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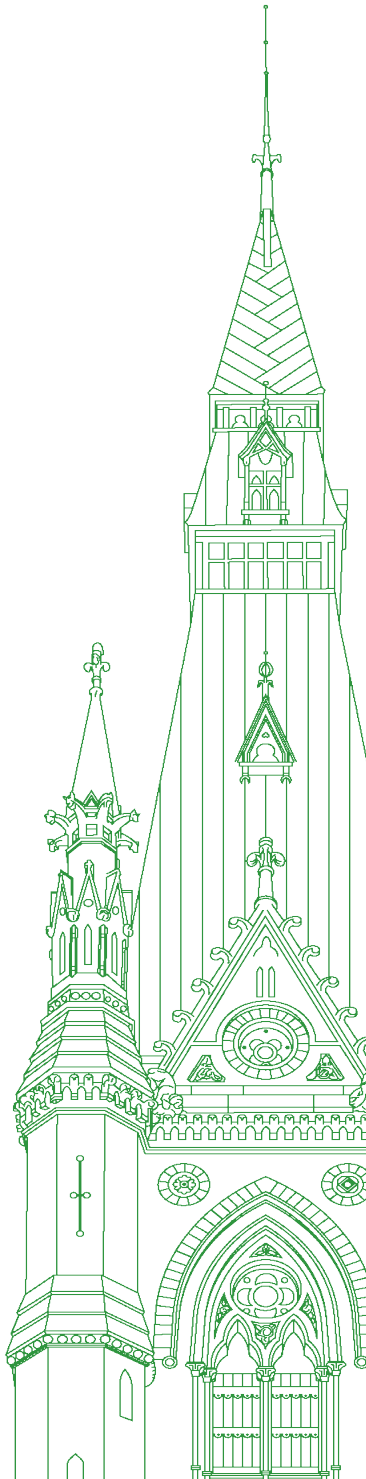

Chair: The Honourable Marc Garneau

Standing Committee on Indigenous and Northern Affairs

Tuesday, May 31, 2022

● (1630)

[*Translation*]

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

I call this meeting to order.

We are unfortunately starting a bit late, but we will try to stick to our agenda.

Welcome to meeting 22 of the Standing Committee on Indigenous and Northern Affairs.

[*English*]

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

Today, we will spend the first hour hearing from our last witnesses on the NIHB study and spend about 30 minutes on drafting instructions for that report. We'll also consider the second version of our draft housing report, which was circulated last week.

Last, but not least, we'll consider the travel budget for our Arctic sovereignty, security and emergency preparedness study for the fall. If we're all in agreement, we'll instruct the clerk to submit that to the liaison committee.

[*Translation*]

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

[*English*]

On today's panel, we are hearing from Lee Allison Clark, manager of policy and research at the Native Women's Association of Canada, who is with us in person. Joy Idlout is here as an individual, as is Grand Chief Jerry Daniels of the Southern Chiefs' Organization.

[*Translation*]

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

The interpretation button is found at the bottom of your screen for English, French or Inuktitut. If interpretation is lost, please let us know and we'll pause to try to fix the problem. The "raise hand" feature at the bottom of the screen can be used at any time if you wish to speak or alert the chair.

Before speaking, please wait until I recognize you by name. If you are on the video conference, please click on the microphone icon to unmute yourself. For those in the room, your microphone will be controlled as normal by the proceedings and verification officer.

When speaking, please speak slowly and clearly. When you are not speaking, your mike should be on mute. I would remind you that all comments should be addressed through the chair.

The way we do this is that each of the witnesses will be invited to speak for five minutes. I would ask you to respect those five minutes, after which we will have a question period.

Thank you to the witnesses who are appearing today. We will now proceed. I will begin by asking Ms. Clark to start.

Ms. Clark, you have five minutes.

Ms. Lee Allison Clark (Manager, Policy and Research, Native Women's Association of Canada): Good afternoon, honourable members.

Thank you for the invitation to come here today on behalf of the Native Women's Association of Canada, to speak about the administration of and accessibility by indigenous peoples to the non-insured health benefits program.

I want to acknowledge that the land that I and others here today are on is the traditional and unceded territory of the Algonquin Anishinabe people.

As you all likely know, NWAC is a national indigenous organization representing indigenous women, girls, two-spirit, transgender and gender-diverse people in Canada. As we all know, accessibility, availability and acceptability of health services indirectly and directly impact indigenous people's health and health outcomes.

Although the NIHB program provides critical financial support for accessing services, more must be done to ensure that indigenous women, girls, two-spirit, transgender and gender-diverse people have access to essential health care services that are acceptable, culturally and gender sensitive, and trauma-informed.

The NIHB program represents a lifeline for indigenous people. Indigenous women utilize the NIHB at higher rates than indigenous men. Previous amendments to the Indian Act have meant that a greater number of individuals can claim or restore their status. Bill C-3, the Gender Equity in Indian Registration Act, and Bill S-3 aimed to eliminate known sex-based inequities in registration. Because of this, many people became entitled to register under the Indian Act.

Understanding that the population with access to NIHB has grown significantly in the past years, with a vast amount of the growth occurring in small and remote communities, NWAC really welcomes discussions on ways to better this. Today I will highlight several scenarios that underscore where the NIHB falls short, and I will welcome discussion throughout the hour to provide tangible solutions to these shortcomings. The examples I will present in the next few minutes represent just the tip of the iceberg.

In nearly every sharing circle, focus group or engagement session focusing on health care experiences that NWAC has held with indigenous women, girls, two-spirit and gender-diverse people, difficulty in accessing services, availability of services, quality of services and experiences of discrimination, racism and sexism are raised. Whether due to straightforward racism or discrimination embedded in institutions, health care services are often inaccessible to the folks who need them the most.

As with many other countries worldwide, women typically have higher prescription rates than men have. This is also true in Canada and remains true for indigenous women when compared with their male indigenous counterparts and the Canadian population overall. Therefore, the NIHB remains critical for indigenous women to survive, and is a gendered issue.

However, the NIHB drug coverage plan, as continually highlighted by the Canadian Pharmacists Association and others, provides less drug coverage than the average Canadian receives. When we consider that indigenous women, girls, two-spirit, transgender and gender-diverse people encounter one of the highest disproportionate burdens of health disparities in Canada, which stems from various determinants of health, this can be catastrophic.

Access to birthing services close to home is something Canadians expect. This is not the case for indigenous pregnant people. A recent study published in the Canadian Medical Association Journal found that indigenous pregnant people in Canada experience striking inequities in access to birth close to home when compared with non-indigenous folks.

Although the NIHB covers many of the expenses associated with travel for pregnancy, it is limited to one pregnant person and the addition of another person, as of 2017. However, often this other person is a doula or a midwife, not a family member or friend. Children are left behind. This is problematic.

Birthing on or near traditional territories in the presence of family and community is a long-standing practice of foundational, cultural and social importance that contributes to overall maternal and infant well-being among indigenous people. It gives them a good start. Most Canadians have the luxury of giving birth near their home, with their partner in the room or perhaps with their family in the waiting room. NIHB simply does not allow for this, creating a standard for indigenous birthing people that is less than that for the Canadian population.

Layers of racism and sexism continue when you consider dental care for indigenous women, girls, two-spirit, transgender and gender-diverse people. Wearing dentures, receiving off-reserve dental care, asking to pay for dental services, perceiving the need for preventive care, flossing more than once a day, having fewer than 21 natural teeth, fear of going to the dentist, never having received orthodontic treatment and perceived impact of oral conditions on quality of life all have been correlated with experiencing a racist event at the dentist's office. Simple tasks that many Canadians take for granted, such as getting their teeth cleaned, become a potentially traumatic event for indigenous folks. This doesn't even begin to tackle the layers of issues that are rife within finding and accessing the dentist.

Before contact with European settlers, first nations and Inuit healers bore the responsibility of health for their people and relied upon a rich body of knowledge of traditional medicines and sociocultural practices. The administration of the NIHB program must integrate this and be culturally and gender sensitive, as well as gender-informed, if we are ever to fully walk the path of reconciliation.

However, respecting the Ottawa Charter for Health Promotion, which was developed in 1986—so many years ago—and as outlined by PHAC, “reductions in health inequities require reductions in material and social inequities.”

● (1635)

When considering the NIHB, this means increasing coverage of easy access to and increasing the availability of preventive allopathic and traditional medicine.

In sum, we cannot risk any more indigenous women, girls, two-spirit, transgender and gender-diverse people falling through the cracks when looking to access the care they have a right to. NWAC wants to be part of the solution of how best to increase accessibility and better the administration of the NIHB program.

I look forward to presenting some more detailed recommendations throughout the hour.

Thank you. *Meegwetch*.

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

We'll now go to Ms. Idlout. You have the floor for five minutes.

Ms. Joy Idlout (Officer, Compensation and Benefits, As an Individual): I believe it would be better for people who are escorts to start getting paid, as going out of town for something medical is really stressful. Having to leave your children at home with someone and then being in a different city, having to remember appointments, taking them to their appointments and preparing for surgery or anything that's required takes a lot out of you, especially when you're escorting an elder.

I'm sorry. I didn't have much time to prepare for what I'd say.

The Chair: If you wish, Ms. Idlout, we can leave it to when questions are asked. Perhaps you can answer at that point, unless you want to speak. If you have some other things to say, you still have three minutes.

Ms. Joy Idlout: I'd prefer questions.

The Chair: Very good. We'll get back to you with the questions.

We'll now turn to Grand Chief Jerry Daniels. You have the floor for five minutes.

Grand Chief Jerry Daniels (Southern Chiefs' Organization Inc.): Thank you.

[*Witness spoke in indigenous language*]

I would like to begin by acknowledging that I'm joining you from Winnipeg on Treaty 1 territory, also the unceded lands of the Dakota.

I want to take a moment to acknowledge our elders, who are the keepers of our knowledge and culture and who faced significant barriers when attempting to access non-insured health benefits.

I want to thank the standing committee for the invitation to appear today.

Right now, there is a documented 11-year gap in life expectancy between first nations people and all others living in Manitoba, and that gap is growing.

I want to remind the standing committee that Canada has a responsibility to provide equitable health services to first nations citizens. According to article 24.2 of the United Nations Declaration on the Rights of Indigenous Peoples, indigenous peoples “have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view [of] achieving progressively the full realization of [that] right.”

First nations also have inherent aboriginal and treaty rights under section 35 of the Constitution Act of 1982, including the right to health and self-determination over health systems. Treaties have affirmed first nations jurisdiction over our health systems and established a Crown obligation to provide medicines and protection.

Due to the existing crisis in health care for first nations, the Southern Chiefs' Organization is actively leading a health care transformation process following the signing of an MOU with Canada in June 2020. Our community engagement process has included input on non-insured health benefit programs and services. The NIHB program has been identified as one of the most significant concerns in its aspects, as it impacts every first nations citizen, from our children and youth through to our elders, both on and off reserves.

The current NIHB services are some of the biggest barriers to positive health outcomes of first nations citizens. The administration of the program and the inconsistent application of the program policy result in citizens receiving substandard services or being denied care outright.

I cannot state strongly enough that our citizens told us that no component of the NIHB program meets their needs. For instance, 61% of southern first nations citizens have a drive time of between one and three hours to get from their nation to the nearest hospital pharmacy. The biggest barrier in getting to the hospital pharmacy is the denial of services by NIHB for medical transportation.

Let's stop and think for a moment about having to seek permission every time you need to get to the hospital or a pharmacy. Even when transportation is approved, NIHB medical transportation rates, including mileage and meals, sit well below the rates provided in other areas and by other programs like Veterans Affairs, for example. The current NIHB medical transportation private vehicle mileage reimbursement rate in Manitoba is 21.5 cents per kilometre. Veterans Affairs is almost double the rate, at 49.5 cents per kilometre.

The current NIHB meal allowance rate for our citizens is set at $48 per day, where Veterans Affairs is $93.50. When travelling to larger urban areas for medical appointments that are not available on reserves, the commercial accommodation rates are not high enough to ensure the safety and comfort of our citizens. Accommodations in Manitoba are at a maximum of $120 per night, whereas with Veterans Affairs it's $157 to $169.

For essential life-saving treatment like dialysis, many are forced to relocate to large urban centres like Winnipeg, because there is no treatment available closer to home, yet no medical transportation is available to our citizens who live in urban centres, even if those citizens are elders.

We could talk about other program inadequacies and fundamental inequities with dental, vision, mental health, prescriptions and other medical supplies, and here are a few examples.

Our citizens face long wait times in backlogged services from the NIHB vision department. Providers, even those on the approved list, are charging additional fees, but these monies cannot be reimbursed as they are above the approved rates. Providers should be required to make clients aware of this, as clients assume that if they are on the approved list, they shouldn't be directly billed, so they're taking on those additional costs.

In order for us to secure long-term, positive outcomes for our citizens and nations, these inadequate NIHB programs and services must be dismantled. I understand that the federal government acknowledges the gaps and the devastating results, but despite identifying this as a problem since at least 2016, there have been almost no improvements in seven years.

In conclusion, these are just some of the reasons that the Southern Chiefs' Organization is building a new first nations health system that will provide better service and close the health gap between Anishinabe and Dakota peoples and the rest of Canada.

● (1640)

I thank you for your time and interest today and look forward to any questions.

The Chair: Thank you, Grand Chief.

We'll now proceed with questions—these are six-minute periods—and we'll begin with Mr. Shields.

Mr. Martin Shields (Bow River, CPC): Thank you, Mr. Chair, and thank you to the witnesses for being here today.

It's good to see you, Grand Chief Daniels. You got through a lot of things in a hurry.

I recently visited with a person on Siksika. In telling stories of health care, she told the story of an elder being in a hospital situation in which language was a barrier. With simple things that they would do in a health centre, they labelled the elder as difficult until someone was able to go to the hospital and translate the language and they could understand the difference in cultural practices.

Can you relate, in the sense of the challenges for elders in the health system?

● (1645)

Grand Chief Jerry Daniels: We have communities that are 100% Anishinaabemowin, and they speak the Ojibwa language. Absolutely, they face those challenges. It's a daily occurrence.

We have to be able to address that in a way that is appropriate. I think training is certainly a huge part of that, but you have to prepare. Many of our citizens who are transporting to these hospitals are aware that they will be there within a certain time and have time to prepare. I know there's a lot of stress right now in the health system, but that is not an excuse for not being able to properly prepare for the admission of our citizens into these health facilities.

Mr. Martin Shields: In your opinion, is it the attending who goes with them that...? As I understand the health system, if I don't have a navigator and I'm the patient, even in my situation I have some challenges.

Are you suggesting that it would be the people travelling with them who could act as their navigator in the health system? Is that the solution?

Grand Chief Jerry Daniels: Well, I think you have to take a combination of that. That can be a solution in a general sense, but in urgent situations I think the medical facility should already be prepared for those scenarios. We already have an idea of the current fluctuations in terms of health needs within these facilities, based on some of the history. That could give us a better idea of how to prepare our facilities for the admission of citizens.

Mr. Martin Shields: Are you talking about an increase in indigenous staffing, then, within the medical facilities?

Grand Chief Jerry Daniels: I would talk about independent indigenous staffing from these facilities. We've already engaged in this with Jordan's principle, for example, with the children's health centre here in Winnipeg.

Mr. Martin Shields: Have you found positive results as you've moved forward on that?

Grand Chief Jerry Daniels: I think that is going to create some unique cultural interaction within the facility, which would create a better outcome. The task of our citizens within these institutions would simply be to ensure that our citizens are adequately dealt with and adequately understood, in the event that they have to be there.

Mr. Martin Shields: As you move forward in this sense, you're looking—and I've heard you speak with the committee very strongly before, in the sense of grassroots decision-making—to understand where the money is, and yet you're not able to control the outcomes from the spending. Would you suggest that is still the case with this?

Grand Chief Jerry Daniels: Absolutely. I think we are quite prepared to engage and show the added value and impact that grassroots control, first nations control, over health can have on the health system.

Mr. Martin Shields: That would also include an expansion of the use of traditional indigenous health and medicine, I would guess.

Grand Chief Jerry Daniels: Absolutely. I would think upstream thinking in health prevention is absolutely essential to changing that 11-year health expectancy gap—that rate of life expectancy.

Mr. Martin Shields: Are you losing that information from your elders? How critical is the time frame, as time is going on, to get that information from your elders?

Grand Chief Jerry Daniels: It's absolutely critical. The knowledge that is being passed down is less and less available to us. Our traditional healers, for example, have less and less ability to transfer that knowledge. We're in a state of crisis in many of our communities. It is quite difficult to create the environment for that education, which has been restricted from the education system itself. There have been barriers to the transition of that knowledge in all aspects of our society.

Mr. Martin Shields: That then ends up in denial and inconsistencies in the treatment, because you're lacking that gap, and you're lacking in knowledge.

● (1650)

Grand Chief Jerry Daniels: There's also a loss of the enrichment of that knowledge in creating a better health system, not only for indigenous people but for all.

Mr. Martin Shields: Right.

Thank you.

The Chair: Thank you, Mr. Shields.

We're now going to Mrs. Atwin.

Just before we do that, Chief, apparently the interpreters had a bit of trouble hearing you. Could you check that your selected mike is the microphone for your headset? Just check that while we're waiting.

I'll turn it over to Mrs. Atwin, for six minutes.

Mrs. Jenica Atwin (Fredericton, Lib.): Thank you, Mr. Chair, and thank you to our witnesses for joining us today.

Most of my questions will be for Ms. Clark from the Native Women's Association of Canada.

I'm a firm believer that NWAC has institutional knowledge, traditional knowledge, and the lived experience needed in order to bring women's voices into this conversation more and more.

In a general sense, you're here today to testify, but are there other ways that NWAC is engaged on improvements around policy regarding the NIHB program?

Ms. Lee Allison Clark: Not on NIHB specifically, although I feel like we definitely have the capacity to be doing that. As you were saying, we have really great knowledge embedded within the association. We have really great leaders, and we're always grounded in culturally relevant gender-based analysis. Everything is always trauma-informed, so that would be something we would welcome; however, currently, we are not.

Mrs. Jenica Atwin: Thank you.

You highlighted something that's really important to me as regards birthing services. You highlighted an example of that with respect to not being able to have an escort, or additional family members outside of the escort, which I couldn't imagine from a woman's perspective. Are there other specific barriers for women, in particular?

Also, perhaps for gender-diverse individuals, are there difficulties in accessing gender-affirming care, trans care? Is there expertise that's lacking in the NIHB system?

I'd love to hear more about that as well.

Ms. Lee Allison Clark: Unfortunately, it is rife with layers of issues. Being someone who would be two-spirit, transgender, gender-diverse, or part of the 2SLGBTQQIA+ community is already difficult. If you then layer on being indigenous, that's only going to become more difficult. The indigenous experience in health care has traditionally been extremely difficult. Combining that with something that's already difficult, as well, would make it, unimaginably, almost impossible.

The idea of being two-spirit is something that is very foreign to most health care providers. They often associate that with being gay, bisexual, or something, and it's just a totally different thing. It's sacred; it's spiritual, and an understanding of that would probably increase the ability to seek gender-affirming care. However, especially if you're in a rural or remote community, it's going to be almost impossible to do that.

In regard to your first comment about having access to birthing services, yeah, it's a decision between bringing your midwife, your doula, or your child, and which child do you choose if you have several? Do you bring your partner, or does your partner look after them? Hopefully, there are elders in the community. There are just layers of having to decide who to have with you.

Mr. Shields was speaking about having a navigator with you. Having a navigator is great, but so is having family, and having just one person is not enough when.... I'm sure many folks here have been around people who have given birth. You're allowed to go to the hospital. It's easy. You drive over, you go, and you get to see the baby. It's incredible.

That doesn't happen for the majority of indigenous people who give birth and have family members. They have to wait until they fly home. Flying is already traumatic for some folks, but never mind with a newborn, so the layers and layers of barriers just continually keep coming up.

Mrs. Jenica Atwin: I looked at NWAC's website just recently to brush up on some of the services, and I really like the section on knowing your rights and informing people about what that looks like, particularly accessing services. I'm just wondering about the other ways you communicate with indigenous people across the country.

Ms. Lee Allison Clark: Obviously, I'm really glad you've seen that. We have several websites that tell you what your rights are and what you're entitled to. Often, when folks go looking for services specifically related to NIHB, it's completely overwhelming. Typically, they'll tell you to reach out to your local organization or association. Those are the people who are able to navigate it, because it's so complex. When you're already facing lots of other issues at home, or layers of discrimination, it becomes impossible to try to figure out without someone to walk you through it.

In terms of what else we're doing at NWAC, again, we have a really great team, as you pointed out earlier. It's not my team, but I have great co-workers who are working on how to know your rights, especially those related to youth and gender equality. We have an initiative right now with.... What does gender equality look like? That is ultimately a health issue. I can't speak to what my colleagues do.

● (1655)

Mrs. Jenica Atwin: Thanks.

In my remaining time, I'd love to focus on mental health, and access to mental health care in particular. I also noticed that you were part of creating a “heal the healers” workshop, as well. That's another critical piece: ensuring that those giving help are also looking after their well-being.

Could you speak to mental health initiatives in particular?

Ms. Lee Allison Clark: I'm really glad you've seen “heal the healers”. That's something I'm quite proud of, to be honest. My team is incredible. We engaged with our elders, knowledge-keepers and traditional healers around the country and were able to develop a program that we delivered through our resiliency lodge model, which seeks to heal the people who are helping to heal others.

If you're having an issue, you might seek out the help of an elder, but who's helping that elder? Typically, it's not a lot of people. We created a two-hour virtual program and an in-person day program that scoots around NIHB, because you have predeterminations for most services. It takes forever to access them and there aren't maximum times for waiting. It allows healing to take place within the culture they are from instead of in an institution, which can be very scary.

We also did a training for community support workers, so they would know how to best deliver health care services to indigenous women and girls and two-spirit, transgender and gender-diverse folks.

The Chair: Thank you.

[*Translation*]

Ms. Bérubé, go ahead first six minutes.

Ms. Sylvie Bérubé (Abitibi—Baie-James—Nunavik—Eeyou, BQ): Thank you, Mr. Chair.

I want to thank the witnesses for joining us today. I also thank the interpreters for the work they are doing in committee.

My question will be for the three witnesses.

In this study, as in previous studies this committee has carried out, including the one on housing, which we just completed, it has been mentioned several times that health is ubiquitous in a number of areas of life of first nations and Inuit. I also think that a healthy population essentially corresponds to healthy community living.

Could you talk to us about the connections between health and various indigenous and community areas of life?

The Chair: Can you tell us to whom you are putting the question?

Ms. Sylvie Bérubé: My question is for the three witnesses.

The Chair: Okay.

[*English*]

We'll start with Chief Jerry Daniels, then we'll go to Ms. Idlout and Ms. Clark to answer that question.

Grand Chief Jerry Daniels: It's quite simple, actually. If you're not healthy, you can't help people. You have to have a great deal of the mental capacity to provide direction and knowledge, and to transfer that knowledge on how to live healthy and to participate in activities in the community that are healthy. Those are all important in enabling people as individuals to help and mentor their families. The families that are very healthy in the community can support and are usually the foundation. The person or people provide a great deal of that secondary support outside of primary families to aunts and uncles who are suffering from health issues. We see it a lot with diabetes. The cancer rate is very high. It's a loss for us.

For example, my mother is in the hospital right now. She's in and out because she has liver disease. It really weighs not only on me, but on my brothers and my family. We're always thinking of her. She's still very young. She's not even 60 yet.

The livelihood and the inability for the health system to provide alternatives or that extra support for her to deal with the health issues...those are transferred as well. Diabetes is very much preventable in our communities, but we continue to see skyrocketing rates that lead to amputations and kidney failure. There's maybe not enough education around that. For her and others who are going through this, if they're able to overcome and manage, that's important for us, the younger population, to understand.

I think it's not something that should be isolated to the health system. It's something that needs to be part of the education system overall.

● (1700)

The Chair: Ms. Idlout, would you like to answer that question?

Ms. Joy Idlout: I lost connection for a bit, so I did not hear the question.

[*Translation*]

Ms. Sylvie Bérubé: Could you talk to us about the connections between health and various indigenous and community areas of life?

[*English*]

The Chair: Did you hear that translated into English, Ms. Idlout?

Ms. Joy Idlout: No. I just turned it on.

The Chair: Okay.

What role does people's health play in the lives of indigenous communities? How important is it?

Ms. Joy Idlout: It really takes a toll on the whole family when someone is sick, because there are no hospitals in most northern communities, so most people have to fly out. We end up having to look for someone to be with that person out of town, which leaves families and kids behind. Being away for months at a time would be hard for everyone.

The Chair: Thank you.

Ms. Clark, would you like to answer the question too?

Ms. Lee Allison Clark: Absolutely. I think it's impossible to speak about health without recognizing everything that goes into health. Health isn't just being healthy. It's having access to safe housing. It's having access to a safe environment. It's access to water. It's so many different things.

In relation to community, when a community doesn't have those things, how can its health possibly thrive? As Ms. Idlout was alluding to, when someone has to leave, that makes a big dent in the community. I was speaking before about how you have to leave your children at home sometimes when you're just having a baby. It's something that is pretty normal, but it disrupts not only your life, but the entire community's life.

I would also like to highlight that health typically isn't as individualized for indigenous folks. It's the community, and you thrive off of your community and what is going on in your community. When one person is ill, the community rallies around. It's not just that he, she or they have diabetes. The whole community comes around.

I would say health is absolutely critical to creating a well-woven community.

[*Translation*]

The Chair: Thank you, Ms. Bérubé.

[*English*]

We'll now go to Ms. McPherson.

Ms. McPherson, you have six minutes.

Ms. Heather McPherson (Edmonton Strathcona, NDP): Thank you very much, Mr. Chair. Thank you for allowing me to participate in this committee meeting today.

Thank you to the witnesses for their testimony. It's been very illuminating.

Ms. Idlout, I'd like to ask you some questions. I'd like to get a bit of a sense of what it is like to be an escort for patients and to provide that support. Could you take a moment to tell us a bit about how difficult it is to be an escort for a patient?

Ms. Joy Idlout: I can. It's really hard having to leave to be an escort, especially when you have kids and you have to leave them behind. You're bringing the patient to the appointments. If they need surgery, for example, you're preparing them for that. It requires a lot of time. It gets really hard. Most times I wonder why people who are receiving surgery can't have two escorts.

● (1705)

Ms. Heather McPherson: Yes. Thank you.

I'm a mother, and we've heard testimony today about the impacts that would have. I can only imagine how difficult it would be, not just for the patient to leave their children behind but also for the escort to have to leave their children behind, sometimes for a very long period of time.

In addition to an escort's having to leave their family, can you talk about the experience of having to leave a job behind? Is that something that happens on a regular basis, or that has happened?

Ms. Joy Idlout: Yes. It has happened to me quite a few times. I work full time. Most times I need to escort my grandmother when she's going to hospital. When I escort her, since she is not my dependant and is not eligible to be my dependant, I have to go on leave without pay.

Ms. Heather McPherson: You have to do that every single time. The income impact on escorts is very challenging, then.

Ms. Joy Idlout: Yes. I'm the only one in the house with a job, so that takes a huge toll on our income.

Ms. Heather McPherson: Are there examples of individuals who are ever able to earn an income when they are an escort for patients?

Ms. Joy Idlout: No.

Ms. Heather McPherson: Okay. Thank you.

Could you tell me roughly how many days or weeks or months you were away from home when you were an escort for your grandmother or for other family members?

Ms. Joy Idlout: The longest was three weeks.

Ms. Heather McPherson: It was three weeks at one time.

Ms. Joy Idlout: Yes. Most times, it's two days to a week.

Ms. Heather McPherson: For those three weeks, as the solely employed person in your household, you had to take time away from your job, without pay, to support your grandmother.

Ms. Joy Idlout: Yes.

Ms. Heather McPherson: Can you tell us, if you're comfortable doing so, about the mental strain or about some of the additional difficulties of being an escort, in addition to the financial burden? Can you perhaps talk a little about the mental strain on you, on members of your household and on members of your community?

Ms. Joy Idlout: It gets to a point where I wonder how I will be able to feed my children. How will I pay the bills on time? Who's going to look after them while I'm away? It's really hard, mentally, to be away and to have to worry about them. Who's going to feed them? Who's going to take care of them? Who's going to put food on the table?

Ms. Heather McPherson: I'm sorry you have to deal with that. We've heard in other testimony that every person has a right to the health care they require. It should not come at the expense of their community, their family, their children or their own well-being. I'm very sorry you have to endure that.

Finally, can you perhaps talk a bit about what it would mean to you and to other members of your community if escorts could be paid for the work they do, escorting their loved ones to treatment outside of the community?

Ms. Joy Idlout: If escorts were paid, it would be less stressful wondering how we're going to get transportation. Most of the time, if there are no drivers, we have to pay for our transportation. If we were getting paid, we wouldn't worry so much about having food on the table, and being on leave without pay wouldn't be so scary.

Ms. Heather McPherson: Thank you for your testimony. It's very important. Thank you for taking the time to share your story with us.

Mr. Chair, I will cede the remainder of my time.

The Chair: Thank you, Ms. McPherson.

We'll now begin a second round. We'll get through at least four.

Mr. Vidal, you have five minutes.

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

I want to thank all the witnesses here today, as well, for their testimony and for sharing—with honest concern—some of the things they face.

Grand Chief Daniels, I want to talk with you about your navigator position for a couple of minutes.

I was looking at your organization's website and the work the navigator does. Back on May 3, we had Dr. James Makokis here. He's a Plains Cree family physician, and he shared how, to get many services covered through the NIHB, there has to be a fair amount of advocacy on his part, on behalf of patients. My expectation is that your community members have faced similar situations. You talked about the inconsistent application of policies. If I'm making the right connections, that's where your navigator position comes in.

My questions for you are as follows. Would you share some of the challenges that are faced? Is it the bureaucracy or the process? How has your navigator position been used to address some of that?

● (1710)

Grand Chief Jerry Daniels: Obviously, the navigator has done a lot of advocacy and navigation, within the NIHB, trying to find solutions to some of the problems our citizens are facing. It's been a tremendous help, I think, in connecting the dots and providing support for many of our citizens. It is one position in a system of hundreds of thousands, in many instances. It is a Monday-to-Friday, nine-to-five position for one person.

The impact can be measured in relative terms. I don't have the day-to-day numbers in front of me, because I haven't been specifically briefed on that in terms of impact or client inflow. I can say that it is a relatively small part of all the existing problems outside of that, in terms of how the NIHB approves, doesn't approve, communicates and connects with communities and the services in communities on reserve. In addition, I don't think there is as much of a presence off reserve, except that they would provide, I think, some of the expenses or approvals of costs associated with health.

Mr. Gary Vidal: I was going to go down that road a bit further, but in the amount of time I have left, I'm going to switch topics and go to something else you referred to, because there's a link to things in my riding.

You talked about the issue with medical taxis and some of the associated costs. We've seen some really significant numbers in the context of fuel prices and inflation. What I'm hearing in my riding is that some of these medical taxi businesses are actually going to cease to operate. That's going to create a huge issue in my northern Saskatchewan riding.

I'm curious if you've heard those kinds of concerns among the first nations you serve, as well. Is there some risk of that becoming a real issue?

Grand Chief Jerry Daniels: Absolutely. What's going on is huge in terms of what the additional costs are. Food security is a huge problem that's going on and a concern.

Even our nurses have been restricted from the north, except in emergencies only, as a result of the high need for nurses in the urban areas. It reflects how first nations communities are not the priority here. It's really focused on the urban areas in terms of how health is managed in the region. It's for those reasons that we need independence from these provincial systems in some ways. We have to take care of ourselves.

We travelled internationally to create a value-added model in partnership with Cuba at one time. We're looking to provide health care service experts for our communities. We also had the ability to train our citizens within the health system over there.

That could have created some solutions to the problems that we experienced with COVID, although we weren't given that ability. We weren't given that opportunity. We were shipping people out of Manitoba, because the system wasn't able to take on the crisis.

Now we're seeing another example of this here in Manitoba, where our nurses are being taken away. In a case like that, where we're not being prioritized, it's quite simple that the system is not putting first nations in the place where we need to be. There's already an 11-year life expectancy gap. It's terrible for our elders, who need to be passing on that knowledge.

We need to create our own system. It needs to be independent. We need to have our health experts looking out for us. Until there's trust built.... I don't know. It's decades and decades of a culture that has not been built to serve the needs and interests of indigenous people.

● (1715)

The Chair: Thank you, Mr. Vidal.

We'll now go to Mr. Battiste for five minutes.

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

I'm always glad to hear from you, Grand Chief Daniels.

As we go through this study, one of the things that keeps popping into my mind is that a lot of the challenges that are being faced are the result of someone besides first nations deciding for first nations how they should manage their health system, what to approve and what not to approve. It's not based on that community's needs or cultural values, but rather what a bureaucrat has decided should be appropriate for our communities.

With the successes I've seen around nations taking on their own jurisdiction, whether it be in education or health, is that part of the solution, Grand Chief, that we need to look at? It's giving nations the ability to take over jurisdiction of their own health with bilateral agreements between the federal government and those nations.

We've seen really good examples of how that's happened, including MK out in Nova Scotia. I wonder if you could speak to that a bit.

Grand Chief Jerry Daniels: I think that's the only solution at this point. The reason is that the life expectancy gap is not changing right now. It's not changing in its trajectory. It's actually getting worse. We need to be innovative in utilizing the very limited health resources that are already allocated and trying to add value to that. That's why we've tried to look internationally. That's why it's important for us to build internal capacity for ourselves and not be tied to a system that is going to look after its own and not necessarily look after us. It's not a system that has put first nations' interests at the top of the list.

We're at the margins of every socio-economic indicator that you can point to in this society. That reflects, from anybody who has independence in their political observations of health.... I think it's important to understand that. It's not going to simply change or tweak because we add a few first nations people in there.

We need to be at the nucleus of the decision-making and have control over that so we can hire the best minds and most seasoned veterans in health. They can take an approach that respects the jurisdiction and first nations patients, and does everything it can to maximize the very limited resources. We understand that's a very limited amount. We need to be able to deal with these things in a way that is going to maximize that impact. That's what we want to do.

Mr. Jaime Battiste: Can I ask if you know of any examples of where this is working, where nations have taken over jurisdiction of health? I'm not aware of any. I thought I'd ask you.

Grand Chief Jerry Daniels: You'd have to go outside of Canada. Let's look at Alaska, where they're running the whole system over there with the school. I think that has been the best example for us. We went there. We saw it. We saw a patient-focused model that's about the patient. It's fulsome. It's not simply a doctor. It's all aspects of one's health, right from the day a person is born all the way until their death. It's the same health team or unit that monitors and provides that health service.

We are looking at those sorts of models to try to maximize and create a health system here in Manitoba.

Mr. Jaime Battiste: Thank you, Grand Chief.

I have a question for you, Ms. Clark. You said at the end of your report that you had some detailed recommendations. I'm wondering if you could speak to the missing and murdered indigenous women and girls calls for justice or the TRC calls to action. What recommendations would you make for us as a committee to move forward on? Perhaps you could name a few. We have only about a minute, so perhaps you could give me the most pressing ones.

Ms. Lee Allison Clark: Is this on the NIHB?

Mr. Jaime Battiste: Yes.

Ms. Lee Allison Clark: Do you mean specifically related to MMIWG?

Mr. Jaime Battiste: If any come to mind, yes. I don't want to put you on the spot. I know that there are 231 calls for justice and 90-some calls to action. I'm wondering if you can give us, from the NWAC's perspective, the pressing recommendations that you think we should move forward on as a committee.

● (1720)

Ms. Lee Allison Clark: I don't think I can fruitfully answer that question in a minute.

Mr. Jaime Battiste: You have some time, and you can put it in writing at a future date. I know it's a lot to ask, but as we try to get a really good study moving forward, we want to have good recommendations moving forward to our government.

Ms. Lee Allison Clark: Absolutely.

Mr. Jaime Battiste: If you could provide those and give it some thought, I think that would be tremendously helpful from the NWAC.

As well, make sure to tell President Whitman I said hi.

Ms. Lee Allison Clark: Absolutely. I will.

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

[*Translation*]

Ms. Bérubé, you have the floor for two and a half minutes.

Ms. Sylvie Bérubé: Thank you, Mr. Chair.

We know very well that the common threads in a number of studies on communities and indigenous affairs are remoteness and isolation.

For communities living in remote regions, as is the case in the north and in my riding, the professional pool patients have access to is considerably reduced.

My question is for the three witnesses.

Do you have any recommendations on access to medical transportation?

What can we do to cut red tape?

The Chair: Thank you, Ms. Bérubé.

[*English*]

We'll start with Ms. Clark, then go to Grand Chief Daniels, and then to Ms. Idlout.

Please be fairly succinct. We have only a couple of minutes.

Ms. Lee Allison Clark: Absolutely.

I think one of the easiest ways we could cut red tape and reduce the time that goes into medical transportation would be flexibility in arrangements and having fewer levels of bureaucracy involved, as Grand Chief Daniels was saying, devolving it from what it is right now and putting it in the hands of indigenous folks. They know what they need. We should ask them. We should let them be able to decide how and what transportation looks like.

Thank you.

The Chair: Go ahead, Grand Chief.

Grand Chief Jerry Daniels: I would say that you transfer jurisdiction, allowing first nations to make the decisions and find alternative ways to create and maximize the use of that funding.

The Chair: Thank you.

Go ahead, Ms. Idlout.

Ms. Joy Idlout: I'm sorry. I don't know how to answer this question.

[*Translation*]

The Chair: We would like to know how to make medical transportation more efficient.

[*English*]

Ms. Idlout, the question was on whether you have any recommendations for how to make the transportation of patients from their homes to medical centres more efficient. You've spoken a lot about escorts. Are there other points you would like to bring up?

Ms. Joy Idlout: No.

[*Translation*]

The Chair: Ms. Idlout has no other recommendations.

[*English*]

I will go to Ms. McPherson for two and a half minutes.

Ms. Heather McPherson: Thank you, Mr. Chair.

I would like to ask a question of Grand Chief Daniels and Ms. Clark, if I could, because I know I have a very short amount of time.

Very clearly, would the mental well-being of indigenous people improve if elders and traditional counsellors were incorporated into the NIHB program, similar to the way other service providers are incorporated?

Grand Chief Jerry Daniels: I wouldn't go down that route, simply because you're sort of trying to put a brown face on a system that is failing already. I think it needs to be controlled by first nations leaders and first nations experts. I think that's really the only way. We will have our elders with us the whole way. It's always been done that way. We always speak and start in a good way.

I would not be in favour of that process. I think that's the process that's been done for the last 30, 40 or 50 years.

Ms. Heather McPherson: Okay. Thank you.

Ms. Clark.

Ms. Lee Allison Clark: Echoing what Grand Chief said, starting in a good way is the best way, but if you cannot start in a good way.... I don't believe the health of first nations has been started in a good way at the hands of the government.

If we can make these small steps, they will lead to improvements in health. Having your traditional people, knowledge and ways of knowing incorporated within your health care is bound to lead to improved mental health for everyone. We're currently looking into this exact topic at NWAC, you know, to put some data behind it.

Ms. Heather McPherson: Ms. Clark, we have about 30 seconds, so if you'd like to reiterate any other learnings that you didn't have an opportunity to say earlier, that would be great.

You get the last 30 seconds.

● (1725)

Ms. Lee Allison Clark: Absolutely. I think an area that has been really overlooked within NIHB is the utilization of pharmacists. Obviously they're dispensing medications, but they can treat minor ailments. Minor ailments can often lead to larger ailments, if you don't get them treated quickly.

Pharmacists are the most accessible health care providers within the country and often are significantly easier to access than doctors. If we can utilize pharmacists in a better capacity, I think that could be one drop in the bucket of getting towards better health for indigenous folks.

Ms. Heather McPherson: Thank you so much.

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

On behalf of the committee, I would like to thank Ms. Idlout, Ms. Clark and Grand Chief Jerry Daniels. Thank you for your opening remarks and your testimony on this very important subject.

We will now engage in the process of putting together a report. You were the last witnesses we've heard. We very much appreciate your taking the time. We apologize for starting an hour late, but we very much appreciated your testimony.

With that, colleagues, we will suspend so that we can go in camera.

[*Proceedings continue in camera*]