Study of Administration and Accessibility of Indigenous Peoples to the Non-Insured Benefits Program

Briefing Note

Prepared By: Indigenous Primary Health Care Council

Purpose: Provide feedback NIHB program from a northern, rural, and urban Indigenous perspective

Prepared For: The House of Commons Standing Committee on Indigenous and Northern Affairs

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Introduction

The Indigenous Primary Health Care Council (IPHCC) was incorporated on November 20, 2019, although it has been operating informally for many years. The IPHCC supports members from 20 Indigenous community health care organizations, including Aboriginal Health Access Centres (AHACs), Indigenous Interprofessional Primary Care Teams (IIPCTs), Indigenous Community Health Centres (ICHCs), and Indigenous Family Health Teams (IFHTs) across Ontario. The sector has been around for thirty plus years, and because of ongoing expansion, the IPHCC decided to establish themselves provincially.

IPHCC is an Indigenous- governed culture-based and Indigenous-informed organization. Its key mandate is to support the advancement and evolution of Indigenous primary health care services provision and planning throughout Ontario.

Indigenous Primary Health Care (IPHC) takes an Indigenous-led and community-centred wholistic approach to improve the mental, emotional, physical, and spiritual health and wellbeing of Indigenous peoples. Traditional knowledge, traditional healing practices, and self-determination underpin IPHC and are central to restoring balance at the individual, familial, community, and nation levels. IPHC also encompasses distinct Indigenous models of care and existing Western knowledge and practices that are adapted to be inclusive of Two-Eyed Seeing and traditional healing and wellness approaches.

Indigenous peoples may choose either approach or a blended mode of care which best facilitates and enhances their wellness journey.

System partners play an important role in promoting Indigenous health in Indigenous hands by advocating for Indigenous health equity and justice, ensuring that primary health care is provided in a culturally safe manner and working to address the broader determinants of health.

Self-determination and traditional knowledges and practices are foundational; they empower individuals, families, and communities to self-heal and lead and manage their well-being. The overall result leads to the improvement of health outcomes for Indigenous peoples.

IPHCC Vision

A health system where Indigenous people have access to high quality, safe care, and are treated with empathy, dignity, and respect.

IPHCC Mission

We enable transformative and decolonizing change within individuals, organizations, and systems.

IPHCC Members

NIHB Program

In providing feedback into the study of the Administration and Accessibility of Indigenous Peoples to the Non-Insured Health Benefits Program, we are doing so through an end user perspective that is First Nations, Inuit, Métis inclusive and solicitous of both northern, rural, and urban Indigenous considerations.

The four buckets of observations include affordability, accessibility, exclusionary, and safety.

Affordability

There are significant challenges or shortcomings with regards to affordability that can be captured categorically as follows:

Upfront/out of pocket costs for clients

1. Many services providers, whether it be dental, optometry, pharmaceutical or others, require Indigenous clients to pay for their services upfront and then independently submit receipts to NIHB for reimbursement. For some, this creates affordability challenges, as the services can be quite expensive. When looking at eye wear expenses, costs can be hundreds of dollars. Costs for emergency dental care can be upwards of thousands of dollars. Costs for root canal therapy alone averages from $520 to $1200 per tooth.
2. Out of pocket costs for travel remain a significant challenge for Indigenous peoples in northern, rural, and urban settings. For those living in northern and remote regions, there are out of pocket costs for travel that are continuing to escalate with increasing gas prices. For instance, the fees for driving are currently .22 cents per km, this fee is not keeping up with the costs of inflation and it further impedes the affordability of individuals to access appropriate health care.
    - Comparably, Reasonable allowance rates, identified by The Government of Canada website for 2022 are as follows:
        - 61¢ per kilometre for the first 5,000 kilometres driven
        - 55¢ per kilometre driven after that
        - In the Northwest Territories, Yukon, and Nunavut, there is an additional 4¢ per kilometre allowed for travel.
        - In addition, meals are reimbursed at a maximum of $60 per day; compared to Government of Canada website at $69 per day, without receipts.
3. As well as out of pocket costs that are not reimbursed for when more than one approved escort is required. Which is often the case when individuals are having surgery, cancer treatments, or care provided to infants and children. In many cases, clients are often denied medical escorts even though they are required due to cultural and language differences. Or for those who miss their scheduled transportation

arrangements or do not meet the NIHB guidelines, they are required to cover those costs.

4. For the urban Indigenous population, all travel is out of pocket as access to designated NIHB medical transportation is minimal due to the expansiveness of service provision. Individuals travelling to urban settings for services are required to pay up front for taxis or parking and gas. Both costs are extensive, especially in metropolitan areas where most speciality services are housed. Parking alone can range upwards of 30 plus dollars in the downtown core of major metropolitan areas.

Upfront/out of pocket costs for travel and services, creates significant affordability for those who may not have the required payment readily available. And as a result, this may force them to abandon their much-needed care completely, and when they eventually enter the system, it is now for emergency or curative services vs preventative.

Limited services provided

1. With regards to dental, braces are funded but not for cosmetic purposes, with orthodontics there are large fees, which many service providers require payment up front as there are reported significant challenges with the prior approval process. In addition, it is reported by providers that the wait times to receive payment back from NIHB is extensive, so some providers are opting not to register as a provider.
2. There is no coverage for physiotherapy. Chiropractic services require a physician referral and coverage amount is limited to $150 per year.
3. Occupational therapy services are available for on-reserve population but very difficult to attain approval for coverage for First Nations living off-reserve. For assistive devices where express scripts are required, they are not associated with non-insured and require pre-approval. For those who do receive pre-approval for services, the wait times are long.
4. For travel, coverage only applies to certain hotels and are paid directly from non-insured. It is reported that some hotels are removing their involvement with the NIHB program because of the length of time it takes to receive reimbursement. In addition, hotels require individuals to use a credit card upon check in or they are required to pay a deposit. Deposits to hotels seem to range between $50 to $300. This causes additional affordability challenges for some.
5. With regards to laboratory services, certain services are not covered by OHIP, and it is reported that clients are told that if it is not funded by OHIP, NIHB does not cover it. Depending upon the test requested, costs can range from $50 upwards in additional fees to the client.
6. For optometry services, many require payment up front and coverage is every two years from NIHB.
7. There are system difficulties responding to emergency request. Our NIHB system

Lack of awareness surrounding NIHB program

1. There is a general lack of awareness among service providers regarding the NIHB program, especially in urban settings. Many service providers are unaware of the program and their ability to access or register. As such, in many cases, Indigenous clients are not offered the option of provider-submitted reimbursement, or that approach to payment is requested by the client, it is denied. On the other hand, many service providers that are aware of the NIHB program choose not to participate, or worse-yet serve, Indigenous clients because of the administrative challenges related to NIHB billing and pre-determination processes.

Accessibility

With regards to accessibility, some of the challenges experienced by those living in northern, rural, and urban settings can be categorizes as follows:

Service Providers

1. There is limited access to services delivered by Indigenous practitioners. While there is a NIHB provider list for mental health, it is mostly comprised of non-Indigenous practitioners delivering mainstream services. Developing a similar list, and funding Indigenous practitioners with an emphasis on traditional healing is essential to supporting culture as healing. Reclaiming with culture, land-based healing, and connecting with cultural service providers are well-known strategies successfully supporting the Indigenous population on their healing journeys.
2. Many service providers will not work with NIHB and thus not accept status cards. For those who cannot afford to pay for the services upfront and await reimbursement from NIHB, this creates a significant accessibility to services issue.

Travel

1. The approval process for medical transportation is delayed or not expediated in a timely manner. This results in clients having to cancel their appointments. And we know that the wait time for most specialists and diagnostic testing is quite lengthy, so further delays required treatment and care.

NIHB Support

1. Connecting with NIHB representatives in real-time when experiencing an issue or having questions is a significant challenge. This is a well-known reason why service providers choose not to work with NIHB, it is a contributing factor to many Indigenous people not receiving the care they need. In many cases, out of frustration, they will abandon their care plan as trying to attain the supports through NIHB is time-consuming, complex, and labour intensive.

E-Literacy/Digital Equity

1. With the recent introduction of the e-portal for submission of claims, accessibility issues as related to e-literacy and digital equity. Many older people are not e-savvy, and thus unable to utilize on online portal.
2. Many Indigenous people do not have the tools required to leverage the e-portal, whether its devices or strong enough internet connectivity.
3. Those experiencing e-literacy and digital inequity are forced to continue using the archaic submission approach that was not working well, rather than having a readily available individual to help walk them through or complete the submission on their behalf.

Exclusionary

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.

Safety

Racism 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. When we speak about the anti-Indigenous acts of racism we reflect on the treatment of Joyce Echaquan, Brian Sinclair, and others. But we also reflect on those who did access needed services until it was too late, or at all, because of the anticipated treatment they would have received.

There is a significant gap in access to culturally safe care. We recommend mandatory Indigenous Cultural Safety training for those working internal to NIHB and those included on the provider list. Considering a consistent approach to cultural safety training with outlined expectations of completing a recognized course.

We also recommend implementation a communication blitz through regulatory bodies of services providers, or national associations, such as the Canadian Dental Regulatory Authorization Federation, to increase awareness of not only the NIHB program but also on the importance of cultural safety and providing services in a good way.

Recommendations

Challenges experienced by end users of the NIHB program are vast and complex. And it is only those with lived experiences that will be able to share where the program has been unsuccessful and how best it can be modified to meet their health needs. As such, we strongly recommend that the standing committee work with Indigenous organizations and those with lived experience to improve upon the challenges identified through this study. Applying a Two-Eyed Seeing approach to modification of the existing program will ensure that the knowledge and expertise of both Indigenous and non-Indigenous counterparts are heard and included in the solution-focused discussions.

Respectfully,

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