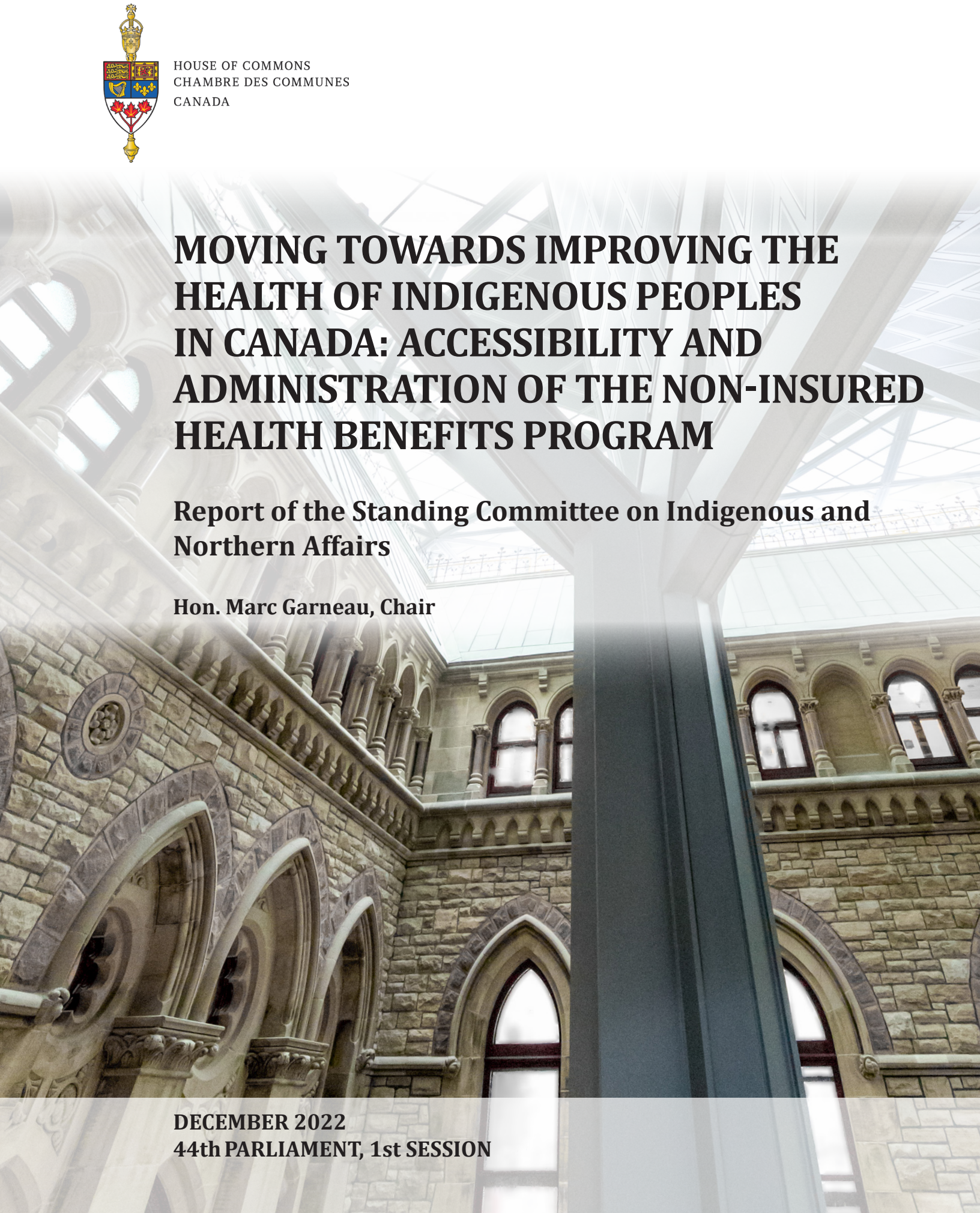

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

MOVING TOWARDS IMPROVING THE HEALTH OF INDIGENOUS PEOPLES IN CANADA: ACCESSIBILITY AND ADMINISTRATION OF THE NON-INSURED HEALTH BENEFITS PROGRAM

Report of the Standing Committee on Indigenous and Northern Affairs

Hon. Marc Garneau, Chair

DECEMBER 2022
44th PARLIAMENT, 1st SESSION

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NOTICE TO READER

Reports from committees presented to the House of Commons

Presenting a report to the House is the way a committee makes public its findings and recommendations on a particular topic. Substantive reports on a subject-matter study usually contain a synopsis of the testimony heard, the recommendations made by the committee, as well as the reasons for those recommendations.

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has the honour to present its

SIXTH REPORT

Pursuant to its mandate under Standing Order 108(2), the committee has studied the administration and accessibility of Indigenous Peoples to the Non-Insured Health Benefits (NIHB) program and has agreed to report the following:

TABLE OF CONTENTS

LIST OF RECOMMENDATIONS

As a result of their deliberations committees may make recommendations which they include in their reports for the consideration of the House of Commons or the Government. Recommendations related to this study are listed below.

Recommendation 1

Recommendation 2

Recommendation 3

Recommendation 4

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MOVING TOWARDS IMPROVING THE HEALTH OF INDIGENOUS PEOPLES IN CANADA: ACCESSIBILITY AND ADMINISTRATION OF THE NON-INSURED HEALTH BENEFITS PROGRAM

INTRODUCTION

Before the creation of the government of Canada and the provinces, First Nations, Métis and Inuit successfully administered their own health systems. Since the implementation of colonial laws and policies, Indigenous peoples' health indicators have dived to the bottom of all conditions compared to other Canadians. Canada continues to fail Indigenous peoples in respect of Indigenous services.

In Canada, health care is generally administered and delivered by the provinces and territories. The federal government mainly plays a role in this area through funding transfers; these transfers have an impact on the delivery of health care services.[1] The federal government also delivers primary and supplementary health services to certain populations, such as status First Nations and Inuit. Notably, it administers the Non-Insured Health Benefits (NIHB) program, which offers coverage to eligible First Nations and Inuit[2] for health benefits not covered by other social programs, private insurance plans, and provincial or territorial health insurance.[3]

Administered by Indigenous Services Canada's First Nations and Inuit Health Branch, the NIHB program covers goods and services related to vision care, dental care, mental health counselling, medical supplies and equipment, prescription and over-the-counter medications (pharmacy benefits), and medical transportation (when medically required services are not offered locally). The NIHB program differs from other group health plans

1 The Canada Health Transfer is the federal government's main way of financially contributing to provincial and territorial healthcare systems. See: Sonya Norris, "Federal Funding for Health Care," Library of Parliament, Background Paper, Publication No. 2018-45, 29 December 2020.

2 First Nations registered under the *Indian Act* and Inuit recognized by an Inuit land claim organization are eligible to the Non-Insured Health Benefits program. Children under the age of two years with an eligible parent are also eligible for the program. According to the First Nations and Inuit Health Branch's 2020–2021 annual report, a total of 898,839 individuals (848,247 First Nations and 50,592 Inuit) were eligible to receive benefits as of 31 March 2021.

3 Government of Canada, Non-insured health benefits for First Nations and Inuit.

insofar as it is "not income-tested and there are no copayments or deductibles."[4] The program's pharmacy benefits represent most of the program's expenditures as well as "one of the largest publicly funded drug plans in the country," according to the Minister of Indigenous Services, the Hon. Patty Hajdu.[5]

Indigenous people continue to face health inequities and unequal access to medical services as a result of colonization, discrimination, systemic racism, sexism, intergenerational trauma and social exclusion, among other factors.[6] The Government of Canada needs to transform and modernize the way it delivers health care to Indigenous people, and to address the inequalities in health outcomes between Indigenous and non-Indigenous people to advance reconciliation. Failure to properly administer the NIHB program leads to poorer health outcomes for the First Nations and Inuit who rely on it to access essential medical services, drugs and equipment. According to Dr. Alika Lafontaine, President-Elect of the Canadian Medical Association, "[i]mproving the administration and accessibility of the [NIHB] program is a key part of addressing the health inequities between [I]ndigenous and non-[I]ndigenous people in Canada."[7]

Grand Chief Jerry Daniels of the Southern Chiefs' Organization declared that, as it currently stands, the NIHB is actually an impediment to First Nations' health: "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."[8] Similarly, the Kwanlin Dün First Nation described the NIHB program

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4 House of Commons, Standing Committee on Indigenous and Northern Affairs [INAN], *Evidence*, 6 May 2022, 1300 (the Hon. Patty Hajdu, Minister of Indigenous Services).

5 Ibid.

6 INAN, *Evidence*, 29 April 2022, 1310 (Cassidy Caron, President, Métis National Council); INAN, *Evidence*, 29 April 2022, 1320–1325 (First Vice-Chief David Pratt, Federation of Sovereign Indigenous Nations, Assembly of First Nations); INAN, *Evidence*, 3 May 2022, 1630 (Dr. Alika Lafontaine, President-Elect, Canadian Medical Association); INAN, *Evidence*, 3 May 2022, 1640 (Dr. Evan Adams, Vice-President, Indigenous Physicians Association of Canada); INAN, *Evidence*, 3 May 2022, 1720 (Dr. James A. Makokis, Plains Cree Family Physician, Kinokamasihk Nehiyawak Nation, Treaty Number Six Territory, As an individual); INAN, *Evidence*, 6 May 2022, 1300 (Minister Hajdu); INAN, *Evidence*, 6 May 2022, 1405 (Colleen Erickson, Board Chair, First Nations Health Authority); INAN, *Evidence*, 10 May 2022, 1620 (Marg Friesen, Minister of Health, Métis Nation-Saskatchewan); INAN, *Evidence*, 13 May 2022, 1315 (Caroline Lidstone-Jones, Chief Executive Officer, Indigenous Primary Health Care Council); INAN, *Evidence*, 13 May 2022, 1405 (Isabelle Wallace, Community Health Nurse, Madawaske Maliseet First Nation); INAN, *Evidence*, 31 May 2022, 1630 (Lee Allison Clark, Manager, Policy and Research, Native Women's Association of Canada); Kwanlin Dün First Nation, *Submission to the Standing Committee on Indigenous and Northern Affairs*, 28 July 2022, p. 1.

7 INAN, *Evidence*, 3 May 2022, 1630 (Dr. Lafontaine).

8 INAN, *Evidence*, 31 May 2022, 1635 (Grand Chief Jerry Daniels, Southern Chiefs' Organization Inc.).

as a "failure" that is "not designed for low-income users, the socio-economic reality for many Indigenous peoples in Canada."[9]

Moreover, given that "Indigenous women utilize the NIHB at higher rates than [I]ndigenous men," the problems surrounding the NIHB program, and health care more broadly, must be looked at through a gendered lens.[10] According to Lee Allison Clark, Manager of Policy and Research at the Native Women's Association of Canada (NWAC), "more must be done to ensure that [I]ndigenous 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."[11]

On 1 February 2022, the House of Commons Standing Committee on Indigenous and Northern Affairs (the committee) agreed to undertake a study on accessibility to, and administration of, the NIHB program and the implementation of the Calls to Action nos. 18 to 24 of the Truth and Reconciliation Commission on the topic of health (see Appendix A). Specifically, the committee decided to look into:

- the recognition of Indigenous traditional counsellors as culturally relevant mental health supports;
- the accessibility of client escorts for patients required to travel to access health care, including compensation for client escorts; and
- the redress of compensation delays for services providers.

The motion adopted by the committee reads as follows:

> That, pursuant to Standing Order 108(2), the committee undertake a study to review the healthcare rights of Indigenous Peoples through the accessibility and administration of the Non-Insured Health Benefits program (NIHB), as it pertains to implementation of the Truth and Reconciliation Commission Calls to Action on Health (#18 to 24), specifically, recognizing existing First Nations, Métis and Inuit traditional counsellors as culturally relevant mental health supports to be accessible through Non-Insured Health Benefits program (as affirmed by the Truth and Reconciliation Call to Action #22), medical escorts for patients

9 Kwanlin Dün First Nation, *Submission to the Standing Committee on Indigenous and Northern Affairs*, 28 July 2022, p. 1.

10 INAN, *Evidence*, 31 May 2022, 1630 (Ms. Clark).

11 Ibid.

> required to travel to access health care, and redressing the delay of compensation for service providers creating a flight of available health providers for Non-Insured Health Benefits users; that the committee invite the Minister of Northern Affairs and the Minister of Indigenous Services, health care providers, representatives of Indigenous communities, and government officials to examine this issue; that the committee hold a minimum of six meetings on this issue; and that the committee report its findings and recommendations to the House; and that, pursuant to Standing Order 109, the committee request that the government table a comprehensive response to the report.[12]

The committee collected a range of evidence on the NIHB program, its importance, and its shortcomings. The present report aims to highlight the committee's findings and recommendations related to the issues above, but additional issues raised by witnesses during this study are also explored at the end of the report. As part of this study, the committee heard from 40 witnesses across six meetings and received eight written briefs. The committee wishes to thank all participants for their invaluable contribution.

TRADITIONAL HEALING, CLIENT ESCORTS AND COMPENSATION DELAYS

As noted above, the committee's study focused on three specific issues: the recognition of traditional counsellors and healers as mental health supports, the accessibility of medical and non-medical escorts (also known as "client escorts"), and the delays in compensating service providers. This report considers the testimony pertaining to these three issues in turn.

Traditional Healing and Indigenous Knowledge

Many Indigenous peoples have a holistic view of health and health care, all aspects of a person's health (physical, mental, psychosocial, emotional, and spiritual) being

12 INAN, *Minutes of Proceedings*, 1 February 2022.

connected.[13] Marceline Tshernish, Director, Health Sector, Innu Takuaikan Uashat Mak Mani-Utenam, said that, "For us, health is a whole."[14]

During this study, the committee heard about the importance of traditional healing and Indigenous knowledge:

> [F]irst [N]ations had our own health care system prior to contact. We relied on a lot of our spiritual and traditional healers, and we still do. A lot of our [F]irst [N]ations people utilize both [Western and Indigenous] systems of care. If they are being treated for cancer, they also take our traditional medicines and healers and it has worked for a number of them.[15]

For Inuit as well, the committee heard, traditional and Western health care systems "can live together and support one another in a diagnosis and in treatment."[16]

The NIHB program covers medical transportation for clients who need to travel to see Elders and traditional healers; however, these Elders and healers are not compensated by the program. Instead, the patient is responsible for compensating the Elder or healer.[17] Witnesses noted that traditional Indigenous counsellors and healers play a particularly important role in Indigenous health; as such, they should be recognized and compensated fairly for their services.[18]

Ensuring access to services provided by Indigenous Elders and healers is also essential. According to Dr. James A. Makokis, a Plains Cree Family Physician from the Kinokamasihk Nehiyawak Nation on Treaty Number Six Territory, "we need to systematically rebuild

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13 INAN, *Evidence*, 29 April 2022, 1335 (President Caron); INAN, *Evidence*, 29 April 2022, 1335 (First Vice-Chief Pratt); INAN, *Evidence*, 3 May 2022, 1705 (Dr. Adams); INAN, *Evidence*, 6 May 2022, 1415 (Carl Dalton, Chief Executive Officer, Nishnawbe Aski Mental Health and Addictions Support Access Program); INAN, *Evidence*, 6 May 2022, 1505 (Jessie Messier, Interim Manager, Health Services, First Nations of Quebec and Labrador Health and Social Services Commission); INAN, *Evidence*, 10 May 2022, 1620 (Minister Friesen); INAN, *Evidence*, 10 May 2022, 1720 and 1745 (Marceline Tshernish, Director, Health Sector, Innu Takuaikan Uashat Mak Mani-Utenam); INAN, *Evidence*, 13 May 2022, 1350 (Ms. Lidstone-Jones).

14 INAN, *Evidence*, 10 May 2022, 1745 (Ms. Tshernish).

15 INAN, *Evidence*, 29 April 2022, 1335 (First Vice-Chief Pratt).

16 INAN, *Evidence*, 29 April 2022, 1405 (Natan Obed, President, Inuit Tapiriit Kanatami).

17 INAN, *Evidence*, 3 May 2022, 1710 (Dr. Makokis).

18 INAN, *Evidence*, 29 April 2022, 1325 (First Vice-Chief Pratt); INAN, *Evidence*, 29 April 2022, 1405 (President Obed); INAN, *Evidence*, 3 May 2022, 1730 (Dr. Makokis); INAN, *Evidence*, 3 May 2022, 1615 (the Hon. John Main, Minister of Health, Government of Nunavut); INAN, *Evidence*, 10 May 2022, 1725 (Ms. Tshernish); INAN, *Evidence*, 13 May 2022, 1330 (Ms. Lidstone-Jones); INAN, *Evidence*, 13 May 2022, 1345 (Maggie Putulik, Vice-President, Health Services, Nunasi Corporation).

[I]ndigenous health systems. That starts with funding [I]ndigenous healers, [E]lders, medicine people and young people who can train in their footsteps."[19] Dr. Makokis referred to the training program offered at the Navajo Nation's Diné College as a promising example:

> [T]hey have a training system for [I]ndigenous traditional medicine people and for Navajo students to learn from their own [E]lders within their communities. We need to have processes for doing that in this country, whether that's [I]ndigenous medical students, [I]ndigenous medical schools, where we're training alongside our [E]lders and traditional medicine people and providing care in a culturally safe, appropriate way that is as equal and as valid as western medicine.[20]

The committee heard that, in Canada,

> There is limited access to service delivered by [I]ndigenous practitioners. While there is an NIHB service provider list for mental health, it is mostly comprised of non-[I]ndigenous practitioners delivering mainstream services. Developing a similar list and funding [I]ndigenous 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 [I]ndigenous population on their healing journeys.[21]

According to Minister Hajdu, her department is "supporting increased access to quality, culturally grounded wraparound care," including through the provision of "flexible supports to organizations that support people to stay connected to their culture, traditional healing and traditional ways of being."[22] The Minister also noted that traditional healer services are now, for the first time, covered as part of the supports offered for mental wellness.

Valerie Gideon, Associate Deputy Minister at Indigenous Services Canada, explained that traditional healing services are not, however, directly administered and compensated by the department; instead, Indigenous organizations or governments manage these services with federal funding: "For traditional healing services, we do not recognize them or certify them or anything. We usually receive a letter or a note from the Inuit or

19 INAN, *Evidence*, 3 May 2022, 1710 (Dr. Makokis).

20 INAN, *Evidence*, 3 May 2022, 1730 (Dr. Makokis).

21 INAN, *Evidence*, 13 May 2022, 1310 (Ms. Lidstone-Jones).

22 INAN, *Evidence*, 6 May 2022, 1300 (Minister Hajdu).

the [F]irst [N]ation community organization that advises that this traditional healer or this cultural practitioner is recognized or is part of their services."[23]

According to Ms. Clark,

> The administration of the NIHB program must integrate [Indigenous peoples' rich body of knowledge of traditional medicines and sociocultural practices] and be culturally and gender sensitive, as well as gender-informed, if we are ever to fully walk the path of reconciliation… When considering the NIHB, this means increasing… access to and increasing the availability of preventative allopathic [Western] and traditional medicine.[24]

She later added that "[h]aving your traditional people, knowledge and ways of knowing incorporated within your health care is bound to lead to improved mental health for everyone."[25]

Based on the testimony, the committee recommends:

Recommendation 1

That the Government of Canada, in partnership with First Nations and Inuit, take immediate action to formally recognize the important role of traditional Indigenous counsellors and healers as part of the Non-Insured Health Benefits program; and that they work together to determine the best way to compensate traditional counsellors and healers as part of the program.

In parallel to improving access to traditional healing and Indigenous practitioners, one witness recommended mandating cultural safety[26] training for those administering the NIHB program and service providers.[27] The committee heard that "[t]here is a significant gap in cultural safety and culturally safe care"[28] and that this situation "has extremely

23 INAN, *Evidence*, 6 May 2022, 1330 (Valerie Gideon, Associate Deputy Minister, Indigenous Services Canada).

24 INAN, *Evidence*, 31 May 2022, 1630 (Ms. Clark).

25 INAN, *Evidence*, 31 May 2022, 1720 (Ms. Clark).

26 On its website, the First Nations Health Authority defines "cultural safety" as "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care."

27 INAN, *Evidence*, 13 May 2022, 1315 (Ms. Lidstone-Jones).

28 Ibid.

harmful consequences for the health of members of the First Nations and on Métis and Inuit."[29] In Dr. Makokis' opinion,

> [T]he bureaucrats who work under the program are completely out of touch with the reality of the lived experiences of people on the reserve and the communities that they're supposed to provide care for. They act as an extreme barrier to the provision of basic, standard care. They don't have any training about [I]ndigenous peoples, about [I]ndigenous peoples' health, about our treaty promise to health and the provision of health care, medical services and supplies. That is a huge issue.[30]

Angela Grier, Lead of Indigenous Initiatives at the Canadian Counselling and Psychotherapy Association, also criticized the fact that people working under the program "may not have the cultural competency to work within our populations. We're at the mercy of these individuals."[31] In its brief, the Indigenous Primary Health Care Council recommended "mandatory Indigenous Cultural Safety training for those working internal to NIHB and those included on the provider list."[32]

According to Indigenous Services Canada, starting in January 2020, a new policy "was introduced requiring [departmental] management and employees at all levels to complete the equivalent of 2 days (15 hours) of Indigenous cultural competency learning on an annual basis."[33] However, the testimony received by the committee indicates that this new policy is either insufficient or inadequate.

Based on the testimony, the committee recommends:

Recommendation 2

That the Government of Canada work with First Nations and Inuit experts and community members to review the First Nations and Inuit Health Branch's 2020 policy mandating cultural competency training; and that the results of this review be used to improve the policy, and to ensure that the training is also trauma-informed and gender-based.

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29 INAN, *Evidence*, 13 May 2022, 1410 (Ms. Wallace).

30 INAN, *Evidence*, 3 May 2022, 1650 (Dr. Makokis).

31 INAN, *Evidence*, 10 May 2022, 1755 (Angela Grier, Lead, Indigenous Initiatives, Canadian Counselling and Psychotherapy Association).

32 Indigenous Primary Health Care Council, Study of Administration and Accessibility of Indigenous Peoples to the Non-Insured Benefits Program, 13 May 2022.

33 Government of Canada, Health.

Recommendation 3

That the Government of Canada, in partnership with Indigenous health organizations, and while respecting provincial and territorial jurisdiction, work with the provinces and territories, and their health professional regulatory authorities, to require health care professionals, where necessary, to participate in cultural safety training as part of continuing professional development requirements.

Recommendation 4

That the Government of Canada take feedback from Indigenous health professionals and organizations on the effectiveness and cultural understanding of Non-Insured Health Benefits (NIHB) bureaucrats, and work within the NIHB offices to improve their awareness about the First Nations and Inuit communities that they serve, and to identify and eliminate barriers the NIHB office has created that impede Indigenous Canadians from accessing basic, standard care by providing training for NIHB employees.

Client Escorts

The NIHB program covers costs such as air travel, accommodations and meals when a client needs to travel to access medically required services. Medical transportation benefits may also cover costs for a client escort. Client escorts include medical escorts (such as a physician or nurse) and non-medical escorts (for instance, when the client is a minor or a pregnant woman, requires assistance with daily tasks, or faces language barriers). Client escorts can also act as social, psychosocial and emotional supports.[34] On a case-by-case basis, the department may cover costs for more than one escort for a client.[35] The committee learned that issues surrounding the approval of escorts are a particular concern in the North, where people must often travel to receive medical services.[36]

The committee also heard that there are significant delays related to client escort benefits; clients often have to wait weeks or months for the department to approve or deny their medical escorts, and they are not always given a reason for denials.[37] Grand Chief Ken Kyikavichik of the Gwich'in Tribal Council said “[i]t is common for us to hear of

34 INAN, *Evidence*, 13 May 2022, 1315 (Ms. Putulik).

35 INAN, *Evidence*, 6 May 2022, 1340 (Minister Hajdu).

36 INAN, *Evidence*, 13 May 2022, 1410 (Grand Chief Ken Kyikavichik, Gwich’in Tribal Council).

37 INAN, *Evidence*, 29 April 2022, 1330 (President Obed); INAN, *Evidence*, 3 May 2022, 1540 (the Hon. Julie Green, Minister of Health and Social Services, Government of the Northwest Territories).

residents who require a medical travel escort and do not receive one… [O]ur people are often caught in the bureaucracy and are required to prove their conditions, otherwise… this essential support is seemingly automatically denied."[38]

The criteria for approving a client escort were also described as "narrow" and "vague."[39] Witnesses said that the policy surrounding medical escorts should be more flexible and account for additional, cultural considerations, and that the criteria for medical escorts' eligibility should be clearer to avoid misinterpretation.[40]

Additionally, the committee was told that the NIHB program does not cover certain non-medical escorts:

> We get a lot of complaints from people coming from small communities who are not accustomed to travelling to places even the size of Yellowknife, which is a very small city, let alone to Edmonton and further south. They would like people to accompany them. Elders, especially, would like people to accompany them. This kind of compassionate accompaniment is not considered in the benefits of NIHB. They consider whether you need interpretation, mobility assistance and so on, but not compassionate travel. I'm concerned that what we're offering is not really culturally appropriate to the population, and I would like to see some discussion around that as a change.[41]

Finally, the committee heard that, although they are compensated for their travel, medical and non-medical escorts are not remunerated.[42] Some witnesses believed that client escorts should be remunerated.[43] However, a representative of the Government of the Northwest Territories, which administers parts of the NIHB program pursuant to a service agreement with the federal government[44]—expressed concerns about the costs associated with formally remunerating client escorts.[45] For her part, Caroline Lidstone-

38 INAN, *Evidence*, 13 May 2022, 1410 (Grand Chief Kyikavichik).

39 INAN, *Evidence*, 3 May 2022, 1605 (the Hon. Tracy-Anne McPhee, Minister of Health and Social Services, Government of Yukon); INAN, *Evidence*, 13 May 2022, 1315 (Ms. Putulik).

40 INAN, *Evidence*, 3 May 2022, 1610 (Minister Main); INAN, *Evidence*, 13 May 2022, 1315 (Ms. Putulik).

41 INAN, *Evidence*, 3 May 2022, 1600 (Minister Green).

42 INAN, *Evidence*, 3 May 2022, 1730 (Dr. Makokis); Kwanlun Dün First Nation, *Submission to the Standing Committee on Indigenous and Northern Affairs*, 28 July 2022, p. 3. As explained in the Non-Insured Health Benefits Program Medical Transportation Policy Framework, "[m]edical transportation benefits do not include the payment of a fee, honorarium or salary to medical or non-medical escorts."

43 INAN, *Evidence*, 3 May 2022, 1620 (Minister Main); INAN, *Evidence*, 13 May 2022, 1340 (Ms. Putulik); INAN, *Evidence*, 31 May 2022, 1635 (Joy Idlout, Officer, Compensation and Benefits, As an individual).

44 INAN, *Evidence*, 3 May 2022, 1540 (Minister Green).

45 INAN, *Evidence*, 3 May 2022, 1620 (Minister Green).

Jones, Chief Executive Officer of the Indigenous Primary Health Care Council, indicated that her organization provides a daily honorarium to client escorts.[46]

Joy Idlout, a compensation and benefits officer testifying as an individual, described the impact of this unpaid work on client escorts and their families:

> [T]here 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… 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… I'm the only one in the house with a job, so that takes a huge toll on our income… It gets to a point where I wonder how I will be able to feed my children.[47]

Based on the testimony, the committee recommends:

Recommendation 5

That the Government of Canada work with First Nations and Inuit partners to undertake an urgent review of the Non-Insured Health Benefits program's medical transportation policy framework to clarify the eligibility criteria for client escorts; and that compassionate accompaniment be accepted as an eligibility criterion for client escorts.

Recommendation 6

That the Government of Canada work with First Nations and Inuit partners to recognize the role of client escorts in the context of the Non-Insured Health Benefits program, for example, by considering compensation mechanisms for lost wages and other expenses, such as those incurred for childcare, due to travel.

Compensation Delays

The NIHB program works like any collective insurance plan. To operate efficiently, service providers must agree to join the program and they must be compensated in a timely manner. Yet, the committee heard that "[reimbursement] from NIHB to service providers is rife with delay and denials."[48] When compared to other health benefit programs,

46 INAN, *Evidence*, 13 May 2022, 1345 (Ms. Lidstone-Jones).

47 INAN, *Evidence*, 31 May 2022, 1700–1705 (Ms. Idlout).

48 INAN, *Evidence*, 29 April 2022, 1320 (First Vice-Chief Pratt).

"providers routinely say that the NIHB program is the most difficult and causes the most harm to patients when they want to access it."[49]

As a result, services providers are increasingly refusing to take part in the program, or they are requesting that clients pay upfront (and then seek reimbursement from the NIHB program themselves).[50] For people on a fixed or limited income, paying upfront for medical services may not always be possible: "It can result in people having to decide between food, shelter or essential medical needs. This places them in danger of compromising their mental and physical health outcomes even more."[51]

The committee was surprised to learn of this issue, given that other public and private plans in Canada appear to be able to compensate service providers in a timely manner. Regarding delays, Dr. Lafontaine stated the following:

> There is a considerable amount of time and energy that physicians, patients, their families and NIHB administrators use in navigating paperwork and decision-making structures. Unlike provincial and territorial medicare, where physicians can provide direct approval and access to services, the added administrative layers of the NIHB create opacity on the physician's role and jurisdiction in these processes.[52]

Dr. Lafontaine also criticized the program's lack of integration of modern technology:

> Navigating paperwork and people can take up hours of their physicians' time, filling out paperwork and looking to connect with people over the phone. These paper forms must then be faxed through an asynchronous communications system that dooms too many of these requests to disjointed dead ends. The physician is often the last to learn the loop was never closed, delaying care and often resulting in worsening patient outcomes. NIHB has yet to be tightly integrated with a mature, centralized patient experience and quality improvement departments, so these situations are likely not tracked or addressed in a broadly consistent way. Secure, digital communication where patients engage with providers on their own journey from beginning to end now exists in many health systems across Canada. In place of a series of non-contiguous faxed forms, secure digital communication can close that loop, informing, tracking progress and answering questions regarding a medically necessary request that is processed through the NIHB. It

49 INAN, *Evidence*, 3 May 2022, 1650 (Dr. Makokis).

50 INAN, *Evidence*, 29 April 2022, 1320 (First Vice-Chief Pratt); INAN, *Evidence*, 29 April 2022, 1400 (President Obed); INAN, *Evidence*, 6 May 2022, 1410 (Ms. Messier); INAN, *Evidence*, 10 May 2022, 1755 (Ms. Grier); INAN, *Evidence*, 13 May 2022, 1305 (Ms. Lidstone-Jones); Indigenous Primary Health Care Council, Study of Administration and Accessibility of Indigenous Peoples to the Non-Insured Health Benefits Program, Brief, 13 May 2022.

51 INAN, *Evidence*, 29 April 2022, 1320 (First Vice-Chief Pratt).

52 Ibid.

> also provides a digital audit trail that could improve patient experiences and iterative quality improvement.[53]

Rudy Malak, a pharmacist from Little Current Guardian Pharmacy, also noted that faxes are sometimes lost, leading to further delays:

> [W]e send a fax to the NIHB for approval. Sometimes we follow-up three or four days later and say that we sent an approval and ask if there is any response. They say they didn't get it. Well, I know I sent it and I have confirmation that it was sent, but they haven't received it, so we have to start the process again.[54]

According to Jessie Messier, Interim Manager of Health Services for the First Nations of Quebec and Labrador Health and Social Services Commission, "[t]he administrative burden required to provide access to non-insured health benefits… has frustrated professionals, who view it as a significant overload of work."[55] She also argued in favour of modernizing the program.[56]

Based on the testimony, the committee recommends:

Recommendation 7

That the Government of Canada, in partnership with First Nations and Inuit, conduct a review of comparable private and public group health plans in Canada to identify and promptly implement ways for the Non-Insured Health Benefits (NIHB) program to modernize and digitize its services to improve efficiency and compensate service providers and NIHB plan members in a timely and efficient manner that matches or exceeds comparable private sector standards; and specifically, that the Government of Canada's digital modernization create secure digital communications that inform patients and medical professionals, track progress, and provide a digital audit trail.

In addressing that recommendation, the federal government must consider that many Indigenous communities still lack access to digital technologies and the Internet. As Ms. Lidstone-Jones told the committee, "[w]e still have a major digital divide, especially for many of our remote [F]irst [N]ations communities, so that becomes an ongoing

53 Ibid.

54 INAN, *Evidence*, 10 May 2022, 1755 (Rudy Malak, Pharmacist, Little Current Guardian Pharmacy, As an individual).

55 INAN, *Evidence*, 6 May 2022, 1410 (Ms. Messier).

56 INAN, *Evidence*, 6 May 2022, 1440 (Ms. Messier).

challenge with the stability of Internet and lack of broadband, those kinds of things. That also adds further complexity to navigating the system."[57]

Program Design and Parameters

Administrative Burdens

Above all, the committee heard that the NIHB program is rife with administrative burdens and needs modernizing. Virtually all witnesses criticized the program's rigidity and complexity. The Kwanlin Dün First Nation wrote that the "reimbursement and appeals process is heavily bureaucratic" and that the program is difficult to access and navigate.[58] Dr. Makokis criticized the "large bureaucracy" in Gatineau, Quebec: "the money that's provided for [I]ndigenous people is actually siphoned off by this large bureaucracy, and a very small amount actually ends up getting to the people who require it the most."[59] Mr. Malak described the approval process as "very long"[60] and "overly complicated."[61] He explained that

> Due to the complexity in the processes and procedures, a lot of pharmacies are not able to serve NIHB clients. This is because of the time needed to complete one task, or because of the lack of funding to the provider. A major part of the day is spent dealing with a lot of paperwork or on the phone trying to get something approved, instead of providing direct patient care. I'm sure every department and committee would like to provide the best possible care to our most vulnerable patients, but the amount of paperwork, phone calls and bureaucracy involved makes everything difficult, time consuming and financially not feasible.[62]

Similarly, Ms. Tshernish said that

> The process to access health benefits is onerous, and the wait times, significant. Those wait times affect the quality of care received by community members. The red tape involved in accessing health benefits contributes to a lower quality of life for [F]irst [N]ations members, who have to go through two levels of government [provincial and federal] in order to access care and services… In addition, when patients do receive information, it is often quite incomplete. The procedure for the supporting documents

57 INAN, *Evidence*, 13 May 2022, 1325 (Ms. Lidstone-Jones).

58 Kwanlun Dün First Nation, *Submission to the Standing Committee on Indigenous and Northern Affairs*, 28 July 2022, p. 5.

59 INAN, *Evidence*, 3 May 2022, 1715 (Dr. Makokis).

60 INAN, *Evidence*, 10 May 2022, 1710 (Mr. Malak).

61 INAN, *Evidence*, 10 May 2022, 1730 (Mr. Malak).

62 INAN, *Evidence*, 10 May 2022, 1710 (Mr. Malak).

> patients have to provide is not explained clearly. I would also say that the health care professionals, themselves, do not fully understand the procedures for the NIHB program.[63]

According to her, "the application and approval processes should be streamlined… Memorandum of understanding should be established with the various care providers, whether dental care providers or private clinics, to streamline the process and ease the burden on patients."[64]

For his part, Dr. Lafontaine indicated the following:

> Canadian physicians agree that NIHB needs modernization. Modernization should reduce fragmentation in the patient experience and provide efficient and clear decision-making pathways for physicians and NIHB administrators to make patient care decisions. Health care systems should be focused on getting patients to the right care at the right time, in a patient-centred way. The [Canadian Medical Association] has long advocated for reducing health care fragmentation through modernization.[65]

Dr. Lafontaine highlighted two categories of fragmentation within the program: "The first category is overly complicated workflows, where roles are poorly understood… The second category is a lack of integrating modern technology toward patient-centred, patient-engaged efficiency."[66]

Natan Obed, President of Inuit Tapiriit Kanatami, noted that clients face "barriers in accessing and receiving NIHB program benefits due to the existing program structure, its restrictive policies and administrative processes."[67] First Vice-Chief David Pratt, testifying on behalf of the Assembly of First Nations, similarly stated that "NIHB can be seen as a bureaucratic and intimidating entity."[68] According to Ms. Isabelle Wallace, Community Health Nurse of the Madawaska Maliseet First Nation, "[t]he additional complexities generated by the NIHB program are… quite simply an unnecessary burden for a community health nurse."[69]

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63 INAN, *Evidence*, 10 May 2022, 1720 (Ms. Tshernish).

64 INAN, *Evidence*, 10 May 2022, 1740 (Ms. Tshernish).

65 INAN, *Evidence*, 3 May 2022, 1630 (Dr. Lafontaine).

66 Ibid.

67 INAN, *Evidence*, 29 April 2022, 1305 (President Obed).

68 INAN, *Evidence*, 29 April 2022, 1315 (First Vice-Chief Pratt).

69 INAN, *Evidence*, 13 May 2022, 1400 (Ms. Wallace).

Dr. James A. Makokis indicated that "[t]o get anything covered through NIHB requires extensive and exhaustive advocacy."[70] Dr. Makokis also explained that:

> It is only when physicians make drastic statements that supplies, equipment and medication are covered. We should not have to do this. Family physicians, specialists and allied health professionals repeatedly state how difficult it is to work within this program and to attain appropriate coverage for [I]ndigenous peoples and they ask how this can be improved.[71]

Similarly, Ms. Clark from NWAC described the program as "overwhelming."[72] Dr. Philip Poon of the Canadian Dental Association added that most procedures require pre-approval from the NIHB program, which may take up to 10 days, even though the procedures are almost always approved.[73] His colleague, Dr. Lynn Tomkins, recommended reducing the reliance on pre-authorizations for procedures and services that are regularly approved as a way of reducing administrative burdens.[74]

Other witnesses suggested alleviating bureaucratic burdens by decentralizing and devolving the administration of health programming to Indigenous peoples themselves.[75] For instance, the Indigenous Physicians Association of Canada told the committee that:

> It doesn't make sense for [F]irst [N]ations health to be run from Vancouver or from Ottawa. Perhaps more local workers and local knowledge could be incorporated. We've understood that sometimes our workers, who are meant to be helpful and not hurtful, are not well versed in our communities and community needs, and that a clerk in an office in Vancouver making health decisions that supersede those of an [I]ndigenous physician who's on the ground—or any physician or health care worker on the ground—is completely inappropriate, and we had to change the way that business was practised.[76]

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70 INAN, *Evidence*, 3 May 2022, 1635 (Dr. Makokis).

71 Ibid.

72 INAN, *Evidence*, 31 May 2022, 1650 (Ms. Clark).

73 INAN, *Evidence*, 13 May 2022, 1350 (Dr. Philip Poon, Lead, Non-Insured Health Benefits Subcommittee, Canadian Dental Association).

74 INAN, *Evidence*, 13 May 2022, 1350 (Dr. Lynn Tomkins, President, Canadian Dental Association).

75 INAN, *Evidence*, 10 May 2022, 1810 (Ms. Grier); INAN, *Evidence*, 31 May 2022, 1710 (Grand Chief Daniels); INAN, *Evidence*, 31 May 2022, 1720 (Ms. Clark).

76 INAN, *Evidence*, 3 May 2022, 1655 (Dr. Adams).

Based on the testimony, the committee recommends:

Recommendation 8

That the Government of Canada work with First Nations and Inuit experts and community members to: modernize the Non-Insured Health Benefits (NIHB) program and streamline the approvals process by introducing automatic approvals for certain procedures; take further steps to simplify, for example, by streamlining the application and approval processes and workflows; make use of the most up-to-date technology available in an effort to digitize the program and reduce administrative burdens; and that any efforts at modernization be patient-centred and patient-engaged, focused on providing adequate and timely medical benefits to NIHB members while, at the same time, ensuring that modernization does not become a technological barrier to accessing services.

Focus on Cost Containment

First Vice-Chief Pratt said that "the NIHB program remains primarily concerned with cost containment rather than providing adequate and timely medical benefits and services to First Nations."[77] President Obed stated that the program must reflect and respond to Inuit needs and that "[t]here must be clear and specific priorities that are delivered in a timely and distinctions-based way."[78] Dr. Makokis recommended "that the NIHB program be evaluated by [I]ndigenous scholars, allies and users of the program and then changed to create an inclusive, responsive and comprehensive program that actually meets the real health needs of [I]ndigenous peoples. The current NIHB system only further contributes to our early morbidity and mortality, and its use is a risk factor for our early death."[79]

As noted above, the NIHB program covers transportation, meals and accommodation when a client needs to travel to access medically required services. Other than in emergency situations, medical transportation benefits must be pre-authorized before a client may travel. However, Grand Chief Daniels noted that

> 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.

77 INAN, *Evidence*, 29 April 2022, 1315 (First Vice-Chief Pratt).

78 INAN, *Evidence*, 29 April 2022, 1305 (President Obed).

79 INAN, *Evidence*, 3 May 2022, 1640 (Dr. Makokis).

> 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.[80]

Ms. Tshernish also described the medical transportation component of the NIHB program as "underfunded" and with limited coverage.[81] In its brief, the Kwanlun Dün First Nation wrote that "[t]he NIHB allowance rates are not sufficient to meet the daily nutritional needs of most clients" and do not account for inflation and the unique dietary requirements of people with chronic conditions such as diabetes and gluten intolerance.[82] The First Nation also indicated that allowance rates for accommodation are too low and that NIHB clients often have to pay the security deposit out-of-pocket.[83]

Based on the testimony, the committee recommends:

Recommendation 9

That the Government of Canada work with First Nations and Inuit partners to undertake a review of the Non-Insured Health Benefits program to ensure that it provides medical benefits that meet the health needs of First Nations and Inuit, including ensuring that medical transportation benefits are comparable to those of other groups that receive similar benefits from the Government of Canada, such as veterans.

ADDITIONAL ISSUES RAISED BY WITNESSES

During this study, witnesses raised several issues that went beyond the scope of the committee's motion. These issues, however, are critically important and the committee would be remiss not to cover them in this report. It should be noted that, since they were not the focus on this study, these issues were not covered extensively in the testimony. The committee reserves the right to conduct further studies into these issues and to present additional recommendations to the government in the future.

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80 INAN, *Evidence*, 31 May 2022,1635 (Grand Chief Daniels).

81 INAN, *Evidence*, 10 May 2022, 1720 (Ms. Tshernish).

82 Kwanlun Dün First Nation, *Submission to the Standing Committee on Indigenous and Northern Affairs*, 28 July 2022, pp. 3–5.

83 Ibid., p. 4.

Eligibility Limited to Status First Nations and Inuit

Métis citizens experience poorer health outcomes compared to the general Canadian population.[84] Yet, only First Nations registered under the *Indian Act* and Inuit recognized by an Inuit land claim organization are eligible to the NIHB program.[85] In its brief, the Indigenous Primary Health Care Council wrote the following:

> The most significant challenges as it relates to exclusionary are with regards to those who are not recognized in the *Indian Act* or by an Inuit land claim organization. Section 35 of the *Constitution Act* recognizes Indian, Inuit, and Metis as all Aboriginal with existing rights; yet non-status First Nations, Metis and Inuit without beneficiary card are not eligible to participate in the NIHB program. Through the *Indian Act*, many Indigenous people lost their status and refuse to reclaim it today because of the harms that were done to their families and ancestors. Extending the eligibility to all Aboriginal groups as defined in the *Constitution Act* will introduce equitable distribution of services to all recognized Indigenous groups.[86]

As noted by President Cassidy Caron of the Métis National Council, "[i]n the current system, Métis are underserved and marginalized."[87] She advocated for a "self-determined Métis version of the [NIHB program that] will work toward improved health and well-being for Métis citizens, families and communities now and for future generations."[88]

Frances Chartrand, Minister of Health and Wellness, Manitoba Métis Federation, similarly said that, "[i]n order to provide equitable and culturally appropriate services, Métis citizens in Manitoba require health and social programs and services that are developed and delivered by Métis citizens and Métis people."[89] "Provisions are needed

84 INAN, *Evidence*, 10 May 2022, 1615 (Frances Chartrand, Minister of Health and Wellness, Manitoba Métis Federation).

85 The Government of the Northwest Territories administers its own Métis Health Benefits program; this program is the only one of its kind in Canada. In the brief it submitted to the committee, the Kwanlin Dün First Nation also indicated that, for First Nations, "[a]n expired status card, a bureaucratic technicality, can prevent a client form being able to access care" through the Non-Insured Health Benefits program.

86 Indigenous Primary Health Care Council, Brief submitted to the committee, 13 May 2022.

87 INAN, *Evidence*, 29 April 2022, 1310 (President Caron).

88 Ibid.

89 INAN, *Evidence*, 10 May 2022, 1615 (Minister Chartrand).

to negotiate agreements or to promote the health, safety and welfare of Métis citizens within a defined area of pharmaceutical and medical services, and to enhance access," Minister Chartrand later added.[90] Marg Friessen, Minister of Health, Métis Nation-Saskatchewan, indicated that health care and medication are unaffordable to many Métis citizens: "For example, citizens may [need to] choose between their basic needs, such as shelter and food, and their medications and prescriptions."[91]

According to Lee Thom, elected official of the Kikino Metis Settlement, the federal government has obligations to the Métis following the Supreme Court of Canada decision in *Daniels v. Canada (Indian Affairs and Northern Development)*.[92] These obligations may involve addressing inequalities facing the Métis, including in the area of health care.

Minister Friessen indicated that the 2017 *Canada-Métis Nation Accord*[93] and the 2019 self-government agreements[94] signed with the Métis Nation of Alberta, the Métis Nation of Ontario and the Métis Nation-Saskatchewan, clearly identified Métis priorities, including in the area of health.[95] Métis representatives who appeared before the committee want their citizens to have access to benefits like those offered to First Nations and Inuit through the NIHB program, but they also seek ongoing funding and agreements to offer self-determined and self-governed health care by Métis governments.[96]

90 INAN, *Evidence*, 10 May 2022, 1620 (Minister Chartrand).

91 INAN, *Evidence*, 10 May 2022, 1620 (Minister Friessen).

92 INAN, *Evidence*, 10 May 2022, 1630 and 1645 (Lee Thom, Elected Official, Kikino Metis Settlement), citing *Daniels v. Canada (Indian Affairs and Northern Development)*, [2016] 1 SCR 99 [*Daniels*]. In that decision, the Supreme Court of Canada unanimously declared that Métis and non-Status First Nations are "Indians" under section 91(24) of the *Constitution Act, 1867*, meaning that "it is the federal government to whom they can turn" (para. 50).

93 Prime Minister of Canada, Justin Trudeau, Canada-Métis Nation Accord.

94 Government of Canada, "Historic self-government agreements signed with the Métis Nation of Alberta, the Métis Nation of Ontario and the Métis Nation-Saskatchewan," *News release*, 27 June 2019.

95 INAN, *Evidence*, 10 May 2022, 1640 (Minister Friessen).

96 INAN, *Evidence*, 10 May 2022, 1650 (Adel Panahi, Director, Health, Métis Nation-Saskatchwan); INAN, *Evidence*, 10 May 2022, 1655 (Minister Chartrand).

Based on the testimony, the committee recommends:

Recommendation 10

That the Government of Canada work with Métis governments and organizations to ensure Métis people who are currently not eligible for Non-Insured Health Benefits have access to health services comparable to that of other Indigenous people; and that the Government of Canada do so while continuing to close the gap in services between Indigenous and non-Indigenous populations.

Inequalities

Racism and Discrimination

Several witnesses spoke about systemic racism and discrimination against Indigenous people in the health care system. The Indigenous Primary Health Care Council wrote that "[r]acism in the health system is deep-rooted since the time Indian hospitals were created in the 1930's. Indigenous people experience inequitable access to health services and receive subpar care that too often result in death."[97]

First Vice-Chief Pratt stated that "[s]ystemic racism is another issue that leads to our people receiving substandard care and sometimes to death, as was the case with Joyce Echaquan."[98] Dr. Makokis also spoke about Joyce Echaquan, adding that "people are dying because of systemic racism."[99] Colleen Erickson, Board Chair at the First Nations Health Authority, said that:

> Historic mistreatment of [F]irst [N]ations people in Canada has resulted in generations of trauma, racism and unequal access to health care services. While status [F]irst [N]ations people across Canada have access to basic health benefits, we believe that the policies and funding levels perpetuate health inequities. These challenges are further exacerbated by anti-[I]ndigenous racism that exists in the health system.[100]

97 Indigenous Primary Health Care Council, Brief submitted to the committee, 13 May 2022.

98 INAN, *Evidence*, 29 April 2022, 1325 (First Vice-Chief Pratt).

99 INAN, *Evidence*, 3 May 2022, 1720 (Dr. Makokis).

100 INAN, *Evidence*, 6 May 2022, 1405 (Ms. Erickson).

Based on the testimony, the committee recommends:

Recommendation 11

That the Government of Canada, in partnership with First Nations and Inuit, and in compliance with Joyce's Principle, implement measures to address systemic racism within the Non-Insured Health Benefits program, and that the issue of systemic racism be considered at all phases of their review and reform of the Non-Insured Health Benefits program.

Rural-Urban Divide

The committee also heard that people's experience with the NIHB program and health care depends on whether they live in urban or rural areas. While services may be more readily available in urban areas, certain costs are not covered: "For the urban [I]ndigenous population, all travel is out of pocket, as access to designated NIHB medical transportation is minimal due to the expansiveness of service provision."[101]

Grand Chief Daniels also raised this issue: "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."[102]

Based on the testimony, the committee recommends:

Recommendation 12

That the Government of Canada work with First Nations and Inuit partners to review the Non-Insured Health Benefits program for the purpose of expanding medical transportation benefits to individuals in urban centres.

101 INAN, *Evidence*, 13 May 2022, 1305 (Ms. Lidstone-Jones).

102 INAN, *Evidence*, 31 May 2022, 1635 (Grand Chief Daniels).

Issues Related to Specific Health Benefits

Diabetes Monitoring

The committee heard about the high prevalence of diabetes among Indigenous people.[103] Grand Chief Daniels explained that "[d]iabetes is very much preventable in our communities, but we continue to see skyrocketing rates that lead to amputations and kidney failure."[104] According to Mr. Malak:

> [R]educing complications of diabetes early will save a lot in the future. I believe the limiting factor is funding and allocation, but I believe that a lot of money would be saved in the long run if we reduced the burden on the health care system. That, I think, can be done through primary prevention—intervening before health effects occur.[105]

In its brief, the First Nations Health Authority (FNHA) also stated that prevention and health promotion for conditions that disproportionately affect First Nations (such as diabetes) could help to reduce future needs. The FNHA mentioned new innovations in the management of diabetes.[106]

In her brief, Dr. Catharina A. L. Felderhof, M.D., also wrote about advanced sensor-based glucose monitoring technology:

> These systems are accurate, timely and empowering for people with diabetes. They are also digitally enabling so that I can monitor my patients remotely and virtually, which is helpful given the diverse geographic distribution of many Indigenous peoples. In fact, having initiated the use of this glucose monitoring system within one [I]ndigenous community in my region, I have witnessed a level of total engagement and have observed significant improvements in diabetes management. As a result and based on the clinical and real-world evidence associated with this technology, I predict that millions of dollars

103 INAN, *Evidence*, 29 April 2022, 1350 (First Vice-Chief Pratt); INAN, *Evidence*, 10 May 2022, 1615 (Minister Chartrand); Catharina A.L. Felderhof, M.D., Brief submitted to the committee, 3 May 2022; Abbott Laboratories Co., Brief submitted to the committee, 3 May 2022.

104 INAN, *Evidence*, 31 May 2022, 1655 (Grand Chief Daniels).

105 INAN, *Evidence*, 10 May 2022, 1710 (Mr. Malak).

106 First Nations Health Authority, Brief submitted to the committee, 6 May 2022.

> will be save[d] within the health care system by placing blindness, renal dialysis and amputations, etc. in the rear view mirror.[107]

However, Dr. Felderhof notes that the NIHB program only covers such devices through a burdensome case-by-case process: "This is neither an appropriate nor equitable treatment of Indigenous peoples… Therefore, I am respectfully advocating for all Indigenous peoples with diabetes, regardless of age, to have complete and barrier-free access to this new technology through the NIHB Program to better manage and improve diabetes outcomes."[108]

In its brief, Abbott Laboratories Co., the company which manufactures the FreeStyle Libre Flash Glucose Monitoring System, made similar points:

> Innovative technologies have significantly evolved from the current NIHB access to painful, inconvenient finger-pricking tools such as blood glucose monitoring and glucose test strips. Today, advanced sensor-based glucose monitoring systems are currently reimbursed by the NIHB on a limited basis, either through case-by-case or for a very narrow NIHB patient population. However, these systems, such as FreeStyle Libre family of Flash Glucose Monitoring systems, are more widely available through provincial public drug plans including the Ontario Drug Benefit Program. Access to advanced glucose monitors in various provinces, enables better patient self-management, fewer hypoglycemic episodes, significantly improved quality of life and subsequent health systems savings. In short, new technology is life-changing for many Canadians living with diabetes and should be equitably available to support Indigenous people as well.[109]

Abbott Laboratories Co. made the following recommendations:

> We respectfully recommend that the NIHB Program be funded appropriately to a) equitably align with the publicly-funded services that many Canadians are already receiving through their provincial programs, but are not available to Indigenous peoples, and b) address the most significant and costly chronic conditions such as diabetes that are

107 Catharina A.L. Felderhof, M.D., Brief submitted to the committee, 3 May 2022.

108 Ibid.

109 Abbott Laboratories Co., Brief submitted to the committee, 3 May 2022.

> disproportionately impacting Indigenous peoples across Canada through access to appropriate and innovative technologies for all ages.[110]

Based on the testimony, the committee recommends:

Recommendation 13

That the Government of Canada work with First Nations and Inuit partners to review the Non-Insured Health Benefits program to ensure that, rather than having medical devices such as sensor-based glucose monitoring systems approved on a case-by-case basis, coverage for medical devices is comparable to that of the provincial or territorial program that provides the broadest coverage.

Dental Care Benefits

The committee received testimony from the Canadian Dental Association (CDA). The CDA called "for better access to facilities where dental treatment can be performed under general anesthesia… 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."[111]

The CDA also mentioned that administrative burdens are a barrier to accessing dental care through the NIHB program:

> 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 [PSDCP]. 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 not covered by the NIHB program… Given that [I]ndigenous oral health outcomes have lagged behind those of the non-[I]ndigenous population, the NIHB program should aim to facilitate efficient, quick access to care, rather than focusing on [cost] 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.[112]

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110 Ibid.

111 INAN, *Evidence*, 13 May 2022, 1300 (Dr. Lynn Tomkins, President, Canadian Dental Association); See also: Canadian Dental Association, Administration and Accessibility of Indigenous Peoples to the Non-Insured Health Benefits (NIHB) Program, 3 May 2022.

112 Ibid.

Finally, the CDA highlighted that none of the over $5 billion in dental care funding contained in Budget 2022 will specifically target First Nations and Inuit eligible to the NIHB program:

> This [budgetary commitment] may actually increase the significant oral health inequities between this group and the broader Canadian population. The federal government should, in partnership with [I]ndigenous governments and other relevant stakeholders, develop an oral health investment strategy to improve the oral health of [I]ndigenous communities. Beyond the concerns outlined earlier, this [investment strategy] could also include things like investments in education and awareness campaigns, public health programs providing preventative care, as well as access to clean drinking water and community water fluoridation.[113]

Based on witness testimony, the committee recommends:

Recommendation 14

That the Government of Canada work with First Nations and Inuit partners and relevant stakeholders to review dental benefits provided under the Non-Insured Health Benefits program to ensure that coverage for procedures is comparable to other dental programs, such as the federal public service dental care plan, and that the approval process for procedures is also comparable to similar programs.

Recommendation 15

That the Government of Canada work with First Nations, Inuit, and Métis partners and relevant stakeholders to develop an oral health investment strategy to improve the oral health of Indigenous communities.

Vision Care Benefits

Maggie Putulik, Vice-President of Health Services at the Nunasi Corporation, spoke about vision care benefits. Her organization recommended

> [Updating] 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. 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

113 Ibid.

> 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.[114]

Based on witness testimony, the committee recommends:

Recommendation 16

That the Government of Canada increase the vision care benefits provided under the Non-Insured Health Benefits program to reflect actual costs incurred for eye exams and glasses, and that coverage include contact lenses and, where appropriate, laser eye corrective procedures.

Mental Health and Counselling

First Vice-Chief Pratt cautioned that many communities are currently facing an addictions and mental health crisis, and that investments are critically needed in these areas.[115] The Honourable John Main, Minister of Health of the Government of Nunavut, indicated that, in Nunavut, "needs are increasing quite steadily when it comes to… mental health and addictions."[116] Ms. Grier explained that "[t]he mental health needs of Indigenous peoples are higher than average due to the harms brought about by colonization, residential schools, the Sixties Scoop and the [reserve] system."[117]

The committee heard about the Nishnawbe Aski Nation's HOPE Mental Health and Addictions Support Access Program, which "offers a virtual, holistic, rapid-access approach to mental health, addictions and crisis support that is available 24 hours a day, seven days a week and 365 days a year by telephone, web chat, video and text messages."[118]

Ms. Grier highlighted one barrier to accessing mental health care:

> In 2015 CCPA [Canadian Counselling and Psychotherapy Association]'s Canadian certified counsellors, CCCs, were delisted as mental health practitioners from the non-insured health benefits program, NIHB, for First Nations and Inuit in provinces that had

114 INAN, *Evidence*, 13 May 2022, 1315 (Ms. Putulik).

115 INAN, *Evidence*, 29 April 2022, 1355 (First Vice-Chief Pratt).

116 INAN, *Evidence*, 3 May 2022, 1555 (Minister Main).

117 INAN, *Evidence*, 10 May 2022, 1715 (Ms. Grier).

118 INAN, *Evidence*, 6 May 2022, 1415 (Mr. Dalton).

> not yet regulated the profession of counselling. As a result, access to essential mental health services was restricted depending upon the province of residence… By restricting access to CCCs who are currently eligible providers in other federal health benefit programs as well as in the First Nation Health Authority, which is NIHB's counterpart in British Columbia, the federal government is not providing equitable access to mental health care for all [I]ndigenous peoples nor at the same standard as they are providing to non-Indigenous Canadians. This policy also discriminates against CCCs who are First Nations or Indigenous practitioners, like myself. As NIHB is the primary source of mental health funding, many cannot practice in their communities or traditional territories.[119]

The CCPA recommended that Indigenous Services Canada "immediately reinstate [Canadian certified counsellors] in unregulated provinces under the NIHB program. This will add close to 1,500 providers in Alberta, Manitoba, Saskatchewan and Newfoundland and Labrador."[120] "These [Canadian certified counsellors] are an integral part of a solution to address [the] mental health crisis."[121]

Based on witness testimony, the committee recommends:

Recommendation 17

That the Government of Canada immediately reinstate Canadian certified counsellors in unregulated provinces under the Non-Insured Health Benefits program.

Service Providers Opting Out of the Program

Based on what the committee heard, the fact that services providers are opting out of the NIHB program is directly linked to other issues, such as compensation delays. First Vice-Chief Pratt explained that services providers are increasingly refusing to participate to the NIHB program:

> I will give you an example right now. Some optometrists in the Saskatchewan region are no longer taking NIHB. People have to prepay and then they have to submit their receipts to NIHB, because the optometrists will no longer submit them for them. That's one example of a broken system that needs to be fixed… I don't think people should be allowed to opt out of NIHB.[122]

119 INAN, *Evidence*, 10 May 2022, 1715 (Ms. Grier).

120 Ibid.

121 Ibid.

122 INAN, *Evidence*, 29 April 2022, 1400 (First Vice-Chief Pratt).

According to Ms. Messier:

> In recent years, many professionals have decided to stop working with the program, leaving patients to pay for services and seek reimbursement on their own. Sometimes it can take several weeks between the request for pre-approval for a service and the response from the program indicating whether the request is accepted or refused. This reality is of great concern, especially for remote and isolated areas where the number of professionals located close to the community is limited.[123]

Ms. Lidstone-Jones explained that "many service providers that are aware of the NIHB program choose not to participate because of the predetermination processes and the length of time to process."[124]

Lack of Awareness of the Program

Additionally, there are many services providers who are not aware of, or knowledgeable about, the NIHB program. According to Ms. Messier,

> The lack of awareness by professionals and [F]irst [N]ations of the program's services is an additional barrier to access. All eligibility criteria for services and treatments are not transmitted, which is a major barrier for professionals who must determine the best treatment plan for their patients. This issue creates unacceptable delays for patients and professionals, who must take specific steps to have some of these services covered by the program.[125]

Ms. Lidstone-Jones echoed those comments:

> [T]here 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 [I]ndigenous clients are not offered the option of actually having the provider submit reimbursement on their behalf. If the client requests direct billing to NIHB, it is often denied by the service provider.[126]

In its brief, the Indigenous Primary Health Care Council recommended implementing "a communication blitz through regulatory bodies of services providers, or national associations, such as the Canadian Dental Regulatory Authorization Federation, to

123 INAN, *Evidence*, 6 May 2022, 1410 (Ms. Messier).

124 INAN, *Evidence*, 13 May 2022, 1305 (Ms. Lidstone-Jones).

125 INAN, *Evidence*, 6 May 2022, 1410 (Ms. Messier).

126 INAN, *Evidence*, 13 May 2022, 1305 (Ms. Lidstone-Jones).

increase awareness of not only the NIHB program but also on the importance of cultural safety and providing services in a good way."[127]

Based on witness testimony, the committee recommends:

Recommendation 18

That the Government of Canada work with First Nations and Inuit partners, health professional regulatory authorities, and health professional associations to increase awareness of the Non-Insured Health Benefits Program.

CONCLUSION

First Nations and Inuit need to have access to health care services that are equal to the services provided to other Canadians. The provision of healthcare services that comprehensively meet the needs of Indigenous people is essential for reaching true reconciliation with Indigenous people in Canada.

The NIHB program currently serves as the main coverage plan for many First Nations and Inuit.[128] It has been described as a "lifeline for [I]ndigenous people."[129] The program is imperfect, but "without NIHB, many patients would be without any meaningful access to certain types of care."[130] Issues surrounding the program's accessibility and administration need urgent action. Better health outcomes in First Nations and Inuit communities, as well as among Indigenous people living in urban areas, depend on it.

Once again, the committee wishes to thank all the individuals and organizations who took part in this study. Their testimony highlighted urgent needs that the committee believes ought to be addressed immediately by the Government of Canada. The committee wishes to reiterate the words of President Caron of the Métis National Council: "[e]veryone in Canada has the right to health."[131]

127 Indigenous Primary Health Care Council, Brief submitted to the committee, 13 May 2022.

128 INAN, *Evidence*, 31 May 2022, 1630 (Ms. Clark).

129 INAN, *Evidence*, 29 April 2022, 1320 (First Vice-Chief Pratt).

130 INAN, *Evidence*, 3 May 2022, 1630 (Dr. Lafontaine).

131 INAN, *Evidence*, 29 April 2022, 1310 (President Caron).

APPENDIX A
CALLS TO ACTION 18 TO 24 OF THE TRUTH AND RECONCILIATION COMMISSION OF CANADA

Call to Action no. 18

We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

Call to Action no. 19

We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess longterm trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services.

Call to Action no. 20

In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.

Call to Action no. 21

We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

Call to Action no. 22

We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

Call to Action no. 23

We call upon all levels of government to:

i. Increase the number of Aboriginal professionals working in the health-care field.

ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.

iii. Provide cultural competency training for all healthcare professionals.

Call to Action no. 24

We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the *United Nations Declaration on the Rights of Indigenous Peoples*, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

APPENDIX B
JOYCE'S PRINCIPLE

Joyce's Principle

Joyce's Principle aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health.

Joyce's Principle requires the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health.

Source: Council of the Atikamekw of Manawan and Council of the Atikamekw Nation, *Joyce's Principle*, November 2020.

APPENDIX C
LIST OF WITNESSES

The following table lists the witnesses who appeared before the committee at its meetings related to this report. Transcripts of all public meetings related to this report are available on the committee's webpage for this study.

Organizations and Individuals	Date	Meeting
Assembly of First Nations	2022/04/29	16
David Pratt, First Vice-Chief, Federation of Sovereign Indigenous Nations		
Inuit Tapiriit Kanatami	2022/04/29	16
Pierre Lecomte, Senior Policy Advisor		
Natan Obed, President		
Métis National Council	2022/04/29	16
Cassidy Caron, President		
As an individual	2022/05/03	17
Dr. James A. Makokis, Plains Cree Family Physician, Kinokamasihk Nehiyawak Nation, Treaty Number Six Territory		
Canadian Medical Association	2022/05/03	17
Dr. Alika Lafontaine, President-Elect		
Government of Nunavut	2022/05/03	17
Hon. John Main, Minister of Health		
Government of the Northwest Territories	2022/05/03	17
Hon. Julie Green, Minister of Health and Social Services		
Government of Yukon	2022/05/03	17
Hon. Tracy-Anne McPhee, Minister of Health and Social Services		
Indigenous Physicians Association of Canada	2022/05/03	17
Dr. Evan Adams, Vice-President		

Organizations and Individuals	Date	Meeting
Department of Crown-Indigenous Relations and Northern Affairs	2022/05/06	18
Nancy Kearnan, Director General, Northern Governance Branch		
Department of Indigenous Services	2022/05/06	18
Dr. Evan Adams, Deputy Chief Medical Officer of Public Health		
Keith Conn, Assistant Deputy Minister, First Nations and Inuit Health Branch		
Scott Doidge, Director General, Non-Insured Health Benefits Directorate, First Nations and Inuit Health Branch		
Christiane Fox, Deputy Minister		
Valerie Gideon, Associate Deputy Minister		
Hon. Patty Hajdu, P.C., M.P., Minister of Indigenous Services		
First Nations Health Authority	2022/05/06	18
Colleen Erickson, Board Chair		
Richard Jock, Chief Executive Officer		
First Nations of Quebec and Labrador Health and Social Services Commission	2022/05/06	18
Jessie Messier, Interim Manager, Health Services		
Isabelle Verret, Advisor, Health Access Services		
Nishnawbe Aski Mental Health and Addictions Support Access Program	2022/05/06	18
Carl Dalton, Chief Executive Officer		
Orpah McKenzie, Director, eHealth Telemedicine Services		
As an individual	2022/05/10	19
Rudy Malak, Pharmacist, Little Current Guardian Pharmacy		

Organizations and Individuals	Date	Meeting
Canadian Counselling and Psychotherapy Association	2022/05/10	19
Angela Grier, Lead, Indigenous Initiatives		
Innu Takuaikan Uashat Mak Mani-Utenam	2022/05/10	19
Marceline Tshernish, Director, Health Sector		
Kikino Metis Settlement	2022/05/10	19
Lee Thom, Elected Official		
Manitoba Métis Federation	2022/05/10	19
Frances Chartrand, Minister of Health and Wellness		
Métis Nation-Saskatchewan	2022/05/10	19
Marg Friesen, Minister of Health		
Adel Panahi, Director, Health		
Canadian Dental Association	2022/05/13	20
Dr. Philip Poon, Lead, Non-Insured Health Benefits Subcommitee		
Dr. Lynn Tomkins, President		
Gwich'in Tribal Council	2022/05/13	20
Grand Chief Ken Kyikavichik		
Indigenous Primary Health Care Council	2022/05/13	20
Caroline Lidstone-Jones, Chief Executive Officer		
Madawaska Maliseet First Nation	2022/05/13	20
Isabelle Wallace, Community Health Nurse		
Northwest Territory Métis Nation	2022/05/13	20
Betty Villebrun, Vice-President		
Nunasi Corporation	2022/05/13	20
Maggie Putulik, Vice-President, Health Services		
As an individual	2022/05/31	22
Joy Idlout, Compensation and Benefits Officer		

Organizations and Individuals	Date	Meeting
Native Women's Association of Canada Lee Allison Clark, Manager, Policy and Research	2022/05/31	22
Southern Chiefs' Organization Inc. Grand Chief Jerry Daniels	2022/05/31	22

APPENDIX D
LIST OF BRIEFS

The following is an alphabetical list of organizations and individuals who submitted briefs to the committee related to this report. For more information, please consult the committee's webpage for this study.

Abbott Laboratories

Canadian Dental Association

Felderhof, Catharina A.L.

First Nations Health Authority

Indigenous Primary Health Care Council

Kwanlin Dün First Nation

Nishnawbe Aski Mental Health and Addictions Support Access Program

Northwest Territory Métis Nation

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the committee requests that the government table a comprehensive response to this Report.

A copy of the relevant *Minutes of Proceedings* (Meetings Nos. 16, 17, 18, 19, 20, 22, 30 and 41) is tabled.

Respectfully submitted,

Hon. Marc Garneau
Chair