

Appearance before the Standing Committee on Indigenous and Northern Affairs (INAN): Administration and accessibility of Indigenous Peoples to the Non-Insured Benefits Program

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I'm pleased to join from Treaty 8 territory today, the traditional and present-day territory of the Woodland Cree, Dene and Metis Nations.

I am Dr. Alika Lafontaine, a Metis Anesthesiologist of mixed Indigenous ancestry working in Grande Prairie, AB. It's my pleasure to appear before you as President-Elect of the Canadian Medical Association today and commend the Standing Committee on Indigenous and Northern Affairs for undertaking this study and inviting the Canadian Medical Association to be a witness.

Improving the administration and accessibility of the Non-Insured Health Benefits (NIHB) program is a key part of addressing the health inequities between Indigenous and non-Indigenous people in Canada. The Canadian Medical Association is committed to promoting equitable access to timely, quality care in all Canadian health systems and strongly supports Indigenous health transformation towards these goals.

The CMA recognizes that the most important voices in this evaluation are those directly impacted - First Nations and Inuit patients who access these services directly. We hope that communities, families and patients who utilize the NIHB program are fully engaged and heard throughout this study.

I hope to enhance this discussion by sharing two perspectives. The first is the lived experience of non-Indigenous physicians who support patients eligible for NIHB programs. The second is my own personal experience as a specialist physician in a regional centre that accepts patients with a considerable proportion being of Indigenous ancestry. Unlike my primary care colleagues, I do not interact with NIHB directly, but I do support patients who depend on NIHB programs like medical travel to safely transport to and from our regional hospital. It is important to acknowledge that without NIHB, many patients would be without any meaningful access to care.

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. Healthcare systems should be focused on getting patients to the right care, at the right time, in a patient-centred way. The CMA has long advocated for reducing fragmentation through modernization in the health care system. Our recent call for federal leadership on pan-Canadian, integrated health human resources planning is a case in point. Similarly, we support the increase in consistent integration of resources within the NIHB program to promote more coordinated support for patients and inform the teams of health providers helping them navigate the program.

Fragmentation can be considered in different categories. I will address two. The first category is overly complicated workflows where roles are poorly understood. 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 Medicare where physicians can provide direct approval and access to services, the added administrative layers of NIHB create opacity on the physician's role and jurisdiction in this process.

The CMA's president, Dr. Katharine Smart, is a pediatrician in the Yukon. Dr. Smart's experience of teaching herself how to utilize and navigate NIHB on behalf of her patients and families is a shared experience of many physicians across Canada.

The second category is a lack of integrating modern technology towards patient-centred, patient-engaged efficiency. Navigating paperwork and people can take up hours of their physicians time filling out paper forms and looking to connect with people over the phone. Those paper forms must then be faxed through an asynchronous communications system that dooms too many requests to disjointed dead ends. The physician is often the last to learn that the loop was never closed, delaying care, and often resulting in worsening patient outcomes. NIHB has yet to be tightly integrated with 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 file, from beginning to end now exists in many health systems across Canada. In place of a series of non-contiguous faxed forms, digital communication can close the loop, informing, tracking progress, and answering questions regarding a medically necessary request that is processed through NIHB. It also provides a digital audit trail that could improve patient experiences and iterative quality improvement.

Colonization, systemic racism, and lack of investment in healthcare infrastructure add additional layers of complexity to the modernization of NIHB.

The CMA recommends that this initiative be coupled with sustained investments to address the ongoing, structural inequities that marginalize Indigenous Peoples; advance the inclusion of Indigenous Peoples in societal systems and sectors; and, commit to collaborative and respectful relationships with Indigenous patients and communities.

Thank you Chair.