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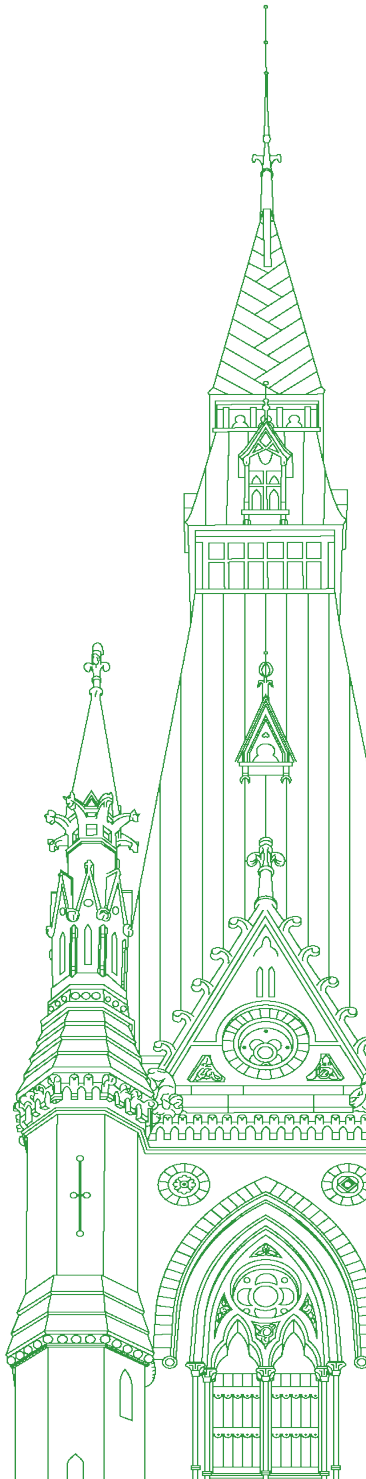

Chair: The Honourable Marc Garneau

Standing Committee on Indigenous and Northern Affairs

Friday, May 13, 2022

● (1300)

[*English*]

The Chair (Hon. Marc Garneau (Notre-Dame-de-Grâce—Westmount, Lib.)): Good afternoon, everyone. I'm calling this meeting to order.

[*Translation*]

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

[*English*]

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

This is just a reminder, before we get going, about those 12 witnesses we had to supply for the fourth study by noon today, as well as the requirement for the rest of them by noon on May 20 so that the analysts can get on with inviting these witnesses.

[*Translation*]

Today, we are continuing our third study on the Administration and Accessibility of Indigenous Peoples to the Non-Insured Health Benefit, or NIHB, program.

[*English*]

I will get to our first panel in a moment, but first a few reminders.

[*Translation*]

I would like to remind everyone to abide by the requirements established by the Board of Internal Economy concerning physical distancing and mask wearing.

[*English*]

To ensure an orderly meeting, I would like to outline a few small rules. Members or witnesses may speak in the official language of their choice. Interpretation services in English, French and Inuktitut are available for the first part of today's meeting. Please be patient with the interpretation. Sometimes it has to go from Inuktitut to English and then to French, or vice versa, so there will be a little delay.

The interpretation button is found at the bottom of your screen with the choice of English, French or Inuktitut. If interpretation is lost, please le me know and we'll stop proceedings and try to rectify the problem before continuing.

Before speaking, please wait until I recognize you by name. If you use the "raise hand" feature, you can get my attention that way if you need to. If you are on the video conference, please click on the microphone icon to unmute yourself. For those in the room, as you know, your microphone will be controlled as normal by the proceedings and verification officer. When speaking, please speak slowly and clearly. When you are not speaking, your mike should be on mute.

As a reminder, all comments should be addressed through the chair. Also try to stick to the time that is allotted to you.

We start off with the witnesses each making a five-minute statement. Two of the three witnesses are here, so we'll get on with it.

I would like to welcome Dr. Lynn Tomkins and Dr. Philip Poon from the Canadian Dental Association. As well, Caroline Lidstone-Jones, chief executive officer of the Indigenous Primary Health Care Council will join us hopefully shortly. Finally, we have Maggie Putulik, vice-president, health services, Nunasi Corporation, who is in person today.

Without further ado I will invite Dr. Lynn Tomkins to start off our proceedings today.

Dr. Tomkins, you have five minutes.

Dr. Lynn Tomkins (President, Canadian Dental Association): Thank you, Mr. Chair.

[*Translation*]

Good afternoon, members of the committee.

[*English*]

I am speaking to you from Toronto on the traditional territory of the Huron-Wendat, the Haudenosaunee and the Anishinabe nations, and the Mississaugas of the Credit First Nation.

I am pleased to be joined by Dr. Philip Poon, who leads our subcommittee on the non-insured health benefits program and has extensive experience on this subject. He joins us today from Winnipeg, located on Treaty 1 territory and the homeland of the Métis people.

At the Canadian Dental Association, we know that oral health is an essential component of overall health, and we believe that all Canadians have a right to good oral health. That is why we are fully supportive of efforts by all levels of government to improve Canadians' oral health and to increase their access to dental care, especially for Canadians who need it most.

CDA has long advocated for investments in indigenous oral health and access to dental care. We have been collaborating for over a decade with officials who manage the dental component of the NIHB program and provide technical advice on its administration. Today, we would like to offer three recommendations in the context of your current study.

First, we are calling for better access to facilities where dental treatment can be performed under general anaesthesia. Many high-needs patients, particularly children, require dental procedures performed under sedation, specifically under general anaesthetic, and this requires a surgical facility. This is often the case for indigenous children who live in remote communities without access to regular dental care. These children often have severely decayed teeth, which can be difficult to treat in a conventional dental office setting.

Although the treatment is covered by the NIHB program, it is often a challenge to access the surgical facilities in which to provide the treatment. In many cases, hospital operating rooms are used. Even prior to the pandemic, it could be challenging to find the necessary OR space or staff. Treatment was often delayed for months, and this has all been worsened by the toll COVID-19 has taken on the health care system. The resulting surgical backlog means that this issue will likely persist for some time.

One option is to make better use of private surgical facilities that exist in many large cities. However, these clinics often charge rates significantly higher than the NIHB program's reimbursement levels, or they impose fees that are outside the standardized system of dental treatment codes, which are not reimbursed at all. Another option could be to construct dedicated, indigenous-run surgical facilities in communities that serve a high number of patients who qualify for the NIHB program.

Second, although the NIHB program compares favourably to other publicly funded provincial or territorial dental programs, some patients continue to face significant barriers in accessing care due to the program's burdensome administration. Many common treatments, such as partial dentures, require preauthorization, despite the exceptionally low rejection rates. The preauthorization process for other treatments, such as crowns, can also be more complex under the NIHB program compared to other dental programs, including the federal government's public service dental care plan.

Furthermore, other common services, such as night guards for bruxism, or tooth grinding, are included as a service under most dental plans, such as the PSDCP, but are not covered by the NIHB program.

The program has already made significant improvements in the past, such as removing the preauthorization requirement for root canal treatment. It's much appreciated. Given that indigenous oral health outcomes have lagged behind those of the non-indigenous population, the NIHB program should aim to facilitate efficient and quick access to care, rather than focusing on cause containment. We recommend that the program conduct a comprehensive review of the administration of dental coverage to ensure that any preauthorization requirements are in line with best practices of other dental programs, both public and private.

Finally, CDA applauds the historic investment in budget 2022. However, at a time when the federal government has committed to investing over $5 billion in dental care for Canadians, indigenous oral health must not be overlooked. As it currently stands, none of this funding targets the nearly one million first nations and Inuit in Canada eligible for the NIHB program. This may actually increase the significant oral health inequities between this group and the broader Canadian population.

The federal government should, in partnership with indigenous governments and other relevant stakeholders, develop an oral health investment strategy to improve the oral health of indigenous communities. Beyond the concerns outlined earlier, this could also include things like investments in education and awareness campaigns, public health programs providing preventative care, and access to clean drinking water and community water fluoridation.

● (1305)

Thank you for this opportunity to participate in the study of this important federal initiative. Dr. Poon and I would be happy to answer any questions that you might have.

The Chair: Thank you, Dr. Tomkins. We're glad you could join us today.

Next will be Caroline Lidstone-Jones, CEO of the Indigenous Primary Health Care Council, who has now joined us.

Ms. Lidstone-Jones, you have five minutes.

Ms. Caroline Lidstone-Jones (Chief Executive Officer, Indigenous Primary Health Care Council): *Aaniin*, everyone.

As a representative from the Indigenous Primary Health Care Council, which supports indigenous primary health care organizations across the province of Ontario, we would like to thank the House of Commons Standing Committee on Indigenous and Northern Affairs for the opportunity to appear as a panel witness in view of its study, administration and accessibility of indigenous peoples to the NIHB program.

In providing feedback to the study on the non-insured health benefits program, we are doing so through the lens of an end-user perspective that is first nations, Métis and Inuit inclusive and solicitous of the northern, rural and urban indigenous communities we service here in Ontario. The four themes and observations we would like to report on are contained under affordability, accessibility, exclusionary and safety.

With regard to affordability, significant challenges noted for the northern, rural and urban indigenous populations include the following.

Many service providers, whether they be dental, optometry, pharmaceutical or others, require indigenous clients to play for their services up front and then independently submit receipts to NIHB for reimbursement. For some, this creates affordability challenges, as the services can be quite expensive. When looking at eyewear expenses, costs can be hundreds of dollars. Costs for emergency dental care alone can be upwards of thousands of dollars. For example, root canal therapy alone averages between $520 to $1,200 per tooth.

Plus, there is a general lack of awareness among service providers regarding the NIHB program, especially in urban settings. Many service providers are unaware of the program and their ability to access or register. As such, in many cases, indigenous clients are not offered the option of provider-submitted reimbursement. Therefore, in many cases, indigenous clients are not offered the option of having the provider submit reimbursement on their behalf. If the client requests direct billing to NIHB, it is often denied by the service provider.

On the other hand, many service providers who are aware of the NIHB program choose not to participate because of the predetermination processes and the length of time to process. In addition, it is reported by providers that the wait times to receive payment back from NIHB is extensive, so some providers are opting not to register as a provider or to remove themselves as a provider on the preapproved registry list.

Finally, out-of-pocket costs for travel remain a significant challenge for indigenous peoples in northern, rural and urban settings. For those living in northern and remote regions, their out-of-pocket costs for travel continue to escalate with increasing gas prices. For instance, the fees for driving are currently established at 22¢ per kilometre. This fee is not keeping up with the costs of inflation, and it further impedes the affordability of individuals to access appropriate health care.

Comparatively, reasonable allowance rates that were identified on the Government of Canada website for 2022 were as follows: 61¢ per kilometre for the first 5,000 kilometres driven, 55¢ per kilometre driven after that, and, in the Northwest Territories, Yukon and Nunavut, there was an additional 4¢ per kilometre. In addition, meals are reimbursed at a maximum of $60 a day, compared to the Government of Canada website of $69 per day without receipts.

For the urban indigenous population, all travel is out of pocket, as access to designated NIHB medical transportation is minimal due to the expansiveness of service provision. Individuals travelling to urban settings for services are required to pay up front for taxi and parking. Both costs are extensive, especially in metropolitan areas, where a lot of the specialty services are housed. Parking alone can range upwards of $30-plus a day in the downtown core.

All in all, upfront and out-of-pocket costs for travel and services create significant affordability issues for those who may not have the affordability to do so up front. As a result, this may force them to abandon their much-needed care completely. When they eventually enter the system, we are now seeing them in emergency settings rather than in curative or in preventative-type settings.

● (1310)

There are some additional things that we see with regard to challenges. There is limited access to service delivered by indigenous practitioners. While there is an NIHB service provider list for mental health, it is mostly comprised of non-indigenous practitioners delivering mainstream services.

Developing a similar list and funding indigenous practitioners with an emphasis on traditional healing and wellness supports is essential to healing, especially when we accept culture as treatment and culture as healing. Reclaiming with culture, land-based healing and connecting with cultural service providers are well-known strategies that successfully support the indigenous population on their healing journeys.

Travel also poses additional challenges from an accessibility lens. Often the approval process for medical transportation is delayed or not expedited in a timely manner, especially if specialty services are accessed at the last minute. This results in clients having to cancel their appointments. We know that the wait times for most specialists and diagnostic testing is quite extensive so this then imposes further delays to their treatment and care.

Connecting with NIHB representatives in real time when experiencing an issue or having questions is a significant challenge. This is a well-known reason why service providers choose not to work with NIHB. It is a contributing factor to many indigenous people not receiving the care that they need. In many cases, out of frustration, they will abandon the process and not obtain supports through the NIHB program because of it being time-consuming, complex and labour-intensive to navigate.

● (1315)

The Chair: Ms. Lidstone-Jones, you are six and a half minutes already, so could you wrap up, please?

Ms. Caroline Lidstone-Jones: Yes.

The final one I will focus on is racism in the health care system. Racism in the health care system is deeply rooted since the time of Indian hospitals, when they were created in the 1930s. Indigenous people experienced inequitable access to health care services and received subpar care. This often results in death.

When we speak about the anti-indigenous acts of racism, we reflect on the treatment of Joyce Echaquan, Brian Sinclair and others, but we also reflect on those who did not access much-needed services because it was too late or because of their anticipation of how they would be treated.

There is a significant gap in cultural safety and culturally safe care. We recommend that mandatory training be imposed on all NIHB services and service providers to ensure that safety is the ultimate lens.

We also—

The Chair: Thank you. I'm going to have to stop you there.

Ms. Maggie Putulik, you have the microphone now, for five minutes.

Ms. Maggie Putulik (Vice-President, Health Services, Nunasi Corporation): *Nakurmiik. Ullaakut.*

[*Translation*]

Good afternoon, everyone.

[*English*]

Thank you, members of the committee.

My name is Maggie Putulik. I'm here today as the vice-president for health services for the Nunasi Corporation.

I would like to start off by saying that it is an honour for me to talk to you about the importance of the non-insured health benefits program for Nunavummiut Inuit. At the end of my presentation, I am going to outline three key recommendations to improve the policy.

Nunasi Corporation, which I work for, is a Nunavut Inuit birthright corporation owned by two regional Inuit associations, the Qikiqtani Inuit Association and the Kivalliq Inuit Association, and one regional development corporation called the Kitikmeot Corporation.

Ours is the oldest Inuit development corporation in the country. We were created in 1976 by the Inuit Tapirisat of Canada, at the time. It is now known as Inuit Tapiriit Kanatami. Nunasi Corporation was created to be used as a vehicle to ensure Inuit participation in economic development.

Nunasi has investments in the medical accommodations known as largas. We are situated in Ottawa, Winnipeg, Edmonton and Yellowknife. As there are no specialized medical services in the north, Inuit must be sent to the south to receive specialized medical services. The largas are known as a home away from home, with culturally appropriate programs offered to medical patients and their escorts. We provide accommodation, lodging and transportation covered by the non-insured health benefits program.

Nunasi also owns Polar Vision, which is located in Yellowknife but offers services for optical care in Nunavut communities.

The non-insured health benefits program is a significant program for Inuit, and although there are many benefits to the program, today I'm going to offer three specific areas of improvement that would greatly improve outcomes.

First of all, the federal government should enter into a long-term, 10- to 15-year agreement with the territorial Government of Nunavut to ensure that appropriate investments can happen. Long-term agreements provide greater certainty in securing the essential services we at the largas provide to Nunavummiut.

Second, the Government of Canada should develop and implement a territorial user transportation policy. I use the term “user”. In the medical world, a user is a patient or an escort. That's the term that is used. It should develop a territorial user transportation policy both for Nunavut and the Government of Northwest Territories to avoid misinterpretation of the policy pertaining to medical escort eligibility.

Escorts provide a critical function in Inuit health services. They accompany the patients and assist them with mobility issues and language barriers, as well as social, psychosocial and emotional support. We have experienced many inconsistencies in applying the escort policy, particularly in the GNWT. The federal government needs to implement a clear policy that specifically outlines who can be eligible to have an escort, because the policy as it is at the moment is vague and broad, and it could be misinterpreted by medical travel personnel, in particular, within those two levels of government.

Nunasi's third and final recommendation is to update the non-insured health benefits program policies related to vision care in Nunavut. Currently, the NIHB pays $300 to $400 for one pair of glasses every two years for adults and every year for children. These program benefits are below what is considered standard in vision care programs elsewhere in Canada.

● (1320)

We have been given the most basic amount to cover our glasses. We recommend that NIHB pay market rates or close to them for eye exams and glasses so that Nunavummiut can afford to utilize this program. As well, contact lenses should be included, and laser eye corrective procedures should be eligible in appropriate cases.

Finally, service days from opticians in the Nunavut communities are very limited. We frequently hear that the low number of available service days prevents Nunavummiut from accessing vision care. That is unacceptable.

As a professional who has worked in the health services network for the past 15 years and has been working diligently with the largas, Polar Vision and other health care providers that utilize the NIHB program, I have outlined for you today these three key policy recommendations. I believe that we could work collectively to make the program even better. I look forward to your questions.

[*Translation*]

Thank you for offering me the opportunity to appear before you today.

[*English*]

The Chair: Thank you, Ms. Putulik.

We'll now proceed with the questions. We'll start with Mr. Schmale.

Mr. Schmale, you have six minutes.

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

Thank you to the witnesses for their great testimony today.

In previous committee meetings, we've heard about the crippling level of bureaucracy within this program.

I think, Ms. Lidstone-Jones, you were just getting into a roll on that, and your time ran out. You're nodding. Would you like to complete your thought?

Ms. Caroline Lidstone-Jones: Yes, it's much appreciated.

We can speak from our Ontario perspective here for the communities that we service here. We're hearing that a lot of the resistance we have from current providers who are already registered or may have expressed an interest is because of the amount of bureaucracy and labour intensity tied to having to go through that process. It's something that they just don't have the time to do. This is especially in light of the fact that right now we are in massive HR crises, where recruitment and retention and the increased wait times become an additional burden on their time. [*Technical difficulty—Editor*] create supports to be able to do that.

It isn't necessarily that they are outright not interested in serving, but because of the bureaucracy tied to participating in the program, it becomes their choice to say that, for the amount of time it takes them to register, to go through all of the pre-approval and then the length of time for them to receive payment, they are just not able to keep up with the administrative burden to do that.

That has been something we are seeing, where more and more people are walking away from services because they can't afford to pay up front for them and then seek reimbursement from NIHB.

● (1325)

Mr. Jamie Schmale: Those people sadly just don't get the service they need.

Ms. Caroline Lidstone-Jones: Yes, and that's why we mentioned that many of them end up instead of in preventative stages—if we're looking upstream versus downstream—now entering into emergency where it's then more costly for the system to service them later on.

Mr. Jamie Schmale: Absolutely.

Just out of curiosity, are your members communicating with the department through fax?

Ms. Caroline Lidstone-Jones: Some are. It just depends on the location. We still have severe challenges. One of the recommendations we had also ties to not having.... We still have a major digital divide, especially for many of our remote first nations communities, so that becomes an ongoing challenge with the stability of Internet and lack of broadband, those kinds of things. That also adds further complexity to navigating the system. We have a combo of both.

Mr. Jamie Schmale: In a previous meeting, we had testimony from a pharmacist who talked about having to use a fax, because I guess email hasn't gotten to that department yet. He also mentioned that sometimes when you fax, the paperwork gets lost. Physicians have to start the process over again, and this also compounds the already frustrating system that exists.

Ms. Caroline Lidstone-Jones: Yes, and wait times.... If paperwork gets lost, the pre-approval process, then, is impacted. If you secure an appointment time and that paperwork is not done in time, that delays your travel, whether it be a flight, booking accommodations or whatever. It just trickles down and delays everything. We have had people miss their actual appointments because of the system failing in that regard.

Mr. Jamie Schmale: This lays out a pretty troubling road map, when you think about it—the fact that health care professionals are forgoing this because of the administrative burden that exists, the potential lost paperwork within the health care system in general, and then the fact that the payment takes so long to get. It's also to your point that preventative measures don't get completed at that time; you just get the worse case, which is going to the emergency room. In many parts of the country, we have hallway health care because our health care system is overwhelmed.

Ms. Caroline Lidstone-Jones: Absolutely.

Mr. Jamie Schmale: You mentioned that a bit in your testimony. Maybe you could expand on ideas you have or your organization has that could potentially relieve some of this pressure, at least the administrative burden, or even speed up the whole regulatory process that exists.

Ms. Caroline Lidstone-Jones: We have to find a better way around the paperwork system and the number of all of these pre-approvals, and then their having to take paperwork with them to prove they were at the appointment. It's not only leading up to the appointment. It's once you get to the appointment and the paperwork beyond that.

Sometimes you have people who also, because of the travel times and all that, miss getting the specialist to sign the paper and then that impacts their next travel, so it's all of those pieces. They don't realize that it's right from the start of the system up and down, and it then impedes their ability to get future access to the program.

What we need to do as health care providers is to really work together to establish a system on how we can more collaboratively tackle the length of time it takes the administrative bureaucracy to do this. We have had a few providers here in Ontario who took it upon themselves to administer the NIHB program, but the sad reality is that they experienced the length of time and delay for getting the process payment from NIHB as well. Then what happens is that it impedes the ability of the community to continue to travel because they don't have enough cash flow to be able to do that.

Again, I think that, when we're looking at the long term and in the long run, if we're again comparing upstream to downstream, it's so much less costly to catch them in preventative-type stages. When we get into acute care, we're already talking like there's something to diagnose and something to treat. We've now missed this whole part of the system here where we could have prevented worse-case outcomes or outcomes that require more types of treatment.

● (1330)

The Chair: Thank you, Mr. Schmale.

We'll now go to Mr. Battiste.

Mr. Battiste, you have six minutes.

Mr. Jaime Battiste (Sydney—Victoria, Lib.): I'd like to thank the witnesses for their testimony. We're hearing you loud and clear about the need, not only to ensure the prices and the costs are done more efficiently, but also the need to catch up in terms of what our government is providing.

When we're looking at some of the issues that are in the northern areas or rural and indigenous communities, one of the things that often comes into my head when I'm thinking about these problems is that often the challenge is that we have to travel as indigenous people to find the services elsewhere.

On the underlying issue of capacity on reserves or in the north, what can we do as a government to try to ensure that communities have the capacity so their community members don't have to travel off reserve or from the north? Is there a way in which we can work with universities? Is there a way we can create programs that increase the amount of indigenous participation in health?

Can you talk to us a little bit about any best practices out there in Canada right now that are working to increase the number of participants we have from the indigenous communities in the health studies?

I guess we could start with Ms. Lidstone-Jones.

Ms. Caroline Lidstone-Jones: Yes, absolutely. I can give you some concrete examples of our network here in Ontario with the Indigenous Primary Health Care Council. At our health care council, we are actually status-blind when it comes to providing service to indigenous peoples: first nations, Métis and Inuit. We have entered into a lot of relationship agreements with our first nation communities to bring care into those communities.

Where we are challenged, of course, is in our ability to have enough service capacity to do that. Right now, we are also trying to increase our capacity in the number of positions and primary health care providers that we get so that we can further our scope and our outreach.

We are also in relationship with the Northern Ontario School of Medicine, to talk about how we train our students, how we connect the western and traditional approaches to medicine and how we promote that internally in our communities.

The other thing that is advantageous to our system is bringing things such as presurgical clinics into the communities and gathering people who can do that, screening buses and things like that, where you can have captured people actually go for care. The other thing we have done is to institute mobile units. We were fortunate enough to get funds during times of COVID-19 to use as mobile units for testing assessments for COVID-19. We now have an opportunity and a system to have that for primary health care service delivery, which can take those services into the community to do more of those prevention type things.

Those are the things that we need to invest in to be able to take more services to the communities. Instead of communities having to go to where those services are, we need to look at the opposite to make sure that the accessibility is there.

Mr. Jaime Battiste: Ms. Lidstone-Jones, you talked about something that caught my attention, land-based healing, as an example of a promising practice within indigenous communities. Can you tell us a little more about that and how it's working effectively to address mental health, within indigenous youth especially?

Ms. Caroline Lidstone-Jones: Yes. It's huge.

We've seen a massive increase in the use of our traditional healing and medicines program, especially during times of COVID-19, where we had more increases in mental health concerns, people who had never experienced anxiety or depression before—all of those things—due to isolation.

Throughout our network, we have created land-based programs with various components. We have hunt camps, fish camps, traditional teachings and ceremonies where they can go in for specialized ceremonies or naming ceremonies. We've also had traditional healers who went out with our communities to learn how to pick traditional medicines, how to do and cure the medicines and how to use them for whatever purpose [*Technical difficulty—Editor*] picking.

We also found that the role-modelling and mentoring of having youth out on the land with people who are able to navigate the land is a huge piece, and that has been very successful for us. The other piece that we're working on in traditional healing—again, speaking in the Ontario context—is doing better at what we refer to as "two-eyed seeing", incorporating primary care delivery with our traditional medicines and connecting those two services so that they become harmonized instead of two disjointed programs.

Those are things that we are working on right now. We are doing a lot of work in that area right now because we've seen the massive increase in utilization as a way forward, especially when it comes to mental health and addictions.

● (1335)

Mr. Jaime Battiste: Thank you.

That's about it for me, I think.

The Chair: Thank you very much.

[*Translation*]

Ms. Gill, the floor is now yours for six minutes.

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

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

I would like to talk about a very important subject that we addressed in another study, one that dealt with housing. Obviously, we noted the impact that lack of access to housing can have in remote communities: it has caused an exodus of the population to urban centres.

Is not having access to health care where they live also a factor that prompts people to leave their community?

Ms. Putulik, do you have any comments about that?

Ms. Maggie Putulik: Thank you for the question, Ms. Gill.

[*Witness spoke in Inuktitut as follows:*]

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[*Inuktitut text interpreted as follows:*]

I will answer you in Inuktitut.

[*English*]

A lot of people do leave the north due to a lack of housing. For sure, that's one big important reason, but most of the patients and escorts do go back home.

A lot of people from the north will leave the north seeking employment in the southern cities or due to various personal reasons. They leave the north escaping either violence or abuse. Many of them are affected by substance abuse once they are in the south, but the majority of our patients—

[*Translation*]

Mrs. Marilène Gill: I'm thinking of the problem that the need to get dialysis treatments three times a week can cause, for example.

So from what I understand, not having access to health services is not one of the factors that cause people to leave the communities.

[*English*]

Ms. Maggie Putulik: No.

[*Translation*]

Mrs. Marilène Gill: Thank you.

I'd like to ask the other witnesses to speak on this subject too.

[*English*]

The Chair: Ms. Lidstone-Jones, do you want to take a crack at answering that question? Then we'll go to Dr. Tomkins.

Ms. Caroline Lidstone-Jones: Sure. I just found the translation, so hopefully I caught it all.

If I understand correctly, you were asking whether people leave their communities because of their treatment. The answer is yes. Some people do have to leave their community when it comes to treatment.

You mentioned the use of dialysis. Dialysis is huge. It's not only the accessibility of the program, but access to the quality of water that is in a lot of our communities. Some of them are having to leave those circumstances to be able to access that program and that service.

Anything that requires more specialized care.... You have some people, in fact, making the choice where they just choose that they're not going to do it because they have to travel so far, and their health care gets worse. The other thing is that, when they do leave, many times it's leaving by themselves to have that care, so there's the fear and the loneliness factor.

[*Translation*]

Mrs. Marilène Gill: I'm sorry, Ms. Lidstone-Jones.

I think my question was misunderstood. I didn't want to talk about leaving the community occasionally; I am talking about leaving permanently in order to access health care that is not accessible in the community.

I don't know whether that's how you had understood my question, Ms. Lidstone-Jones. Is your answer the same?

● (1340)

[*English*]

Ms. Caroline Lidstone-Jones: Yes, there are some who do that as well.

Again, it depends a lot of the times on the complexity. I can speak to that personally. I have a husband who has to be here in the GTA because of the complexity of the health care services we need. I'm originally from northern Ontario, and we're here because of health care.

[*Translation*]

Mrs. Marilène Gill: Thank you.

I wanted to be sure.

[*English*]

Ms. Caroline Lidstone-Jones: Yes, the answer is yes.

The Chair: Dr. Tomkins, do you want to answer the question? I know you're in a different part of this discussion, but go ahead, if you wish.

Dr. Lynn Tomkins: I'll keep it short.

I would say that, in terms of dentistry, since most of the treatment we do is very much on time, it would not be a cause for somebody.... It would be very unusual unless somebody had a cranial facial disorder, for instance a child, that needed a lot of surgical care, but again, that would be viewed as a temporary—maybe six months to one year—leave and not a permanent move away from the community.

[*Translation*]

Mrs. Marilène Gill: I'd like to thank all the witnesses for their answers.

My next question concerns the accessibility of health care. The problem arises because of the cost, on the one hand, but also because of the distance to travel to get care and the availability of specialist practitioners. The communities do not necessarily have specialists living there.

Is there a solution to what I would imagine to be the two biggest problems, the availability of specialists and access to care?

It may be utopian to think there could be one big solution to this problem, but do you have any proposals to make to us on this subject?

What would your recommendations be?

Ms. Tomkins, I know it's a bit different for you, again, but I'd still like to hear your opinion on this subject.

[*English*]

Dr. Lynn Tomkins: Thank you.

I would have to say that if you build it, they will come. I'm thinking of dental specialists, especially in things like oral and maxillofacial surgical specialties, who require highly technical operating suites. If we were to see surgical centres in communities that have a high utilization of NIHB services, then you would have the oral and maxillo-facial surgical specialists as well as the dental anaesthesia specialists.

Yes, that would be one of our recommendations.

May I ask Dr. Poon to comment on anything more technical on that?

Dr. Philip Poon (Lead, Non-Insured Health Benefits Subcommitee, Canadian Dental Association): Thanks for that, Dr. Tomkins.

That echoes my exact feelings. An example would be pediatric dentistry wait times. Presently in central Ontario we've heard wait-time stories of eight to 14 months for pediatric general anaesthesia for dental surgeries. I think setting up remote surgical centres would provide pediatric dentists an opportunity to go to the communities to perform the work.

I would echo those comments.

The Chair: Thank you.

We'll now go to Ms. Idlout.

Ms. Idlout, you have six minutes.

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

ᖁᔭᓐᓇᒦᒃ ᐃᒃᓯᕙᐅᑕᖅ. ᐊᐱᕆᓚᐅᙱᓐᓂᓐᓂ ᒥᒐᓐᒧᑦ ᐊᐱᕆᓂᐊᕋᓗᐊᖅᓱᖓ ᑭᓯᐊᓂ ᒥᐊᕆᓕᓐ ᐊᐱᖅᑯᑎᖏᓛᖅᑕᖓᓐᓂᒃ ᑭᐅᖃᐅᖅᑐᕈᒪᓗᐃᓐᓇᖅᓱᖓ. ᓇᒻᒥᓂᖅ ᖃᐅᔨᒪᔭᖃᖅᑐᖓ ᒪᕐᕉᓐᓂᒃ ᐃᓄᓐᓂᒃ, ᐱᖃᑖ ᓴᓂᑭᓗᐊᕐᒥᐅᑕᕕᓂᖅ, ᐱᖃᑖ ᐸᖕᓂᖅᑑᕐᒥᐅᑕᕕᓂᖅ ᓄᓇᒥᓐᓂ ᕿᒪᐃᒋᐊᖃᓚᐅᖅᑐᑦ ᐋᓐᓂᐊᕐᕕᖕᒪᓐᓂᑦ ᐱᔾᔪᑎᖃᖅᑕᐅᕙᓐᓇᙱᓐᓂᖕᒋᓐᓄᑦ, ᖃᓪᓗᓈᕐᒥᐅᑕᐅᓯᒪᓕᖅᑐᑦ ᐋᑐᕚᒥᐅᑕᐅᓕᓚᐅᖅᑐᑦ, ᓲᕐᓗ ᑕᐃᐊᓚᓯᔅ ᐱᑕᖃᓚᐅᙱᒻᒪᑕ ᓄᓇᖕᒋᓐᓂ. ᒥᒋᒧᑦ ᑐᖀᕐᓂᐊᕆᕋᒪ ᐊᐱᕆᔪᒪᒪᒐᒃᑭᑦ ᑐᓴᕐᓂᕆᖅᑲᐅᒐᒃᑭᑦ ᐋᓐᓂᐊᖅᑐᕆᓇᕐᒥᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐃᖅᑲᓇᐃᔮᒃᓴᕆᔫᓂᕐᒥᓂᒃ ᐊᒻᒪᓗ ᑐᓴᖅᑲᐅᒻᒥᒐᒃᑭᑦ ᐅᖃᐅᓯᖅᑲᐅᒐᕕᑦ ᐋᓐᓂᐊᕙᕆᐊᖅᑐᑦ ᐃᑲᔪᖅᑎᖏᑦ ᐱᔾᔪᑎᖃᖅᑕᐅᒋᐊᖃᕐᓂᖏᓐᓂᑦ ᑖᓐᓇ ᐊᑐᐊᒐᖅ ᑐᑭᓯᓇᑦᑎᐊᙱᓐᓂᖓᓐᓄᑦ, ᑭᓯᐊᓂᓕ ᑖᒃᑯᐊ ᕿᒪᒦᖅᑲᑦᑕᖅᑐᑦ ᓃᖅᑲᐃᒻᒪ ᐃᓂᖅᖅᑎᑦᑎᓃᖕᒍᒻᒪᑕ ᐋᓐᓂᐊᕙᕆᐊᖅᑐᓄᑦ ᐃᑲᔪᖅᑎᒋᔭᖕᒋᓪᓗ, ᖃᓄᕐᓕ ᐃᓱᒪᓇᔭᖅᐱᑦ ᑖᒃᑯᐊ ᐋᓐᓂᐊᕙᕆᐊᖅᑐᓄᑦ ᐃᑲᔪᖅᑎᖕᒋᑦ ᐊᑭᓕᖅᑐᖅᑕᐅᖃᑦᑕᕈᑎᒃ ᐃᑲᔪᖅᐹᓪᓕᖃᔭᖅᐸ ᓄᓇᕗᒻᒥᐅᓂ.

[*Inuktitut text interpreted as follows:*]

Thank you, Mr. Chairperson.

I will have a question for Maggie, but first I want to respond to Marilène's question. I know of two Inuit, one from Sanikiluaq originally and one from Pangnirtung originally, who had to leave their homes and communities because they could not get medical services in their communities. They had to move to Ottawa for medical care because of their dialysis needs. We do not have them in our communities.

Maggie, I enjoyed your presentation. You talked about how you have been involved for many years in health issues. I was very pleased when you said that you work with largas. You talked about medical escorts and how that could be improved, but we know that people who stay at larga have escorts and staff looking after them.

When they have escorts, how do you feel about the escorts being on the payroll with full-time jobs?

Ms. Maggie Putulik: [*Witness spoke in Inuktitut as follows:*]

ᑕᐃᒫᓪᓇᕆᒃ ᐃᑲᔪᖅᓯᒐᔭᖅᑐᑦ ᑕᐃᒃᑯᐊ ᒪᓕᒃᑎᐅᓃᑦ ᐃᑲᔪᖅᑎᐅᓃᑦ ᐋᓐᓂᐊᕐᕕᓕᐊᕐᓯᒪᔪᒥᒃ ᒪᓕᒃᓱᑎᒃ ᓲᕐᓗ ᐱᖕᒐᓱᒥ ᐊᓪᓛᑦ ᐃᖅᑲᓇᐃᔮᕐᒥᓂᒃ ᐊᓪᓛᑦ ᐊᑭᓕᖅᑐᖅᑕᐅᙱᓪᓗᑎᒃ ᐊᐅᓪᓚᖅᓯᒪᓃᖕᒍᒻᒪᑕ, ᐊᑭᓕᖅᑕᐅᖅᑕᖕᒫᕈᑎᒃ ᐊᒻᒪᓗ ᐱᔭᐅᓂᖕᒪᑕ ᑕᐃᔭᐅᓂᖕᒪᑕ ᓄᐃᑕᐅᓂᖕᒪ ᓲᕐᓗ patient navigator ᑕᐃᔭᐅᓕᕐᓗᑎᒃ ᑕᐃᒫᒃ ᐊᑭᓕᖅᑐᖅᑕᐅᖕᒫᖅᑲᑦᑕᕈᑎᒃ ᐱᐅᓂᖅᓴᐅᒐᔭᖅᑐᖅ ᐃᑲᔪᖅᑐᓪᓚᕆᒻᒪᑕ ᐊᑐᕐᓂᖅᑲᓪᓚᕆᒃᓱᑎᓪᓗ ᐃᓱᒪᒃᑯᑦ ᐃᐸᓐᓂᐊᕐᓂᒃᑯᑦ ᑎᒥᒃᑯᓪᓗ ᐃᑲᔪᖅᑕᐅᒋᐊᓕᓐᓂᒃ ᐃᑲᔪᖅᓯᓪᓚᕆᒻᒪᑕ, ᑖᓐᓇ ᓄᐃᑕᐅᖅᑯᒐᔭᖅᑕᖃ ᑮᓇᐅᔾᔭᓴᖅᑑᓕᖅᑎᓪᓗᒍ ᐃᓂᐅᕗᖅ ᐱᓇᓱᒐᐅᓕᕐᓗᓂ.

[*Inuktitut text interpreted as follows:*]

The escorts who are interpreters and assistants and who aid the patient leave their full-time jobs, often without pay, to take time off to do this service. It is very important. They should be called a patient navigator and be under a payroll, because they are an essential service to the person they're assisting.

It is a very critical job that they do. They should be remunerated as such, because the job they do is very important.

● (1345)

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

ᖁᔭᓐᓇᒦᒃ ᑭᐅᑦᓯᐊᕙᑦ. ᐱᖃᑖᓂ ᐊᐱᖅᑯᑎᖃᖅᑲᐅᒍᒪᕗᖓ, ᖃᐅᔨᒪᕗᐃᓐᓇᐅᖅᑯᖃᑦᑕ ᓄᓇᖃᖅᑳᖅᓯᒪᕗᑎᒍᑦ ᐃᓐᓇᕐᓂᓪᓗ ᐃᓄᓐᓂᓪᓗ ᐃᑲᔪᖅᑎᑦᑎᐊᕙᖅᑲᖅᑐᐊᓘᒐᑦᑕ. ᑖᓐᓇ ᓄᓇᖃᖅᑳᖅᓯᒪᕗᓄᑦ ᐋᓐᓂᐊᖃᓐᓂᑦᑐᕆᓂᖅᒧᑦ ᓇᓪᓕᐅᒃᑯᒫᖅᑲᓐᓂᑦᑐᓄᑦ ᐃᑲᔫᓯᐊᖅ, ᐅᖃᐅᖅᔭᐅᓚᐅᖃᑦᑕ ᐊᑭᓕᖅᓯᖃᑦᑕᖃᓗᐊᖅᒪᑕᒎᖅ ᐊᒥᓲᙱᑦᑐᓂᒃ, ᑖᓐᓇ ᑐᓴᐅᒪᖅᑕᐅᒪᕙᓖᑦ ᑖᒃᑯᐊ ᐃᓅᓯᓕᕆᓃᑦ ᓲᕐᓗ mental health, ᓄᓇᖃᖅᑳᖅᓯᒪᕗᐃᑦ ᐊᒥᓲᓪᓗᑎᒃ ᐊᑭᓕᖅᑐᖅᑕᐅᙱᓴᓗᑎᒃ ᐃᑲᔪᖅᑎᐅᖃᑦᑕᖅᒪᑕ, ᑖᓐᓇ ᐅᖃᐅᓯᕆᖃᑦᑕᐅᕙᓐᓇᖅᐱᖅᑲᐃ ᖃᓄᖅ ᑖᓐᓇ ᐱᕚᓪᓕᖅᑎᑕᐅᕙᓐᓇᕐᒪᕙᓖᑦ ᖁᕝᕙᖅᑎᑕᐅᒃᑲᓐᓂᕈᓐᓇᒪᕙᓖᑦ?

[*Inuktitut text interpreted as follows:*]

Lastly, we all understand that we aboriginal people, we indigenous people, have very good traditional healers. You provide mental health services to first nations and Inuit. They use the counselling benefit under NIHB. What is the tracking system when it comes to mental health patients and outcomes?

They also need to have escorts when they travel. I believe they should be paid as well.

Ms. Maggie Putulik: [*Witness spoke in Inuktitut as follows:*]

ᑮᓇᐅᔭᖃᖅᑎᑕᐅᔭᕆᐊᓕᒃ ᑕᒪᓐᓇ, ᐅᕙᒍᑦ ᐃᓄᑐᐃᓐᓇᐅᔪᒍᑦᐃᑲᔪᖅᑎᖃᕿᑦᑕ ᐃᓱᒪᒥᒍᑦ ᐃᑉᐱᓐᓇᕐᓂᒃᑯᓪᓗ ᐃᓄᓕᕆᔨᐅᓲᓂᒃ ᑕᐃᓐᓇ Cambridge Bay (ᐃᖃᓗᑦᑑᑦᑎᐊᕐᒦᑦᑐᖅ) ᐃᔾᔭᕿᒃᓴᐅᒻᒪᑦ ᓯᐊᒻᒪᑎᑕᐅᓪᓗᓂᓗ ᓄᓇᓕᓕᒫᓄᑦ, ᐃᓄᐃᑦ ᐃᓕᓐᓂᐊᖅᑎᑕᐅᔭᕆᐊᓖᑦ ᐱᕆᖅᓴᖅᑎᑕᐅᔭᕆᐊᓖᑦ ᐃᓄᓕᕆᔨᐅᒃᓴᓂᕐᒥᒃ ᑮᓇᐅᔾᔭᓴᕐᓗᑎᒃ. ᑕᒪᓐᓇ ᑮᓇᐅᔭᖃᖅᑎᑕᐅᔪᒃᓴᐅᕐᑯᑎᕆᔭᕿ ᒐᕙᒪᑐᖃᒃᑯᓐᓄᑦ ᐱᒻᒪᕆᐅᑎᑕᐅᓗᓂ, ᐃᓱᒪᐅᑉ ᖃᓄᑦᑐᑎᖕᒋᑦ ᐅᓄᕐᑑᒻᒪᑕ ᐅᓄᕐᑑᒻᒪᑕ ᐃᓱᒪᒃᑯᑦ ᖃᓄᐃᑦᑐᑎᓖᑦ ᐊᒥᓱᒻᒪᑕ ᐃᒻᒥᓂᐅᕐᓂᒧᑦ ᐊᓪᓛᑦ ᑎᑭᐅᑎᕙᑦᓯᑎᒃ ᐃᓚᖕᒋᓪᓗ ᕿᒃᓴᑐᐃᑦ ᖃᓂᒪᒪᒥᒃ ᓲᕐᓗ ᑳᓱᖅᓱᑎᓪᓘᓐᓃᑦ ᐃᑲᔪᑕᐅᒋᐊᖃᕐᒪᑕ ᐊᒥᓱᐃᑦ, ᑕᒪᓐᓇ ᐱᒻᒪᕆᐅᒻᒪᑦ ᓄᐃᑕᐅᔭᕆᐊᖃᓪᓚᕆᒃᑐᖅ ᐅᖄᔭᐅᑐᐃᓐᓇᙱᓪᓗᓂ, ᓇᑯᕐᒦᒃ.

[*Inuktitut text interpreted as follows:*]

Yes. We ordinary people have support systems. We have people and counsellors whom we rely on for mental and spiritual health. We all need that in order to be whole and healthy. Traditional Inuit should be involved in traditional healing and medicines. It should be recognized as a very important service, because we practice it today. Many are in need of mental health supports. Many will suffer from terminal illnesses like cancer. They need someone to support them as well and to be there as a caregiver.

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

ᐄᓛᑦᑎᐊᖅ, ᐱᕕᖃᕈᒪ ᓱᓕ, ᑭᖑᓂᐊᒍᑦ ᑐᓂᓯᒐᔭᕈᓐᓇᖅᐲᑦ ᑎᑎᖅᓯᒪᔪᒥᒃ ᑖᓐᓇ ᐃᖃᓗᑦᑑᑦᑎᐊᒥᑦ ᐊᑐᖅᑕᐅᓲᖅ ᑐᓴᐅᒪᔭᐅᒃᑲᓐᓂᓛᕐᒪᑦ ᑭᖑᓂᐊᒍᑦ ᑎᑎᖅᑲᒃᑯᑦ ᖃᐃᑦᑎᔪᓐᓇᕐᒪᖔᕐᐱᑦ?

[*Inuktitut text interpreted as follows:*]

We acknowledge them, but we should also acknowledge them with pay.

The situation in Cambridge Bay that you briefly talked about, can you put that in writing and explain it to us?

Ms. Maggie Putulik: [*Witness spoke in Inuktitut as follows:*]

ᐊᐅᔭᐅᓯᒪᓕᖅᑎᓪᓗᒍ ᓯᑯᑦᓴᔭᒦᑎᓪᓗᒍ ᖃᐃᔪᓐᓇᑦᑎᐊᓛᖅᑕᕿ ᐅᓐᓂᑑᑎᒥᓗᒍ proposal–ᖑᑎᓪᓗᒍ ᐅᓐᓂᑑᑎᐅᑎᓪᓗᒍ, ᑕᐃᓐᓇ ᐃᔾᔭᕿᒃᓴᖅᑎᓪᓚᖓᐅᒻᒪᑦ ᓯᐊᒻᒪᕆᐊᖅᖅᓱᓂᓗ ᓄᓇᓕᒥᒫᓂ ᐱᐅᔪᓪᓚᖓᐅᔫᒻᒪᑦ ᐃᑲᔪᖅᓯᒪᓪᓗᓂᓗ ᓄᓇᖕᒐᓂ ᑖᕙᓂ, ᖁᔭᓐᓇᒦᒃ.

[*Inuktitut text interpreted as follows:*]

Yes, I will write the report to you and explain the situation of what happened. It's a very good case study of how we can be more community-based when it comes to healing and assisting our people.

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

ᖁᔭᓐᓇᒦᒃ. ᐱᕕᖃᖅᐳᖓ ᓱᓕ?

[*Inuktitut text interpreted as follows:*]

Thank you.

The Chair: Ms. Idlout, you still have a minute. Is it okay if we proceed to the next?

Ms. Lori Idlout: If I still have a minute, I'd like to ask Caroline Lidstone-Jones something.

[*Member spoke in Inuktitut as follows:*]

ᐊᐱᕆᔪᒪᕙᕆᑦ ᑖᓐᓇ ᓄᓇᖃᖅᑳᖅᓯᒪᔪᓂᑦ ᐃᑲᔪᖅᑎᐅᔪᑦ ᐃᓄᓕᕆᔩᑦ ᐅᖃᐅᓯᕆᔪᓐᓇᖅᑕᐅᒻᒪᖔᒍ ᐊᑭᓕᖅᑕᐅᔾᔫᒥᔭᐅᔭᕆᐊᖃᕐᒪᖔᑦ ᐊᒻᒪᓗ ᖃᓄᖅᑑᑎᓂᑦ ᐱᖁᔨᕚᖔᕈᑎᓂᑦ ᐱᖃᑦᔭᕐᒪᖔᖅᐱ?

[*Inuktitut text interpreted as follows:*]

Caroline Lidstone-Jones, indigenous leaders who are involved in working with youth are providing a very important role as role models and mentors. They ought to be paid as well. What do you think?

Ms. Caroline Lidstone-Jones: Absolutely. We actually pay them on a payroll. We view them as part of and in alignment with primary care. We hold them as valued as your doctors, nurses and NPs. That's where we hold ours.

Similar to.... I'm sorry, I'm missing the name of the previous speaker. We also fund our navigators. We call them “natural helpers”. Any time somebody goes out into a medical situation or as an escort, we will help give an actual honorarium to that individual per day, because they're there in a helper role. We also recognize the importance.

As you mentioned, the spirit is important. If we don't take care of that spirit, that is the way we do it as a community. That is part of our foundational teachings. A lot of us as Inuit people share that, so we recognize that. We're absolutely willing to share any policies and procedures we have about that with anybody who is interested.

● (1350)

The Chair: Thank you very much.

We're going to proceed to a quick second round, a shortened one, starting with Mr. Vidal.

Mr. Vidal, I can give you three minutes.

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

Dr. Tomkins, I was watching your expression as my colleague, Mr. Schmale, was talking to Ms. Lidstone-Jones about some of the frustrations around the bureaucracy and providers not engaging. You just heard the chairman limit my time, which is fair, but I want to give you a quick chance to respond to your experience in your profession, and if that's true there. Maybe you could quickly add to that what you think some of the solutions might be to that challenge.

Dr. Lynn Tomkins: Thank you very much. I'll be brief, because I'll defer to Dr. Poon as well, who's our technical adviser.

Definitely as a provider it can be extremely frustrating, because you have a patient in the chair, they need the treatment, but you have to get pre-authorization or predetermination. You know from previous experience that it's going to be approved, but unless you get it approved they're not going to cover it. You have a patient who's in pain and sometimes you have to send them away with a prescription for an opioid or an antibiotic—which contributes to a whole bunch of other problems—and then have them come back to actually have the problem addressed. Between those appointments they might end up in the emergency department at a hospital, where all they do is give them more opioids and antibiotics.

If I may, I'll ask Dr. Poon to comment on that as well.

It is one of our recommendations to reduce the administrative burden and the amount of pre-authorization for things that always come back approved anyway.

Dr. Philip Poon: Thanks again.

I'll try to make it brief. Maybe I'll just give an example of what might happen in my office. I've been practising dentistry for 42 years, most of the time in downtown Winnipeg, which has a high proportion of indigenous patients. Some of them are from up north, because of the geography of Manitoba.

I'll give an example of what happens probably at least once a week, maybe once a month. We have a patient from Garden Hill, Manitoba, which is a fly-in reserve with winter ice roads. He's lost his front teeth from an accident. They were extracted on the reserve by the visiting dentist. He has to wait for the ice roads to come in. He drives into Winnipeg and comes to my office. The NIHB program is supposed to be a comprehensive program that includes all treatments. He comes in requesting a partial denture. I can't proceed with that partial denture. I have to do a predetermination or pre-approval with the predetermination centre. Sometimes it's by fax. The approval process may take three to 10 days.

This is the catch. It's so strange. It's never denied. Rarely is it denied. The patient meets the requirements for a partial denture. We know the rules. We submit it. It's not denied, but we still have to wait. After three or four days of being in town he has to go back, because he's only in town for a medical appointment or as an escort. We couldn't proceed with that treatment. I don't have to explain to the people here the costs of medical transportation, either to the system or to the patient.

That's my one in-person example where this is a problem.

The Chair: Thank you very much.

We will go to Mr. Badawey.

Mr. Badawey, you have three minutes.

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

I guess my interest is with Ms. Lidstone-Jones with respect to some of the comments she made about community health centres and some of the initiatives you're already on.

Ms. Lidstone-Jones, what is your vision as it relates to indigenous communities in establishing community health centres, including the services we're discussing today, and other ancillary services that are accessible?

When I say ancillary services, I'm talking about endocrinology, cardiac, neuro and things that sometimes we don't see in indigenous communities and people have to travel for but that can be established within indigenous communities. Can you comment on that?

Ms. Caroline Lidstone-Jones: Yes. I'm thrilled if you're thinking in that direction, for sure.

We promote a model of holistic health and well-being. That is our model of care. We have a lot of integrated services already, so wherever we can integrate, we do. I know one of the previous speakers asked a question about housing and things like that. Where we can do supportive relationships that way, those are the things....

For example, it became loud and clear during COVID that one of the places [*Technical difficulty—Editor*] secure people to do housing. That then became an impact on health care and health care delivery.

Absolutely, we are fully integrated. Right now we have nurses and physicians. We have midwifery under us. We have mental health and addictions. We have traditional healing and wellness. We have some rapid-access medicine programs. We have programs where we can link up with hospitals and do testing on site. Those specialists will come to us, and we will bring the patients into that setting, a setting that they are comfortable in and used to.

We have, in some cases, some oral health dental programs, not as much as we would like, but wherever there is an opportunity for us to expand those services, we 100% feel that's the way to go because then it creates a hub where people don't have to individually navigate pieces of the system. The system then is supportive of them rather than them trying to navigate the system. That, to us, is about our primary responsibility as health care providers. Wherever we can do that, we 100% do that. We have many models in place where we continue to integrate.

Some of the things we're starting to integrate now are, for example, home [*Technical difficulty—Editor*] people in their homes and be able to do that. We have also started to add in programs where we do palliation in the home, so we can help families navigate, deal with pain and all of those kinds of things.

Wherever we can keep people in communities or as close to the community as possible, we help facilitate.

● (1355)

Mr. Vance Badawey: That's wonderful.

Mr. Chair, I know you're going to cut me off any time now, but I will just—

The Chair: Yes. I'm afraid I have to do that.

Mr. Vance Badawey: —ask this in closing.

Ms. Lidstone-Jones, if you can contact my office so we could talk more about this, I would truly appreciate it because it is, in fact, something I'm looking at doing.

Ms. Caroline Lidstone-Jones: I will, 100%. Absolutely.

The Chair: Thank you.

[*Translation*]

Ms. Gill, the floor is yours for a minute and a half.

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

I'd like to hear Ms. Putulik's and Ms. Lidstone-Jones' comments on the question of the availability of physicians and access to health care.

What might be the best solution for Inuit and Indigenous communities?

The Chair: Thank you.

[*English*]

Ms. Lidstone-Jones, do you want to start, and then we will go to Ms. Putulik?

Ms. Putulik, did you hear that? Perhaps you could start.

Ms. Maggie Putulik: It would be best to invest in infrastructure to repatriate certain specialities, for instance, nephrology. People on dialysis have to be relocated to the south on a permanent basis until they are eligible for a kidney donor. It's very sad to see, especially unilingual elders having to leave their natural environment, their home community, not being able to speak a second language, permanently being away, having an escort once in a while and not having permanent family members with them at all times.

It is essential and vitally important to invest in infrastructure with proper water filtration systems for dialysis treatment centres. Thank you.

The Chair: Thank you.

Ms. Idlout, you have 90 seconds for a question.

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

ᖁᔭᓐᓇᒦᒃ, ᒥᒋᓐᒧᑦ ᐊᐱᕆᒃᑲᓐᓂᕐᓂᐊᕋᒪ. ᑖᒃᑯᐊ ᒪᓕᒐᓕᐅᖅᑎᔪᐊᑎᒃᑲ ᑐᑭᓯᐊᓂᖅᑰᙱᓚᒪᑕ ᓲᕐᓗ ᐃᓄᓕᕆᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐱᑕᖃᑦᑎᐊᙱᓐᓂᖕᒋᓐᓂᑦ ᓄᓇᕗᒻᒥᐅᓄᑦ ᑐᑭᓯᐊᒥᐊᒃᑲᓐᓂᕈᓐᓇᐲᑦ ᖃᓄᐃᒻᒪᑦ ᑖᓐᓇ ᐱᖁᔨᕗᖕᒋᖅᑲᐅᙱᒻᒪᖕᒋᖅᐲᑦ ᑖᐸᓯᒪ ᒥᒃᓵᓄᑦ?

[*Inuktitut text interpreted as follows:*]

Thank you.

My question is for Maggie.

I don't think the other members of Parliament fully understand that vision care is not really available in Nunavut.

Can you explain its importance and what we're lacking in vision care?

Mme Maggie Putulik: [*Witness spoke in Inuktitut as follows:*]

ᑕᐃᒃᑯᐊ ᐃᔨᓕᕆᔩᑦ ᐃᔭᐅᑎᓕᕆᔩᓪᓗ ᐊᕐᕌᒍᑦ ᐃᓗᐊᓂ ᖃᑦᓯᕕᐊᐱᒃᓯᑎᒃ ᑭᓯᐊᓂ ᓄᓇᓕᓐᓄᑦ ᐊᕐᕕᑲᓲᖅ ᐊᒻᒪᓗ ᐃᑭᑦᑐᐊᐱᓐᓂᒃ ᐊᑯᓂᐅᙱᑦᑐᖅ ᓄᓇᓕᓐᓂ ᐃᓗᐊᓃᓐᓂᐊᖅᓯᑎᒃ, ᑕᐃᒃᑯᐊ ᐃᔨᓕᕆᔨᐅᔪᒪᓚᓗᐊᑦ ᐱᕕᑭᑦᑑᓗᐊᕐᒪᑦ ᐃᔨᓕᕆᔨᐅᔪᓐᓇᙱᑦᑐᑦ ᐊᒻᒪᓗ ᐊᒥᓲᑦ ᑲᓛᑦ ᓄᑕᖅᑲᐃᑦ ᑕᒃᐲᑦᑑᑦᓯᑎᒃ ᐃᓕᓐᓂᐊᓂᐊᒃᐸᒃᑐᑦ, ᑕᑉᐲᑦᑑᑯᒥᓂᖕᒪᓄᑦᑕᑯᔭᖅᑭᓐᓇᙱᓐᓇᓂ ᐊᓪᓚᑕᐅᔪᓂ ᐃᓕᑦᓯᓂᖕᒋᑦ ᑭᖕᒍᓯᖅᐳᑦ, ᑕᐃᒃᑯᐊ ᐃᔨᓕᕆᔩᑦ ᖃᖕᒪᓪᓚᕋᓚᐅᓕᖅᒪᑦ ᑭᓯᐊᓂ ᓄᓇᓕᓐᓄᑦ ᐊᕐᕕᑕᔩᖕᒍᒪᑕ ᑕᒪᓐᓇ ᐋᖅᑭᒋᐊᓇᐊᓕᒃ ᐊᒻᒪᓗ ᐃᔨᓕᕆᕖᑦ ᓄᐃᑕᐅᒋᐊᖅᑲᖅᓯᑎᒃ ᓄᓇᓕᒻᒥ, ᐊᕐᕕᑕᖅᑐᐃᑦ ᑭᓯᐊᓂ ᐱᒍᔨᖅᑲᑦᑕᕐᓂᐊᙱᒻᒪᑕ, ᑕᐃᓐᓇ ᐃᓪᓗᖅ ᐃᔨᓕᕆᔨᐅᕕᒃ ᓄᐃᑕᐅᓪᓚᕆᔭᐅᔭᕆᐊᖅᑲᖅᑐᖅ ᓄᓇᓕᒫᓂ, ᖁᔭᓐᓇᒦᒃ.

[*Inuktitut text interpreted as follows:*]

Special eye care comes to the communities maybe once or twice a year. They have very limited time in the community. Those who want to see the eye specialist do not all get seen. Children, especially, who have eye problems are attending school with poor vision. That affects their learning.

The eye specialists do not come to the communities often or regularly enough. There are many patients to be seen in each community regarding eye problems. We need an eye clinic in the communities.

Thank you. I hope that is a good response and one that you are looking for.

● (1400)

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

Thank you, sincerely, to all of our witnesses today.

Thanks to Dr. Lynn Tomkins on the issue of dental care and her colleague, Dr. Philip Poon.

Thank you very much, Caroline Lidstone-Jones.

Thank you, Maggie Putulik, for shedding light on some of the challenges with respect to non-insured health benefits.

Thank you for answering our questions today. You've made an important contribution to our study.

With that, colleagues, we'll suspend very briefly and prepare for the next panel.

● (1400)

_____________________(Pause)_____________________

● (1400)

The Chair: I'd like to welcome our witness as we begin this second panel.

[*Translation*]

We have Ken Kyikavichik, Grand Chief of the Gwich'in Tribal Council, Isabelle Wallace, community health nurse, Madawaska Maliseet First Nation, and Betty Villebrun, Vice-President, Northwest Territory Métis Nation.

● (1405)

[*English*]

Welcome to our panel today.

This is just a reminder that, on the bottom of your screen in the centre, there's a symbol that looks like a globe. That's your interpretation button. If you use that, you can get translation into the language you want to listen to. Don't hesitate to use that because sometimes people will speak in French, English or Inuktitut.

With that, the way we start is with each witness being asked to make an opening statement of five minutes. I'll try to hold you to that.

I'm not sure which one is not with us, but I do see Isabelle Wallace in front of me on the screen.

[*Translation*]

Ms. Wallace, the floor is yours for five minutes to make your presentation.

Ms. Isabelle Wallace (Community Health Nurse, Madawaska Maliseet First Nation): Thank you.

Qey, hello, *bonjour*.

N'toliwis [My name is] Isabelle Wallace and I am a community health nurse in the Madawaska Maliseet First Nation, which is where I come from and of which I am a member. I am a proud Wolastoqey nurse who has had the opportunity to practise in a number of First Nations, Métis and Inuit communities, including in New Brunswick on my traditional unceded land, and in northern Quebec, Ontario and Manitoba.

I have Indian status, and have had since I was born. I believe that my master's thesis on Indigenous cultural competence, my professional career, and my experience as a Wolastoqey woman equip me to make a considered judgment of the NIHB or Non-Insured Health Benefit Program. I am honoured to be able to share my opinion and suggestions in connection with this study. Thank you for inviting me to appear before the committee.

To put my testimony in its proper context, I'd like to tell you about the profile of my community. The Madawaska Maliseet First Nation is located in northwestern New Brunswick, on the Quebec border and the border with Maine, in the United States. We represent 196 members who live on the reserve land and 404 members who live off the reserve.

Ours is the only First Nations reserve where French is the majority language spoken and English is the minority. However, because of the violent assimilation measures imposed by successive governments over the years, no one in our community speaks Wolastoqiyik, our ancestral language.

In 2021, we won a victory in our land claim, after which we had a large part of the city of Edmundston recognized as being located on our "reserve" lands. So you can see that we are close to Edmundston and the members of our community have access to the regional hospital and various health professionals in the private sector.

As a community health nurse, my role is to provide care in various sectors of health care, including public health, community health, home care, and primary health care. Before the pandemic, we were already asking for a nurse to deal with a complex and flawed health care system. Now, we also have to do crisis management, plan numerous vaccination and testing clinics, educate the members of our community, and find innovative solutions to respond to health care needs.

The additional complexities generated by the NIHB program are therefore quite simply an unnecessary burden for a community health nurse. I am even prepared to say that the numerous flaws in the program fuel racism in our region.

A recent example was last week, when I contacted a private sector health care provider to facilitate communication between that professional and a client.

When we were discussing a member of my family, the person not being aware of that relationship and so that I am part of the community myself, the person said: "Personally, Indians, I don't deal with that."

After I asked for clarification so I could determine whether she was refusing to provide services only to First Nations, she told me that all clients had to pay in advance, but that, she said, she was going to have trouble getting paid by an "Indian".

I think my role, as a community health nurse, is to advocate for my clients and my family so they get access to equitable health care, while, at the same time, I also have to deal with racist remarks on a daily basis.

Because of a lack of training on the program, my role is to educate providers about navigating the system and to act as a facilitator.

Unfortunately, I have several other examples where I was able to feel and observe, concretely, the consequences of these failures and of the closed and unacceptable attitude on the part of health care providers, whether as a client or as a colleague.

I could say more about the laborious administrative duties that come with the program or the hours spent on following the appeal process. However, I think the essence of my testimony would get lost.

● (1410)

In my opinion, the lack of sensitivity and of rigorous, continuous training on the part of health care professionals in all sectors has extremely harmful consequences for the health of members of the First Nations and on Métis and Inuit.

Instead of looking after their welfare, the NIHB program contributes to widening the gulf between its clients and non-Indigenous people.

Woliwon. Thank you.

Thank you for giving me the opportunity to speak on this important subject and to represent the members of my community.

I will be happy to answer your questions.

The Chair: Thank you, Ms. Wallace.

[*English*]

I notice that Grand Chief Kyikavichik of the Gwich'in Tribal Council is with us.

Over to you, Grand Chief. You have five minutes for your opening remarks.

Grand Chief Ken Kyikavichik (Gwich'in Tribal Council): *Drin Gwiinzii*. Good afternoon, Mr. Chair and honourable committee members.

My name is Ken Kyikavichik, and I am the grand chief of the Gwich'in Tribal Council of the Northwest Territories. I was elected in September of 2020, and I am here speaking on behalf of the over 3,500 participants in our Gwich'in Comprehensive Land Claim Agreement, which we signed with Canada in April of 1992.

I would like to thank you for the opportunity to speak to the committee on today's topic. Today I will focus on how we, as the Gwich'in Tribal Council of the Northwest Territories, feel that the non-insured health benefits program, or NIHB for short, is failing not only our Gwich'in participants but the broader majority-indigenous population of the Northwest Territories.

The confusion and miscommunication between the NWT health care system and the NIHB leads to gaps and non-client-centred care. The issue of medical escorts is a major concern for residents of the north. Our people are often at least a full day's travel away from larger medical facilities and centres in Yellowknife and Edmonton. For specialist care, community health centres in our communities of Aklavik, Fort McPherson and Tsiigehtchic, along with our regional hospital in Inuvik, NWT, are not well equipped. As a result, our residents are required to travel to these southern locations for the care they require.

It is common for us to hear of residents who require a medical travel escort and do not receive one. This is especially concerning when we are dealing with the elderly. Some examples that we flagged in the summer of 2021 for NWT health minister Julie Green included procedures with sedation, back surgery, those in a wheelchair or walker, and those who have language and mobility issues.

When medical travel escorts are sought from the NWT Health and Social Services Authority, our people are often caught in the bureaucracy and are required to prove their conditions, otherwise this essential support is seemingly automatically denied. As one can imagine, this leaves our residents and families feeling very angry, frustrated, disappointed, stressed and ultimately hurt, as they are engulfed in the policies, procedures and red tape associated with these government benefits in the NWT.

Esteemed members of this committee, picture yourself being in what are supposed to be your golden years. Perhaps you are a residential school survivor. You are told that you require a medical procedure in the south, far away from home. You are then told that you are to be picked up by a van for transport to the nearest airport. You get to the airport often hours in advance because there are other trips to coordinate. You fly almost six hours into Edmonton through Yellowknife and then wait for the transport to your accommodations. By the time you lay your head on your pillow, as many as 16 hours may have elapsed.

You wake in the morning, and you're told where to be for pick-up for your appointment. In all of this, it is expected that you are able to speak English, but there are many in the NWT who do not speak English as a first language. You arrive at the hospital, and you wait once again for your appointment. Sometimes you may see people arrive after you and be seen before you. You wonder why, but you really don't know who to ask.

When you finally see a physician or specialist, you may be asked some uncomfortable questions about your personal life, things such as, “Do you drink?” or “Do you smoke?” You may have limited means while in the city. Many are at the complete mercy of the system, and some cannot afford things such as a good place to eat, taxis or a hotel should they get lost in the shuffle. At times, you may feel judged about your lifestyle, which is not common in southern Canada. Some of these individuals are over 80 years of age.

You see, honourable committee members, we revictimize some of our residents when there is no advocacy or support. Many NWT residents go without a medical travel escort, even when they require support. It is often those most vulnerable who are left without support and advocacy. That is the reason I am here speaking with you today, to highlight the serious issues in which that we find ourselves in the Northwest Territories.

The interpretation of “escort” and exceptions policies appear to be a flashpoint for both the Government of the NWT and the NIHB. We often hear from the GNWT that the medical travel system is not a compassionate system. That is very odd terminology to be using in a post truth and reconciliation world.

Ultimately, honourable committee members, that is what we are seeking—basic care and compassion by the Government of the NWT and for NIHB to respond appropriately to the diverse and unique medical situations of our people. We must establish a common standard for all residents of the NWT, Yukon and Nunavut.

● (1415)

I would like to share that, first, the provision of NIHB benefits is not working for residents of the NWT, which includes our Gwich'in participants. Second, we are also seeing and experiencing systemic denials of medical travel escorts for our people, especially those who are indigenous. Third, the medical travel system in the Northwest Territories appears to lack the compassion that is required for these very sensitive situations our residents face. Fourth, to this end, the Gwich'in Tribal Council would be pleased to share our experiences with the governments of Canada and the Northwest Territories so that we can develop a more comprehensive and coordinated NIHB system for all.

In closing, the Gwich'in Tribal Council would like to recommend that, first off, a review be undertaken that looks into how the Government of the NWT works with NIHB on the provision of medical transportation services. It is our understanding that the NWT Health and Social Services Authority administers the NIHB medical transportation on behalf of NIHB to offer a more seamless provision of services for patients from the Northwest Territories accessing care outside of their communities. We need to assess the timeliness of the program, from approval to denial, and an expedited appeal process to provide some clarity.

Second, if there are any opportunities to review the NIHB medical transportation provisions more closely, the Gwich'in Tribal Council would be open to exploring options on behalf of the government for medical transportation that includes or involves our Gwich'in participants. We recently applied for and were denied an NIHB navigator position. The reasons for this denial cited a population-based formula that dictated the creation of NIHB positions across the country. It is apparently one NIHB navigator for every 65,000 residents.

Based on the complexity of the many issues and examples that I stated today, clearly the reality for northern residents is fundamentally different from that in the south. A standard, nationwide, formulaic approach once again does not meet the needs of the residents of the north.

Hai'. Thank you for your time and the opportunity to present today.

The Chair: Thank you, Grand Chief.

We'll now go to our third witness, Betty Villebrun.

Ms. Villebrun, you have five minutes.

Can anybody else hear?

[*Translation*]

The Clerk of the Committee (Ms. Vanessa Davies): Mr. Chair, her microphone isn't plugged in.

[*English*]

The Chair: Ms. Villebrun, your microphone doesn't appear to be connected. Can you check that part? Your headset is connected into the computer. Can you disconnect it and then reconnect? Let's try that.

● (1420)

The Clerk: We'll have IT contact Ms. Villebrun. In the meantime, Mr. Chair, you can start the questions.

The Chair: Very good. We'll do that.

Hopefully, we'll get back to you, Ms. Villebrun, and be able to hear your testimony.

We'll start with the questions for the first round.

Mr. Vidal, you have the microphone for six minutes.

Mr. Gary Vidal: Thank you, Mr. Chair.

I want to thank our witnesses today for taking time to be with us.

Grand Chief, I'll start with you. It's good to see you again. We had a good conversation a few months back.

You answered a bunch of this in your testimony already, but I want to give you a little bit more of an opportunity to talk about the medical transportation issue. It's an issue that has come up in many of our meetings in the last few weeks of talking about this topic. It's obviously very different for you, where you come from, compared with my riding in northern Saskatchewan, which I know you're familiar with because you did some work in Saskatchewan some years back.

You have explained many of the challenges. I'm just wondering if you would take a minute and offer what you think some of the solutions would be to those travel challenges. You talked about initiating a review, but what specific things would work for your communities and be a significant improvement in that travel component of the medical transportation system of NIHB?

Grand Chief Ken Kyikavichik: Thank you for the question, MP Vidal.

I think that before we get into solutions I must also share about the two-tier system that we find ourselves with here in the NWT.

If you are a government employee, chances are, by a factor of four, that you are a non-indigenous person. Your medical travel benefits allow for a hotel of your choosing, rental vehicle or taxis, flexibility in travel and the treasury rate of approximately $135 per day for meals and incidentals. Many of the employees of the governments of NWT or Canada often use these medical travel excursions to extend and see family or go off to other destinations on personal travel. It is a true benefit.

If you are a resident of the Northwest Territories who is not a government employee, chances are you are indigenous as we compose the majority of the population. Some of these individuals are status Indians under the Indian Act. NIHB benefits apparently mandate that you either stay at the larga house in Edmonton or the Vital Abel home in the community called N'Dilo, which is adjacent to the city of Yellowknife. Your location depends on where your medical appointments or procedures may be located. If either of these facilities are at capacity, as they often are, you are required to stay at the Chateau Louis Hotel in Edmonton or the Slave Lake Inn hotel in Yellowknife, and I must say, you are mandated to those locations.

You're often told that you are to travel with as little notice as two to three hours prior to a flight and God forbid you need to modify your return. You are provided with a response from the administration at the NWT Health and Social Services Authority that this can only be done at your cost, which is often anywhere from $100 to $500. You are provided with transportation that, at times, can have individuals waiting in an airport for up to 90 minutes and a grand total of $18 per day for meals and incidentals. You then have to submit a travel expense for these costs. I might add, it's $18 a day and it may take as much as two months for a cheque or an EMT to arrive for you to be reimbursed for those expenditures.

I think that is the first thing that needs to be addressed, that two-tier system we have in the NWT.

I spoke about care and compassion, and we would welcome the opportunity at the Gwich'in Tribal Council to administer a medical travel program on behalf of NIHB, because we feel that nobody knows our people and the personal situations that many of them find themselves in better than our own people. A program administered by the council would be more understanding and provide a latitude for our managers to be able to make some of these decisions, because often what we find is that our government of the NWT staff who are enforcing the policy take a very narrow view of the policy, which results in denials that then get escalated. Appeals are denied and then they get escalated to elected officials such as the Minister of Health or people like me or other MLAs of the Northwest Territories. Then some of those decisions are finally rescinded, changed and overturned to allow for medical travel escorts, as I mentioned earlier.

Having that level of care, whichever way brings that level of care that I speak about that is so desperately needed in the system, however we did that, we certainly would see a dramatic improvement in the delivery of these services.

● (1425)

Mr. Gary Vidal: Thank you. I have a minute left. I want to ask one other quick question.

Ms. Wallace, my question is going to be for you.

We were having a conversation with somebody this morning—and I'm going to try to get this out quick—about the challenge of retention of nurses in northern and remote communities, which I'm sure you all experience. I just want to give you an opportunity to speak to that really quickly, as I think we see people moving towards more urban centres, and the challenge that creates in some of the northern and remote communities like the ones that you and I come from.

I'm going to give you some time to quickly speak to that, the challenge and maybe some ideas of solutions.

Ms. Isabelle Wallace: Thank you for your question. It's also a great question to close our nursing week.

I have experience in working in northern and remote communities. The last one I was in was in northern Ontario during the wildfires last summer. One of the many reasons why I had to leave was working conditions. We ended up being two nurses working 24-7, being on call and really just rotating between the two of us for a week. Our rotations were for a month at a time. While we were down south, we needed to self-isolate for two weeks at a time because of the pandemic before going back.

My community was facing a shortage too. We only have one nurse for our whole community, and she was on medical leave. They approached me and asked me to cover being the only RN for my community. I gladly accepted, but that's just one of the examples of why we have such a shortage of nurses. We're kind of sent everywhere, and by having the training in primary care, we're a rare commodity as well. My training with Indigenous Services Canada was a great asset for my community too.

The working conditions are terrible. They were terrible before the pandemic, but things have gotten worse. I see lots of nurses going through the onboarding program through Indigenous Services Canada. They last two to six months and then leave. I heard that one year in northern Ontario half of their onboarded staff left within the first year of their employment. That's a lot of costs.

I feel that if we just would invest more funding in the working conditions and the work satisfaction for nurses, we would avoid having some of those breaks in services. We've seen some communities without nurses sometimes, and that is tragic for me. I don't see how that is still happening in 2022.

The Chair: Thank you very much.

We'll now go to Mr. McLeod for six minutes.

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

Mr. Chair, I was hoping that I'd be able to ask Betty Villebrun some questions. I'm not sure if we're going to reconnect with her.

The Chair: If you want to do half now, hopefully, we can get to her. You can take that chance, or do all six minutes with the other two witnesses.

Mr. Michael McLeod: I'll start with Grand Chief Kyikavichik.

Ken, thank you for presenting here today. I think you brought us a lot of information, a lot of real-life scenarios and many things that I've also experienced and heard about.

We heard from the federal minister, who talked about the areas that they want to focus on, but there's one area that concerns me, and I want you to let us know if this is an area that you've had to deal with. It's regarding escorts. More specifically, it's about people who are medevaced out. They're usually in critical condition and on a stretcher. They're taken from the health centre and sent south. They don't have an escort. They're there for emergency purposes.

When things turn around, when they're better or it's time for them to go home, because they never came with an escort, they can't have an escort to leave. The hospital brings them to the door and says, “Okay, sir,” or “Okay, madam, it's time for you to go.” A lot of times they're not dressed properly or they don't speak the English language well enough. There are a couple of horror stories that I've encountered over the last while.

Can you talk about that as an area that maybe we need to start really focusing on to make sure that escorts are provided? For me as an MP, the biggest issue on medical travel is the issue of escorts.

● (1430)

Grand Chief Ken Kyikavichik: *Marsi*, MP McLeod. Thank you for the question.

I'd like to share with you, as I often do, a specific example. In October of 2020, we had a 75-year-old elder who truly lived a subsistence lifestyle in our territory. He found himself very ill at his remote camp in the Mackenzie Delta region. His family requested a medevac via helicopter, as this was during the fall freeze and the only means of transportation.

The local community health centre in Fort McPherson is operated by the NWT Health and Social Services Authority, and was the main point of contact for the family. The RCMP had also been engaged to assist. The family was advised that an extraction via helicopter may cost $20,000 to $30,000, for which they would be responsible. Recognizing the personal emergency and the apparent lack of affordable options, the family reached out to the Gwich'in Tribal Council for assistance. As we are a shareholder in a helicopter business in Inuvik called Gwich'in Helicopters, we dispatched a helicopter to extract the individual.

He then received the initial assessment of his condition at Inuvik Regional Hospital. He had a lung infection, an inflamed liver and a heart condition. X-rays that were taken revealed two masses that required further assessment. Two days later, he was taken by medevac to Yellowknife, and then eventually to Edmonton to receive further care.

All told, the helicopter extraction cost us a grand total of $2,215. However, it took an intervention by us as an indigenous government to make this happen. The charge was eventually reimbursed by the NWT Health and Social Services Authority two months later. To add insult to injury, when seeking travel to meet the patient as an escort, his sister was denied medical travel from Inuvik to assist and advocate for her brother. As a result, the family was required to pay for a one-way ticket from Inuvik to Edmonton at a cost of approximately $700, plus accommodations.

After the bureaucratic process of submitting multiple letters from an approved physician to the NWT Health and Social Services Authority, all of which were denied, a separate request was made directly to the NIHB program, by a social worker the family was in contact with, which then approved the hotels and meals five days after the helicopter dispatch.

Sadly, the patient in care passed away about a week later from cancer. NIHB required that the patient's sister return home on the following Saturday, two days after the elder's death. Arrangements with the funeral home to respect the patient's wishes for cremation were required. However, due to COVID-19, the funeral home was limited in its ability to respond quickly.

The family wanted their loved one cremated with his remains transported back to Inuvik, followed by a two-hour drive on the Dempster Highway to Fort McPherson. Once again, the GTC was required to intervene, cover the costs of accommodation and allow time for the family's wishes to be respected. Repeated requests to the NWT Health and Social Services Authority were denied due to a lack of disclosure of a reason for the patient's condition in the many letters that were submitted. The physician was limited in what they could include in the letter due to health information disclosure requirements. Thus, the request was caught in the conundrum of a catch-22 situation.

I see this as a prime example of why medevac situations, where you do have a patient that is suffering from a severe condition, should be automatically provided with a medical travel escort that would follow soon after, as many of these individuals are unable to actually travel in the medevac with the patient themselves.

● (1435)

The Chair: Thank you very much.

I understand that Betty is with us now. Although I can't see her, I understand that she is with us.

Ms. Villebrun, you have five minutes to make your presentation.

Ms. Villebrun, we can't see you at the moment, but you are unmuted. Can you perhaps turn on your camera?

There we go. Would you like to start talking and see if we can hear you?

No, we're not hearing you, unfortunately. I'm very sorry. We'll have to see if we can at least get your written brief. We'll have to carry on with the panel today.

[*Translation*]

Ms. Gill, you have six minutes to question the witnesses who are now with us.

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

Ms. Wallace, I would first like to congratulate you: you are the first Indigenous woman to hold a nursing position in the Madawaska Maliseet First Nation. I would also like to convey my recognition of the work you did in northern Quebec and northern Ontario during the COVID-19 pandemic. I have to say that I am biased, since my mother is a nurse herself. I know what things are like in that profession.

You mentioned nurses' working conditions. Of course, health care falls under both federal jurisdiction and the jurisdiction of the governments of Quebec and the provinces.

Generally speaking, do you think increasing funding by the federal government, that is, health transfers, might be a good thing when it comes to nurses' working conditions, particularly in the communities, and indirectly, when it comes to health care for Indigenous people and for the Métis and Inuit?

Ms. Isabelle Wallace: Thank you for the question.

Thank you for conveying your recognition. The members of my community are also very proud of that. They are really proactive when it comes to education. They supported me throughout my studies, from my bachelor's degree to my master's. I am really happy to finally be home, to give back to the community what I have received from it.

Regarding working conditions, it would certainly be a good thing to increase funding. Personally, being the only nurse working at the health centre, I find myself doing everything. That means I am working at 150 miles an hour. In a day, I may get 40 calls, and I also do home visits, since the doctor only comes to the health centre once a week. In the meantime, people are constantly coming in to consult me. I also handle vaccination, and I raise awareness in social networks. I take on so much work that I can't tell you everything I do in a day.

I often stop and say to myself, if I could just have help from a nursing assistant, from support staff, who would go to homes to be kind of my eyes and hands, I could be informed about problems that could be avoided before it was too late. That's when I experience mental distress as a nurse.

My colleagues are aware of the fact that I can't go on like this in the long term. During the pandemic, we realized that the workload was much heavier than before. I'm the only one who knows the system, and as the nurse, I have the responsibility of preparing announcements or looking for funding, for example. I have to argue my case to my chief and my councillors to get support, but I don't have enough time in a week to do it all. So the situation is very difficult.

If we had more money, it would enable me to get more help, to improve the working conditions, and increase job satisfaction as a result. I could devote more time to the young members of my community. For example, there is a young woman who comes to the clinic to help me. She is studying health sciences, because she wants to become a doctor. She would be the first doctor in the community. So I could mentor her. That's the goal I have adopted as a community health nurse.

● (1440)

Mrs. Marilène Gill: In fact, Ms. Wallace, the federal government needs to provide more health transfers. Certainly, additional funding would enable you to acquire more resources.

In a way, you are a model in your community. You are the first Indigenous woman to hold this position, and you certainly want to get other people involved, like the young woman you mentioned. If she sees that you are always tired or worn down by the weight of all the work you have to do, it may seem to her like a very difficult job. I am thinking about retaining staff, and especially about you. The community wants to bring in health care professionals like you, but that must not be done at the expense of their health.

Am I wrong about that?

Ms. Isabelle Wallace: That is absolutely it.

Even at my age—I'm still young—I have experienced burnout in the past because of my work in the north, for a number of reasons. There was the pandemic, forest fires, the shortage of nurses in the north. There are also the interaction with managers, emergency management, pharmacy management, and x-rays. A nurse does a lot of work in the north. I'm even trying to understand how I managed to function in that situation. We run on adrenaline, but burnout is very real among my colleagues.

Mrs. Marilène Gill: Working conditions are also difficult. You did well to mention that. You work in the community, but you also sometimes have to travel to remote regions, where I have in fact visited. All of that has to be taken into account.

From what I understand, it is harder to be a nurse in an Indigenous community, because you have to do more. You are kind of a specialist in pretty much all areas, even though you are a generalist professional.

Do you think this might endanger everyone's health, in other words, not just your own health, but patients' health as well?

Ms. Isabelle Wallace: Every week, we worked 24 hours a day, seven days a week. Imagine the situation. When I went to bed at night, I was careful to put the phone nearby, because, since I was on call, I couldn't refuse to take a single call. The phone rang all night. The next morning, I had to be at the clinic to do my job from 9:00 a.m. to 5:00 p.m. That was where I vaccinated children and provided various kinds of care, in addition to emergencies. I was so exhausted. I didn't have time to eat or stick to any daily routine, which would have been beneficial for my mental health.

One time, I was asked whether I had vaccinated the right person. I was so afraid that I felt my stomach turn. My colleague said, "Isabelle, you're good," but that was when I realized that it could become very dangerous. I worked on incident management at the national office in Ottawa. We reviewed cases where mistakes had been made. At that time, I didn't understand how that could happen, and that's one of the reasons why I went to work in Ottawa.

We have to remember that we hold people's health in our hands. We have to exercise critical judgment in making decisions. Fatigue is a factor that weakens our judgment. I have also seen assessments done by colleagues who had been on call all night. After reviewing the assessments, I realized, the next day, that there were critical factors in connection with a medical evacuation by air, or MEDEVAC, and that a request for a physician on board had to have been made. That might have fallen through the cracks.

The Chair: Thank you, Ms. Gill.

Since you recognize that this is the week when we recognize our nurses, you mentioned your mother.

I'd like to take the opportunity to say that my mother was a nurse and I married a nurse. So bravo to our country's nurses.

[*English*]

With that, I'll go to Ms. Idlout.

Ms. Idlout, you have six minutes.

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

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[*Inuktitut text interpreted as follows:*]

First, I'd like to thank you for your wonderful presentation. It was very informative. It gives a better picture of what's going on in the field. We know that the situations you talked about affect everyone in the communities. We have all encountered similar problems.

My question is this. When it comes to mental health counsellors and healers, how are you keeping track of aboriginal and indigenous healers? What is the current approach to tracking mental health outcomes for first nations and Inuit who use the counselling benefit under the NIHB program? How are those results being reported to the indigenous communities and the government?

If you could all respond to this, I would appreciate it. Thank you.

● (1445)

The Chair: If you are ready to respond, Grand Chief, go ahead, please.

Grand Chief Ken Kyikavichik: Thank you, Mr. Chair and other members of the committee, and thank you to MP Idlout for her question.

At the current time, there isn't a very formalized process for the tracking or the listing of our healers and mental health counsellors with our organization. We do have what are known as “resolution" health support workers in each of our communities who are providing part-time support. Especially when we're encountering tragedies or deaths in the community, they provide immediate support. On an ongoing basis, they provide that localized community support.

What we are finding the most effective, however, is on-the-land programming. To that end, the Gwich'in Tribal Council is investing significantly, in partnership with the Government of Canada, in retrofitting a wellness facility about 15 kilometres south of the town of Inuvik on the east branch of the Mackenzie River. It's so that we can offer mental health and wellness programming in our communities. They're not treatment centres, per se, but maybe detoxification. We may be able to offer aftercare services in addition to other services locally that allow our people to reconnect with the land, which we find is incredibly powerful to restoring their mental health.

In terms of how it is reported, I don't have that data directly in front of me. However, I can say that we do have the workers and the staff within our health and wellness department who are able to provide that vital service at the community level.

[*Translation*]

The Chair: Ms. Wallace, do you want to answer that question?

[*English*]

Ms. Isabelle Wallace: Unfortunately, we don't have a tracking system for mental health services. We do have three social workers. We sometimes will send people to neighbour communities, such as Tobique First Nation, for land-based healing. Unfortunately, we don't have that in our community.

We have the detox centre, but oftentimes people in our region are reluctant to even go there for that type of service due to the fear of stigma. We all know each other. Even having their car seen at the social worker's office is something they avoid. There is a big gap in mental health services in our region.

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

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[*Inuktitut text interpreted as follows:*]

Thank you.

Would you have a resolution or a recommendation as to how we can improve the recognition of traditional mental health workers who are community-based? Do you have any recommendations on how we can bring that up to par with other counsellors?

The Chair: Do you want to start, Grand Chief?

Grand Chief Ken Kyikavichik: Sure, Mr. Chair.

My recommendation would be to look at it in a manner that is well removed from western science, if you want to call it that. We are finding that the traditional approach to mental health counselling has been to provide a counsellor from outside of a community into the community. We are firm believers that our counsellors exist and that they interact on a less formal basis, on a day-to-day basis. What we are finding most effective is providing people who will listen to our people and not judge them for their particular situations.

In terms of improving the recognition of mental health workers at the community level, it's removing all of the credentials, if you will, all of the very high levels of post-secondary education. It's recognizing and placing value on the social awareness and the knowledge of our culture, our language and our protocols, and understanding how people are provided with that counselling in the Gwich'in way, as we would say, which is a lot of listening and not much talking.

● (1450)

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

We are running up against the clock, but we can have a quick second round like we did the first time, if committee members are willing.

We could start with Mr. Schmale for three minutes.

Mr. Jamie Schmale: Thank you, Chair.

Thank you, witnesses, for this great testimony.

I'll continue with you, Ms. Wallace. We were talking about mental health just a little while ago. In previous testimony in this meeting and in prior meetings, we heard about the bureaucracy being a barrier to care, especially on the preventative side, in terms of bureaucratic red tape and issues with communication and reimbursement, etc. I know that you talked about it earlier on in your testimony and in questioning, but maybe you could expand on that in terms of the mental health side of it.

Are you noticing, or have you experienced, mental health situations where, especially on the preventative side, extreme delays in getting access to treatment then led to an even worse case, where individuals, perhaps for a whole variety of reasons, were being taken to a hospital emergency room—or worse?

Ms. Isabelle Wallace: Thank you for the question.

Yes, in many instances where we probably would have cases of overdoses, we knew that they would have been preventable, but we didn't have the connectivity or even the staff to run the programs to connect them virtually with a mental health professional, even if it was a psychiatrist or, if we remove all credentials, if we wanted to provide land-based healing or traditional healing. I've seen many overdoses.

It's very frustrating because we know that these would have been preventable. As nurses, we don't have the time to even sit down with our patients and have a conversation. That would often happen when they are on their hospital bed and the action has already happened. Then we would try to be briefly with them.

It happened that over the weekends I had instances where I couldn't connect with a social worker or a professional, and I was told by a doctor who was sitting in his apartment in Toronto, “We won't be dealing with a mental health crisis on a Friday night. This has to wait until Monday morning.” That was unacceptable.

I tried to advocate for the patient, but I had to send her back to her home. She was at a high risk of committing suicide, and that's very heartbreaking. We worked very hard over the weekend to make sure that she was safe and that as nurses we were too, but that's what we were told. The doctor is often the one who will decide who will be sent down south, if they can justify it. That's one example.

The Chair: Thank you, Mr. Schmale.

We'll go to Ms. Atwin for three minutes.

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

Thanks so much to our witnesses today for joining us and for your testimony.

With my short time, I'd love to ask Ms. Wallace some questions.

[*Translation*]

Thank you for being with us today, Ms. Wallace. It's always a pleasure to cross paths with you.

[*English*]

You talked a bit about overt instances of racism and the systemic racism that's part of the system. I'm wondering as well about whether there are significant language barriers to accessing services through the NIHB and if you could speak to that.

Ms. Isabelle Wallace: Absolutely.

[*Translation*]

It's a majority francophone community. In fact, it's the only one. The other communities in New Brunswick have access to funds and services, but those services are very often offered in English only.

We are often told that our community is in a remote corner of the province. Because we are isolated, I have to turn to Quebec to find resources and materials. For services, we rely only on the Edmundston Regional Hospital and the Vitalité Health Network.

Regarding the NIHB program, when my colleagues and the other health professionals try to contact the call centre staff, the person who takes the call often can't speak French or, when they can, they don't have the answers to their questions. They simply weren't given the information. So there are delays, and that causes a lot of frustration.

I know that professionals were unable to enrol in the program because they were unable to communicate with someone who speaks French. I find that unacceptable. The program exists and staff want to collaborate. However, there is a language barrier. So that aspect has to be looked at more closely. As well, the call centre employees automatically think we're coming from Quebec, when the Quebec health care system is different from New Brunswick's. There is a lot of confusion and a lot of time gets wasted.

● (1455)

Mrs. Jenica Atwin: Thank you.

Do I have any speaking time left, Mr. Chair?

The Chair: You have less than a minute left.

[*English*]

Mrs. Jenica Atwin: Would there perhaps be additional barriers for women and members of the 2SLGBTQ+ community as well?

Ms. Isabelle Wallace: Absolutely. My brother is transgender—two-spirit—and we ran out of options for them. Essentially, what I had to tell them was, “Move to Montreal and seek private services, because I don't have the answers for you.” Our community doctor couldn't provide the care, and it just came to that point where they moved to Montreal, unfortunately.

The Chair: Thank you very much.

We'll go to Madame Gill.

[*Translation*]

Ms. Gill, the floor is yours for about a minute and a half.

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

I will ask Ms. Wallace one last question relating to the language issue. I know it came up during the last meetings, particularly in connection with Indigenous languages. The issue was that there were problems, particularly for seniors, in accessing services in their language.

Ms. Wallace, you referred to French and the fact that the community seems to have lost its language, Wolastoqey. I'm not certain.

What can we do to help you and for people to be able to get care in their language?

Ms. Isabelle Wallace: I have thought about it this week, and I have tried to find solutions. We talked about the possibility of getting funding to have an Indigenous navigator to help us with NIHBs, but our population doesn't meet the criteria required. Our community having help from a francophone would be important. We are working to revitalize the Wolastoqey language in our community, but we are a long way from seeing it come back to life there. In the nation, there are still people who speak that language, but it is very threatened.

On the other hand, I'd like to have the help of a francophone Indigenous navigator to support people in New Brunswick, which is a bilingual province. We aren't the only francophone First Nation; there are others in other communities. Being able to get this in ours would be important.

The Chair: Thank you very much.

[*English*]

Ms. Idlout, you have time for a quick question. You have about 90 seconds.

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

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[*Inuktitut text interpreted as follows:*]

Thank you.

Very quickly, the Truth and Reconciliation Commission produced recommendations on health, recommendations 18 to 24. Have you worked with and implemented those truth and reconciliation recommendations in your work?

[*English*]

Are they being implemented? Do you feel that the federal government is doing an adequate job in implementing the calls to action?

The Chair: Madam Idlout, did you direct that at a particular witness?

Ms. Lori Idlout: I'm sorry. That was to both.

The Chair: We have time for one. Is there a preferred witness?

● (1500)

Ms. Lori Idlout: Yes, the grand chief, please.

The Chair: Go ahead, Grand Chief.

Grand Chief Ken Kyikavichik: Thank you for that.

I guess we live this every day. It all speaks to how our people are being treated in the system.

In full disclosure, we are minority owners of a company called Larga Ltd., which provides boarding-home services for medical travel for visitors from the NWT and Nunavut in Edmonton, Alberta. We've been providing this for over 30 years. The genesis of Larga Edmonton was that we were seeing residents returning to our communities sicker than when they'd left. Oftentimes these individuals were being medevaced. It was determined that the major reason was the diet that was imposed upon our medical travellers.

The early owners of Larga decided to propose to the Government of the NWT that they purchase a home staffed with northerners who relocated to the Edmonton area and arranged at times for the provision of traditional foods, such as fish and caribou, for the residents. From the recognition of this gap in the service that was created as a result, Larga Ltd. has been a tremendous success story, offering residents of the north a home away from home while also having the ability to interact with others who are on medical travel themselves.

Larga has now expanded into other jurisdictions, which I am sure you are aware of, such as Winnipeg and eastern Canada. It is culturally considerate care for those who need to be in southern Canada for short periods of time, and truly a model that was well ahead of its time in a pre-TRC world.

The Chair: Thank you very much. That brings us to the end of the panel.

I would like to thank Isabelle Wallace for her testimony. I would like to thank Grand Chief Kyikavichik for his testimony today and for answering all of our questions. I want to thank Betty Villebrun for being with us.

I'm sorry that we could not hear your testimony. I'll be speaking to the committee to see if there's a way we can hear it. We have one small window left. We would like to have heard you and to have asked you a couple of questions. We'll get back to you on that.

Thank you very much to all of our witnesses today.

For committee members, before we wrap up, there are three very quick things I wanted to do.

One is to remind you that you should have received the draft of the housing study today, and we'll be discussing that one week from today on May 20. That's the second study we did—the housing study.

This is addressed to the Conservatives. The second thing is that there was an email from my colleague David asking whether you would be ready to hear our first batch of witnesses on emergency preparedness, the next study after this one, and to focus on those in the firefighting area, because at the moment those who are focused on floods are pretty busy these days, so we would hear from them in the fall.

Mr. Schmale, are you all right with that?

Mr. Jamie Schmale: I believe so. I don't recall seeing that email, but I will have another look for it.

The Chair: Okay. The NDP, the Bloc and the Liberals are okay with it.

We're going to have witnesses, but we will focus on firefighting. They probably will be busy later on this year, unfortunately, but at the moment, it might be the best group to hear from.

Finally, we do have another session on non-insured health benefits next Tuesday. At the moment, we have one hour reserved for three more witnesses, followed by an hour to discuss drafting instructions for the non-insured health benefits study.

One possibility that might allow us to hear from Ms. Villebrun is if we had four witnesses and went for an hour and 20 minutes and then reserved the last 40 minutes for drafting instructions. Is that something that would be acceptable to the committee members?

I see some heads nodding.

An hon. member: We're good with it all, Marc.

The Chair: Betty, if you're still listening to us, we're going to get you back next Tuesday. Hopefully, you will be available and we'll hear your testimony.

With that, I wish everybody a happy weekend. This meeting is adjourned.

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