Ms. Grier.

I enjoyed your presentation.

It is very important that indigenous caregivers, physicians and health professionals look after the community. They are the best people to look after the community. If we indigenous people, I believe, could participate more in health issues and be more involved, we could go a long way in improving health in our own communities. Indigenous people are very qualified when it comes to looking after the lives and health of the people.

Thank you.

• (1810)

Ms. Angela Grier: I agree.

I was told one time by one of my teachers that it takes highly qualified and skilled people to work with indigenous people to make a difference. We've seen a lot of people work in our communities, but a quality professional has to know over and above what your average Canadian knows in order to work with our population and make a difference.

I completely agree.

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

Can you give us an example or cite an example so that we have a better understanding? Because we sit here at the committee and we hear things for the first time that are actually happening in the real world, things that we should be administering more carefully, more expediently and more professionally.

What is the best way that indigenous people can get help in health delivery? What are your final thoughts on how best to provide help in health delivery?

The Chair: I'll have to ask you to be succinct on that, please.

Ms. Angela Grier: I would take out the middleman: fewer Ottawa dollars, more dollars on the ground, more authorities to the first nations and more authorities to the communities. That's really what's going to make the change. We are the experts of our own lives. We do not need dictation from Ottawa anymore to do that—we never did.

Thank you.

An hon. member: Hear, hear!

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

I would like to thank you, Rudy Malak and Marceline Tshernish.

[*Translation*]

Thank you for sharing your views with the committee and answering our questions. You have made a major contribution to our study on non-insured health benefits, and we sincerely appreciate it. Thank you for taking the time to speak with us.

That brings us to the end of our meeting, honourable members. As a reminder, we are meeting at one o'clock on Friday.

Thank you everyone.

The meeting is adjourned.

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