HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

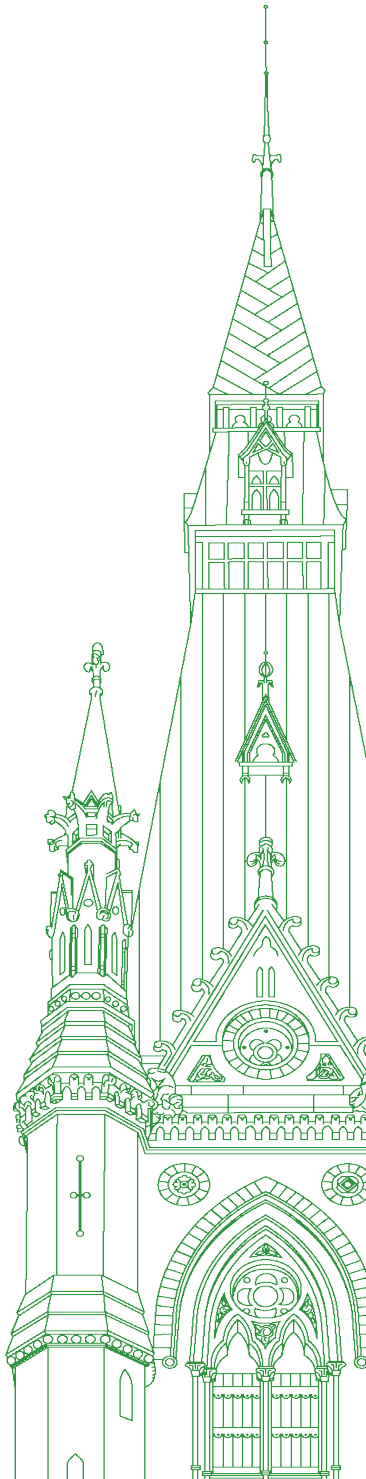
44th PARLIAMENT, 1st SESSION

Standing Committee on Indigenous and Northern Affairs

EVIDENCE

NUMBER 016

Friday, April 29, 2022



Chair: The Honourable Marc Garneau

Standing Committee on Indigenous and Northern Affairs

Friday, April 29, 2022

● (1305)

[*Translation*]

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

I call the meeting to order.

Welcome to the 16th meeting of the Standing Committee on Indigenous and Northern Affairs.

[*English*]

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

[*Translation*]

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

[*English*]

We will have three witnesses today. One of them is not yet online, but we're going to start the meeting with the hope that he will join us. At two o'clock, we'll proceed to our in camera meeting to discuss committee business.

[*Translation*]

I would like to remind you to respect the requirements of the Board of Internal Economy regarding physical distancing and wearing masks.

[*English*]

I would also like to outline a few rules to follow in our interactions.

Members or witnesses may speak in the official language of their choice. Interpretation services in English, French and Inuktitut are available for the first part of today's meeting. Please be patient with the interpretation. There may be a delay, especially since the Inuktitut has to be translated into English first before it can be translated into French, and vice versa. The interpretation button is found at the bottom of your screen with the choice of English, French or Inuktitut. If interpretation is lost, please inform us, and we'll stop the meeting until we can rectify the problem.

Before speaking, please wait until I recognize you by name, and if you are on the video conference, please click on the microphone icon to unmute yourself. When speaking, please speak slowly and clearly, and when you're not speaking, your mike should be on mute. I remind everyone that all comments should be addressed through the chair.

We're going to start with each of the witnesses speaking for five minutes.

Today, we have Vice-Chief David Pratt, Federation of Sovereign Indigenous Nations, appearing on behalf of the Assembly of First Nations. Vice-Chief Pratt is not yet online. We also have Natan Obed, president of the Inuit Tapiriit Kanatami, accompanied by Pierre Lecomte, senior policy adviser of the ITK. Finally, we have Cassidy Caron, president, Métis National Council.

Given that Vice-Chief Pratt is not here yet, I would ask Mr. Obed, if he is ready, to kick us off with a five-minute presentation.

Mr. Obed, please go ahead.

Mr. Natan Obed (President, Inuit Tapiriit Kanatami): *Nakurmiik*, Mr. Chair. It's great to be here talking about such an important topic.

I'm Natan Obed. I'm the president of Inuit Tapiriit Kanatami, which is the national representational organization for Canada's 65,000 Inuit.

The majority of Inuit live in Inuit Nunangat, which is our homeland that encompasses 51 communities across the Inuvialuit Settlement Region in the Northwest Territories, the entirety of Nunavut, Nunavik in northern Quebec and the Nunatsiavut region in northern Labrador.

Many Inuit also live in southern centres. When it comes to the considerations for non-insured health benefits, those Inuit who live out of jurisdiction are still indigenous peoples and still have the ability to access non-insured health benefits but in very different ways.

There are three points I hope you take from my presentation.

First, the majority of Inuit rely on non-insured health benefits and access a range of medically necessary health care products and services that are not otherwise provided through provincial and territorial health programs, social programs or private insurance plans. Inuit are not a part of the Indian Act, so the jurisdiction and the service delivery flow primarily through provinces and territories or through Inuit self-governing mechanisms, which are emerging and will continue to evolve as we are successful in achieving self-determination over the health care system.

My second point is in relation to Inuit beneficiaries facing barriers in accessing and receiving NIHB program benefits due to the existing program structure, its restrictive policies and administrative processes.

Finally, there's a clear need for the development and implementation of Inuit-specific goals and objectives to address barriers to care and to provide timely, responsive and equitable access to NIHB by Inuit, no matter where they reside.

The NIHB program plays a key role in health care access and delivery in Inuit Nunangat, from medical transportation, pharmaceuticals, dental care, vision care, medical supplies and equipment, and other services. These health care products are administered and delivered to Inuit by the NIHB program and they directly impact our health outcomes. Given the state of Inuit health and the challenges of health care delivery across Inuit Nunangat, it's fundamentally important that the NIHB program provides timely and accessible health care products and services to fully support the health care needs of Inuit.

To this end, the program must be properly resourced, offer unique and adaptable administrative processes and be accountable to the goal of timely access to care. The things we are hoping for from any improvements to the NIHB program are a recognition and commitment that demonstrate the government's willingness and leadership to better meet the needs of Inuit, to be truly responsive to Inuit-specific circumstances and realities, and to provide a firm commitment on improving timely access to care.

These changes have to be made to improve the program's approach and delivery in order to support the needs of Inuit across Inuit Nunangat. There must be clear and specific priorities that are delivered in a timely and distinctions-based way. They must also allow for considerations of Inuit positions in the way in which these services are considered and delivered.

In conclusion, we urge the standing committee to seriously consider the importance of providing inclusive and Inuit-specific goals and objectives as part of its review of the NIHB program's administration and accessibility objectives and, further, to truly demonstrate a clear commitment to eliminate barriers to timely access and develop responsive processes to better meet the needs of Inuit.

Thank you for the opportunity.

● (1310)

The Chair: Thank you, President Obed.

[*Translation*]

I will now give the floor to the president of the Métis National Council.

Go ahead, Ms. Caron. You have five minutes.

[*English*]

Ms. Cassidy Caron (President, Métis National Council): *Tanshi*. Thank you.

Good afternoon, Chair and committee members. Thank you for the opportunity to participate in your hearing today.

I am here as the president of the Métis National Council to speak to you on the administration and accessibility of non-insured health benefits for Métis people. This has been identified as a top health priority for the Métis Nation's citizens.

On April 13, 2017, the Canada-Métis Nation Accord was signed by the Métis National Council, its governing members and the Prime Minister on behalf of Canada. It recognizes the Métis Nation as a distinct indigenous nation with inherent rights and formalized the nation-to-nation, government-to-government relationship between the Métis Nation and the Government of Canada.

The Métis Nation, with its own collective identity, language and way of life, continues to advance its right to self-determination, including self-government in Canada, through democratically elected governance structures and registries. Each governing member is mandated to represent its citizens. As a constitutionally recognized indigenous people, Métis must have the same opportunity as first nations and Inuit to contribute to the achievement of an overall health status comparable to the Canadian population, and shift the focus of health service delivery from an illness model to a prevention, wellness and health promotion model.

Métis people do not have poor health outcomes because they are Métis. Poor health outcomes are a result of oppressive policies that have effectively sought to erase or assimilate the Métis. Health is not merely the absence of disease. For the Métis Nation, it is a state of balanced and interconnected relationship between physical, mental, social, spiritual, environmental and cultural well-being.

A self-determined Métis version of the non-insured health benefits will work toward improved health and well-being for Métis citizens, families and communities now and for future generations. It is increasingly clear that these health inequities arise from disparities in Métis social determinants of health and the processes of colonization, forced assimilation and social exclusion.

In 2013, the Health Council of Canada reported that despite significant investment to address inequities in the health status and health outcomes of aboriginal peoples, the impact of these initiatives is unclear. None of the noted federal health services available to other indigenous people are currently available, nor have they ever been available, to Métis people. Provincial supports and services are also not meeting the needs of Métis citizens.

However, a positive example can be found in the territories. The Government of the Northwest Territories' Métis health benefits program provides Métis with access to a range of benefits not covered by standard hospital and medical care insurance, including eligible prescription drugs, dental services, vision care, medical supplies and equipment, and medical transport and accommodation. Benefits of this nature should be available to Métis citizens across the homeland.

Métis non-insured health benefits should be financially sustained by federal financial resources and coordinated with provincial authorities and private insurance providers. With secured resources, the MNC's governing members are ready to action the exploration of operational and financial models responsible for the needs of Métis citizens. These actions will include feasibility analyses of benefit plans, coverage, cost-benefit analysis, burden of disease, health and economic impact assessments.

Everyone in Canada has the right to health. This right is defined and protected by international human rights treaties that Canada has ratified. The International Covenant on Economic, Social and Cultural Rights affirms the right to enjoy the highest attainable standard of physical and mental health.

In the Canadian context, the preamble to the Canada Health Act states:

> —that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

Specific to indigenous peoples, the Truth and Reconciliation Commission's call to action number 20 calls upon the federal government to "recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples."

These rights mean that all indigenous people should be able to access the health and wellness programs, services and non-insured health benefits they need, when and where they need them, without suffering financial hardship or encountering anti-indigenous racism. Many Métis cannot realize the right to health as it currently stands.

In the current system, Métis are underserved and marginalized, resulting in poorer health outcomes and vulnerability. The Canadian federal, provincial and territorial governments have an obligation to support the opportunity for barrier-free, high-quality, culturally safe and equitable health programs, services and benefits for Métis citizens.

● (1315)

We are working alongside the government and having conversations, and we hope to propose a self-determined Métis non-insured health benefits plan. The Métis Nation is committed to working with all levels of government as an equal partner to make this happen. We look forward to actioning a Métis non-insured health benefits program.

Thank you again for the opportunity to articulate the immediate health priority of the Métis Nation and express the voice of Métis citizens.

We welcome any questions you may have. *Marci*.

The Chair: Thank you, Ms. Caron.

Vice-Chief David Pratt is now with us.

Vice-Chief Pratt, you have five minutes to make your initial presentation.

● (1320)

Vice-Chief David Pratt (First Vice-Chief, Federation of Sovereign Indigenous Nations, Assembly of First Nations): Thank you, Mr. Chair.

Good afternoon, everyone.

[*Witness spoke in Ojibwa as follows:*]

Aaniin chigwaa daan siikiwaa.

[*Ojibwa text translated as follows:*]

Hello to everyone.

[*English*]

First of all, I want to acknowledge the Treaty 6 territory that I am calling from today.

I want to greet the members of the Standing Committee on Indigenous and Northern Affairs who are gathered here, and you, Chair Garneau. It is my pleasure to appear before you to speak on the non-insured health benefits program.

I am joining this committee presentation today from Treaty 6, as I stated previously. I am David Pratt, vice-chief of the Federation of Sovereign Indigenous Nations in Saskatchewan. I am the Saskatchewan representation on the chiefs committee on health at the Assembly of First Nations.

I am presenting today on behalf of the Assembly of First Nations. I would like to thank this committee for taking the time to explore this matter of great importance to first nations communities, and that is the non-insured health benefits program. It has consistently been identified as an irritant for first nations and a high priority area for AFN advocacy and transformation.

The NIHB program is perhaps the most frequently cited grievance related to federal health programs and has many factors, including inadequate coverage, lack of timely access, inconsistent adjudication of claims and burdensome administrative cases.

The AFN notes that the NIHB program remains primarily concerned with cost containment rather than providing adequate and timely medical benefits and services to first nations. As you are likely aware, there is an AFN-FNIHB joint review of the NIHB program. The pandemic has stalled some of the progress of this important work, but we look forward to continuing to move forward with this review to make meaningful changes together.

For our first nations, NIHB can be seen as a bureaucratic and intimidating entity. Our NIHB navigators work tirelessly in every region and are a source of immense support, and we thank them for their service. They are on the front lines working with families to navigate the overwhelming system, dealing with the consequences of national policies and guidelines at the grassroots level, and this work can be challenging, to be sure.

It is critical to note that first nations are very clear that the NIHB program is funded in the federal fiduciary responsibility based on guarantees through treaty. Our elders teach us that treaties between the first nations and the Crown are an articulation of the Creator's gifts and wisdom. In addition, they are sacred. The treaties articulate relationships and ongoing legal obligations.

In the case of health, treaties reaffirm first nations' jurisdiction over their own health care systems and establish the positive obligation on the Crown to provide medicines and protection. Crown treaty obligations are founded both in verbal commitments and in the text of the treaties. To be clear, AFN is not a rights holder. Individual first nations and citizens holds these rights; however, AFN does play an important role in advocating with first nations for these rights to be upheld.

We know from lived experience that the health status of first nations is far below our national potential, given the financial resources and health system capacity in Canada. In essence, it means that we interact with the health care system more frequently throughout our lifespan than other Canadians.

Numerous national and regional reports from RCAP in 1996, the TRC calls to action in 2015 and the MMIWG calls to justice in 2019 have confirmed that the mental, physical and spiritual health of first nations are severely compromised by policy obstacles and constraints, disjointed jurisdiction, proximity to services and overt racism in the health care and justice systems.

NIHB was constructed to be the payer of last resort, but for many first nations this is their only option. For that reason, we must offer remedies that address the operational and systemic deficits within this program. From what we see and hear, the administrative challenges with the NIHB program have been cumbersome, with the burden carried by our citizens. Reimbursements from NIHB to service providers is rife with delay and denials. Service providers are dropping out of the NIHB program at an alarming rate. For first nations who may already have trouble finding a service provider, it becomes even more of a challenge to find care when dentists and optometrists refuse to deal with NIHB anymore.

For those who do stay on, frustrated with the NIHB program delays, more and more service providers are expecting upfront payments from our people. This is an incredible burden on our citizens, particularly elders and others on a fixed or limited income. 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.

I would like to touch on related concerns regarding health care for first nations. The COVID-19 pandemic has aggravated existing health and social inequities, and today we see and hear of the multiple and concurrent gaps that affect people's ability to find culturally appropriate supports for their mental wellness and/or addiction issues.

● (1325)

Systemic racism is another issue that leads to our people receiving substandard care and sometimes to death, as was the case with Joyce Echaquan. Systemic racism leads to our people delaying seeking care from health service providers. Their health may then deteriorate to the point where mostly costly intervention is required and time away from home is extended.

Maternal and child health, along with reproductive health services, were placed under a microscope when news of the forced sterilization of indigenous women and girls was revealed. This criminal practice demonstrates the deeply embedded racist views of some medical professionals. Forced sterilization is yet another act of genocide against first nations. At present, NIHB does not cover costs associated with supports for these women, nor are their fertility needs calculated into the benefits.

Currently, the western health system is failing our people, and many are returning to traditional healing to add vigour to health regimes. Traditional and spiritual counsellors and healers need to be properly recognized and fairly compensated. It should not be up to federal civil servants to determine what eligible expenses are, when this should clearly be guided by first nations ourselves.

Moving forward, NIHB funding must be matched to health needs on an ongoing cycle to ensure sustainability of the program. A long-term strategy must be developed for funding, premised on realistic expenditures and utilization projections. This includes population growth, aging projections, inflation trends and an annual escalator attributable to utilization, new treatments, changes in the delivery of health services and geography, as well as other factors.

We also recommend that the Government of Canada support, through policy and funding, the formal inclusion of traditional healing in the NIHB program. This process, like all decisions, must be led by first nations for first nations. The systemic failures of the NIHB program continue to occur because there is very little accountability to first nations, and as such, we need reliable and credible data presented in a meaningful way, so we can assess the cumulative deficits and construct policy solutions.

We welcome continued engagement and encourage collaborative efforts to address concerns with the NIHB program. Together, we hope to reform and realign wellness programs and services according to first nations priorities that do not place continued restrictions on our health as the NIHB administration process seems to do. Our people deserve better.

As stated in the United Nations Declaration on the Rights of Indigenous Peoples in article 21—

The Chair: Thank you, Vice-Chief. We have to wrap up now.

Vice-Chief David Pratt: —our people have the right to improved health outcomes.

Thank you, Mr. Chair.

The Chair: Thank you, Vice-Chief Pratt.

We'll go to the first round of questions, each lasting six minutes.

We'll begin with Mr. Viersen.

Mr. Arnold Viersen (Peace River—Westlock, CPC): Thank you, Mr. Chair.

I want to thank the witnesses for being here, many of whom I've gotten to know, particularly Natan. I've gotten to know him over the last few years for sure, so welcome.

This is an important study. I know that whenever the government is dealing with health care and the intrusion...not necessarily intrusion but the caretaking of individual lives, the government must tread carefully. As we have seen with the residential schools situation in the past, here we are again with a large government institution that is trying to manage the day-to-day lives of individuals. I want to thank the witnesses for their testimony on this important topic.

One of the things I know, coming from northern Alberta and representing 14 first nations, is that access to health care is a big challenge, and I want to commend the individual nations for.... They all have a system of transport.

I'll start with Natan, in particular. How does getting to health care facilities in his region work? Is that a challenge? Are there areas that need to be worked on around that?

I know [*Technical difficulty—Editor*] in northern Alberta, there are these big white Ford vans. The ones I'm thinking of, in particular, have "Driftpile medical transport" written on the side of the vans, and I see them regularly coming through Barrhead, my hometown, bringing folks to their health care appointments. It's not just to the hospital. They can get an ambulance for that, but the vans bring them to their everyday medical appointments.

Natan, I'm wondering if you could elaborate on how that works in your neck of the woods.

● (1330)

Mr. Natan Obed: Thank you, Mr. Viersen, for that question. It has been good to get to know you over the last six years on a lot to do with indigenous and Inuit issues.

This is a point of contention within the NIHB program for Inuit, and it's about the way in which decisions are made. Often decisions made in relation to medical transportation are not happening in real time, and sometimes people can experience weeks or months of delays in being approved for medical transportation or for escorts—people who can help the patient get to care. This is vitally important because of where the care happens.

There are 51 Inuit Nunangat communities, and just about each one of these communities doesn't have access to roads to the south. Inuvik and Tuktoyaktuk in the Northwest Territories technically have southern road access, but medical care doesn't flow through that road access. It still flows through flights to Yellowknife and then to Edmonton, largely.

If people are in urgent need of care and need help to get to that care, the NIHB program can be a lifeline to ensure that culturally safe and immediate care happens, especially in the language of choice of the recipient of care.

Sometimes there are programs within the province or territory that interact with the NIHB program about medical transportation, but too often we are hearing complaints from Inuit about either not being given clear decisions or being denied either medical transportation or escorts within medical transportation. This really is at the crux of what we can—

Mr. Arnold Viersen: Natan, would you have a fairly specific recommendation around transportation?

Mr. Natan Obed: The specific recommendation would be that.... Within the delivery of NIHB...?

Mr. Arnold Viersen: Yes. The ability to take an escort along, is that really where the crux of the problem is?

Mr. Natan Obed: I think for the solution that we're looking for, it would be a model within NIHB that is Inuit-specific and distinctions-based and that also has particular timelines for decision-making and clear links to the service delivery provision within the region.

Mr. Arnold Viersen: Ms. Caron, I'm not sure if you're still there. Your camera went off.

Ms. Cassidy Caron: I'm here. I just had to move.

The Chair: You have 30 seconds, Mr. Viersen.

Mr. Arnold Viersen: In that case, I will just recognize some of the hard-working Métis people of northern Alberta and Saskatchewan. In particular, I just want to recognize how many of them work in the resource sector and the oil patch in my neck of the woods and are still frustrated by having to pay the carbon tax and travel to get to medical appointments, with the carbon tax adding an increased burden on that.

You can confirm that, but I've probably used up all of my time at this point already.

Thank you.

The Chair: Thank you, Mr. Viersen.

We'll now go to Ms. Atwin.

Ms. Atwin, you have six minutes.

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

Thank you to all of our witnesses.

Today I'm speaking to you on the unceded traditional territory of the Wolastoqiyik here in Fredericton, New Brunswick.

I wanted to begin, as well, by congratulating you, President Caron, for being the first woman to represent the Métis National Council and for bringing women's voices in general to this really important discussion.

With the signing of the 2017 Canada-Métis Nation Accord, I understand that NIHB has begun to transfer funding for distinctions-based, Métis-specific programming. How is this process going?

Ms. Cassidy Caron: We have a lot of work to do within the Métis National Council, and thank you for your kind comments.

We've rapidly progressed since signing the Canada-Métis Nation Accord. We were really left out of a lot of different processes. We didn't have any established mechanisms to negotiate different policies or programs with the federal [*Technical difficulty—Editor*].

We still struggle to implement these programs into our communities due to a lack of infrastructure and a lack of capacity. Just throwing money at us to all of a sudden deliver programs and services to our people is fantastic. However, we have, at the same time, had to develop our capacity and our infrastructure to be able to do so. We've been playing catch-up and delivering these services all at the same time.

The work of the governing members of our Métis governments is just absolutely incredible. They are up to the challenge in doing all of that work. However, [*Technical difficulty—Editor*] there was an established program specifically for Métis people.

● (1335)

Mrs. Jenica Atwin: Thank you very much.

What would some key pillars be to the ideal model that would best serve your nation? It's kind of specific, but if you can give us some key themes, that would be really great.

Ms. Cassidy Caron: For sure.

We have already started having these different conversations and have actually just wrapped up developing the Métis Nation's vision for health. It's a health care framework that is largely the beginning of the process that the government is going to be doing in developing the distinctions-based health care legislation. We got to work in consulting with our communities to find out exactly what is needed for health care with Métis people.

The biggest thing we have is that it has to be holistic. Health care needs to encompass all of the social determinants of health. We make sure that we have conversations around even how climate change is affecting the health of our people. The biggest theme in our vision for health is ensuring that it is holistic and takes into consideration all of the different social determinants of health that are affecting our people.

Mrs. Jenica Atwin: That's excellent.

I'll turn to Vice-Chief Pratt, if I could.

I understand there's an ongoing review of the benefits that is being co-led by the AFN. This has resulted in funding from budget 2017 that had coverage for mental health counselling provided by traditional healers.

What has this meant for communities? Are there other areas in health care where solutions like this could be implemented? Mental health is very close to my heart, so I'd love to hear how this is working.

Vice-Chief David Pratt: Thank you for the question.

First of all, of course, first nations 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 first nations people utilize both 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.

Our position here in Saskatchewan, as well as in many of the other regions, is that our healers and our elders have to be part of the system. They bring such knowledge and I know they've helped a number of our people. One thing we know for sure, with all due respect to our European brothers and sisters, is that the western system of treatment, whether for addictions or mental health services, does not work. First nations have to drive it. It has to be holistic, and it has to be based not only on the spiritual connection but the mental and emotional connection. Even the connection to the land is so important.

There are some great things happening on the ground here with a lot of our traditional healers and their being incorporated, but non-insured health benefits have to properly respect them and give them that same level as a person with a medical degree or a person with a Ph.D. in psychology. That's key and that's critical as part of this long-term reform that we're talking about today.

I hope that answers your question.

Mrs. Jenica Atwin: Thank you very much.

You also mentioned Joyce Echaquan and the need for Joyce's principle in particular to be implemented across health care for indigenous peoples.

Can you speak more about that and some about systemic racism and how that impacts health care delivery for your communities?

Vice-Chief David Pratt: Oh, my goodness. At the FSIN, and I'm sure at the other regions, we have literally stacks of reports. Recently, the federal government committed to a first nations health ombudsperson and that work is starting.

There is encouraging news in Saskatchewan, in that over 70% of the health care professionals in a survey by Saskatchewan Health Authority recognize the need to do more for first nations' health. They recognize that we have to implement the TRC recommendations specifically for health care. There's 30% that hold the systemic and institutional racism that's impacting our people's health. We're dealing with cases right now, but there's a lot that has to happen.

As we move forward on this transformative work on NIHB, it can address some of those inequities and those discriminatory practices and hold the system accountable to our people when they walk through the doors of those emergency rooms and clinics.

● (1340)

[*Translation*]

The Chair: Thank you very much.

Mrs. Gill, you have the floor now for six minutes.

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

I'd like to thank all the witnesses for being with us today. What they are telling us about non-insurance health benefits is obviously very important.

Mr. Pratt, as you mentioned in your opening remarks, you were involved in the joint review of the NIHB program from 2015 to 2017. The Assembly of First Nations, or AFN, was there.

Since then—it'll be five years this year—what improvements do you think have been made? You can put it in many ways, depending on your priorities.

I'd also like to have your assessment of what remains to be done, in order of priority.

[*English*]

Vice-Chief David Pratt: Thank you for the question.

First of all, I just want to say that the work is continuing and is ongoing right now. It's a work in progress. There was some movement on that, but of course the pandemic put the brakes on everything when it came to the very important work that we're conducting right now.

I know that in terms of changes there are a lot of good conversations that have happened with Canada, where they were hearing the concerns from each of the regions. In terms of the implementation, I think we still have a lot of work to do, so that joint task force has to continue its work. That will be a priority at the AFN as we're moving forward. Especially now that we're coming out of the pandemic, we want to be able to continue to make sure that all the issues are being heard from all the 10 regions in Canada so that very important transformative work can happen.

I want to acknowledge our health navigators in each of the regions, because they do tremendous work. I speak not only on behalf of the FSIN but the other regions as well. When there's an issue and I bring it up, they elevate it and deal with the NIHB. Denials are reversed many times and, in a lot of cases, particularly with elders.

As I said in our statement, we had one elder who had to choose between paying her rent and paying for her dentures, because the NIHB pays for dentures only every five years. We got some advocacy going, she paid for her dentures—because she couldn't eat without them, obviously—they reimbursed her and she was able to make the rent.

Those are just some of the prime examples. A lot of first nations people rely on this program. We have to make sure that's it sustainable. Number one, we have a booming population, and number two, we have to make sure that it meets all the needs that the Crown agreed to when we signed the treaty, particularly the medicine chest clause of Treaty No. 6.

Meegwetch.

[*Translation*]

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

In short, following the review, there were consultations, but the implementation of the recommendations—in other words, the concrete actions—are still pending. The COVID-19 pandemic must be taken into account, but I would point out that from 2017 to 2020, three years have passed, and I hope that progress has been made during that period.

I would also have liked to hear from all of the witnesses on one part of the motion before us, which concerns call to action 22. My colleague Ms. Atwin mentioned this a little earlier, and it's about traditional first nations counsellors.

I have, of course, followed the work of the commission, but I wasn't involved in all the conversations. I would like you to tell us about the role of traditional counsellors. There are certainly elements that vary according to the different communities and the different peoples.

Could you explain what the traditional counsellors do? How do they work with individuals in the communities?

The motion and the Truth and Reconciliation Commission of Canada talk about recognition. How could their work be recognized?

I'd ask you to make your answer brief because I don't have much time left.

● (1345)

[*English*]

Vice-Chief David Pratt: How much time do I have, Mr. Chair?

The Chair: You have two minutes.

Vice-Chief David Pratt: Okay. I'll try to get it under 45 seconds.

First of all, thank you for that question.

I do want to say that the traditional healers, the elders in our first nations communities, do a lot of great work that's recognized. I know that they've done some excellent work in terms of healing.

I don't want to share too many stories here because of the time factor—and there's not enough time—but there are numerous occasions when there are no healers, and the elders—

[*Translation*]

Mrs. Marilène Gill: I'm sorry for interrupting you, Mr. Pratt.

It’s true that we don't have a lot of time and that's very limiting, but you could send the committee additional information, if you wish. That might complement what you were going to say.

Thank you.

[*English*]

Vice-Chief David Pratt: I'd be happy to. The AFN will prepare a brief note for the committee, and we'll forward more information on them. I really appreciate that you're interested in that. It shows that there's some interest in terms of our traditional medicines, our traditional ways and our elders.

We'd be happy to provide that to you as a follow-up to this committee.

Thank you, Mr. Chair.

The Chair: You're welcome.

[*Translation*]

Go ahead, Ms. Idlout. You now have the floor for six minutes.

[*English*]

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

ᖁᔭᓐᓇᒦᒃ ᐃᒃᓯᐸᐅᑖᖅ, ᐃᓘᓐᓇᓯ ᑐᓐᖓᓱᒃᑎᑦᑐᒪᕚᑦᓯ, ᖁᔭᓐᓇᒦᒃ ᐅᓂᒃᑳᑦᓯᐊᖅᑐᐃᓐᓇᐅᓚᑦᓯ ᐋ ᑕᒪᓐᓇ ᐱᒻᒪᕆᐊᓘᒻᒪᑦ ᐋ ᖃᐅᔨᒪᔪᐃᓐᓇᐅᖅᑰᕋᑦᑕ ᐋ ᐊᒥᓱᐃᑦ ᓄᓇᖅᑲᖅᑳᖅᓯᒪᔪᐃᑦ ᐊᑭᓕᖅᑐᖅᑕᐅᓇᑎᒃ ᐋ ᐃᑲᔪᖅᑐᐃᖃᑦᑕᕐᒪᑕ ᐋᓐᓂᐊᖃᕐᓇᖏᑦᑐᓕᕆᓂᐅᑉ ᒥᒃᓵᓄᑦ, ᐋ ᐊᐱᕆᔪᒪᕚᑦᓯ ᑖᒃᑯᐊ ᐋ ᐋᓐᓂᐊᕐᐱᓕᐊᖅᑐᓄᑦ ᐋ ᐃᑲᔪᖅᑎᐅᖃᑦᑕᖅᑐᑦ ᐋᒻ ᐃᓚ ᑕᐃᒃᑯᐊ ᐋᓐᓂᐊᕐᐱᓕᐊᖅᑐᑦ ᐃᑲᔪᖅᑎᖃᕆᐊᖃᓰᖕᒍᒻᒪᑕ ᑖᒃᑯᐊ ᐃᑲᔪᖅᑎᐅᔪᑦ ᐊᑭᓕᖅᑐᖅᑕᐅᓇᑎᒃ ᐃᓚᒥᓐᓂᒃ ᕿᒪᐃᓪᓗᑎᒃ ᐃᖅᑲᓇᐃᔾᔭᒥᓐᓂᒃ ᕿᒪᐃᓪᓗᑎᒃ ᐃᓛᓐᓂᒃᑯᑦ ᐊᑯᓂ ᑕᖅᑭᓂᒃ ᐊᐅᓪᓚᖅᓯᒪᕚᑦᓱᑎᒃ, ᐋ ᑭᐅᔪᓐᓇᖅᑐᐃᓐᓇᐅᕕᓲᒃ ᐋ ᓲᕐᓗᖃᐃ ᑳᓴᑎᑉ ᓯᕗᓪᓕᐅᓗᓂ ᓇᑖᓐ ᐊᒻ ᑕᐃᕕᑦ ᕿᖑᓪᓕᐅᓗᓂ ᑖᒃᑯᐊ ᐋ ᐊᐅᓪᓚᖃᑕᐅᒋᐊᖃᕈᑦ ᐃᑲᔪᖅᑎᐅᒋᐊᓖᑦ ᐋᓐᓂᐊᕐᐱᓕᐊᖅᑐᓂᒃ ᐊᑭᓕᖅᑐᖅᑕᐅᓐᓂᖅᐸᑕ ᐃᑲᔪᖅᐹᓪᓕᕋᔭᖅᐸᖅᑲᐃ ᐋ ᓄᓇᑲᖅᑳᖅᓯᒪᔪᐃᑦ ᐋᓐᓂᐊᖅᑲᖅᑕᐃᓕᒪᔾᔪᑎᖕᒥᓐᓂᒃ ᑖᓐᓇ ᓯᕗᓪᓕᖅ ᐊᐱᖅᑯᑎᒐ.

[*Inuktitut text interpreted as follows:*]

We know that many aboriginal people volunteer as medical escorts when people have to travel south. The medical escorts usually are volunteers without pay. They volunteer. They leave their families and children behind. Sometimes they may be away from their family for up to a month.

Cassidy, I'll ask you first, and then Natan and David.

The medical escorts make a big difference to the patient. They are volunteers. I would like to see them paid as medical escorts.

Can you answer my first question?

[*English*]

Ms. Cassidy Caron: Thank you. It's great to see you again.

Specifically for medical transport, once again, Métis people don't have access to NIHB. We have been developing medical transport systems on our own, with each of our governing members, for quite some time now. It's based on various contribution agreements that we get through federal, provincial and territorial governments, and sometimes even just by applying for grants through not-for-profit organizations.

As a specific example, Métis Nation Saskatchewan has set up their own medical transportation system from northern communities to the south. I don't have the actual stats on that and if they pay their support people who travel. That is something I'll have to look into.

You're absolutely right. The family members who travel with our community members down south to access health services have to put their lives on pause to be able to support their family member or friend who needs to access health services. If we can honour their time in ways they're not being honoured right now, I think it would be very beneficial.

Mr. Natan Obed: From the Inuit Tapiriit Kanatami perspective, this dovetails into official language rights and official language status. Inuktut has no federal status as an official language and doesn't have status even as an official language in Inuit Nunangat by the federal government. It has official language status within three of the four Inuit jurisdictions. Therefore, services that are provided by provincial or territorial governments sometimes can be delivered as a right in Inuktut.

Largely, medical escorts are also providing interpretation services. We need greater recognition of Inuktut within the way the federal government provides service delivery to Canadians to ensure that these services are not given by family members or people who have no training within the medical field, but that they are providing services on behalf of a health system and patients.

I think that some of the roles that escorts play are medical system roles. When those roles are provided, there should be a real clear understanding and focus by health systems about the compensation necessary in the provision of health services.

● (1350)

Vice-Chief David Pratt: Hello. Thank you for that question.

First of all, I want to acknowledge that medical transportation does present a lot of challenges, even in Saskatchewan. A number of our people have come forward, of course, with the rising costs of gasoline now. The mileage is inadequate for them to be able to get somewhere to meet the needs of our people, particularly when they're transporting our people, for example, to a dialysis treatment. Of course, diabetes is very prevalent amongst first nations people. We're not built for this western diet of Big Macs and fast food and processed foods that are sold at the Northern Store. We're off that diet now. It's impacting the health and welfare of our people. Medical transportation is a big issue.

You talked about the language, I believe, in terms of the challenges. The language barrier is huge, particularly for our northern and remote communities. For example, in the Dene community, we had an elder who was sick in one of our hospitals, the Victoria Hospital in Prince Albert, and they could not communicate with the doctors and the nurses. It was as simple as them reaching out to the local tribal council and saying, “Hey, we need a Dene speaker here.” It was a Dene nurse who was working on call on a shift who said this elder needs this, this and this. He finally started getting the treatment that he got.

In terms of the families being there to be able to provide those supports, yes, it's inadequate. I do want to acknowledge NIHB, but they need to bring up their hotel rates. Some of the hotels they keep the families in are inadequate. I would not stay there. I would not keep my family there, but because of the ceiling cap on paying for the hotels, they're putting them in hotels that they shouldn't be staying at, particularly when we did sign treaties and agreed to share the wealth of this land. When our people are sick and they're suffering and they need supports, they shouldn't be staying at a run-down hotel and barely getting the gas they need to support their family member.

There are lots of issues. We need major investments and we need sustainability.

Thank you.

The Chair: Thank you very much. That will bring the first round to an end. We have time for a short second round, if everybody is disciplined.

We'll start with Mr. Vidal.

You have five minutes.

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

Thank you to all of the witnesses for being here today.

I have to admit that I'm a little bit surprised at how much discussion we've had about medical transportation today. I thought that would be a more peripheral topic today, and I want to focus a couple of my questions for Vice-Chief Pratt on exactly that topic. He's very familiar, obviously, with my riding in northern Saskatchewan as he just referred to some of the rising costs and the challenges.

I'm going to change it up a little bit to drill into some comments that he made. He talked about the review of the NIHB program and some of that going on. The vice-chief also talked about service providers dropping out at rapid rates, and I know he referred to dental and optometry, but I want to tie that back to travel for a second. Before all of this study began, I actually had some people reaching out to my office about their concerns with trying to survive in the medical taxi business from northern Saskatchewan

In the context of the review, you referred to the high cost, the cost of fuel, etc. In that review, was there any discussion going on about how we ensure that we don't lose those service providers who are providing some of the transport, as well, or is that becoming an issue in Saskatchewan that you are aware of?

● (1355)

Vice-Chief David Pratt: Thank you, Gary.

First of all, it's good to see you virtually. We haven't connected in person for a while, obviously, due to the pandemic. I appreciate that question.

Yes, there are issues around the medical transportation particularly for the north. Dialysis treatment is a prime example, Gary. In your riding, you know well the highways and the distance from first nations communities. They have to drive sometimes five hours one way to receive the dialysis treatment in Prince Albert and Saskatoon. It's five to seven hours one way, and of course when they come off of the treatment, they're weak and they're not well. Then they have to drive back five to seven hours again. It takes a lot out of our elders, so it's important to have access to those treatment facilities closer.

Yes, there is an issue with medical transportation, Gary. That's a huge flag in terms of providing and meeting the needs and challenges, particularly for our region.

I can't remember your second point, Gary.

Mr. Gary Vidal: That's fine. Just because we're so limited on time, I'm going to move on to another one. I'll give you a pass on that one.

The other thing I want to talk about a little bit today is mental health and some of the stuff around that. You and I have had conversations in the past about this, and I want to drill into a couple of things.

As you're well aware, one of my first experiences as a member of Parliament back in 2019 was experiencing the declaration of a state of emergency in one of the first nations in my riding. Shortly after that, there was an announcement of some funding, and I was actually privileged enough to be present in Saskatoon when that was.... You and I were there together. There's little information I'm able to find on how the department measures or evaluates the performance of these kinds of.... I don't know if “ad hoc investment” is right, but it was something that was a reaction to a situation at the time.

I'm curious as to whether you can shed any light on the impact that funding over two years ago had, how it gets measured, how the money got spent and how many first nations in Saskatchewan were impacted by that announcement from December 2019, if I'm not mistaken. I think you'd be very familiar with that.

Vice-Chief David Pratt: Thanks, Gary.

I'll be real quick with my remarks. I'm getting feedback here.

Definitely, that $2.5 million was a result of Chief Margaret Bear of Ochapowace first nation and Chief Ronald Mitsuing in Makwa Sahgaiehcan—which is in your riding, Gary—declaring states of emergency. That happened right during the AGA that year in December. They had a number of suicides. These weren't just young people; these were also older men.

Committee members, right now in Saskatchewan region we are in a full-blown mental health crisis with addictions to crystal meth and fentanyl overdoses. It's really bad out here, as I'm sure it is in all the other regions. You're hearing reports of overdoses. There's an overdose every day. Maybe two or three times every day somebody is dying in Saskatchewan with an overdose of fentanyl or crystal meth. You have that exacerbated by the pandemic and isolation for two years. Addictions have risen and mental health issues have risen.

Gary, of that $2.5 million, $2 million flowed directly. We knew that $2 million wasn't enough. It was a drop in the bucket for what we needed in Saskatchewan. We didn't want to be the judge and jury like Solomon, dividing where which part should go or who should have it. We just decided to break it up. We have our funding formula that we use for SIGA. We busted it all up by population and got the money out the door. Some good work came out of that.

I'll give you an example. Peter Ballantyne, which is one of our largest bands—it is in your riding—put on an event for three or four days for their young people because they were experiencing a crisis. A 10-year-old girl killed herself in Southend, and it kind of spurred the chief and council of the first nation to bring their youth together. They were able to take $150,000, which was their allocation out of the $2 million, to put on a four-day event and bring their youth to Saskatoon to build them up and teach them coping mechanisms. They did the ASIST training. They were able to talk to one another on how to prevent people from taking their own lives.

Some good outcomes came out of that, but, Gary and committee members, we need more and not just in Saskatchewan. We have a comprehensive life promotion program ready to go, but we just need the funding. I can probably say the same for all the regions. We are in a full-blown mental health crisis. We need those investments and those resources across the board.

I'll keep it at that. Thank you very much.

The Chair: Thank you, Mr. Pratt.

Mr. Powlowski, you have five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Following on that, Chief Pratt, I worked for quite a few years as a doctor, including a couple of years in Norway House. I totally agree with you that the European health care system has totally failed in mental health and addiction. The implementation or the approach really has not worked well in indigenous communities.

I'd also suggest that our present system isn't very cost-efficient. When you have to fly somebody out of the community after they've overdosed, you have to pay $30,000 or something. That $30,000 would be much better spent on providing the services in the communities.

I agree with you that we should be doing way more in terms of funding indigenous healers within the communities. These are people who are far more likely to be successful than people with a purely western, European approach to mental health problems.

Are we doing enough in terms of mental health services in the communities? It sounds like you're from an area where there are a lot of isolated communities. Do most of those isolated communities have any mental health services on an ongoing basis, especially with a traditional component?

● (1400)

Vice-Chief David Pratt: Thank you for that question.

The sad part about it is the western way, like you said. When there's a crisis in a community and the community declares a state of emergency over a mental health issue, whether it's a string of suicides by youth or overdoses, they bring in the community supports. Canada or ISC or FNIHB will bring in those counsellors and therapists to provide the wraparound supports for three or five days. Maybe they're in there for two weeks, but then it starts taking a toll on them. When Makwa Sahgaiehcan declared a state of emergency, they had to replace the mental health workers because they were burning out from carrying all the burdens of the community and the people.

In terms of traditional ways of knowing, I think that's where it's at. We could look at what NAN is doing with the choose life program in their northern nations in Ontario. That program is working. It's all land-based and connected to the land.

I think we need to look at that same approach here in Saskatchewan. A lot of people are going back to the land and realizing that there is healing in nature and in rebuilding that connection first nations people have had for thousands of years here on Turtle Island. I think we need to restore that and look at those.

The western model is not working. Let's try the first nations' way and see if that helps. If the current system is failing, let's try something new. That's my recommendation.

Meegwetch.

Mr. Marcus Powlowski: Does that NAN program have funding from NIHB and would they be willing to finance something similar in your communities?

Vice-Chief David Pratt: They may use them if there's an attempt. They provide the individuals, if they are not successful with the wraparound supports that they need....

I believe the choose life program was funded by ISC and partially by the first nations and Inuit health branch. However, I believe they are now using a prevention program to create these life centres in each of their first nations.

I don't want to speak on behalf of my good friend, Chief Derek Fox, but I recognize a good program that's working for them. We need to look at that and incorporate it all across our regions. We will see the numbers come down, and we will be able to provide those supports to each of our member nations.

Mr. Marcus Powlowski: Quickly, you talked about people opting out of NIHB. I can see that people might get frustrated having to deal with the bureaucracy and getting paid through NIHB, but doctors aren't allowed to opt out of the publicly funded health care system.

Should people be allowed to opt out of the NIHB?

Vice-Chief David Pratt: I don't think so.

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.

Mr. Marcus Powlowski: Would you agree that we shouldn't allow people to opt out of NIHB?

Vice-Chief David Pratt: No. I don't think people should be allowed to opt out of NIHB.

A lot of the time, they look at our own independent job service health programs first, before they even go to NIHB as a last resort. I guess it's because of the challenges of getting paid, or whatever the issues are there.

The system needs reform. I believe we can fix it if we work together on it, but the government needs the bureaucracy to step back and listen to the experts on the ground who know the issues that are going on with first nations people.

Meegwetch.

Mr. Marcus Powlowski: If I have any time, Natan, do you have any response to allowing people to opt out of NIHB?

Mr. Natan Obed: Thanks for the question.

This is one of the great concerns about the way in which NIHB is delivered across Inuit Nunangat and across Canada for eligible Inuit. I would imagine it's the same for first nations and Métis.

Depending on the service provider, you might have to pay up front. Maybe it's the pharmacy, the optometrist or the dentist. In other cases, there is a wraparound system, so the client, the person who is eligible for a service, doesn't have to pay any upfront costs and the system takes care of that. It depends on where you are in the country, and that is entirely inequitable, especially when we're dealing with a population that has such poverty as the Inuit population, in relation to other Canadians.

Sometimes Inuit don't have credit cards or other methods of payment, so if they are in a setting where they would have to pay for their dentist or their glasses out of pocket, that is a huge barrier to accessing health care, and it's health care that they are eligible for. That is entirely inequitable.

This program should be reformed to ensure that those types of scenarios don't happen.

● (1405)

[*Translation*]

The Chair: Thank you very much.

Mrs. Gill, the floor is now yours for two and a half minutes.

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

Earlier, I asked a question about traditional counsellors. Mr. Pratt generously agreed to answer and, of course, I would also have liked to hear the comments of Mr. Obed and Ms. Caron, who represent the Inuit nation and the Métis, respectively.

I therefore give them the floor.

[*English*]

The Chair: Mr. Obed, if you remember the question, why don't you go first?

Mr. Natan Obed: Yes. I believe this was in relation to traditional counsellors.

There are many different types of mental health services that can help an individual. From an Inuit perspective, there are clinical mental health services that some Inuit may need, and then there are more traditional or culturally specific mental health supports and services that Inuit need. Those two systems can live together and support one another in a diagnosis and in treatment. In many cases, the decision-making about the cost for those and whether or not an individual is eligible has not been equitable.

We are seeing the federal government recognize Inuit cultural and technical mental health supports in a much broader way than we did prior to the Indian Residential School Settlement Agreement and the programs that were mandated out of that particular settlement. We have seen over a decade of Inuit-specific mental health supports and services being provided through federal funds that have helped thousands of Inuit.

We hope that the NIHB program can seamlessly accept those types of mental health supports alongside clinical supports.

The Chair: Thank you.

[*Translation*]

Ms. Caron, would you like to add anything?

[*English*]

Did you want to respond to that question?

Ms. Cassidy Caron: Yes. There are a lot of Métis health researchers across the Métis homeland right now, and they're doing a lot of looking into and researching access to health services for Métis people. They're looking into different areas, specifically in mental health or other types of services, and largely, the number one recommendation that's coming out of those research reports is the need for more Métis health care providers. That means actual Métis people entering the health care or mental health care profession to be able to weave our ways of knowing into these systems in ways that work for our people, to deliver culturally responsive and culturally safe care to our people.

For example, we recently travelled over to Rome to meet with the Pope. We brought a Métis psychotherapist with us. That person has been trained in the western ways of clinical psychotherapy; however, being a Métis woman herself and a practitioner of our traditional ways, she weaves those pieces into the systems of working with our people in a way that traditional health care systems do not and cannot.

It largely comes from increasing supports to promote the health care profession with our people and within our communities, and I think that's a model we can look at, extending health care education into our communities so that people are wanting to go toward those paths.

● (1410)

The Chair: Thank you very much.

We'll conclude with Ms. Idlout. You have two and a half minutes.

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

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[*Inuktitut text interpreted as follows:*]

Thank you for your reply. Could you all respond to me, with Natan first?

What do you think of aboriginal people? Would their lives improve regarding mental health issues if the aboriginal counsellors were paid like mental health workers and were recognized like mental health workers?

[*English*]

Mr. Natan Obed: Absolutely. The services that, in our case, Inuit counsellors provide, provide just as much support as the clinical services provided by non-indigenous people and also are just as complex. They rely on just as much knowledge. It's just that it has been passed down or the people have learned it in a very different way. So, absolutely, much more work needs to be done to ensure pay equity and basic recognition of Inuit counsellors.

Ms. Cassidy Caron: I have nothing more to add. I absolutely agree with everything President Obed just said within the Métis context.

Vice-Chief David Pratt: I totally concur with President Obed. Definitely, we need our people to be recognized. I'll give you an example here. With the funded FNIHB, non-insured health benefits, for mental health counsellors here in Saskatchewan there is a list where you have to declare, you do your services and you submit billing. There's an example we're dealing with right now with a traditional healer who listed herself as a psychotherapist prior but now changed the designation of her position and her practice as a spiritual healer. Now, because she changed the designation of her title, there's an issue with FNIHB or non-insured health benefits not paying her. We're actually dealing with that right now as we speak—our staff at FSIN.

There are issues around that. If she had a Ph.D., or a mental health master's, psychologist, boom, no problem, she'd paid right away, but the minute she changed her designation on the NIHB list of qualified mental health therapists, she was denied billing. It's an issue that has to be addressed. We have to reform this system, members of Parliament. We have to get this right and to make sure that our two systems can exist side by side with mutual respect and not one being higher than the other or recognized as superior. Thank you. *Meegwetch*.

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

That brings our panel to a close.

On behalf of the committee, I'd like to thank Vice-Chief David Pratt, President Obed and President Caron for your testimony today. Thank you for answering the questions on our study of the NIHB. You were the kickoff meeting, a very important meeting. We very much appreciate your taking the time to be with us today.

We'll now suspend momentarily, so that we can go in camera and continue with committee business.

Thank you very much.

[*Proceedings continue in camera*]